AN ECONOMIC ASSESSMENT OF TENNCARE EXPANSION IN 2023

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EXECUTIVE SUMMARY

Tennessee has a strong and growing economy. Over the past 10 years, Tennessee on average has ranked in the top quartile of states in growth rates for Gross Domestic Product.[1] Despite the progress in economic prosperity, Tennessee ranks in the bottom 10 among all states in overall health. Tennessee ranks poorly in general health, but specifically on risky health behaviors, access to care, utilization of primary care services, prevalence of chronic health conditions, poverty, frequency of mental distress, prevalence of cardiovascular diseases, and other key markers.[2] Poor population health is known to inhibit economic growth, particularly when paired with an aging population. Individuals in poor health are less likely to participate in the labor force, and evidence suggests poor health affects the Tennessee labor market. The *2019 Economic Report to the Governor of Tennessee* documented that on average, Tennesseans exit the labor force approximately five years earlier than the national average and have higher rates of chronic conditions. When individuals in poor health do participate in the labor force, they tend to miss more work (absenteeism), be less effective when at work (presenteeism), and are more expensive to insure. Improving population health is important in its own right, but also presents an opportunity for Tennessee to attract more business. So, although Tennessee has a strong economy, improving population health will likely be a crucial step toward continued strong economic growth.

As stated above, Tennessee ranks near the bottom in terms of poverty rates, access to care, use of preventative care, illicit substance use, incidence of multiple chronic health conditions, and premature death. All these factors point to a greater need for increased access to health care, particularly for low-income households. Lack of affordable health insurance is a considerable barrier that prevents Tennesseans from receiving the health care they need to reach their full potential as workers and citizens of their community. In 2021, Tennessee ranked among the 10 states where cost was most commonly cited as a barrier to accessing health care. Nearly 12 percent of Tennesseans said they avoided seeking care due to cost concerns. Tennessee also ranked in the bottom quartile (37th) for the share of the population without insurance (approximately 700,000 persons).

[1] Source: Bureau of Economic Analysis

[2] https://www.americashealthrankings.org/explore/annual/state/TN

TENNESSEE RANKS NEAR THE BOTTOM IN TERMS OF POVERTY RATES, ACCESS TO CARE, USE OF PREVENTIVE CARE, ILLICIT SUBSTANCE USE, INCIDENCE OF MULTIPLE CHRONIC HEALTH CONDITIONS, AND PREMATURE DEATH.

One of the primary reasons Tennesseans may not have health insurance—despite the immediate financial protection and long-run benefits—is cost. While federal premium subsidies are available for individuals in households earning over 100 percent of the Federal Poverty Level, there is a coverage gap for working households below the poverty threshold. For these families in the gap, premiums may cost over 50 percent of their total income. Even among households that do qualify for subsidized marketplace insurance, out-of-pocket costs can limit their de facto access to care. To close coverage gaps and lower cost burdens for low-income households, 39 states (including the District of Columbia) have chosen to adopt Medicaid expansion to extend health coverage to adults in households earning less than 138 percent of the FPL. Tennessee remains one of 12 that has not. This paper examines the economic case for expanding Medicaid in Tennessee from several perspectives.

ECONOMIC AND FISCAL IMPACT

Expanding TennCare eligibility to all individuals earning less than 138 percent of the FPL would yield several economic benefits to the state. First, federal funds will reimburse for Medicaid expenses at a much higher rate for newly eligible enrollees than traditional Medicaid. For Fiscal Year 2023, the federal Medicaid reimbursement rate in Tennessee is 66.1 percent—meaning the federal government reimburses the state 66 cents for every dollar it spends on Medicaid. Under the expansion, however, the federal government would reimburse 90 cents on the dollar for Medicaid expenditures for the newly eligible population. Based on the most recently available data, if TennCare is expanded, over 300,000 persons would be newly eligible.[3] Based on enrollment evidence from states that have previously adopted expansion, we anticipate that increasing access to TennCare could bring at least 200,000 new enrollees. These new enrollments would lead to over $1 billion per year in new federal funds to fuel the state economy. Not only would expansion have considerable economic benefits, it would also be more than self-funding from a fiscal perspective. For every dollar that Tennessee spends on health care for new enrollees, it would recoup an additional $1.50 in tax revenues from increased economic activity. In addition to those economic and fiscal benefits, the federal government will pay a $1.3 billion bonus to Tennessee over the first two years as an extra incentive to expand.

REDUCING NEGATIVE CONSEQUENCES OF UNCOMPENSATED CARE

Reducing the uninsured share of the population would substantially reduce both the direct and indirect costs of providing uncompensated care. Simply put, when individuals without insurance visit the emergency room, the care they receive is not "free"—not to the hospital, not to the patient, not to employers, and not to the rest of the population of the state. The costs of uncompensated care are not limited to those households but are spread across all participants in the health care system. Uncompensated care leads hospitals to negotiate higher rates with insurance companies to offset those unreimbursed costs. Consequently, insurance companies increase premiums for group plans in subsequent years, raising costs for employers and workers alike.

Expanding TennCare eligibility would not only help slow the growth of insurance premia but may play a role in keeping rural hospitals open. Over the past 10 years, 16 rural hospitals have closed in Tennessee. While this problem is common in states that have not expanded Medicaid, the situation in Tennessee is particularly severe. Tennessee has ranked highest among all states in terms of per-capita hospital closures and conversions to limited-service clinics. Tennessee hospitals provided $2.5 billion of uncompensated care in 2022. Although hospitals treat TennCare patients at a loss, some reimbursement is better than zero. Expanding TennCare would therefore help protect rural hospitals from insolvency, ensuring rural Tennesseans have access to necessary care.

[3] The estimate based on 2020 American Community Survey Data is actually 380,000. However, 2020 was not a representative year for earnings and/or income. As the labor market tightened considerably in the aftermath of the pandemic, we expect the current number of newly eligible individuals to be slightly lower, but still over 300,000. Other estimates place the current number of newly eligible recipients at 340,000.

ECONOMIC BENEFITS FROM EFFICIENT DISEASE MANAGEMENT AND IMPROVED POPULATION HEALTH

Beyond the immediate effects, access to affordable health care and health counseling can reduce the overall burden of health expenditures to the state. Diseases such as cancer, as well as chronic conditions such as heart disease, COPD, and uncontrolled Type II diabetes, are at least partially preventable, but very expensive to treat. Estimates place the costs of excess disease burden (not total costs of disease, but rather those costs attributable to higher-than-average rates in Tennessee) at well over $5 billion per year.[4] These costs are not just from the provision of health care, but also lost workplace productivity, decreased labor force participation, and increased death rates. Expanding TennCare will increase access to affordable preventive care, gradually decreasing the costs of chronic disease over time.

The balance of this report examines the economic trade-offs of expanding TennCare through four questions:

- What is Medicaid? Why are the incentives for expansion so strong right now, and what has expansion meant in other states?
- What does TennCare mean to Tennessee from a high-level fiscal and economic perspective?
- Who would become eligible if TennCare was expanded?
  - What are the demographic characteristics of this group?
  - What are the health characteristics of this group?
  - What is the potential economic impact of expansion at the individual level?
- What can we learn from experiences of other expansion states?

The summary finding is that expanding TennCare would have a strong positive financial and economic impact. We develop an estimated economic impact of expansion, detailing how the influx of federal dollars can boost the economy, create jobs, and increase sales tax revenues. In every year, expanding TennCare will be more than self-funding.

When we compare those who would be newly eligible under expansion to state averages, we see they are an integral part of the labor force but are more likely to lack access to insurance through their employer. These individuals are more likely to live in rural areas but are also present in every metropolitan area.

We also compare the newly eligible population to current enrollees and the ineligible population in terms of health status, health behaviors, and incidence of chronic disease. The newly eligible individuals have higher than average rates of chronic disease and are at a higher risk for future expensive conditions due to high rates of smoking and obesity, and low rates of exercise. They also have the most challenges accessing health care. Expansion will help keep these individuals healthier in the long run and empower them to increase their engagement with the labor market.

Finally, in the debate surrounding Tennessee's decision not to expand TennCare in 2015, there was some lack of clarity around how expanding Medicaid would affect individuals' labor market decisions and participation in other social programs, and what those implicit economic costs would be. Seven years later, we have the benefit of learning from the experience and evidence from states that have adopted Medicaid expansion. Evidence from expansion states indicates that expanding access to Medicaid has a multitude of "ripple effect" benefits: increased access to care for veterans, help with the substance use disorder epidemic, reduced disability rates, improved rural hospital solvency, and reduced incidence of chronic illness. By contrast, there is no evidence that expansion has increased disability enrollments, reduced labor force participation or produced other adverse outcomes.

