Nebraska Medicaid Expansion 2018 Update

Protecting a Critical Infrastructure

Supporting Main Street

Improving Worker Health and Productivity

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Introduction

A central feature of the Patient Protection and Affordable Care Act (ACA) was the expansion of Medicaid coverage to significantly reduce the number of Americans who lacked health insurance coverage. This strategy was jolted by the June 2012 *National Federation of Independent Business (NFIB) v. Sebelius* Supreme Court decision which upheld the constitutionality of the ACA, but included the totally unexpected ruling that individual states could decide the issue of Medicaid expansion. The court decision set off a flurry of economic impact studies as states sought to identify the costs and benefits before deciding whether to proceed with expansion. It was a substantial decision – expanding Medicaid coverage to all citizens with incomes less than 138 percent of the Federal Poverty Level (FPL) would extend benefits to 16 – 17 million low-income people across the nation. [1] Medicaid expansion in Nebraska would extend coverage to an estimated 87,214 by FY2021-2022. [2]

Beginning in 2013, Medicaid expansion bills were proposed in the Nebraska Unicameral. None of the legislative proposals became law, so in 2018 public interest groups decided to address expansion through the state's initiative petition process. In March 2018 supporters began collecting signatures for Initiative 427, which would require that Nebraska provide Medicaid coverage for all persons under the age of 65 with incomes equal to or below 138 percent of the FPL. Initiative 427 also requires the Nebraska Department of Health and Human Services to file a state expansion plan with the Centers for Medicare and Medicaid Services on or before April 1, 2019.

On July 5, 2018, supporters submitted 136,791 petition signatures to the Nebraska Secretary of State for validation. On August 24, 2018, the Secretary of State announced that the petitions contained 104,477 valid signatures, exceeding the 84,269 valid signatures required by law. Further, signatures of more than 5 percent of registered voters were collected in 47 of the state's 93 counties, thus meeting the law's distribution requirement of a minimum of 38 counties. Opponents of expansion filed a lawsuit in July, but that suit was dismissed on August 28th by a Lancaster County District judge. The opponents then filed an appeal with the Nebraska Supreme Court, which ruled against their motion on September 12th. With this court decision, the issue of Medicaid expansion is on the November 6, 2018 ballot.

This report is intended to help voters consider both the costs and benefits of the proposed change to Nebraska statutes. Medicaid coverage does not go to a low-income recipient and stop; it flows through the recipient to medical providers and ripples through the state economy. The report considers the costs to the state identified by the Legislative Fiscal Office. Benefits include supporting the local economy by increasing disposable income for low-wage workers; cost-effective job creation relative to existing state tax incentive programs; reducing subsidization of the uninsured now done through taxes and increased

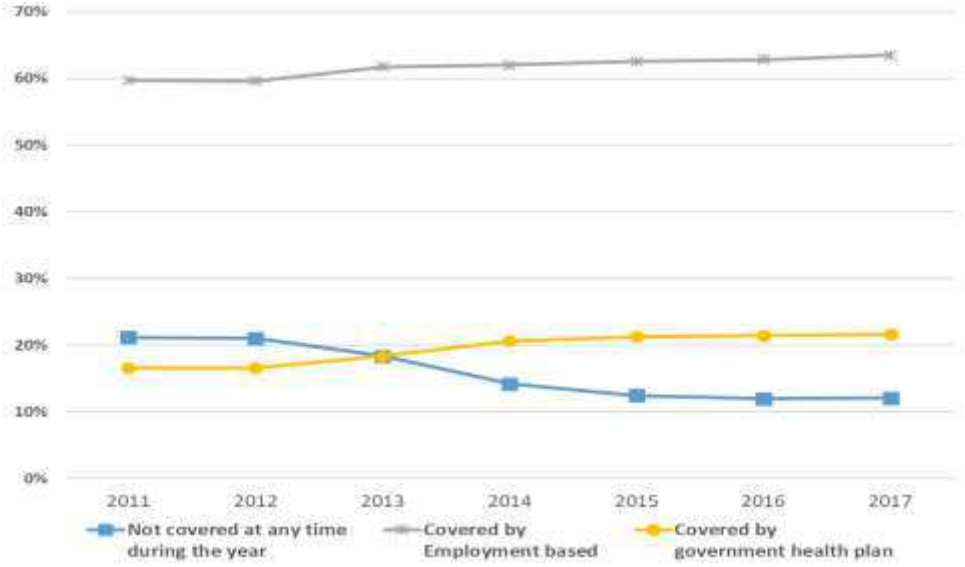
private insurance premiums; protecting local businesses by reducing medical-related bankruptcy; helping businesses and workers by improving worker health and productivity; and reducing uncompensated care for providers.

