

# Getting Crowded: Second-Order Effects of Medicaid Expansion Refusal

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## **Abstract**

The Patient Protection and Affordable Care Act (ACA) is one of the most debated, and dividing, pieces of legislation in recent memory. One of the main elements of the ACA is the mandatory expansion of Medicaid eligibility from the poverty line to 138% of the poverty line. Immediately following law's passage, a number of states sued for the law to be ruled unconstitutional. While the majority of the law held up to judicial scrutiny, the Supreme Court did rule that the mandatory expansion violated states' rights and thus states could opt out. Nearly all of the debate has focused on the direct effects of the newly covered, but there are also important secondary effects to consider. If the newly-eligible portion differs from the general populace then an expansion of Medicaid can affect the private market for health insurance. In this paper, we use policy-level data from the Health Insurance Exchanges to identify and estimate the effects of Medicaid expansion on the private health insurance market. We find that adopting the expansion reduces average monthly premiums by \$48.68.

JEL Codes: **I13, I18, I38, G22**

Keywords: **Affordable Care Act, Health Insurance, Crowding Out**

## Introduction

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Later that day, 14 states brought suit questioning the constitutionality of the act. An additional 13 states either joined existing litigation or filed separately. These cases merged together into *National Federation of Independent Business v. Sebelius*. This case was heard before the U.S. Supreme Court in March, 2012. In addition to numerous other clauses, the act provided for significant expansion of Medicaid programs while simultaneously permitting the Secretary of the Department of Health and Human Services to withdraw existing Medicaid funds to states failing to comply with those expansion plans. There are many parts to the Medicaid expansion; the raising of the income ceiling for eligibility from 100% of the poverty line to 138% is our focus in this article.

It is projected that the Medicaid expansion provision of the PPACA would increase overall Medicaid enrollment by more than 20 million<sup>1</sup>. If fully implemented, the Medicaid expansion could reduce the number of uninsured by 48% compared to non implementation (Holahan, 2012). While the majority of the PPACA held up to judicial scrutiny, the Supreme Court ruled that mandatory expansion of Medicaid was unconstitutional. This gave states the option of “opting out” of the expansion. The debate, in both congressional and judicial halls, over the expansion largely weighed the direct benefits to the individuals newly covered vs. the accounting cost of doing so Harrington (2010b). In this article, we examine potential effects that a state’s refusal may have on the private market for health insurance. We find that opting out of the expansion increases average monthly premiums by \$48.68.

Two other policies enacted by the PPACA, and upheld by the Supreme Court, are especially important to our story: limits on medical underwriting and the individual mandate. Historically, health insurers have been allowed to screen plan enrollees to identify their potential risk factors; under the PPACA, insurers may only vary premiums based on: age,

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<sup>1</sup>Nearly 21.3 million individuals could gain Medicaid coverage by 2022, of which 14.3 million would only be eligible if all states opted into the expansion.

tobacco usage, self vs. family coverage, and geographical area. Importantly, health insurers are not allowed to underwrite based on the income of the individual. Because Medicaid eligibility is largely determined by income, insurers will not be able to identify people in the range of the expansion. In states that refused the expansion, this will affect the price of health insurance for all individuals given two assumptions are met: enough people who would have been covered by the expansion must buy insurance on the private market and those who do must have different expected costs.

The former assumption is supported by the individual mandate portion of the PPACA. This requires that individuals must have “minimum essential coverage” or pay a tax penalty.<sup>2</sup> However the literature on the existence of “crowding out” effects of public insurance remains open. The extant literature on “crowding out” focuses largely on the effects of prior Medicaid expansions. Previous works on such changes generally focus on the effects public exchanges have on the private market share.

For overall demand for health insurance, Cutler and Gruber (1996) find a negative relationship between private, employer sponsored coverage and Medicaid eligibility. They argue that as public insurance eligibility increases, potential insureds may drop their private coverage. In testing this hypothesis, Cutler and Gruber (1996) use the Medicaid expansion for pregnant women and children from 1987-1992 and find evidence that a significant portion of the increase in Medicaid coverage was successively followed by a reduction in private insurance coverage. Ham and Shore-Sheppard (2005) find that, for children in families eligible for Medicaid, the crowding out effect is not significant, though overall take up increases, indicating that the new insureds are not typically private market participants.