[4] https://www.sycamoreinstitutetn.org/cost-chronic-disease-tennessee/#:~:text=The%20excess%20burden%20of%20these

A BRIEF INTRODUCTION TO MEDICAID

Medicaid is a joint federal and state government insurance program that provides access to affordable health care for certain individuals with low incomes and/or disabilities. Congress created Medicaid in 1965 through the addition of Title XIX to the Social Security Act. A significant part of the political will to create Medicaid came from the findings of the 1963 *Task Force on Manpower Conservation*. In 1964, that task force published *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*, which documented that nearly half of young men who were drafted were found unfit for military service in 1962. Most of these rejections were due to treatable and preventable physical and developmental conditions.[i] Medicaid was created not only out of concern for low-income Americans, but also over concerns about national security and defense.[ii]

Recognizing that states have different needs and priorities in providing health care for low-income citizens, Medicaid programs are established and operated at the state level. However, the federal government pays for at least half of Medicaid expenses in all states. The federal reimbursement rate, or Federal Medical Assistance Percentage (FMAP) ranged from 50-83 percent pre-pandemic. Tennessee's FMAP in fiscal year (FY) 2023 falls near the approximate middle of that range at middle at 66.1 percent. This rate means that for every dollar spent on Medicaid in Tennessee, the federal government reimburses the state 66 cents. Alternatively, for every dollar that Tennessee spends on Medicaid, the federal government contributes two dollars.

States also have considerable autonomy to determine who is eligible for Medicaid. TennCare (Tennessee's Medicaid program) is available to individuals who fall in to at least one of the following categories:

- Children living in households earning less than 211 percent of the Federal Poverty Level.
- Pregnant women in households earning less than 195 percent of the FPL.
- Parents or caregivers of children in households earning less than certain income thresholds, currently less than 90 percent of FPL for all family structures.
    - o Eligibility requirements for parents fluctuate based on family size.
    - o For a family of two parents/caregivers are only eligible if household income is below 87 percent of the FPL.
    - o For a family of three, parents/caregivers are only eligible if household income is below 84 percent of the FPL.
    - o For a family of five, parents/caregivers are only eligible if household income is below 77.6 percent of the FPL.
- Disabled persons in households earning less than approximately 75 percent of the FPL.
- Adults who require institutional care in households earning less than $2,523/month.
- Children with disabilities or complex medical needs in households earning less than $2,523/month.
- Individuals up to age 26 who aged out of foster care and who received TennCare as a minor.
- Individuals diagnosed with breast or cervical cancer at a CDC prevention site earning less than 250 percent of the FPL.

In general, Medicaid programs yield several benefits. First, some low-income individuals have access to health care (hospital, physician and pharmacy services) who otherwise would not. Before Medicaid was enacted, fewer than half of low-income children had seen a doctor in the previous year. Indeed, without access to Medicaid, individuals with limited income and without employer-provided insurance often cannot seek medical care. Second, access to health care prevents routine health conditions from having severe, lifelong consequences. By making health care affordable for low-income individuals, Medicaid helps beneficiaries remain engaged in the labor force and in their communities. Third, by covering individuals with disabilities, Medicaid helps reduce premiums for group and individual insurance markets.

A BRIEF INTRODUCTION TO MEDICAID EXPANSION

The Patient Protection and Affordable Care Act (ACA) and subsequent court cases (*NFIB v. Sebelius*) established that states had the opportunity, but not the obligation, to expand Medicaid eligibility to all individuals living in households earning less than 138 percent of FPL ($31,781 for a family of three in 2022). States that expanded Medicaid would receive an FMAP of 90 percent for individuals who were newly eligible under the expansion. From a state perspective, the economic incentives providing coverage and fostering access to care to the expansion population are extremely strong. In other words:

- For anyone enrolled in Medicaid in Tennessee who was previously eligible, the federal government would contribute two dollars for every dollar spent by the state on their health care
- For anyone covered under the expansion who was not previously eligible, the federal government would contribute nine dollars for every dollar spent by the state on their health care.

Recognizing the value of expansion, 26 states took that option in 2014. By 2022, 39 states had expanded their Medicaid programs.

For states that have not expanded Medicaid, many individuals in households earning less than 100 percent of the federal poverty line fall into the coverage gap:

- They are not eligible for federal premium subsidies, and
- They are not eligible for Medicaid.

For people in the coverage gap, if their employer does not offer group insurance, they are immediately priced out of individual insurance markets. If they require emergency care, the financial consequences can be catastrophic.

During the COVID-19 pandemic, the need for health insurance became especially pronounced. To encourage the remaining 12 non-expansion states to expand, the American Rescue Plan included new temporary incentives. Effective April 1, 2022, states that adopt expansion will receive a temporary, two-year increase of five percentage points in the FMAP for traditional Medicaid. Because the traditional Medicaid population is much larger than the expansion population, if Tennessee expanded, this new incentive would bring in enough money to offset any costs of expansion for approximately the first 10 years. We quantify the economic benefits of both the higher reimbursement rate for the expansion population and the temporary increase in the reimbursement rate for traditional Medicaid enrollees in the following sections.

STATISTICAL EVIDENCE ON THE EFFECTS OF EXPANSION

Tennessee publicly considered expansion in the winter of 2014/2015. However, much was unknown at the time about how individuals would respond to newly available public health insurance. Much of that uncertainty has been resolved through the experience of states that have adopted expansion.

Top line, expansion in other states has been successful in accomplishing its first-order objectives. Relative to non-expansion states, expansion states have experienced:

- Decreases in rates of uninsured[iii] with little evidence of people switching from private insurance to Medicaid.
- More continuous enrollment in health insurance. Low-income individuals became less susceptible to disruptions in coverage from job loss.[iv]
- Increased utilization of preventative health care.[v]
- Increased and improved treatment for substance use disorders.[vi]
- Lower death rates.[vii,viii]
- Decreases in uncompensated care for hospitals.[ix]

Many of the initial concerns surrounding potential negative consequences of expansion have not been borne out by evidence. Expansion states:

- Have not seen sharp increases in state spending on Medicaid.[x]
- Have not faced budgetary hardships or reduced spending in other categories.[xi]
- Have not seen significant decreases in labor force participation. Employment has actually increased for those with disabilities.[xii]
- Have not seen increases in welfare programs such as TANF, although participation in food assistance programs (SNAP) increased.[xiii]

TENNESSEE VIEW

ECONOMY AND STATE BUDGET – WHERE DOES TENNCARE FIT IN?

The economy of Tennessee continues to experience strong growth. The state's Gross Domestic Product—the total value of goods and services produced in a given year—will approach $450 billion in 2022. Tennessee is certainly among the fastest growing state economies in the U.S.—the specific ranking depends on the methodology and time frame considered.

For Fiscal Year 2022-2023, the recommended state budget of Tennessee was $52.5 billion. Approximately half of that total came from state appropriations, while the balance of those funds were from federal sources ($19.8 billion), departmental revenues ($4.4 billion), and the rest from higher education tuition and fees ($2.0 billion) and bonds ($83.5 million). However, while state appropriations are increasing from FY2021-2022 (+$4.4 billion), incoming federal funds are decreasing (-$3.0 billion) as pandemic assistance programs phase out.

For FY2022-2023, TennCare is a sizeable part of the Tennessee budget at $13.9 billion. Because the federal government covers approximately two thirds of TennCare expenditures (FMAP of 66.1 percent), $8.7 billion of the TennCare budget is projected to come from federal funds, while $4.5 billion will come from state appropriations. While those numbers appear large at first glance, it is worth noting that approximately 1.6 million Tennesseans are enrolled in TennCare as of 2021. Per-capita reimbursements for TennCare enrollees are lower than the statewide average for per-capita health care spending. Considering that TennCare enrollees include nearly 250,000 individuals with disabilities (who require more care and tend to be expensive to treat) these figures reflect considerable efficiency on the part of TennCare.[5]

TennCare provides significant benefits to all Tennesseans, whether they are enrolled or not. For enrollees, TennCare provides access to affordable health care for managing chronic conditions, and for health-and-cost saving preventative care. In the case of emergencies, TennCare is both a means to access care but also a crucial instrument for financial protection.

TennCare also provides tremendous value to non-enrollees, though that value manifests in subtle ways. Suppose someone with limited income needs health care, but does not have health insurance (and therefore generally cannot afford care). When that person inevitably has to seek care, that care is neither free nor costless. Rather, the costs of uncompensated care are spread across groups of patients and practice areas in what is known as "cross subsidy." Higher numbers of uninsured patients mean that hospitals must negotiate higher rates with private insurers, raising costs for employers and workers. To reiterate—the care that eligible individuals receive is being paid for. TennCare enables two thirds of that care to be paid for by *federal* dollars rather than in-state dollars.

THE UNINSURED POPULATION IN TENNESSEE

The exact number of uninsured individuals has fluctuated greatly over the past few years due to changes in individuals' employment and TennCare eligibility related to the pandemic (and recovery). However, estimates for 2020 place the uninsured rate in Tennessee at 12.6 percent, or approximately 716,000 people.[6]

When comparing adults aged 18-64 without insurance to those with insurance using the most recently available data, the two groups are reasonably similar. However, there are some important differences. Both individuals with insurance (76.3 percent) and without insurance (70.7 percent) overwhelmingly participate in the labor force, meaning they are either working or actively looking for work. Those without insurance are more likely to be unemployed but looking for work. Given that most people are insured through their employer, it is not surprising that those temporarily out of work would be more likely to be uninsured.