I. The Existing Health Insurance Environment

Unique among developed countries, in the United States health insurance for working age adults is linked directly to employment (Figure 1). However, in recent years this approach has become increasingly problematic because of two significant constraints. First, employment-based health insurance is not evenly distributed across income groups. For the 25 percent of workers with the lowest incomes, only one-third have access to employment-based insurance. Because the cost of the insurance premium is high relative to the wages for this group, low income workers have a lower "take-up" rate than other income groups. The take-up rate is the percentage of eligible workers who actually enroll for the offered coverage (Figure 2). The second significant constraint is the decreasing number of smaller firms (fewer than 100 employees) now offering employment-based insurance (Figure 3). This trend is particularly troublesome in rural areas, which tend to have few large firms with more than 100 employees.

Figure 1

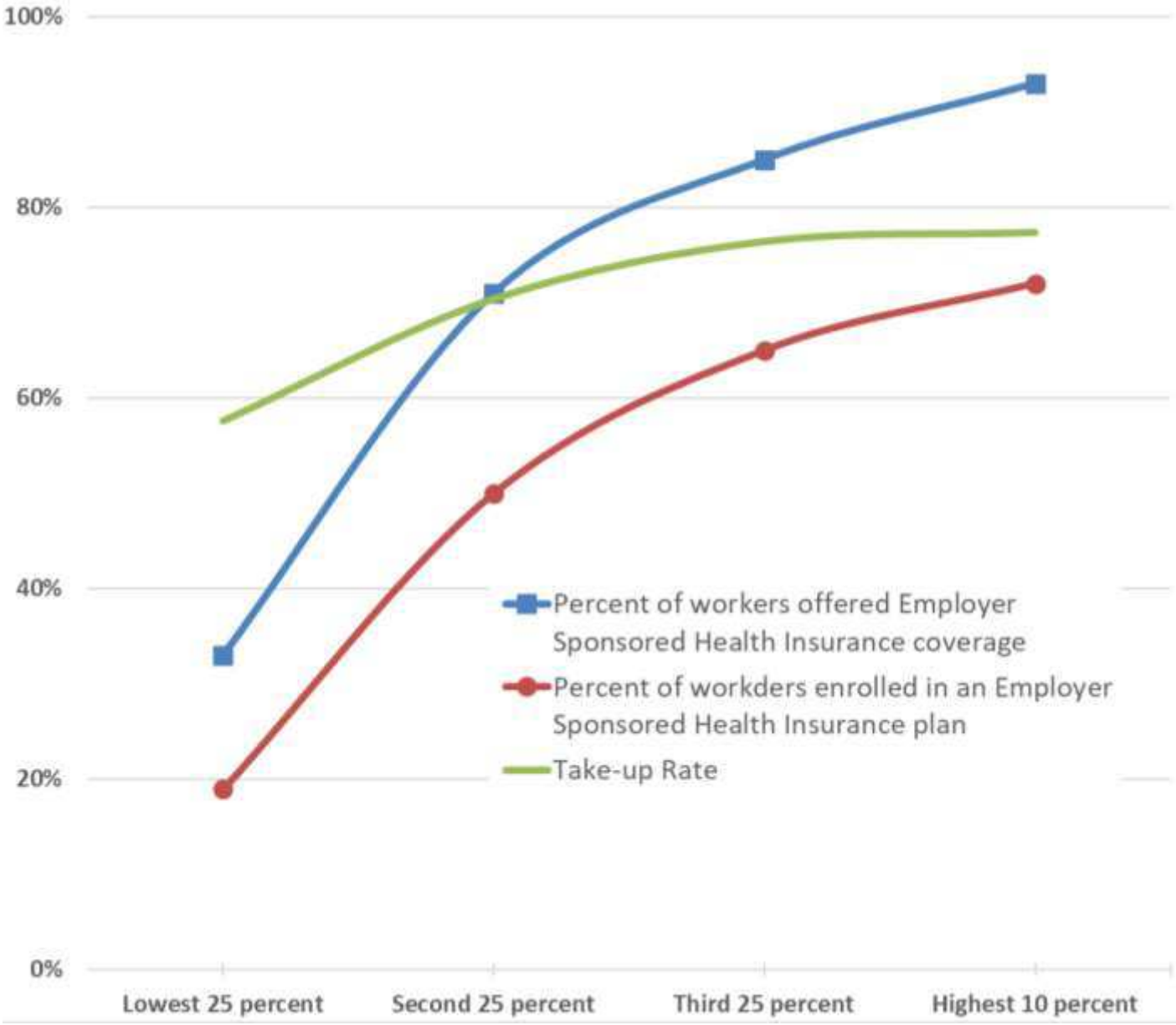
National Health Insurance Status
Ages 18 – 64, 2011-2017