For particular entrants, Selden, Bantlin, and Cohen (1998) find that even with free eligibility, the rates of uninsurance amongst children remained high following previous Medicaid expansion periods. As the children themselves are not able to decide on their insurance,

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<sup>2</sup>Minimum essential coverage includes all Government and job based insurance and most Private Insurance. Short term plans, fixed benefit plans and vision/dental only plans alone do not qualify for the minimum requirement.

it is obvious that their parents are not selecting into the coverage. Selden, Bantlin, and Cohen (1998) further argue that this lack of coverage could be due chiefly to incomplete information. Though the fine imposed by the ACA is designed to be equivalent to the price of the cheapest eligible plan, some consumers may opt out and pay the fine instead, possibly due to this lack of information. Additionally, this fine design is actually being rolled out over a few years. During the time frame of our data, the fine was lower than the price of the cheapest eligible plan.

Crowding out is historically viewed in the health economics literature as the demand push towards public offerings over private when healthcare programs are expanded or created. This was observed to some effect in the Medicaid expansion for children in the late 1980s and early 1990s.<sup>3</sup> However, we expect to see the opposite effect from the new expansion, mainly due to the fact that states are legally allowed to opt out of the expansion, which shifts the policy demand to the private market. Since these new market entrants are required by the individual mandate to maintain minimal essentially coverage, they must either enter into these markets or pay the fine. The observed government intervention in this case pushes the insurance demand to private markets in those states that opt out of the Medicaid expansion. What can be observed in the newly expanded Medicaid markets is in essence “crowding in” - a phenomena in which the new participants/consumers are being pushed into private markets, rather than out.

The other necessary condition is those in the eligibility range have different expected costs than the rest of the consumers in the market. This occurs through two main channels. The first is that income and health are, generally, negatively correlated.<sup>4</sup> The second driving force is that low income consumers tend to be much more price sensitive. Given these relationships, the newly eligible individuals would more than likely represent a higher risk for insurers. As more lower income and, potentially, less healthy enter the market, the risk (and therefore cost) of the overall pool would potentially increase. Further complicating

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<sup>3</sup>Cutler and Gruber find a negative relationship between public offerings and private insurance take up.

<sup>4</sup>We do not require, or assume, a direction of causality.

the issue, health insurance companies cannot charge higher prices based on income alone. As these new potential insureds enter into the private market exchanges (if they live in a State without Medicaid expansion), we theorize that the prices for plans offered within the exchanges will increase to reflect these higher risk entrants.

The link between low income and poor health stems from a number of factors. Poor people are more likely to have insufficient nutrition and lower quality diets which can lead to health problems. Malnutrition lowers the immune system, increasing the likelihood of health problems. Further complicating the issue, many of the poor simply cannot afford the services or medicine they require. This inability to pay also extends to preventative measures, further exacerbating the problem.

In addition to the lack of discretionary funds and malnutrition (which are arguably correlated), lower income individuals also tend to live in rural areas, and are therefore far removed from standard health amenities. This distance reduces access to healthcare and health services, and is arguably yet another contributing factor to the negative correlation between low income and poor health. Finally, the link between income and education cannot be ignored, as the poor are less likely to be educated, and subsequently less likely to be aware of health services offered. The compounded effect of each of these relationships lead to a strong negative correlation between income and health.

Another effect of having a larger pool of low income entrants is price sensitivity. Lower income consumers must spend a larger portion of their income on health insurance, even if subsidized. Given the price sensitivity of lower income consumers, we expect to find evidence of adverse selection, especially into the lower tier/higher coverage<sup>5</sup> exchange plans. Since these lower income individuals must purchase insurance or pay a fine given the individual mandate, we hypothesize that their selection into the private markets of opt out states will result in higher prices in the higher coverage plans offered in the exchanges.

The overall market effect of the Medicaid expansion therefore has a few effects to consider.