The uninsured population is concentrated in rural areas (33.1 percent vs. 27.8 percent) and is disproportionately male. While uninsured adults are less likely to have children in the household, nearly

[5] https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareOnePager.pdf
[6] https://aspe.hhs.gov/reports/trends-us-uninsured-population-2010-2020

Table 1: Characteristics of Insured, Uninsured Populations in Tennessee, by Percent

Characteristic	Uninsured	Insured
Labor Force	70.7	76.3
Currently Employed	59.6	73.3
Unemployment Rate	15.7	3.9
Male	56.8	47.2
White	72.9	78.8
Rural	33.1	27.8
With Children in Household	29.4	41.5
Veterans	2.8	6.0
With Any Disability	14.3	13.5
Homeowner	50.6	68.0
Potential Enrollees	29.0	7.0

one in three (29.4 percent) uninsured adults do have children living with them. Individuals without insurance are slightly more likely to have a disability compared to those with insurance (14.3 percent vs. 13.5 percent). Additionally, more than half of those who are uninsured own their primary residence.

Finally, if TennCare were expanded, 29 percent of those without insurance would become newly eligible compared to 7 percent of those with insurance.

HEALTH STATUS

Tennessee ranks in or near the bottom 10 among all 50 states for most major health markers. Many of these conditions, particularly chronic health conditions, are very costly when poorly managed. Chronic health conditions—particularly among the uninsured—have ripple effects through Tennessee's health care system and economy. First, chronic conditions contribute disproportionately to the rising costs for health care because they are expensive to treat. To the extent these conditions are borne by those without insurance, they increase the need for cross-subsidization—spreading those costs among other patient groups. Finally, many of these conditions are preventable and manageable/treatable—but if individuals do not have access to care, these conditions can lead to early exits from Tennessee's labor force.

Table 2 shows where Tennessee ranks in several health categories, focusing on those that could be improved by expanding TennCare. For each area, we show Tennessee's rank among 50 states, the prevalence of each condition, and the national average as a comparison point.[7]

[7] https://www.americashealthrankings.org/explore/annual/measure/Overall_a/state/TN

Table 2: Tennessee Ranking and Comparison to National Average in Key Indicators

Category	TN State Ranking	TN Average	National Average
Access to Care (score)	40	-0.430	0.0
Avoided Care Due to Cost (percent)	41	11.8%	9.8%
Preventative Clinical Services (score)	40	-0.584	0.0
Smoking rates (percent)	46	19.5%	15.5%
Depression (percent)	48	29.1%	19.5%
Drug Deaths (per 100K population)	41	30.6	21.5
Premature Death (years of life lost)	46	9.9	7.3
Physical Health (score)	42	-0.684	0.0
Multiple Chronic Conditions (percent)	46	13.8%	9.1%
Cancer (percent)	42	7.5%	6.8%
Cardiovascular Disease (percent)	45	11.5%	8.1%
Chronic Obstructive Pulmonary Disease (percent)	47	9.5%	6.2%
Diabetes (percent)	46	14.1%	10.6%
High Blood Pressure (percent)	44	39.3%	32.5%
Obesity	38	35.6%	31.9%

THE COSTS OF UNCOMPENSATED CARE IN TENNESSEE

Having a high share of the population without insurance yields large economic costs on multiple fronts—but it hits hospitals particularly hard. Hospitals are unique in the health care sector because they are the only category of providers *required* by federal law to provide care, no matter the patient's ability to pay. For emergency care, the hospital must ensure the patient is stabilized before costs/insurance or anything related to payment can be discussed at all.

Confounding the problem further, over 70 percent of inpatient hospital visits in Tennessee are paid for by Medicare or TennCare, where fees are highly regulated rather than just market negotiations.[8] For the large majority of patients, hospitals are expected to treat them at a loss. Of the $3.2 billion of uncompensated care provided in 2017, over $1.1 billion in care was written off as "bad debt" or "charity care"—a majority of which was driven by treating uninsured patients. While expanding TennCare will not completely address the issues hospitals face with uncompensated care, it will play a key role in reducing the financial burden of treating low-income limited asset patients.

[8] Tennessee Hospital Association: Hospital Economic Report, 2018

THE OPPORTUNITY FOR EXPANSION

TennCare expansion, under the terms of the ARP, presents a considerable economic opportunity to the state of Tennessee. In this section, we detail the potential benefits of adopting such an expansion, taking into consideration any monetary and implicit costs that may result. Broadly, expanding TennCare presents economic opportunity for low-income Tennesseans, particularly those with health limitations. Expansion can, over time, play a vital role in improving population health while also providing financial protection against expensive to treat chronic conditions. Expansion can make Tennessee a more attractive location for employers, boost economic activity, help protect rural hospitals and positively affect the state's fiscal bottom line.

CHARACTERISTICS OF THE POTENTIAL ENROLLEES UNDER EXPANSION

When considering adopting a program, characterizing the Potential Enrollees can provide some insight on the potential return on investment. Expanding TennCare will have a significant effect on those who become eligible—but what does that mean to the state? All data points need context or frame of reference to be interpretable. To form a comparison for who is affected, we compare Potential Enrollees to other Tennesseans, dividing the adult population into four categories:[9]

- Ineligible: Childless adults who earn above 138 percent of the federal poverty level, and adults of all family statuses and health conditions whose income exceeds the pre-defined thresholds.
- Current Enrollees: Adults who currently qualify for TennCare based on financial or medical need under the criteria listed above, and who are enrolled.
- Eligible but Not Enrolled: Adults who currently qualify for TennCare based on financial or medical need under the criteria listed above but are not enrolled.
- Potential Enrollees: Those who would be newly eligible if the TennCare Expansion is enacted.

I. At a glance: Demographic and Labor Market Characteristics of Potential Enrollees

a. Almost 60 percent of Potential Enrollees participate in the labor force.

b. Expanding eligibility would provide coverage to 16,000 veterans.

c. Potential Enrollees use 1/6th of the social services of Current Enrollees.

d. 144,000 individuals among the Potential Enrollees do not currently have health insurance.

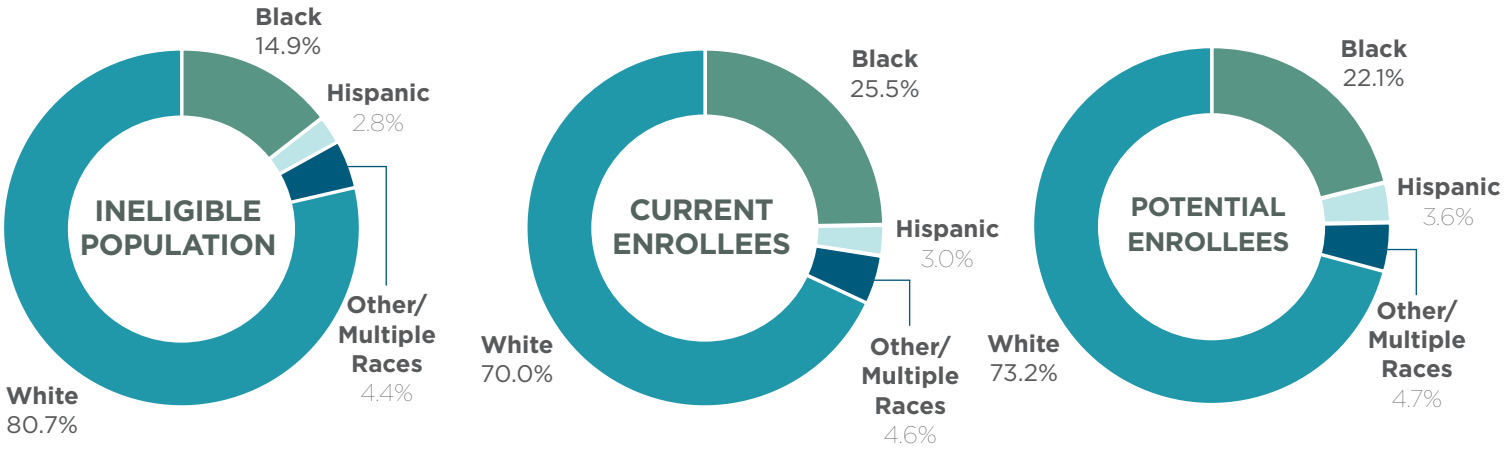
[9] See the Data Appendix at the end of this document for additional technical information.

DEMOGRAPHICS

PERCENT FEMALE

Ineligible Population: **49.4%**
Current Enrollees: **61.9%**

Eligible, but not Enrolled: **58.1%**
Potential Enrollees: **50.5%**



The fact that over 60 percent of adult Current Enrollees are female is largely because non-disabled adults without children in the household are currently not eligible for TennCare. However, just because an individual does not have children in the household does not mean they are childless. Approximately 40 percent of children enrolled in TennCare have a parent outside the home, as do 37.5 percent of children in households of Potential Enrollees. Expanding TennCare to these adults would help provide additional financial protection to children of low-income families by ensuring parents who live outside the primary household residence can access the health care they need to continue to work.