Source: U.S. Census Bureau [3]

Figure 2

Private industry employee access to medical care benefits and participation rates by wage category, March 2016



Source: U.S. Bureau of Labor Statistics [4]

Figure 3

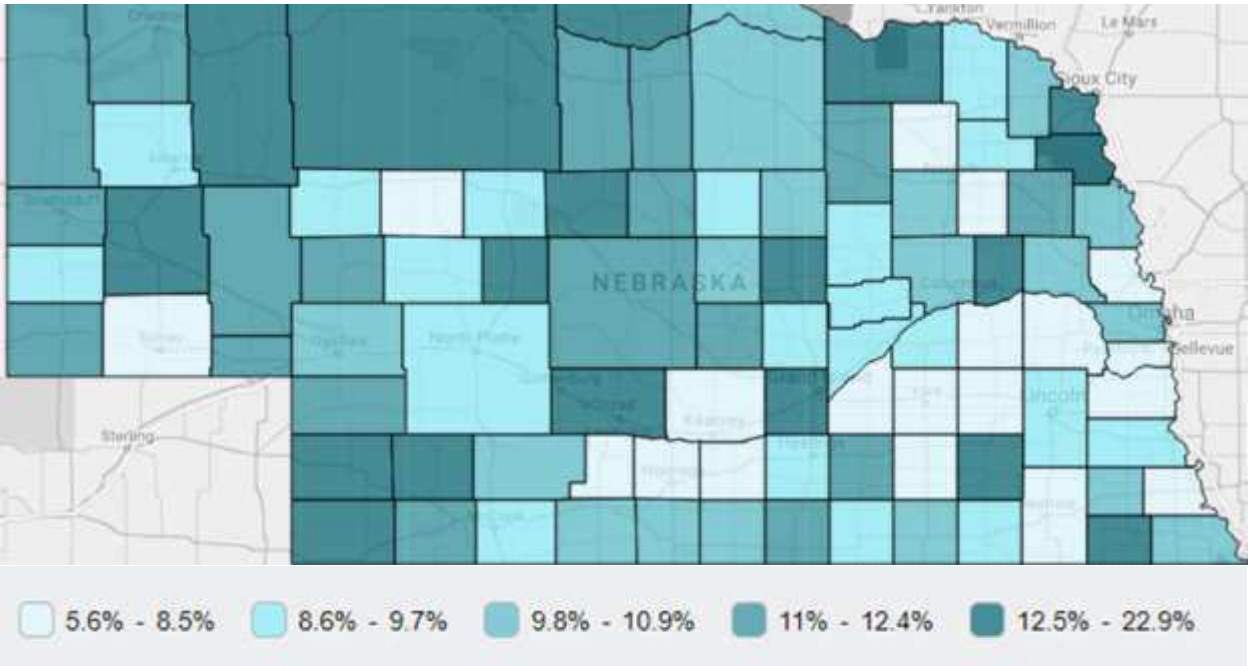
Percent of Private-Sector Establishments that offer health insurance, by establishment size, 2008-2017