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<sup>5</sup>Higher coverage plans, such as Gold or Platinum, would be viewed more favorably by those who actively require insurance.

Due primarily to the individual mandate, the “crowding in” effect will bring in new insureds, which in theory could lower costs by increasing the pool. However, since these new entrants will be lower income and less healthy, they represent a higher than average risk. Additionally, those who choose insurance over the penalty are more likely to actually need insurance, which is indicative of an adverse selection issue and will also drive prices up. We expect this influx of higher risk insureds adversely selecting into the policies will drive prices up. Therefore, we hypothesize that the compounded effects of riskier market entrants and subsequent potential for adverse selection will result in higher prices, *ceteris paribus*, in the private healthcare exchanges in states that opt out of the Medicaid expansion provision of the PPACA.

Given the PPACA’s recency, there exist few empirical studies on the effects of the law. The projected impact of the PPACA is discussed in detail by Harrington (2010a).<sup>6</sup> Sommers et al. (2013) shows the dependent coverage clause, which allows young adults coverage under the private plans of their parents until age 26, substantially increased the coverage rate of young adults aged 19-25. Depew and Bailey (2015) investigate the impact of this mandate and find it led to an increase in premiums for plans of individuals with children. Pauly, Leive, and Harrington (2015) investigates welfare effects on the non-poor who were uninsured prior to the law finding that they are typically worse off. Hilliard et al. (2013) examine the market impact of the supreme court’s decision finding evidence of a negative stock market response to health insurers.

Our contribution to the literature is the focus on the effects of state’s refusal of the ACA’s Medicaid expansion on private markets, which affect a large portion of the population, not just those with incomes in the expansion range.<sup>7</sup> Since individuals are mandated to have health insurance, in the states where the ACA expansion was refused there exists a coverage gap that the private market will, at least partially, pick up. In order to fully assess the welfare implications of Medicaid refusal, the “crowding in” effects on the private markets

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<sup>6</sup>Though the number of working papers grows daily.

<sup>7</sup>Due to data limitations, our empirical focus is on the exchanges set up by the ACA, but we believe the effects generalize to the overall market.

must be considered.

## Institutional Details

The Patient Protection and Affordable Care Act (ACA), passed in March 2010, was a dramatic reform of the United States health care insurance industry. In addition to the Medicaid Expansion described earlier, health insurance firms are restricted in what they can use for medical underwriting, variations in premiums over time are limited, coverage is mandatory (or a fine must be paid if insureds opt out), and online marketplaces were established in every state. These are in addition to numerous other more minor reforms within the industry. The marketplaces play a key role in the goal of expanding coverage. Federal subsidies are only available to those who purchase policies from the Health Insurance Exchange (HIX). The purpose of the HIXs is to promote competition between health insurance companies in the individual and small-group market.

States had three separate paths to the development of their HIXs: design and manage their own, let the federal government design and manage it, or some hybrid approach.<sup>8</sup> Regardless of the path chosen, all of the HIXs run in the same general manner. There are five possible tiers of plans. Catastrophic, high-deductible, plans are the lowest rung, with the other 4 tiers based on the expected share of health care spending the plan covers and identified by different metals: bronze (60%), silver (70%), gold (80%), and platinum (90%). We perform our analysis within these Health Insurance Exchanges.

Outside of the additional standardization of covering “essential health benefits” and a maximum out-of-pocket expenditure (\$6,350 for individuals, \$12,700 for families), insurers are able to tailor their policies in nearly any way, so long as they are within 2% of the targeted actuarial-value and the mandated benefits are covered. Premiums are required to be community-rated and can vary only across ratings areas, age, tobacco use, and family composition. Aside from these restrictions, Insurers are free to set their own initial premiums,

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<sup>8</sup>16 states and DC selected the first option, 27 selected the second, and 7 pursued the third.

but there exists regulation on increasing rates; any rise in premiums greater than 10% must be subject to approval. There also exists a minimum, plan-level, medical loss ratio; all medical loss ratios must exceed 80% for individual and small-group markets and 85% for large-groups else refunds are issued.<sup>9</sup>