EXPANDING TENNCARE TO THESE ADULTS WOULD HELP PROVIDE ADDITIONAL FINANCIAL PROTECTION TO CHILDREN OF LOW-INCOME FAMILIES.

WHERE DO THEY LIVE?

Almost ⅓ of Potential Enrollees live outside of metropolitan areas in rural counties. Potential Enrollees are also represented in every metropolitan area in Tennessee.

PROPORTION NOT IN A METRO AREA

Current Enrollees 36.1%

Eligible, but not Enrolled 32.9%

Potential Enrollees 32.5%

Ineligible Population 26.2%

Almost a third of Potential Enrollees live outside the major metropolitan areas in Tennessee, meaning a higher percentage of these individuals live in rural counties than the state average (28.5 percent). Additionally, over 50,000 of the Potential Enrollees that live in rural counties (40 percent) do not have health insurance.

Among the Potential Enrollees who live in metropolitan areas, slightly more Potential Enrollees live in Knoxville, Chattanooga, and Jackson than the overall working-age adult population. Fewer Potential Enrollees live in Nashville than the state average.

POTENTIAL ENROLLEES

Chattanooga: **6.1%**
Clarksville: **3.1%**
Jackson: **2.2%**
Knoxville: **15.5%**
Memphis: **16.0%**
Nashville: **24.6%**

STATEWIDE POPULATION AGES 18-64

Chattanooga: **5.5%**
Clarksville: **3.4%**
Jackson: **1.7%**
Knoxville: **14.4%**
Memphis: **15.5%**
Nashville: **31.0%**

PROPORTION IN CENTRAL/PRINCIPAL MSA

Current Enrollees **33.8%**

Eligible, but not Enrolled **35.6%**

Potential Enrollees **40.8%**

Ineligible Population **44.5%**

EMPLOYMENT AND LABOR FORCE PARTICIPATION

Potential Enrollees are active in Tennessee's labor force. Almost 60 percent of Potential Enrollees are either currently working or looking for work.

PERCENT CURRENTLY EMPLOYED

Ineligible: **82.4%**
Current Enrollees: **37.3%**
Eligible, but not Enrolled: **45.6%**
Potential Enrollees: **48.1%**

LABOR FORCE PARTICIPATION RATE

Ineligible: **85.0%**
Current Enrollees: **44.7%**
Eligible, but not Enrolled: **55.5%**
Potential Enrollees: **56.9%**

Potential Enrollees are an important part of Tennessee's labor force. Over 215,000 Potential Enrollees participate in the Labor Force, meaning they are either working or actively looking for work. Of the Potential Enrollees in the labor force, approximately 80,000 individuals (over 37 percent) do not have health insurance—approximately three times the state average.

Potential Enrollees are 27 percent more likely to participate in the labor force than current recipients. Conversely, when compared with the ineligible population Potential Enrollees are 33 percent less likely to participate in the labor force and 41 percent less likely to be currently employed.

However, there are three primary structural barriers that keep individuals from gaining and maintaining steady employment: child-care, transportation, and health. Providing Potential Enrollees with the mechanism to access affordable health care will play a vital role in removing one of these obstacles for 165,000 Tennesseans. Additionally, from other expansion states, we see no evidence that expanding Medicaid negatively affected statewide labor force participation rates. Expansion does help individuals with disabilities return to work.

OF THE POTENTIAL ENROLLEES IN THE LABOR FORCE, APPROXIMATELY

80,000 individuals (over 35%)

DO NOT HAVE HEALTH INSURANCE.

PROTECTION FROM LABOR MARKET DISRUPTIONS

Not everyone who leaves the labor force represents a 'permanent' exit. Increasing access to affordable health care can bring some potential workers back in.

WEEKS WORKED IF EMPLOYED

Ineligible: **50.1**

Current Enrollees: **45.8**

Eligible, but not Enrolled: **44.0**

Potential Enrollees: **43.8**

UNEMPLOYMENT RATE

Ineligible: **3.0**

Current Enrollees: **16.5**

Eligible, but not Enrolled: **17.9**

Potential Enrollees: **15.3**

PERCENT NOT IN LABOR FORCE AMONG THOSE WHO WORKED IN LAST FIVE YEARS

Ineligible: **46.2**

Current Enrollees: **27.3**

Eligible, but not Enrolled: **40.4**

Potential Enrollees: **41.9**

The combination of low income and poor health create circumstances that are difficult to escape. Medical care is expensive. Having poor health makes it harder to stay productive and engaged as a worker, and, therefore, get access to the necessary care to engage with the formal labor sector. A single individual earning less than 138 percent of the FPL who is working full time earns less than $9.02 per hour. The share of workers who earn wages near that threshold is surprisingly large. According to a Brookings Institution report, approximately 44 percent of workers were categorized as "low wage," with median hourly wages less than 10.22 per hour.[10] However, workers earning slightly more than $10.22 per hour can easily be Potential Enrollees if there are seasonal gaps in their work or other factors that prevent them from working continuously.

Health conditions are one of the primary factors that cause individuals to have extended absences from work or take short term leave. Potential Enrollees who are employed worked seven fewer weeks per year on average than Ineligible individuals. Additionally, among Current Enrollees and Potential Enrollees alike, unemployment rates are over 15 percent. Note that unemployment is defined as "not working, but actively seeking work". Among individuals not working, Potential Enrollees are more than twice as likely to have worked in the past 12 months as Current Enrollees. Ensuring these individuals have access to affordable health care is a key step in keeping Potential Enrollees engaged and gainfully employed.

[10] https://www.brookings.edu/research/meet-the-low-wage-workforce/

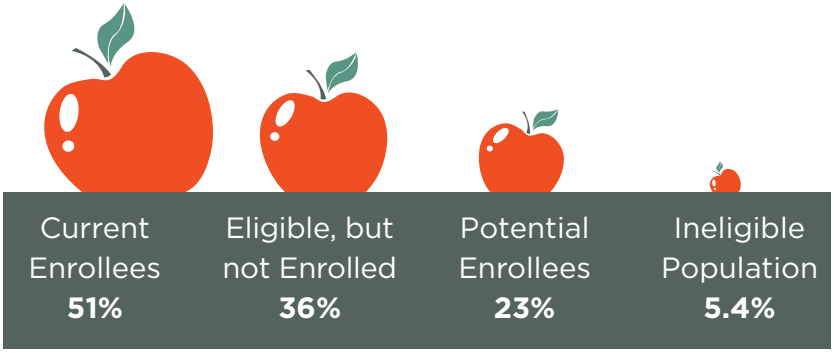
PARTICIPATION IN OTHER SOCIAL ASSISTANCE PROGRAMS

Potential Enrollees utilize government assistance far less than the current TennCare-eligible population. Potential Enrollees are less than half as likely to receive food stamps and receive only 16 percent of the welfare dollars per-capita allotted to Current Enrollees.

For all groups except the Ineligible group, Potential Enrollees have the lowest take up for social assistance programs. Among individuals in limited income groups who do receive social assistance, Potential Enrollees are statistically more likely to be employed or looking for work. Food stamp recipients among Potential Enrollees are 20 percent more likely to participate in the labor force than current recipients. For comparison, Potential Enrollees participate in the labor force at 65 percent of the rate of the ineligible population.

Across all groups, food stamp recipiency rates are highest among those who are temporarily unemployed but looking for work. Across all groups, food stamp recipiency rates are highest for those who are temporarily unemployed but looking for work. Thirty-eight percent of unemployed Potential Enrollees receive food stamps as compared to 63 percent of unemployed Current Enrollees. Among those who have exited the labor force altogether, 25 percent of Potential Enrollees versus 52 percent of Current Enrollees receive food stamps. For Potential Enrollees, the dominant pattern is that social assistance tends to be a temporary support through difficult times rather than a permanent state.

FOOD STAMP RECIPIENCY RATES (PERCENTAGE):



PER-CAPITA WELFARE INCOME[11]

Current Enrollees: **$199.73**

Potential Enrollees: **$39.71**

[11] Some of the difference is attributable to the fact that households earning over 100 percent of the FPL are ineligible for Temporary Assistance for Needy Families (TANF). Approximately 36 percent of Potential Enrollee households are ineligible for TANF.

HEALTH INSURANCE AND UNINSURANCE RATES

Potential Enrollees are three times as likely to be uninsured as the ineligible population even when employed.

Overall, 37.5 percent of Potential Enrollees (144,000 persons) do not have health insurance. More than 58,000 (over 30 percent) of Potential Enrollees who are currently working do not have health insurance. Even among Potential Enrollees currently working full time, over 33,000 do not have health insurance (32.5 percent). Meanwhile, among Potential Enrollees unemployed but looking for work, over 60 percent do not have health insurance. Even those potential enrollees who currently are insured may benefit considerably from expansion. Low-income individuals are more likely to take up high-deductible insurance plans that offer lower up front costs, but afford less financial protection and less comprehensive coverage than TennCare. Therefore, expanding TennCare will not just benefit the uninsured, but may yield significant benefits to low income workers who are currently insured.