Source: Medical Expenditure Panel Survey – Insurance Component(MEPS-IC) [5]

There is also a substantial geographic variation in health insurance coverage, reflecting the employment mix and representative firm size in different areas. For example, county-level data for Nebraska shows an uninsured rate from 5.6 percent to 22.9 percent. This geographic variation has a pronounced impact on the financial viability of local hospitals and health care providers in counties with high uninsured rates. Providing health care to the uninsured presents a formidable challenge for all providers. A Kaiser Family Foundation report calculated that each uninsured individual received $1,702 in implicitly subsidized uncompensated care, at a total cost of $69.4 billion in 2013. [6] With the percentage of uninsured being higher in rural areas, uncompensated care has the greatest financial impact on small, low volume hospitals (Figure 5).

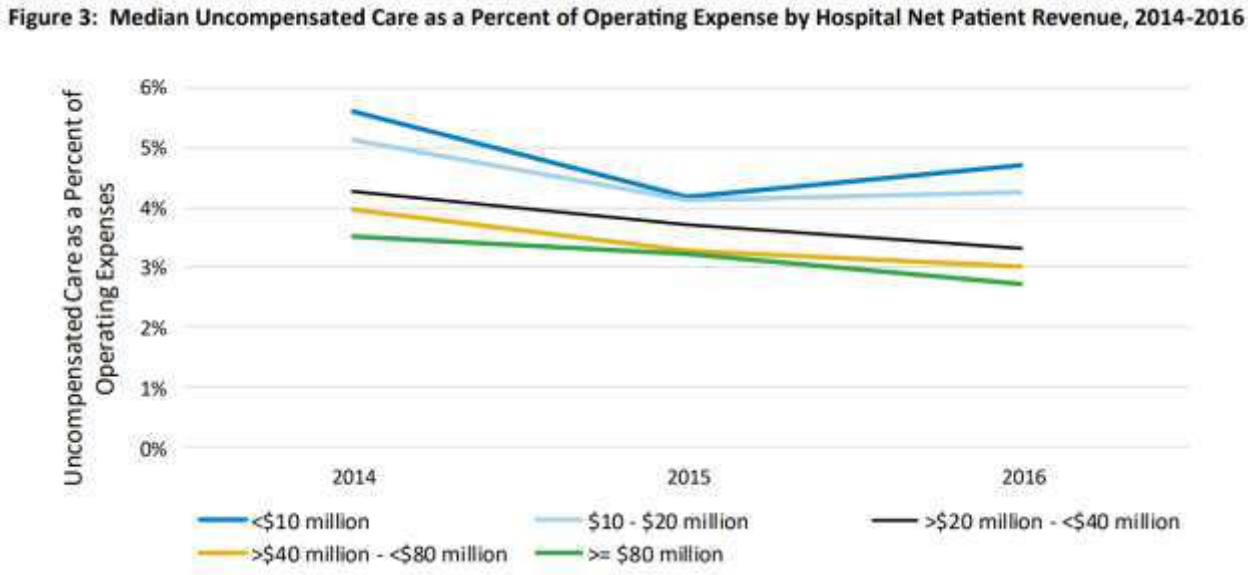
Figure 4

Nebraska Percent Uninsured by County, Under 65 Years of age, 2017



Source: U.S. Department of Census

Figure 5



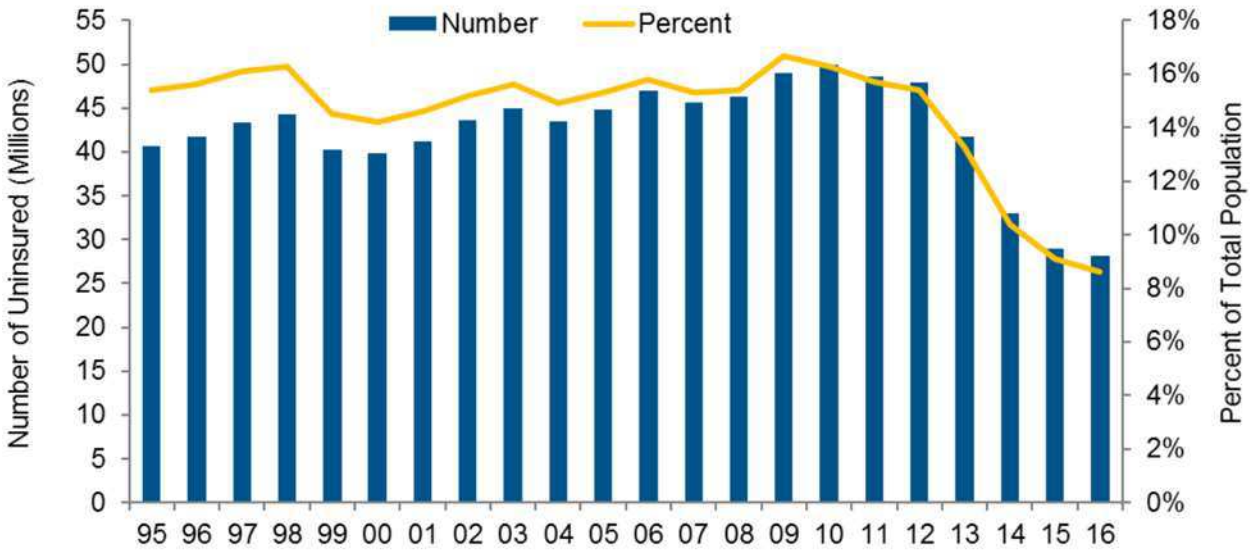
Source: Cecil G. Sheps Center for Health Services Research, University of North Carolina [7]

II. Impact of the Patient Protection and Affordable Care Act

Passage of the ACA in 2010 had a noticeable influence on the health insurance landscape, particularly by reducing the number of uninsured. According to a 2017 report from the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicaid expansion states realized a 9.2 percentage point reduction in the number of uninsured adults (a 49.5 percent decline in the uninsured rate) since 2014. Non-expansion states realized a 7.9 percentage point reduction in the uninsured rate among uninsured adults (a 33.8 percent decline in the uninsured rate) in that same time period. [8] For those with incomes between 139 percent and 400 percent of the FPL, coverage gains were significant in states with or without Medicaid expansion. This finding is expected since it is consistent with the subsidies provided by the ACA for insurance in this income range, regardless of state decisions regarding expansion.

