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The Impact of Medicaid Expansion

Examining costs to consumers and
the net impact on Wisconsin



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Executive Summary

Medicaid expansion in Wisconsin will be a major topic of debate in this year. Currently in Wisconsin, those earning up to 100% of the federal poverty limit are eligible for Medicaid. Medicaid expansion would increase eligibility to 138% of the poverty limit, while increasing the reimbursement rate for Medicaid expenses from the federal government.

Wisconsin is one of 14 states that has not participated in Medicaid expansion, and Governor Tony Evers is likely to make the issue a focal point of his first budget. In order to evaluate the utility of Medicaid expansion, it is vital that policymakers have information about the likely effects of such a decision. Fortunately for Wisconsin, we now have access to several years of data to compare expansion state with non-expanders.

In addition to reviewing existing research, this paper takes advantage of 15 years of data from around all fifty states plus the District of Columbia. We examine the relationship between Medicaid expansion and two variables: private sector healthcare costs and emergency room (ER) visits. Using regression analysis with this panel data, we found the following key results:

- **In states that took expansion, private sector healthcare costs increased by \$177 per person.** While healthcare costs in all states increased in the time frame of analysis, costs increased more in states that participated in Medicaid expansion. This would move Wisconsin from the 7th highest private sector healthcare costs to 4th.
- **A cost-benefit analysis suggests that Medicaid expansion would cost Wisconsin approximately \$600 million per year.** Healthcare cost increases are estimated at \$1.145 billion while fiscal benefits to the state are \$545 million. This works out to a net cost

to the state of over \$600 million per year. Note that this does not account for any positive or negative health effects of the expansion.

- **In states that took expansion, ER visits increased by about 9 per 1,000 residents.** Contrary to rhetoric suggesting that access to Medicaid would increase the use of preventative care while reducing expensive care like ER visits, our results suggest a statistically significant increase in the opposite direction.

These results suggest that Wisconsin should consider other, market-based alternatives to expansion that can reduce costs and help low-income Wisconsinites without these negative effects. This could include increasing access to Short Term Limited Duration plans, and making direct primary care—that eliminates the insurance middle man—more readily accessible.

Background on Medicaid Expansion

The expansion of Medicaid is set to be a topic of renewed interest in Wisconsin following the election of Tony Evers as Governor. During the campaign, Evers voiced support for Medicaid expansion, and has vowed to make it a priority of his administration, with indications that it will be included in his first state budget. But before making such a major policy change, it is important that Wisconsin policymakers fully understand the implications of the passage of such legislation.

In this study, we bring together existing research on the impact of Medicaid expansion along with new research on the impact on private sector health costs and emergency room visits. We show that Medicaid expansion under-delivers on its promise of reducing expensive emergency room care, while also increasing healthcare costs for private sector consumers.

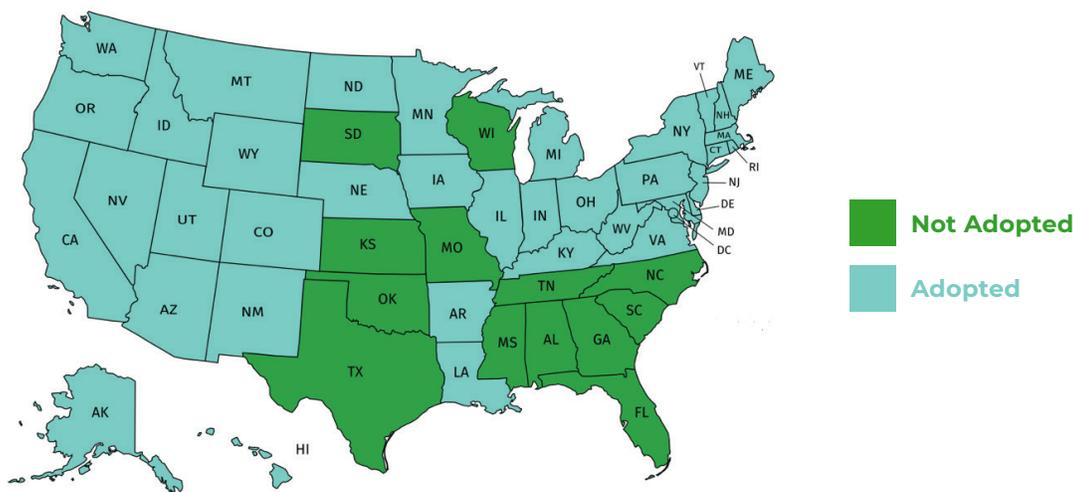
Under the Affordable Care Act (ACA), states were authorized to increase eligibility for