Our research is primarily concerned with the Medicaid expansion provision of the ACA. Though there were a number of provisions to the Medicaid expansion, we focus on the raising of the income ceiling for eligibility from 100% of the poverty line to 138%. From a coverage perspective, it is projected that the Medicaid expansion provision of the PPACA would increase overall Medicaid enrollment by more than 20 million<sup>10</sup>. If fully implemented, the Medicaid expansion could reduce the number of uninsured by 48% compared to non implementation (Holahan, 2012). Indeed the ultimate goal of the Medicaid expansion provision under the PPACA was to significantly increase coverage to those less wealthy individuals within the United States. Though there is no doubt that more coverage comes with more cost (Harrington, 2010a,b), many states opposed the expansion because they were unsure of where the burden of the increased cost would fall.

As of 2015, 15 states have actively<sup>11</sup> opted out of the Medicaid expansion of the ACA, citing budgetary constraints or costs as their main point of opposition. Many of the opt out states are Southern and Midwestern states, with only a few exceptions.<sup>12</sup> Interestingly enough, all the opt out states have republican governors, possibly speaking to the highly politicized nature of the Medicaid expansion and/or the ACA in general. Figure 1 details the current status of the state's decisions to opt in or out of the ACA's Medicaid expansion provision.

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<sup>9</sup>See Abraham and Karaca-Mandic (2011) for an in-depth discussion of focusing regulation on the medical loss ratio.

<sup>10</sup>Nearly 21.3 million individuals could gain Medicaid coverage by 2022, of which 14.3 million would only be eligible if all states opted into the expansion.

<sup>11</sup>A number of states are still debating on whether or not to expand Medicaid. For our analysis they are still considered "opt out" states.

<sup>12</sup>Wisconsin, Maine and Idaho are the only non-Southern/non-Midwestern states that have opted out of the expansion.



## Data

The data for this paper are drawn from a number of sources. The policy details come from the AIS Health Insurance Exchange Database 2015 archive. This is a comprehensive list of all the policies offered in the all of the states in 2015, the covariates include the metal level of the policy, the policy type (HMO, PPO, POS, EPO), and the enrollment level of the rating area.<sup>13</sup> The market covariates are pulled from the county-level data from the Dartmouth Health Atlas and include average Medicare spending per enrollee (to proxy for health care price variation), population, the proportion of people in poverty, the level of “urban-ness” of the county, and the state-level percentage of popular vote that went to President Obama in the 2012 general election.<sup>14</sup>

The policy details from the AIS database include metal level, plan type, and price by county, state and the issuing firm. Plan quality is partitioned out into the following categories : Catastrophic, bronze, silver, gold, and platinum.<sup>15</sup> These metal levels give rankings of overall plan quality, with catastrophic including the highest risk (cost) individuals, and platinum the lowest risk (cost). Plan price median ranges from \$203.71 to \$311.80 for Catastrophic and Platinum, respectively. The average cost of plans on the exchanges is \$266.47. Our sample represents EP, HMO, POS and PPO plan types, with the majority being HMO and PPO. Table 1 details the summary statistics by plan and metal level. Unlike most current studies on the exchanges, we have available information from all of the states.

## Methods

Our main empirical model is:

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<sup>13</sup>We use the percentage of the population that enrolled in a silver plan. We have data on enrollment in other metal levels, but many counties (especially the rural ones we use for identification) only offer silver plans which would greatly limit our data should we include enrollment in other metal levels.

<sup>14</sup>“Urban-ness” is on a scale of 1-9 with 1 being the most urban. The vote data comes from the Federal Election Commission.

<sup>15</sup>Due to the low availability and differing regulations on catastrophic plans we drop them from our analysis.

$$Prem_{pm} = \beta_0 Expand_m + \alpha_0 P_p + \gamma_0 M_m + F + S\epsilon_{fpm}$$

Where, for the equation,  $Prem_{fpm}$  is the premium for plan  $p$ , in market  $m$ ;  $Expand_m$  is binary representing one if the market is in a state that declined the Medicaid expansion and zero else;  $P_p$  and  $M_m$  are vectors of plan and market covariates (respectively);  $F$  and  $S$  are firm and state effects (respectively);  $\epsilon_{fpm}$  is the mean zero, exogenous error term.