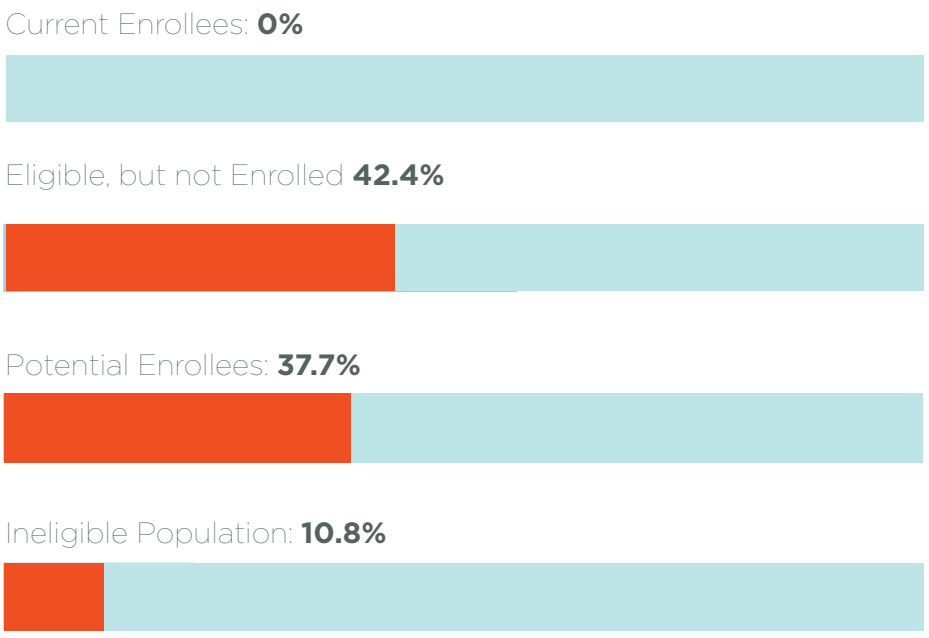
For individuals facing employment gaps, often for factors beyond their control, a lack of a lack of insurance means an unexpected expense or accident can lead to financial stress. For Potential Enrollees, this represents more than half of a year's income. Expanding TennCare will insure against permanent financial consequences from temporary job loss for low-income Tennesseans.

MORE THAN

144,000

INDIVIDUALS AMONG PROSPECTIVE BENEFICIARIES DO NOT HAVE HEALTH INSURANCE.

UNINSURANCE RATE



POTENTIAL IMPACT FOR POPULATION HEALTH

As discussed above, Tennessee ranks in or near the bottom 10 among all 50 states for most major health markers. Many of these conditions, particularly chronic health conditions, are very costly when poorly managed. Expanding TennCare (and access to affordable health care) can have an impact on population health if it targets a group that would benefit.

Here, we examine the health status and risk factors of Potential Enrollees, compared to the TennCare Eligible and Ineligible, in order to illustrate the opportunity that expansion presents for population health.

AT A GLANCE

- Because health and socioeconomic status are interwoven, the Potential Enrollees fall somewhere between the Ineligible and TennCare eligible populations for most health indicators.
- Statistically, Potential Enrollees receive less care and engage in some risky health behaviors. In the absence of care and early warnings, these factors place them at high risk for expensive chronic conditions in the future. Expanding TennCare will provide several benefits:
  - Create opportunities for Potential Enrollees to receive health counseling from a physician, as every TennCare enrollee is assigned to a primary care physician.
  - Reduce the long-run costs of care provision and excess disease burden by improving access to early-stage diagnosis and treatment.
  - Insulate rural hospitals and financially distressed practices from future bad debt.
  - Help ensure those with chronic conditions (e.g., Type II Diabetes) receive maintenance care and avoid disability.

STATISTICALLY, POTENTIAL ENROLLEES RECEIVE LESS CARE, PLACING THEM AT HIGH RISK FOR EXPENSIVE CHRONIC CONDITIONS IN THE FUTURE.

GENERAL HEALTH STATUS

Potential Enrollees' health is statistically better than those individuals currently eligible for TennCare. However, Potential Enrollees are less healthy than the population average.

Although the self-assessed health of Potential Enrollees is substantially better than Current Enrollees, note that roughly the same percentage of respondents said health was a limiting factor on some days (51 percent vs. 53 percent). The difference in reported general health is likely driven by differences in the number of days per month individuals are limited by their health. Individuals eligible for TennCare reported 16 days of poor health on average versus 11 days among Potential Enrollees. Yet even a small number of days when health is a limiting factor can be disruptive for labor market activities.

A big part of the statistically poorer health status of the Currently Eligible population can be attributed to higher rates of disability. The Potential Enrollees, by contrast, have much lower disability rates, but still report poorer than average population health. Expansion therefore presents an opportunity to improve the health of a targeted group where access to care may be pivotal.

Higher than average incidence of chronic disease costs Tennessee over five billion dollars per year. These are not the costs of *all* diseases—just the costs of disease rates above and beyond the national average. Tennesseans on average are less healthy than the U.S. average, and low-income individuals tend to be in poorer health than average, regardless of their state of residence. Using federal funds to provide individuals in this group with necessary care will reduce the financial strain on Tennessee's health care system and improve population health.

INDIVIDUAL'S SELF-ASSESSMENT OF HEALTH STATUS

PERCENT REPORTING VERY GOOD OR EXCELLENT HEALTH:

TennCare Eligible: **30.5%**
Potential Enrollees: **46.3%**
Ineligible: **65%**

PERCENT REPORTING FAIR OR POOR HEALTH:

TennCare Eligible: **36.5%**
Potential Enrollees: **15.5%**
Ineligible: **9.9%**

PERCENT REPORTING POOR PHYSICAL HEALTH IN LAST 30 DAYS

TennCare Eligible: **53%**
Potential Enrollees: **51%**
Ineligible: **39.4%**

ACCESS TO HEALTH CARE AND HEALTH CARE UTILIZATION

Of all groups, Potential Enrollees reported the most limited access to health care and the lowest usage of preventative care. Compared to the population average, Potential Enrollees are 25 percent less likely to have had a checkup in the past 12 months.

PERCENT OF RESPONDENTS REPORTING INABILITY TO SEE A DOCTOR IN PAST 12 MONTHS BECAUSE OF COST:

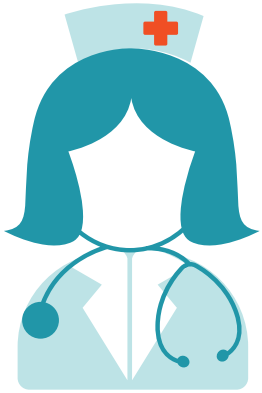
TennCare Eligible: **19.4%**
Potential Enrollees: **25.4%**
Ineligible: **8.2%**

PERCENT OF RESPONDENTS REPORTING A CHECKUP WITHIN THE LAST YEAR:

TennCare Eligible: **76.7%**
Potential Enrollees: **56.3%**
Ineligible: **75.8%**

Among respondents who reported more than seven days of poor health in the past month, 36 percent of Potential Enrollees reported being unable to see a doctor because of cost. Checkup rates were even lower (51 percent) for Potential Enrollees in poor health for at least one week per month. This is the opposite pattern we would see if population health needs were adequately addressed and confirms that access to affordable care is a substantial problem in our state. Accessibility of preventative care is a key factor in preventing emerging health conditions from becoming debilitating.

36% OF POTENTIAL ENROLLEES REPORTED BEING UNABLE TO SEE A DOCTOR BECAUSE OF COST.



OBESITY AND RELATED CHRONIC CONDITIONS

Although Potential Enrollees currently have lower rates of heart disease and diabetes than individuals currently eligible for TennCare, their disproportionate obesity rates suggest that may change in the future.

Obesity is one of the strongest predictors for future heart disease, stroke, cancer, and other conditions that are expensive to treat. Potential Enrollees have the highest obesity rate of any group. By expanding TennCare today, Tennessee can provide financial protection not just for Potential Enrollees, but their families, and their health care providers.

Part of the discrepancy in heart disease and diabetes rates between TennCare eligible individuals and Potential Enrollees is due to reverse causality. Uncontrolled Diabetes and poor cardiovascular health can become debilitating quickly if untreated. Many individuals who are enrolled in disability (SSI) are currently eligible for TennCare. By providing Potential Enrollees with insurance (and access to affordable care), we can help keep disability rates in Tennessee from rising.

PERCENT WITH HEART ATTACK OR HEART DISEASE

TennCare Eligible: **15%**
Potential Enrollees: **4.2%**
Ineligible: **5.5%**

PERCENT WITH DIABETES

TennCare Eligible: **21.6%**
Potential Enrollees: **12.4%**
Ineligible: **12%**

POTENTIAL ENROLLEES HAVE THE HIGHEST OBESITY RATE OF ANY GROUP, MEANING THEY HAVE HIGHER RISKS OF COSTLY HEALTH CONDITIONS IN THE FUTURE.