Figure 6

Change in the Number and Percent of Uninsured, 1995-2016



Source: American Hospital Association, [9]

Of the 33 states (plus DC) now participating in Medicaid expansion, all enacted their expansion in January 2014 except the following: Alaska (September 2015), Indiana (February 2015), Louisiana (July 2016), Michigan (April 2014), Montana (January 2016), New Hampshire (August 2014), and Pennsylvania (January 2015). Virginia and Maine have adopted expansion but have not implemented their programs yet. Arkansas, Iowa, and Michigan introduced cost sharing and premiums for enrollees by expanding under a Section 1115 waiver. Section 1115 of the Social Security Act gives the Secretary of HHS authority

to approve experimental, pilot, or demonstration projects that will likely assist in promoting the objectives of the program.

The reduction in the number of uninsured had positive impacts on the financial circumstances of providers and consumers. At the national level, uncompensated care for hospitals fell from $46.4 billion in 2013 to $38.3 billion in 2016. Insurance coverage also benefited individual families, with fewer families reporting difficulty in paying health care bills (Figure 7). Family financial improvement was particularly strong in the Medicaid expansion states. An ASPE report found that expansion states saw reduced third-party collections of medical debt by $600 to $1,000 per individual. Only 18 percent of adults in the expansion population had trouble paying a medical debt while 53 percent of uninsured adults had difficulty paying for healthcare. [8]

Figure 7

Percent and number of persons under age 65 in families having problems paying medical bills