A potential problem is the existence of unobservable market characteristics correlating with the states decisions whether or not to expand Medicaid. We pursue a sample construction avenue to address this endogeneity issue: using rural counties that border across state lines. This approach has some precedent with Dube, Lester, and Reich (2010) using it to examine minimum wage effects on job growth. We focus on bordering states counties that reside in states that differ in their choice to expand Medicaid. Bordering rural county characteristics tend to vary little across state lines, and given this limited difference we expect there to be few selection issues that vastly differ between these neighboring counties. Summary stats for this limited sample can be found in Table 3. Figure 2 provides graphical representation of the counties used in the analysis.<sup>16</sup>

## Results and Conclusions

Our initial regression analyses indicate a positive relationship between price and the decision to opt out of the Medicaid expansion, indicating higher private insurance costs in the states that opted out of the Medicaid expansion. When aggregating all plan levels across the exchanges, we find that on average states opting out of the expansion see a monthly premium increase of \$53.844. Considering that average monthly premiums across the sample states is \$266.47, this extra cost for opting out is economically significant. This aggregate state analysis is evidence to suggest that the effects of opting out of the Medicaid expansion may

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<sup>16</sup>We could not make use of all of the borders since many states defined ratings areas as something other than counties.

be driving in riskier entrants towards the private market exchanges. The positive relationship between price and opting out provides evidence to support our “crowding in’ hypothesis.

Table 2 provides the results of our overall analysis, focusing on the effect opting out has on low and high coverage plans (Bronze and Gold, respectively). The positive effect that opting out has on the Gold plans supports the notion of an adverse selection issue. The higher price of these plans in opt out states is evidence of a riskier pool of insureds searching for high coverage. The effect on bronze plans provides evidence of adding generally less healthy people.

To control for endogeneity in the decision to expand or not expand Medicaid, we analyze rural cross counties in bordering opt-in/opt-out states. Since there likely exists outside characteristics that are correlated with the decision to expand, we focus our sample on neighboring counties. Based on the assumption that there exist very little differences between these adjacent counties, this sample design to guide the analysis so that it more directly focuses on the state’s decision to expand or not expand. By analyzing these bordering counties, we hope to mitigate any selection or endogeneity issues specific to the state’s decision to expand Medicaid. The results for this analysis are found in Table 4

Our model indicates an overall positive effect on prices (\$48.68) in the private exchanges for states that opt out of the Medicaid Expansion provision of the ACA. Once we fully identify our model, we find even stronger evidence for the adverse selection hypothesis with Gold plans increasing in price by \$74.38 in states that did not expand Medicaid. We do not find evidence for the generally lower health hypothesis.

The PPACA is still hotly debated with many conservatives seeking to repeal the law. Our analysis is too limited to make any broad policy recommendations; instead, we seek to expand on the standard welfare analysis currently being debated with regard to the Medicaid expansion.

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## Tables and Figures

Table 1: Summary Statistics

Statistic	N	Mean	St. Dev.	Min	Max
Opt Out	22,737	0.569	0.495	0	1
Premium	22,618	266.466	67.703	108.740	671.570
% Obama	22,737	47.280	6.889	24.750	60.240
Population	22,737	12.748	1.293	9.030	16.001
MSPE(\$000s)	22,737	9.130	1.158	6.661	14.968
Urban	22,523	3.066	1.765	1.000	9.000
Poverty Perc.	22,737	0.174	0.362	0.022	0.901
Enroll Perc.	22,413	0.024	0.016	0.000	0.117

**Note:** Summary statistics for all individual policies in every exchange except Hawaii and Alaska. Premiums are for a 27 year-old male. *% Obama* is the percent of the popular vote that went to Barack Obama in the 2012 election. *MSPE(\$000s)* is the average Medicare spending per enrollee in the rating area. *Poverty Perc.* is the percentage of the population in poverty. *Enroll Perc.* is the percentage of the population (in the rating area) to enroll in a silver plan on the exchange.