Medicaid up to 138% of the federal poverty line. Currently in Wisconsin, individuals earning up to 100% of the federal poverty limit are eligible for Medicaid (Bentzen, Dyck, Morgan and Whitaker 2017), meaning that implementation of Medicaid Expansion would raise eligibility for those in that gap.¹ To date, 36 states have accepted expansion in some form along with the promise of higher rates of reimbursement for Medicaid expenses from the federal government. Wisconsin is among 14 states that have not. The map below in Figure 1 shows the states in each category.

Geographically, most non-adopters are southern states that have primarily been led by Republican governments. Many of the traditionally-Republican states that have adopted expansion in recent years have experienced interludes of leadership by Democratic governors and legislators. For instance, Louisiana adopted expansion in 2016 when Democrat John Bel Edwards was elected Governor.

Figure 1. Medicaid Expansion: Adopters and Non-Adopters

Source: Kaiser Family Foundation State Health Facts



¹ Wisconsin previously provided coverage up to 200% of the federal poverty line. This was changed by the legislature in 2014. See the cited LFB paper for more information.

The Potential Costs and Benefits of Medicaid Expansion

There are a number of obvious potential benefits of Medicaid expansion. Not least among them, expanding access to care for individuals who are currently unable to afford coverage. While individuals between 100 and 138% of the federal poverty limit are generally eligible for subsidies on the ACA exchanges, many of these individuals still choose not to sign up for care. There are reasonable arguments that expanded access will increase preventative care usage, and could potentially aid in fighting the opioid epidemic (Stumpf 2018).

Proponents argue as well that the increased access to insurance will lead to more preventative medical care, reduce mortality, and improve the financial security of low-income households (West 2019). This is supported by studies finding evidence of a decline in mortality (Sommers 2017) and reductions in financial distress (Hu et al. 2018) following Medicaid expansion. However evidence from the Oregon Health Insurance Experiment, which randomly assigned expanded Medicaid eligibility, is more mixed. Medicaid coverage increased reported health but generated no significant improvements in measured health outcomes or mortality. Medicaid also increased the use of all forms of healthcare services including outpatient care, preventative care, prescription drugs, hospital admissions, and emergency room visits (Baicker et al. 2013, Finkelstein, Hendren, and Luttmer, 2018).

Among the larger topics of debate in recent years has been the effect of expansion on state budgets. In Wisconsin, the primary effect is to move the 38% currently eligible for subsidized care onto the Medicaid rolls. Federal reimbursement rates for the subset of individuals currently eligible for Medicaid in Wisconsin would increase from approximately 59% to at or above 90% depending

on the ultimate year of implementation.² Not all new recipients would be reimbursed at the 90% rate. Because parents and caretakers are already eligible in this income range, their reimbursement rate would remain at 90% (Dyck 2017). According to an analysis by the Legislative Fiscal Bureau, even when the rate of reimbursement is reduced to 90%, the state will still realize savings due to higher reimbursements for other populations. This is consistent with the preponderance of the available literature on the topic (e.g. Sommers and Gruber 2017).