PERCENT OBESE

TennCare Eligible: **40.3%**

Potential Enrollees: **45.1%**

Ineligible: **34.7%**

MENTAL HEALTH

Despite participating in the labor force at 125 percent of the rate of the TennCare eligible population, Potential Enrollees are the most likely of any group to report mental health difficulties. The data are consistent with access to mental health care being an issue for Potential Enrollees.

Compared to the TennCare eligible population, Potential Enrollees are slightly more likely to report poor mental health in the past 30 days, but *less* likely to have been diagnosed with a depressive disorder. The difference likely has to do with access to affordable mental health care.

Substance Use Disorder has its roots in anxiety, depression, and other mental health challenges. To address the substance use epidemic in Tennessee, a good starting point is to ensure those struggling with mental health difficulties have access to care.

PERCENT REPORTING POOR MENTAL HEALTH IN THE LAST 30 DAYS

TennCare Eligible: **42.6%**

Potential Enrollees: **44.8%**

Ineligible: **38.5%**

PERCENT EVER DIAGNOSED WITH DEPRESSIVE DISORDER

TennCare Eligible: **34.3%**

Potential Enrollees: **31.0%**

Ineligible: **21.6%**

POTENTIAL ENROLLEES ARE MORE LIKELY TO REPORT POOR MENTAL HEALTH THAN CURRENT ENROLLEES, BUT LESS LIKELY TO HAVE BEEN DIAGNOSED WITH A DEPRESSIVE DISORDER.

OPPORTUNITY FOR FISCAL AND ECONOMIC IMPACT

IF 200,000 INDIVIDUALS ENROLL AFTER EXPANSION, TENNESSEE WILL REALIZE THE FOLLOWING BENEFITS:

- **$1.03 BILLION PER YEAR IN NEW FEDERAL FUNDS**
- **$1.5 BILLION PER YEAR IN INCREASED EARNINGS FOR TENNESSEE'S WORKERS**
- **$28 MILLION DOLLARS PER YEAR IN NET REVENUES TO THE STATE BUDGET FROM INCREASED ECONOMIC ACTIVITY**
- **$24 MILLION IN SAVINGS PER YEAR FROM REDUCED NEED FOR SAFETY NET PROGRAMS**

AND THE FEDERAL GOVERNMENT WILL ESSENTIALLY PAY A $1.3 BILLION "SIGNING BONUS" TO REAP THESE BENEFITS.

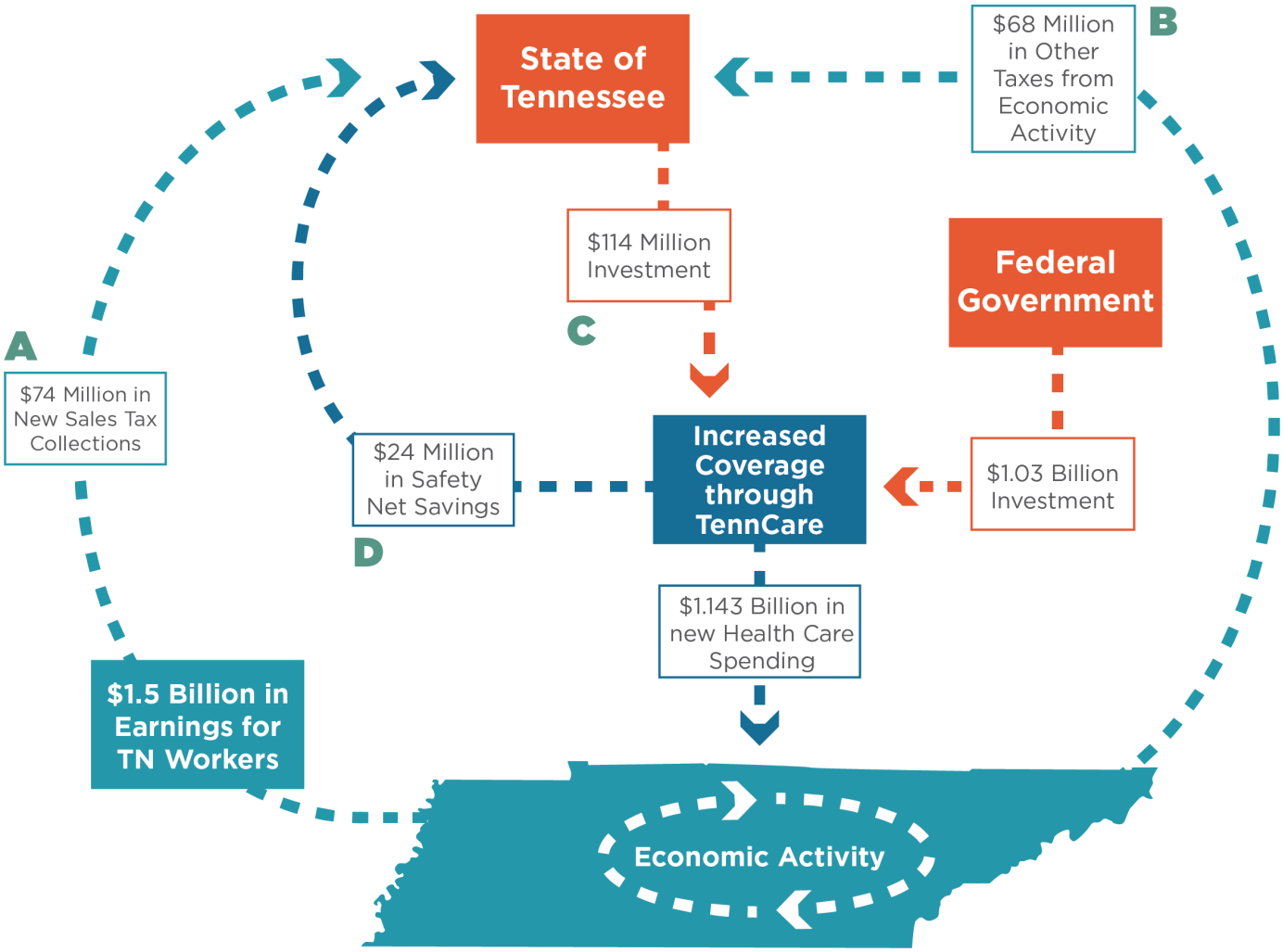
ECONOMIC IMPACT

Expanding TennCare will do much more than make affordable health care accessible to low-income Tennesseans. It will have an immediate impact on Tennessee's economy. The Kaiser Family Foundation reports that as of 2019, TennCare expenditures averaged $5,730 for working-age adults. In states that have expanded Medicaid, enrollees from expansion account for approximately 28 percent of total enrollees. However, it may take some time for individuals who are eligible to become enrolled. Also, states may differ in the share of the population that is eligible under expansion, depending on the characteristics of traditional Medicaid in that state. Recent history from Virginia provides more conservative guideposts for how enrollment under expansion may increase. In 2018, Virginia expanded their Medicaid program. By 2019, the expansion enrollees accounted for 18 percent of all Medicaid enrollees, third lowest among all expansion states.[12] If a similar response were observed in Tennessee, expanding TennCare would increase enrollments by approximately 250,000 persons. For this analysis, we use an even more conservative figure of 200,000 new enrollees to err on the side of caution. If new enrollments are higher, the positive economic and fiscal impacts will be greater than projected here.

The American Rescue Plan provides additional incentives for states to expand Medicaid. Under the American Rescue Plan, states that choose to adopt expansion will receive not only a 90 percent match for all expenses on new enrollees, but also a 5 percent reimbursement on traditional TennCare expenditures for the first two years.

Specifically, these figures imply that every year after expansion, Tennessee is projected to receive $1.03 billion in new federal funds for 200,000 new enrollees, meaning expanding TennCare will effectively serve as a 9-to-1 matching grant. For every single dollar Tennessee spends on the expansion, the federal government contributes nine dollars. While the new spending would first benefit the health care delivery sector, the economic benefits would spread to all sectors and industries in the state. Approximately half of health care operating costs are spent on workers. Therefore, taking into consideration fringe benefit costs, these funds would increase payrolls by approximately $400 million in the health care sector alone.

[12] https://www.kff.org/medicaid/issue-brief/medicaid-expansion-enrollment-and-spending-leading-up-to-the-covid-19-pandemic/



Net Fiscal ROI for State Budgets

Revenue: A + 74 Million B + 68 Million
Expenditures: C + 114 Million D - 24 Million

= 142 Million / 90 Million = **$1.58** for Every Dollar Spent

And...Tennessee Workers are Expected to Receive $1.5 Billion in Additional Earnings

And...Tennessee will Receive an Additional $1.3 Billion as a Signing Bonus over the First Two Years

The paycheck of a health care worker is spent in many sectors across the economy—at the grocery store, restaurant, hardware store, and other places supporting employment and sales tax collections. The money that health care institutions do not spend on labor is spent with vendors for equipment and supplies, but also services. This money also ripples through the state, creating jobs, income and tax revenues.

Using the conservative estimate of 200,000 new enrollees, new spending would create $1.5 billion in increased earnings for residents of the state.[13] Part of the reason earnings will increase is new economic activity from the stimulus will be enough to create over 20,000 new jobs.