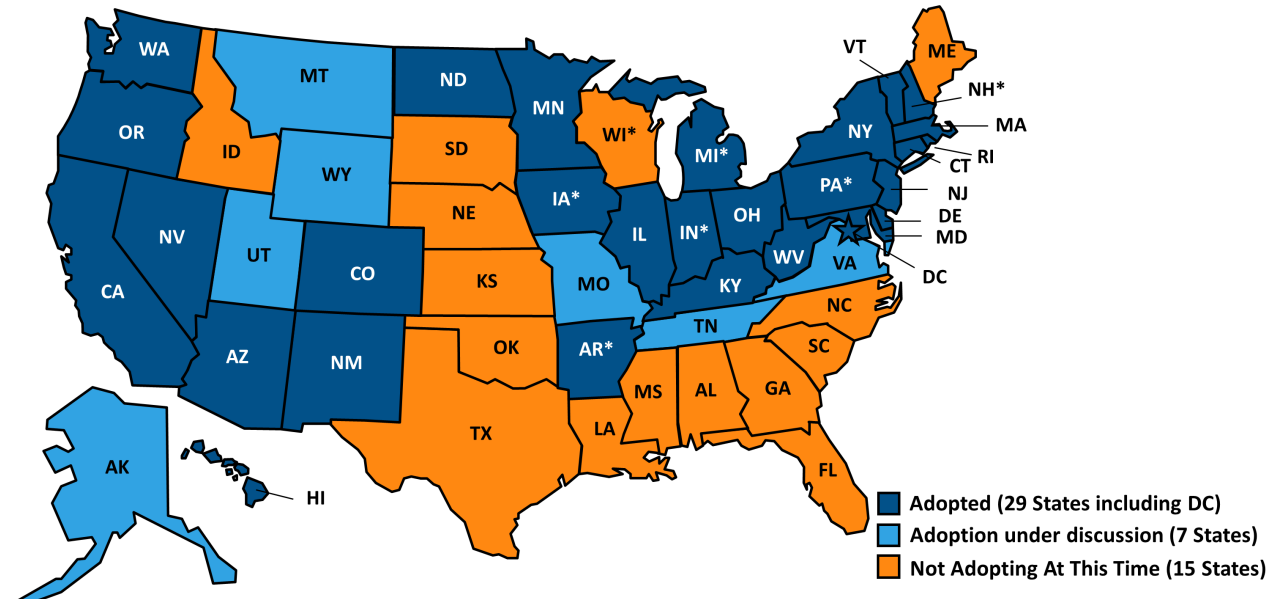
Table 2: Linear Regression Comparing Metal Levels

Dependent Variable: <i>Premium</i>					
	All	Bronze	Silver	Gold	Platinum
<b>Variable of Interest:</b>					
Opt Out	53.844*** (2.858)	42.204*** (13.907)	64.630*** (4.391)	61.248*** (5.399)	-35.917 (32.190)
<b>Controls:</b>					
% Obama	-16.357*** (0.406)	-16.576*** (0.475)	-15.036*** (0.622)	-16.172*** (0.777)	-6.162*** (1.339)
HMO	6.205*** (1.489)	5.386 (5.373)	9.681*** (2.150)	7.414** (3.779)	-7.287 (4.649)
POS	21.280*** (1.957)	17.235** (8.268)	23.513*** (2.846)	26.147*** (4.482)	26.975*** (8.013)
PPO	43.883*** (1.674)	35.129*** (8.155)	46.662*** (2.486)	54.649*** (4.044)	30.483*** (8.804)
Log(Population)	-2.159*** (0.314)	-1.628 (8.153)	-2.124*** (0.469)	-2.445*** (0.660)	-3.891** (1.582)
Perc. Pop Enroll	398.246*** (30.745)	359.399 (304.625)	334.912*** (45.799)	279.227*** (68.657)	715.575*** (122.228)
MSPE	0.000 (0.000)	0.001 (0.006)	0.000 (0.001)	0.000 (0.001)	0.001 (0.002)
Urban	1.143*** (0.178)	1.330 (0.978)	1.120*** (0.264)	1.164*** (0.388)	0.636 (1.012)
Percent Poverty	-0.703*** (0.270)	-0.352 (99.847)	-0.617* (0.350)	-1.525*** (0.513)	-49.723 (39.917)
Constant	717.016*** (14.395)	728.633*** (142.359)	715.132*** (21.992)	804.651*** (27.649)	698.648*** (76.683)
Metal Levels?	Yes	No	No	No	No
State Effects?	Yes	Yes	Yes	Yes	Yes
Insurer Effects?	Yes	Yes	Yes	Yes	Yes
Observations	22,080	6,750	8,795	5,091	1,444
R <sup>2</sup>	0.778	0.693	0.635	0.669	0.754
Adjusted R <sup>2</sup>	0.776	0.684	0.627	0.656	0.738
F Statistic	397.023***	78.603***	78.716***	52.046***	48.239***