It is worth noting that all such analyses assume that federal reimbursement rates will remain at the 90% threshold. With the looming entitlement crisis, it is possible that reimbursement rates could fall below that level in the future, leaving states on the hook to pick up added costs. Even during the Obama administration, there were proposals for the introduction of a “blended rate” to Medicaid, which analyses suggest would increase the burden on states (Butler 2013). What would happen to reimbursement rates if the entire ACA is thrown out by the Supreme Court is also a subject for debate.

But even granting the potential savings to the state, there are a number of other potential downsides to expansion that ought to be considered by legislators. It is possible that expansion may increase the cost of healthcare for those not on Medicaid. One commonly cited reason for potential increases is the crowding out of private insurers. Crowding out occurs when individuals in states that expand Medicaid drop private insurance to utilize the new entitlement. This can be because individuals, rationally, drop insurance that they are paying for directly in favor of newly available free Medicaid, or because employers drop insurance knowing

2 Initially, the federal government reimbursed states that expand at 100%, before declining year-by-year to 90%. If implementation in Wisconsin occurred in 2020 or later, the rate would be 90% (Kaiser Family Foundation 2014).

that their employees can now be covered at no direct cost to them. Because the reimbursement rate for Medicaid is lower than for most private insurance, healthcare providers pass on the costs of Medicaid coverage to their other customers (Bauman, Erickson and Sandefur 2018).

Some evidence of “crowd out” resulting from Medicaid expansion does exist. Research from Christopher Pope of the Manhattan Institute estimates that 57% of the increased insurance coverage since the implementation of the ACA follows from reductions in coverage by private employers (Pope 2018). This is consistent with the roughly 60% crowd-out estimates from previous public insurance expansions (Gruber and Simon 2008). Other recent causal estimates for ACA and Medicaid expansion suggest lower crowd-out rates, closer to 25% (Kaestner et al. 2017, Courtemanche et al. 2017). That is, a Medicaid expansion is associated with an increase in Medicaid coverage of 4 percentage points would reduce the proportion uninsured by approximately 3 percentage points, and decrease private health insurance coverage by 1 percentage point.

What Could We Expect to See in Wisconsin?

All states are different with different healthcare systems. As such, when evaluating the impact of expansion, one important data point to look at in evaluating the likelihood of crowd-out is the current uninsured rate. In states with a large number of uninsured residents, there is likely to be less crowding out, as those who currently lack insurance are likely to fill the rolls. In states with low rates of uninsured, however, crowd-out is more likely as more new Medicaid usage would come from a drop off among those currently insured. Among states that have not yet taken Medicaid expansion, Wisconsin is uniquely positioned as a state with a very low uninsured rate. According to Census data, Wisconsin ranks nationally as the 9th highest state in the rate of residents who have insurance, and first among states that did not take expansion.

Wisconsin is the only state to not take expansion that does not have a coverage gap. All low-

income individuals in the state have access to either Medicaid itself or subsidy programs to help cover the cost of private insurance (Norris 2018). In fact, previous expansions of public insurance in Wisconsin seem to have already increased enrollment among the most vulnerable populations. For example, the 2008 introduction of the BadgerCare Plus program for children and parents expanded public insurance enrollment with a relatively low crowd-out rate of around 20% (Dague et al. 2011). However the majority of new enrollment came from the previously income eligible, not from the expansion of eligibility criteria (Leininger et al. 2011).

Wisconsin's high public insurance take-up rate and low overall uninsured rate suggests that individuals currently with private, albeit potentially subsidized, insurance will be the main beneficiaries of Medicaid expansion. Because Medicaid fee-for-service rates generally lag

Table 1. Adult Uninsured Rate in States that did not Expand Medicaid (Overall Rank)