All estimates of increased new economic activity, earnings, and job creations account for the fact that some people who will become eligible for TennCare (approximately 24,000 persons) are currently receiving federal tax credits for insurance in which they are enrolled through the ACA marketplace. Because premium subsidies are generally only available for those not eligible for Medicaid, these tax credits would no longer be paid for the new beneficiaries.

[13] https://www.healthaffairs.org/do/10.1377/forefront.20160321.054035

FISCAL IMPACT

FOR EVERY DOLLAR THAT TENNESSEE SPENDS ON THE EXPANSION, IT IS EXPECTED TO RECOUP APPROXIMATELY $1.50 IN NEW REVENUES TO STATE COFFERS.

Expanding TennCare is expected to have a net *positive* fiscal impact, because expansion is projected to increase earnings across the state by $1.5 billion. On average, 4.875 percent of earnings end up collected in sales taxes, resulting in $74 million in new revenue. Additionally, businesses also pay various taxes on economic activities. On average, new earnings result in 4.55 percent of non-sales tax collections in other areas. Expanding TennCare is therefore expected to generate $142 million in revenues. If 200,000 new persons enroll in TennCare, Tennessee can expect to spend $114 million. However, expansion is still expected to generate a net annual increase of $28 million to state budgets from the 9:1 federal matching and consequential increased economic activity. Expanding TennCare would therefore not just be self-funding but would provide a net positive return to the state.

Expansion will also help reduce the rising costs of providing a safety net for the uninsured. The Tennessee Department of Health is already spending almost $50 million in safety net programs for the uninsured, including Primary Care Plus services, Project Access Specialty Care Coordination, and the Behavioral Health Safety Net for Adults. Spending on these programs has increased during the pandemic. In addition these programs, TDH has also secured $53 million in donated specialty care for uninsured Tennesseans. Tennessee is therefore already incurring over $100 million in expenses for safety net programs at the present, and that figure will likely increase in 2022. Because these expenses are scaled to the size of the uninsured population, expanding TennCare should

reduce the expenses for these safety net programs by half, while maintaining the ability to continue to provide services at current levels.

Even though the program will be self-sustaining/cost effective, the American Rescue Plan provides an additional strong financial incentive for expansion to make not doing so economically irresponsible. For states that expand, the federal government will provide an additional 5 percentage point reimbursement for *traditional* Medicaid expenditures.

For Tennessee, expanding TennCare would reduce the state's health care costs by over $1.3 billion in the first two years.

Even under the most extreme assumption that economic stimulus from new coverage generates no impact on earnings or revenues, *and* new enrollments are larger than anticipated, the incentives from the American Rescue Plan are large enough to offset the first 7-10 years of expansion costs to the state. To clarify, suppose that new enrollments are 50 percent higher than projected at 300,000 persons. This would mean Tennessee's share of the expansion costs would amount to $147 million per year. However, if the $1.3 billion in ARP incentives paid out in the first two years are used to offset the costs of expansion, this amount of these payments would be sufficient to offset those costs for the first 8.8 years.

In summary, expanding TennCare would have unequivocally positive economic and fiscal impacts on the State of Tennessee. Expenses for safety net programs would decrease by $25 million per year. For every dollar Tennessee spends on the expansion, it would receive approximately $1.50 in new fiscal revenue. Expanding will increase total earnings by $1.5 billion and create over 20,000 jobs. And on top of all that, the federal government will pay Tennessee an additional $1.3 billion in incentives over the first two years to eliminate any fiscal obstacles.

LEARNING FROM EXPANSION IN OTHER STATES

Tennessee considered expansion in the winter of 2014/2015. However, much was unknown at the time about how individuals would respond to newly available public health insurance. Would there be "hidden" economic costs or benefits from expansion? Specifically, it was possible that expansion may have ripple effects on:

- Labor market behavior
- Participation in other social programs
- Crime
- Hospital solvency
- Use of preventative care and management of chronic conditions

Because approximately half of the states expanded in 2014, much of that uncertainty has been resolved. In 2022, we can learn from the experience of states that have previously expanded about how increased availability for public insurance affects these other factors.

STATE BUDGETS AND ECONOMIC OUTPUT

Case studies from Louisiana and Montana show that expansion increased federal funds to their respective economies, generating additional tax revenues, net cost-savings for the state, and positive spillover effects for businesses.[xiv,xv,xvi,xvii]

Additionally, many studies have found that expansion generated savings to states by offsetting costs for behavioral health, criminal justice and other safety net programs similar to those currently provided in Tennessee.[xviii,xix,xx]

RURAL HOSPITAL SOLVENCY

Tennessee has seen the most hospital closures per-capita of any state over the past 10 years. In terms of total closures and beds lost, Tennessee was second only to Texas. Research has shown that expansion can lead to reductions in uncompensated care and improve hospital solvency. Preventing hospital closures in rural areas is vital in ensuring that rural Tennesseans have access to critical care.[xxi]

LABOR FORCE PARTICIPATION AND EARNINGS

Studies have also shown that expansion increases job growth, employment and enrollees' ability to participate in the labor force and/or engage with community activities. When the idea of expansion was first raised, there was suspicion that newly eligible enrollees might exit the labor force. In fact, evidence shows the opposite—that access to affordable health care empowers individuals to increase their labor market engagement. While some studies have found no effects on the labor market, no studies have found *negative* effects on labor force participation. Evidence shows expansion is instrumental in helping individuals with disabilities return to the labor force.[xxii,xxiii,xxiv]

SOCIAL ASSISTANCE PROGRAM PARTICIPATION

Expansion has been shown to decrease enrollment in disability programs. For individuals with health limitations and without access to affordable care, disability (SSI) may be the only option. Expansion states saw a 3 percent decrease in disability rates from 2014-2017.[xxv]

SUBSTANCE USE DISORDER

Tennessee is in the midst of a massive epidemic of substance use disorder. While the epidemic started with prescription opioids and OxyContin, many users have shifted to uncontrolled substances such as heroin and black-market fentanyl. These substances are viciously, relentlessly addictive, and the road to recovery is long and very difficult.

One of the most successful pathways to recovery is the use of Medication Assisted Therapy (MAT) where opioid-dependent individuals receive buprenorphine. Buprenorphine dramatically reduces the drive to use uncontrolled and illicit substances and is absolutely vital, particularly in the early days of recovery.

Like many other goods in a market-based system, making MAT affordable increases usage. Expansion provides key access to Medication Assisted Therapy. States that have expanded Medicaid see higher rates of initiating and staying with MAT regimens to wean patients off uncontrolled substances.[xxvi,xxvii]

SECONDARY PREVENTION

Part of the value of making health care more affordable in Tennessee is improving our long-run health markers, making us a better location for businesses. Evidence shows that expansion leads to individuals consuming more preventive care, earlier cancer detection, and increasing usage of prescription drugs (particularly to manage chronic conditions).[xxviii,xxix,xxx]

LOOKING AHEAD

Expanding TennCare will yield economic benefits in almost every dimension. In the very near future, expansion will have positive fiscal benefits and generate increased economic activity in the state. It will provide vital financial protection for rural hospitals, ensuring rural Tennesseans have access to health care, particularly for time-sensitive emergent conditions.

In the longer run, increased eligibility will yield spillover effects to the state in subtle ways but ways that have immeasurable impact. Expansion can help with the substance use epidemic, reduce disability and permanent exits from the labor force, and reduce rates of chronic illness (or at least empower patients and providers to treat them more efficiently).

The program is more than self-funding, and the federal government is willing to provide Tennessee $1.3 billion to pursue an endeavor which yields nothing but benefits on net.

STATE LAW AND THE PATH TO EXPANSION IN TENNESSEE

The process to pursue expansion would be as follows: First, the House and Senate of the Tennessee General Assembly would need to pass a joint resolution directing the Governor to pursue expansion with CMS. Any specific terms that are agreed to, particularly departures from "traditional expansion," would need to be negotiated at the federal level and potentially authorized by the General Assembly.

IN THE LONGER RUN, INCREASED ELIGIBILITY WILL YIELD SPILLOVER EFFECTS TO THE STATE IN SUBTLE WAYS, BUT WAYS THAT HAVE IMMEASURABLE IMPACT.

APPENDICES

STATE PROFILES

Currently, 39 states (including the District of Columbia) have expanded Medicaid in accordance with the Affordable Care Act. Initially, decisions to expand were unsurprisingly split along political lines. However, in recent years, several strongly conservative states have recognized the economic, fiscal, and practical benefits of ensuring all individuals have access to health insurance *and* health care. In this section, we profile four such states that have undertaken expansion in the last four years, specifically:

Idaho
Indiana
Oklahoma
Utah

For each state, we highlight how the states pursued traditional expansion or waivers for specific features that depart from traditional expansion. Most of the waiver requests focused on three areas:

- Legislating that the newly eligible pay some nominal premium for their insurance
- Enrollment caps for childless adults
- Work or community service requirements

For each state, we also provide an update on whether CMS has approved those waivers. Generally, CMS has not approved waivers for work requirements.[14] However, work requirements in Tennessee fail a basic cost-benefit analysis as the costs far outweigh the benefits.[15] Similarly, enrollment caps fail the cost-benefit test in Tennessee as each additional enrollee provides net positive fiscal and economic impacts. Nevertheless, the specific expansion proposal and current waiver approval status for each state is summarized in the appendices of this report. In all cases, the expansion that ends up being implemented is very close to traditional expansion, but there may be small variations in the features mentioned above.