**Note:** This table represents OLS regressions for individual plans by metal level in every exchange except Hawaii and Alaska. Robust standard errors are in parenthesis. *% Obama* is the percent of the popular vote that went to Barack Obama in the 2012 election. *MSPE* is the average Medicare spending per enrollee in the rating area (not in \$000s). *Poverty Perc.* is the percentage of the population in poverty. *Enroll Perc.* is the percentage of the population (in the rating area) to enroll in a silver plan on the exchange.

Figure 1: Map of States by Medicaid Expansion (as of 2015)

## Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. \*AR, IA, IN, MI, and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on January 1, 2015, but the newly-elected governor may opt for a state plan amendment. Coverage under the IN waiver is set to begin February 1, 2015. NH has submitted a waiver to continue their expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 27, 2015. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



Table 3: Summary Statistics for Border Counties

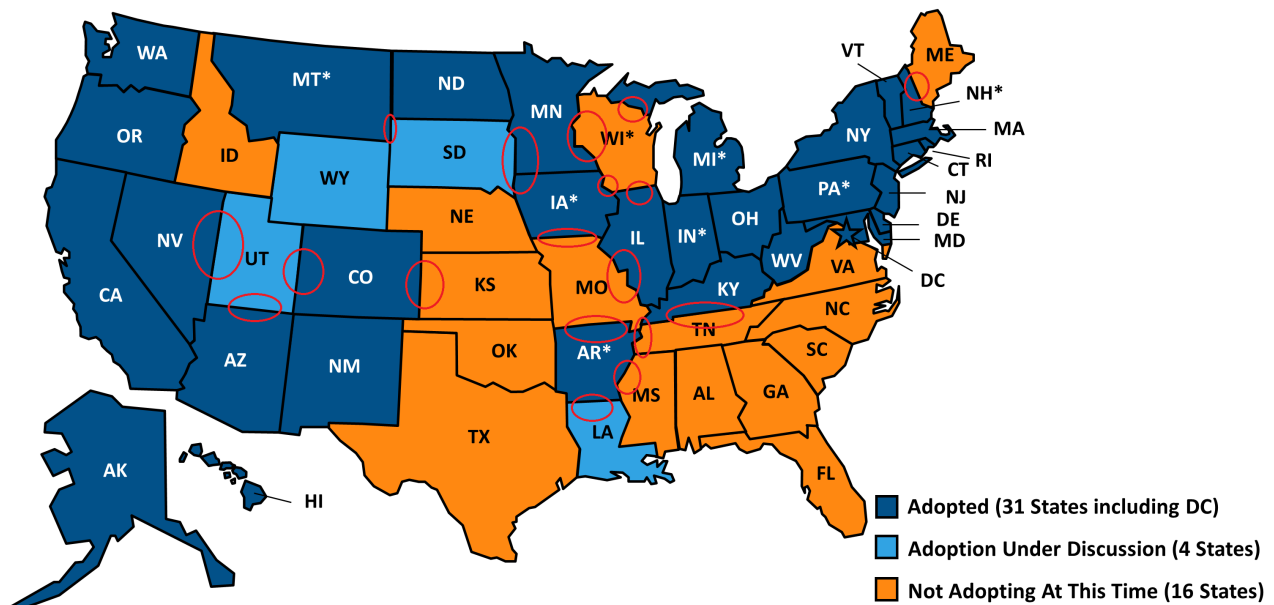
Statistic	N	Mean	St. Dev.	Min	Max
Opt Out	803	0.599	0.490	0	1
Premium	803	271.511	64.504	128.890	574.270
% Obama	803	46.121	11.392	24.750	57.600
Population	803	8.337	0.610	5.474	12.481
MSPE(\$000s)	803	7.942	0.560	7.214	9.017
Urban	803	5.143	1.343	3.000	9.000
Poverty Perc.	803	0.146	0.024	0.015	0.218
Enroll Perc.	803	0.024	0.015	0.000	0.049