Source: United States Census Bureau and Kaiser Family Foundation

State	Uninsured Rate	Overall Rank
<i>Wisconsin</i>	5.88%	9 th
<i>Nebraska</i>	9.42%	29 th
<i>Kansas</i>	10.00%	30 th
<i>South Dakota</i>	10.12%	33 rd
<i>Alabama</i>	11.39%	39 th
<i>Idaho</i>	12.29%	41 st
<i>North Carolina</i>	12.56%	42 nd
<i>South Carolina</i>	12.81%	43 rd
<i>Mississippi</i>	14.59%	46 th
<i>Wyoming</i>	13.19%	44 th
<i>Florida</i>	14.49%	45 th
<i>Georgia</i>	15.53%	48 th
<i>Oklahoma</i>	16.35%	49 th
<i>Texas</i>	19.85%	50 th

behind those negotiated with private insurers, these costs are generally passed on to private sector consumers (AHA 2016). Thus increases in public health insurance enrollment through Medicaid expansion are likely to lead to increased costs for individuals and families who remain with private insurance.

An additional concern is that expanded access to free healthcare may drive up the use of expensive medical services, such as ambulance rides and emergency room visits. This is perhaps counterintuitive, as proponents of the ACA at the time of its passage suggested that expanded access to affordable care would encourage patients to take advantage of regular, preventative care and use emergency rooms less (e.g. Miller 2006). However, there is growing evidence that those on Medicaid become more likely to utilize emergency services rather than lower cost alternatives (Cunningham and Nichols 2005). There are a number of potential explanations for this. Because such individuals may not have had access to traditional healthcare in the past, they may be unfamiliar with the notion of preventative care. Alternatively, it may be that individuals who face no direct cost from the use of expensive medical services consume more services of all types, as discussed above in the case of Oregon (Baicker et al. 2013).

Wisconsin's experience with the BadgerCare Plus Core Plan provides some additional state-specific evidence of the effects of public insurance expansion. In January 2009, the BadgerCare Plus Core Plan was introduced which extended eligibility for public health insurance to childless adults with household incomes below 200 percent of the federal poverty line. However enrollment was capped in October 2009 and the program was eventually ended in 2014. Although short-lived, this program greatly increased demand for health services. Outpatient visits for enrollees increased by 29 percent, and emergency

department visits increased 46 percent. (DeLeiere et al. 2013). However there was also evidence of better healthcare outcomes, as preventable hospitalizations fell by 48 percent.

Beyond increased demand for health services, Medicaid expansion may have negative impacts on employment. Programs like Medicaid which provide public services subject to income eligibility requirements likely reduce the incentive to work. The negative effect on labor supply results from the reduced need for private insurance coverage among recipients, as well as the possibility that increased earnings would disqualify them from public coverage once they cross income limits. Overall the evidence of Medicaid expansion on labor supply is mixed (Baicker et al. 2013, Courtemanche et al. 2017). However the impact likely depends on local labor market conditions, and the evidence in Wisconsin suggests strong negative employment effects. The BadgerCarePlus Core Plan expansion led to a reduction in employment of over 5 percentage points among enrollees relative to a control population (Dague, DeLeire, and Leininger 2017).

New Estimates of the Impact of Medicaid Expansion

Beyond the existing literature, we are interested in evaluating what the most recent evidence tells us about the impact of Medicaid expansion in Wisconsin. How large is the impact of Medicaid expansion on private medical expenditures? What does the data tell us about the cost of Medicaid expansion to private consumers and about ER visits?

One straightforward way to answer this question is to look at the raw average difference in the changes in these numbers in expansion and non-expansion states. Table 1 below does just that for the years 2010 (the first year of Medicaid implementation in a few states) to 2014.

This provides suggestive evidence that both costs and ER visits have been higher in expansion states relative to non-expansion states, but a deeper analysis with control variables is needed to account for other factors that could plausibly affect both variables. We take advantage of variation in the timing of Medicaid expansion around the country to answer these questions.

Methodology

States around the country varied substantially in the timing of their implementation of Medicaid Expansion. Four states and the District of Columbia took advantage of the opportunity to

expand Medicaid prior to the authorized date of 2014 (Kaiser Family Foundation 2012), while 14 states, including Wisconsin, have never implemented it. In the following research, we take advantage of this variation in implementation date to measure the impact of implementation on private healthcare costs, emergency room visits, and employment among low-income individuals.