[14] Initially, CMS approved waivers for work requirements in twelve states. However, virtually all of those waivers were either revoked or allowed to expire during the pandemic. CMS has not been approving waivers to enforce work requirements under the current administration.

[15] A fiscal note attached to TN HB 1551/SB 1728 projected total cost savings of approximately $3 million at the expense of $22 million in case management costs for verifying whether individuals were meeting these requirements. These requirements would therefore cost the state $19 million per year with virtually no fiscal or economic return.

IDAHO

SUMMARY

While waiver requests are still pending, Idaho has implemented a traditional expansion.

In November 2018, voters in Idaho passed Proposition 2 to expand Medicaid, with an effective date of January 1, 2020. After the measure was passed at the polls, the Idaho state legislature subsequently passed legislation (SB 1204) to alter the expansion to impose requirements—with some exceptions—that Medicaid recipients either:

- Work at least 20 hours per week earning at least minimum wage
- Participate in work training programs for 20 hours per week
- Be enrolled at least half time in post-secondary or other education programs
- Some combination of the above for 20 hours per week

The legislature applied for demonstration waivers to attach a work requirement and "coverage choice" to the state's 2018 ballot initiative-directed Medicaid expansion. However, the work-requirement is still pending as of July 2022 and is unlikely to be approved by CMS. Idaho's coverage choice plan—which sought to allow adults between 100 and 138 percent of the FPL to choose between Medicaid and 100 percent federally-subsidized Marketplace insurance—was rejected because it failed CMS's federal deficit neutrality test.[16]

[16] Section 1332 of the ACA allows states to alter aspects of its health care exchanges if such changes do not increase the federal budget deficit (https://www.macpac.gov/wp-content/uploads/2016/08/Comparing-Section-1332-and-Section-1115-Waiver-Authorities.pdf)

INDIANA

KEY FEATURE

Indiana requires some cost sharing—albeit very small—among enrollees. Annual cost sharing for enrollees is not allowed to exceed 5 percent of household income. For virtually all enrollees, the actual share they pay never approaches that number. Enrollees contribute to an HSA on a monthly basis, based on income, where the maximum monthly contribution is $20. The monthly contributions by both enrollees and the state are used to contribute towards the first $2500 of health care expenditures for each enrollee.

Indiana has historically administered its Medicaid program through a Section 1115 waiver. The original Healthy Indiana Plan was the only one of our six case study states to cover childless adults prior to expansion—it made adults with income under 200 percent of the FPL eligible, but capped enrollment of adults without dependents.[17]

While enrollment caps were dropped in expansion, the Healthy Indiana Plan (HIP) 2.0 incorporated several innovations from the original plan. Adults without dependents with incomes between 100 and 138 percent of FPL are enrolled in HIP Plus, which covers vision and dental services and requires contributions to an HSA-style account of up to $20 per month. Smokers face a 50 percent contribution surcharge, and required contributions are reduced for members who seek preventative care annually.[18] Failure to contribute results in six months of ineligibility for expansion adults and rolls non-expansion members into the pared down HIP Basic plan, which features copayments for non-preventative services and prescriptions.[19,20,21] The state contributes the remainder of $2,500 per enrollee, which is used first to pay for services. Finally, unused enrollee contributions to cost-sharing are rolled over each year.

[17] https://www.kff.org/medicaid/fact-sheet/healthy-indiana-plan-and-the-affordable-care-act/
[18] https://www.in.gov/fssa/hip/about-hip/power-accounts/
[19] https://www.in.gov/fssa/hip/about-hip/about-the-hip-program/
[20] https://www.in.gov/fssa/hip/files/IN_HIP_STC_Evaluation_Design.pdf
[21] Each tier has a "State Plan" counterpart, which offers the same benefits as Basic and Plus to traditional Medicaid mandatory populations, without copayments, and special plans for maternity and the medically frail.

OKLAHOMA

SUMMARY

Traditional expansion ended up being more efficient and cost effective than proposed alternatives, particularly during the pandemic.

Oklahoma's SoonerCare expansion came through a 2020 ballot initiative amending the state constitution. The amendment requires Medicaid be offered to all adults with income less than 138 of the FPL. It also expressly forbids the state from imposing any restrictions on enrollment or eligibility for expansion recipients except those in place for traditional Medicaid recipients.[22] The expansion took effect July 2021.

Originally, the governor of Oklahoma had proposed an alternative expansion, SoonerCare 2.0 that would have included premiums, a work requirement and a per-enrollee spending cap. However, increased Medicaid enrollments during the pandemic changed the costs of the alternative expansion relative to traditional expansion, and Governor Kevin Stitt essentially vetoed his own proposal.

[22] https://ballotpedia.org/Oklahoma_State_Question_802,_Medicaid_Expansion_Initiative_(June_2020)#cite_ref-quotedisclaimer_10-0

UTAH

KEY FEATURE

A mostly traditional expansion, but enrollees who have access to employer sponsored health insurance are required to enroll, with the state providing reimbursements for premiums and copays.

Utahns voted in a 2018 ballot initiative to expand state coverage to residents with income up to the 138 percent FPL. The legislature instead overturned the initiative and submitted a Section 1115 waiver limiting expansion to parents with incomes 60 to 100 percent of the FPL (leaving out childless adults entirely) and limiting enrollments of expansion adults based on state budget shortfalls.[23] CMS allowed federal matching to Utah at their traditional 68 percent rate but denied their application for enrollment caps and the full 90 percent FMAP. However, CMS approved a requirement that beneficiaries enroll in available employer-sponsored insurance, with the state reimbursing premiums and copayments. Full expansion came about in July 2020 through the state's fallback plan.[24] The current administration has also withdrawn approval for a work and community engagement requirement.

[23] https://www.kff.org/medicaid/issue-brief/from-ballot-initiative-to-waivers-what-is-the-status-of-medicaid-expansion-in-utah/
[24] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-per-capita-cap-pa.pdf

DATA APPENDIX

The data for this report are taken from two sources:

The American Community Survey (ACS) is published yearly by the U.S. Census Bureau. It is generated from a one percent sample of the population and focuses on demographic data, including labor force participation, housing characteristics, employment. Data at the sub-state level are available selectively. It is the largest annual survey for population data in the U.S. The most recent data available from the ACS that are comparable to other years are the 2020 5-year estimates.

The Behavioral Risk Factor Surveillance System (BRFSS) is produced by the Centers for Disease Control (CDC) and is the world's largest telephone health survey. BRFSS contains coarse information on employment, income, and health insurance, but much richer data on health conditions, medical care utilization, and health behaviors than the ACS. The sample size each year is roughly a tenth of a percent.

Data on expected health insurance premiums were taken from exchange links on healthcare.gov

In this study, we restricted the analysis to non-institutionalized citizens between age 19 and age 64 to achieve similarity in ages when comparing the Potential Enrollees to the eligible and ineligible population. We defined each group (eligible, ineligible, Potential Enrollees) on the basis of stated TennCare eligibility thresholds and stated definitions of the expansion population. ACS reports whether individuals are currently enrolled in Medicaid. We therefore define the TennCare Eligible Non-recipients as those who are eligible for TennCare by income/health/family requirements but report not being enrolled in TennCare. On page 12 ("Where do they live"), 2020 ACS 5-year estimates were used with 2013 definitions of metropolitan areas.

We have conducted considerable sensitivity analysis on our results. The ACS is sample data and as such contains some inherent error. Furthermore, TennCare eligibility is determined by a complex, multi-faceted set of factors including income, percentage of income to poverty level, family composition, individual health factors, family health factors, and personal circumstance. The ACS was designed for broad demographic studies rather than capturing who, precisely, is TennCare eligible. We therefore checked whether our results characterizing the Potential Enrollees population were sensitive to changes in boundaries used to determine TennCare eligibility. We found that at most, including or excluding groups of individuals near the eligibility thresholds changed the reported percentages by +/- 0.5 percentage points.

In the BRFSS data, income is reported in $5,000 increments. When an individual reported income in an interval where they could or could not have been eligible, we treat them as ineligible. We have checked that the findings and implications of this report are not sensitive to treating individuals in those income intervals as eligible (or target) or ineligible. In the ACS data, individuals report whether they are receiving TennCare, thereby enabling us to identify those who are eligible, but not currently enrolled in TennCare. BRFSS does not, meaning that when comparing health statistics for each group, we can delineate groups of interest on the basis of eligibility, but not enrollment. In the BRFSS data, we essentially treat low-income families with children as TennCare eligible and those without as Potential Enrollees. The ACS supports this characterization. Individuals who are currently eligible for TennCare are four times as likely to have a child living with them as Potential Enrollees. BRFSS data were used for the tabulations on pages 11-16. The figures in this report used 2020 BRFSS data.

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