**Note:** Summary statistics for all individual policies in county-defined exchanges that border across state lines in state pairs that are different in their Medicaid Expansion. Premiums are for a 27 year-old male. % Obama is the percent of the popular vote that went to Barack Obama in the 2012 election. MSPE(\$000s) is the average Medicare spending per enrollee in the rating area. Poverty Perc. is the percentage of the population in poverty. Enroll Perc. is the percentage of the population (in the rating area) to enroll in a silver plan on the exchange.



Figure 2: Map of Border Counties Used

## Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. \*AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver will be effective January 1, 2016. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as “adoption under discussion.”

SOURCE: “Status of State Action on the Medicaid Expansion Decision,” KFF State Health Facts, updated December 8, 2015.  
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



Table 4: Identified Linear Regression Comparing Border Counties

Dependent Variable: <i>Premium</i>				
	All	Bronze	Silver	Gold
<b>Variable of Interest:</b>				
Opt Out	48.677*** (13.907)	29.740 (20.893)	46.611** (20.245)	74.377*** (27.228)
<b>Controls:</b>				
% Obama	0.332 (0.475)	0.363 (0.721)	0.357 (0.704)	0.746 (1.219)
HMO	47.167*** (5.373)	41.757*** (7.363)	49.101*** (8.041)	58.360*** (13.338)
POS	67.619*** (8.268)	49.876*** (9.792)	70.444*** (9.230)	86.207*** (14.826)
PPO	83.150*** (8.155)	77.980*** (12.337)	78.948*** (11.372)	97.132*** (15.890)
Log(Population)	16.663** (8.153)	5.889 (12.863)	18.932 (12.226)	26.954 (17.569)
Perc. Pop Enroll	-1,190.797*** (304.625)	-1,346.217*** (464.758)	-1,183.815*** (450.139)	-1,201.041 (810.256)
MSPE	0.013** (0.006)	0.012* (0.007)	0.017** (0.008)	0.019 (0.012)
Urban	-0.208 (0.978)	-1.323 (1.496)	-0.151 (1.474)	0.556 (2.298)
Percent Poverty	15.181 (99.847)	-73.379 (109.333)	-22.673 (135.837)	-8.964 (184.516)
Constant	-164.504 (142.359)	20.220 (225.820)	-151.556 (217.064)	-295.506 (312.736)
Metal Levels?	Yes	No	No	No
State Effects?	Yes	Yes	Yes	Yes
Insurer Effects?	Yes	Yes	Yes	Yes
Observations	803	246	322	192
R <sup>2</sup>	0.900	0.874	0.873	0.875
Adjusted R <sup>2</sup>	0.894	0.848	0.854	0.841
F Statistic	154.594***	34.416***	46.872***	25.711***

**Note:** This table represents OLS regressions for individual plans by metal level in county-defined exchanges that border across state lines in state pairs that are different in their Medicaid Expansion. Robust standard errors are in parenthesis. *% Obama* is the percent of the popular vote that went to Barack Obama in the 2012 election. *MSPE* is the average Medicare spending per enrollee in the rating area (not in \$000s). *Poverty Perc.* is the percentage of the population in poverty. *Enroll Perc.* is the percentage of the population (in the rating area) to enroll in a silver plan on the exchange.