Private health insurance cost data is gathered by the Centers for Medicare and Medicaid Services (CMS). It reflects state-level spending per capita on “personal health services and products (hospital care, physician care, nursing home care, prescription drugs, etc.)” (KFF 2016). Using a fixed effect time series model, we examine the relationship between Medicaid expansion in each state and private health insurance costs since 2002. A second variable of interest is the relationship between emergency room visits and expansion. Among the arguments for Medicaid expansion is that newly insured patients will be more proactive in their care, and thus will visit emergency rooms less often. We test that proposition using additional CMS data on emergency room visits per 1,000 residents. This data goes up to 2016, allowing us to include a few more states as Medicaid expanders that implemented expansion after the 2014 cutoff for our private health insurance variable.

Table 2. Average Health Spending and ER Visits, Expansion vs Non-Expansion States

Measure	Expansion States	Non-Expansion States
<i>Health Spending per capita</i>	\$4,526	\$4,069
<i>ER Visits per 1,000 residents</i>	452	424

We include a number of control variables that are also likely to affect health insurance costs in a state. These include the average age and income of residents of the state, the poverty rate in the state, the urban concentration of the state, and the state's overall population.

Formally, for each state s in year y :

$$\text{Private Healthcare Cost}_{sy} = \alpha + \beta_1(\text{Medicaid Expansion}_{sy}) + \beta_2(\text{Controls}_{sy}) + v_s + \varepsilon_{sy}$$

$$\text{ER Visits per 1,000 Residents}_{sy} = \alpha + \beta_1(\text{Medicaid Expansion}_{sy}) + \beta_2(\text{Controls}_{sy}) + v_s + \varepsilon_{sy}$$

Where v is a state-specific error term invariant based on time, and ε is the traditional regression error term. If, as theorized, Medicaid expansion increases private sector healthcare costs, we would predict a positive coefficient on β_1 . Similarly, in our second equation, if Medicaid expansion increases the number of ER visits, we would expect a positive coefficient on β_1 .

Table 3. Relationship between Private Healthcare Spending & Medicaid Expansion

Variables	Health Spending
<i>Medicaid Expansion</i>	177.2*** (51.68)
<i>Population</i>	0.128*** (0.0387)
<i>Poverty Rate</i>	115.4*** (8.565)
<i>Urban</i>	48.57*** (12.55)
<i>Income</i>	0.0898*** (0.00366)
<i>Average Age</i>	155.6*** (18.65)
<i>Constant</i>	-12,336*** (968.7)
<i>Observations</i>	663
<i>Number of states</i>	51
<i>R-squared</i>	0.822

Standard errors in parentheses * p<0.01, ** p<0.05, * p<0.1**

Results

Private Healthcare Costs

The results in the table below depict the relationship between private healthcare spending and Medicaid expansion, accounting for the control variables mentioned in the preceding section. As a robustness check, some of our control variables work in a manner that would be predicted. For instance, as the average age in a state increases, per capita private healthcare spending increases. Health spending is also higher in states with more urban populations, possibly reflective of poorer health in urban centers or more usage of healthcare.

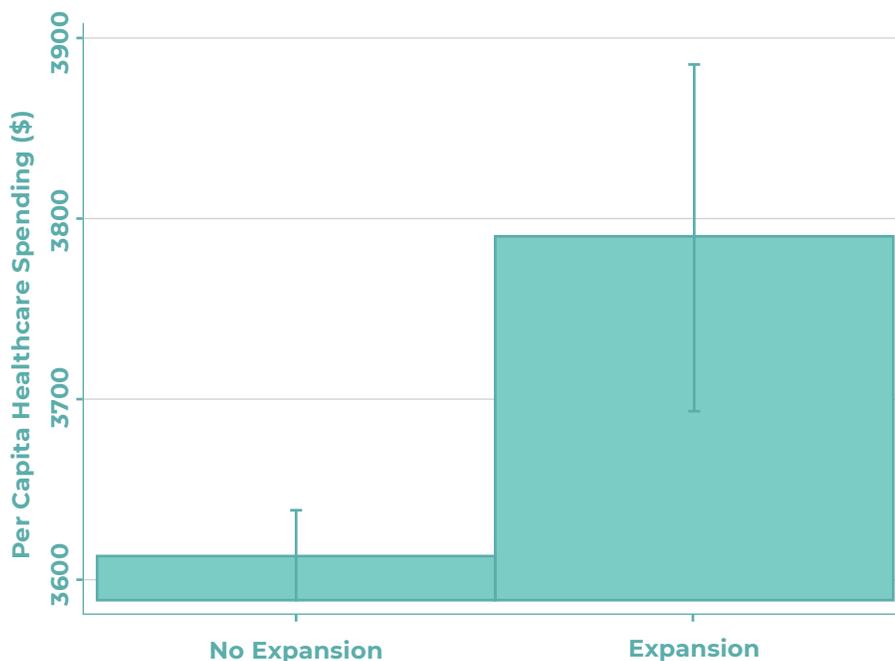
The coefficient on our variable of interest is positive, suggesting that Medicaid Expansion

does raise private sector health spending ($p < .01$). This coefficient is also substantively significant. Expansion of Medicaid in a state is predicted to relate to an increase of \$177 in per-capita private health costs. In the most recent year of data for this variable, yearly private expenditures were \$4,544 on average, meaning the predicted increase is 3.9%.

Wisconsin was a state that already had above-average private sector spending in 2014, at \$5,159 per person. Using an inflation adjustment to make forecasts for 2020, Medicaid expansion would be expected to increase spending from \$5,558 per person to \$5,754 per person—an increase of 3.52%.³

This increase is substantively significant when one considers that Wisconsinites already have higher private sector healthcare expenses than

Figure 2. Predicted Private Spending with and without expansion



³ This figure assumes a cumulative inflation of 10.7% from 2014-2020, including a 2% rate for 2020, consistent with CBO projections.

any neighboring states. The next highest spending state, Iowa, reported spending of only \$4,875 per person in 2014. Nationwide, it would move Wisconsin from 7th in overall private sector healthcare spending to 4th.

Cost/Benefit Analysis

Putting together our results, we can arrive a cost-benefit tradeoff for potential Medicaid expansion in Wisconsin. We base the cost calculations on our estimate of the increased private health expenditures associated with Medicaid expansion. For the benefit side, we rely on estimates by the Wisconsin Legislative Fiscal Bureau (Dyck 2018) of the increased federal expenditure as well as the reduction in state General Purpose Revenue (GPR) which would accompany Medicaid expansion. We are not accounting for, in either a positive or negative way, any impact of expansion on health outcomes. Table 4 summarizes our results.

For the benefits, we use the Legislative Fiscal Bureau (LFB) 2020-2021 estimates, which assume that Medicaid has fully phased in. As the LFB notes, Medicaid expansion would lead to an overall increase in government expenditure

of \$360.3 million in that year, which results from a reduction in state GPR expenditure of \$184.9 million and an increase in federal spending of \$545.2 million. However instead of netting out the figures for the total increase in government health spending, we add them to derive benefit from the state's vantage point. That is, the federal expenditure is essentially a pure benefit to the state, as the increased costs to the federal government would result in a minimal increase in taxes on Wisconsin residents. In addition, because some of the federal spending replaces previous state expenditures, that frees up state GPR for other uses. Thus although the net increase in health spending is \$360 million, the gross benefit to Wisconsin is \$545 million.

For the costs, as described above we estimated an increase of \$177 in per capita private health expenditures (as of 2014) associated with Medicaid expansion. Projecting this to 2020 to be consistent with the LFB cost estimates (using CPI inflation as above) gives \$196 per capita. The mid-year population estimate for Wisconsin in 2018 was 5.81 million, and the population has grown at 0.26% per year since 2014. Projecting this to 2020 gives a population of 5.84 million,

Table 4. Cost-Benefit Analysis for Medicaid Expansion in 2020

Benefit		Cost	
<i>Increased government spending</i>	\$360.3 million	<i>Per capita private spending increase</i>	\$196
<i>Reduced State GPR Spending</i>	\$184.9 million	<i>Wisconsin population</i>	5.84 million
Gross Benefit	\$545.2 million	Total Cost	\$1,145.5 million
Net Cost: \$600.3 million			

and so a total cost estimate of \$1.145 billion of increased private health expenditures.

Therefore we estimate that the net cost associated with Medicaid expansion would be total cost minus total gross benefits, or \$600.3 million in 2020. Further declines in the reimbursement rate for Medicaid, whether because of the move to a blended rate or other reasons, would serve to inflate this cost to the state even further.

Emergency Room Visits

The table below shows our results for the relationship between ER visits per 1,000 residents

and Medicaid expansion. Once again, our control variables function in a manner consistent with expectations. For example, higher poverty rates in a state are related to an increase of 4.544 ER visits per 1,000 people ($p < .01$), while an increase in the average age of the residents of a state is related to an increase of 3.56 ER visits ($p < .1$). Our variable of interest, Medicaid expansion, is also significantly related to change in the number of ER visits, but not in the manner that many expansion advocates might predict. On average, states that have undergone Medicaid expansion see an increase of 9 ER visits per 1,000 residents ($p < .05$). When one considers the expensive

Table 5. Relationship of ER Visits per 1,000 Residents and Medicaid Expansion

Variables	ER Visits
<i>Medicaid</i>	9.96** (5.011)
<i>Population</i>	-0.00195 (0.00355)
<i>Poverty Rate</i>	4.544*** (0.919)
<i>Urbanicity</i>	4.644*** (1.409)
<i>Income in \$1000s</i>	24.25*** (3.749)
<i>Age</i>	3.560* (1.837)
<i>Constant</i>	-220.3** (104.5)
<i>Observations</i>	816
<i>Number of states</i>	51
<i>R-squared</i>	0.289

Standard errors in parentheses *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

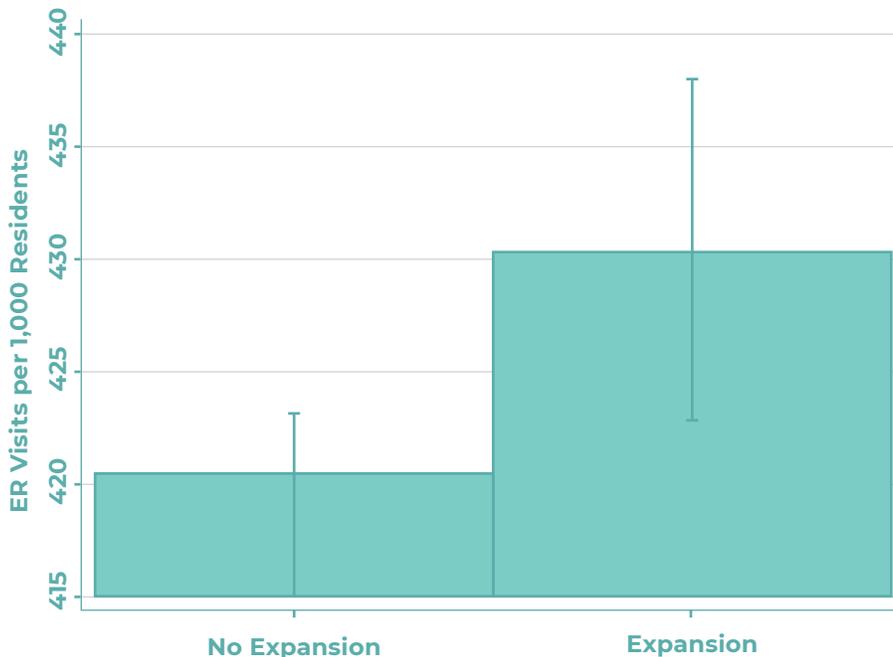
nature of emergency room visits, this increase is substantively significant as well.

This finding may partially explain some of our results in the preceding section, where it was found that Medicaid expansion increases private healthcare costs. Not only is Medicaid reimbursement at a lower rate than private sector healthcare, but it appears that Medicaid users are choosing a more expensive vehicle for healthcare delivery.

This finding is consistent with other research on the effects of the ACA. In addition to the studies cited above, including Wisconsin's previous public insurance expansion, a survey of physicians conducted on behalf of the American College of Emergency Physicians found that approximately 75% of respondents reported that emergency room traffic had "increased greatly" or "increased

slightly" since the passage of the ACA. Moreover, a study of Illinois after the implementation of Medicaid expansion found a significant increase in emergency room visits by Medicaid users (Dreseden et. al. 2016). It is important to note that visits from uninsured patients declined according to this study. However, because emergency rooms are the most expensive delivery method of healthcare, the taxpayer bears the brunt of the cost of increased Medicaid ER visits.

Figure 3. Predicted ER Visits with and without Expansion



Conclusion

Medicaid expansion may well result in fiscal savings to the state thanks to high reimbursement rates from the federal government. Even when reimbursement rates fall to 90% in later years, the state is likely to benefit from the additional federal funding provided. However, it is important that policymakers weigh these potential benefits with the very real costs to consumers that could result from making this policy change. Private sector healthcare costs are likely to increase as healthcare providers pass on the costs from low Medicaid reimbursement rates to consumers. Rather than falling, as predicted by many expansion supporters, visits to the ER are likely to increase substantially.

The good news is that there are more market-based alternatives that are becoming increasingly possible, given regulatory changes at the federal level. Short Term Limited Duration insurance can offer far more inexpensive policies for low-income Wisconsinites because such policies are not subject to the onerous requirements

of the ACA (Cannon 2018). While, under the Obama Administration, such plans could only be three months long, the Trump administration has allowed them to be up to 12 months, and renewable for 3 years. Another intriguing possibility is for states to authorize the purchase of insurance from US territories. Since 2014, territories have not been subject to most of the regulations of the ACA, meaning that they can offer insurance at far more reasonable rates (Livingston 2019).

Before creating additional dependence on government, policymakers should consider these and other market-based alternatives that could result in more affordable coverage for Wisconsinites across the income spectrum.

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Appendix

Table A1. Logged Health Spending and Medicaid Expansion

Variables	Log Health Spending
<i>Medicaid Expansion</i>	0.0269** (0.0132)
<i>Population</i>	4.03e-05*** (1.00e-05)
<i>Poverty Rate</i>	0.0304*** (0.00222)
<i>Urbanicity</i>	0.0147*** (0.00327)
<i>Log Income</i>	1.200*** (0.0471)
<i>Age</i>	0.0596*** (0.00488)
<i>Constant</i>	-8.692*** (0.433)
<i>Observations</i>	663
<i>Number of states</i>	51
<i>R-squared</i>	0.850

Standard errors in parentheses * p<0.01, ** p<0.05, * p<0.1**

Table A2. ER Visits and Medicaid with Income Logged

Variables	ER Visits
<i>Medicaid</i>	11.91** (4.993)
<i>Population</i>	0.000500 (0.00397)
<i>Poverty Rate</i>	4.295*** (0.973)
<i>Urbanicity</i>	4.700*** (1.486)
<i>Log Income</i>	116.6*** (20.19)
<i>Age</i>	2.552 (1.970)
<i>Constant</i>	-1,337*** (182.9)
<i>Observations</i>	765
<i>Number of states</i>	51
<i>R-squared</i>	0.261

Standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1





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