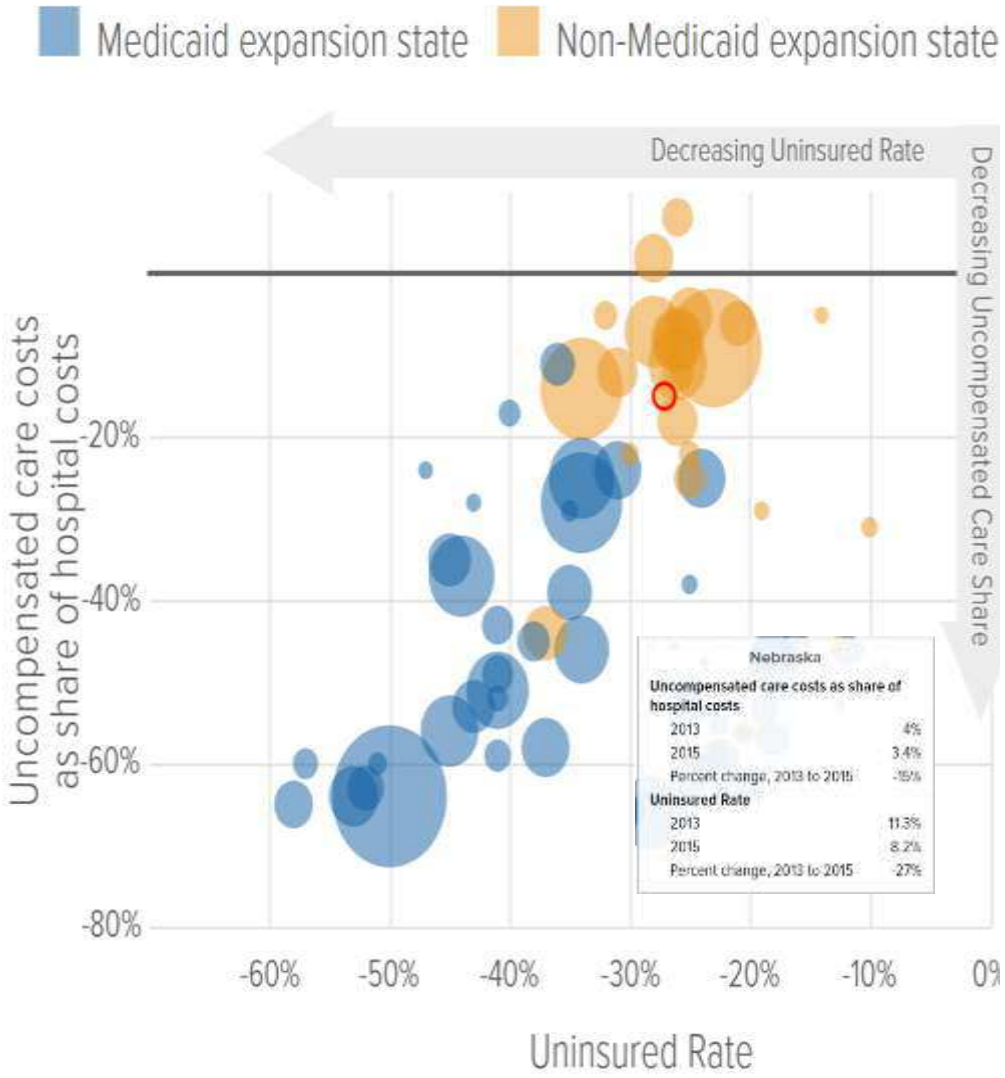
Source: Center for Disease Control

On the important issue of uncompensated care, multiple studies are showing a 50-70 percent decrease in expansion states. ASPE research presents a substantial collection of information on this issue. Based on insurance coverage gains in 2014, ASPE estimated that hospital uncompensated care costs were $7.4 billion lower in 2014 than they would have been had coverage remained at the 2013 level; $27.3 billion versus $34.7 billion. This represents a 21 percent reduction in uncompensated care in the first year of expansion. The 28 Medicaid

expansion states in 2014 (plus DC) accounted for $5.0 billion of this reduction, seeing a 26 percent decrease in uncompensated care (68 percent of total savings). The 22 non-expansion states saw a $2.4 billion decrease (16 percent) reduction in uncompensated care (32 percent of total savings). ASPE estimated that if non-expansion states had proportional increases in Medicaid coverage as the expansion states, their uncompensated care would have declined by an additional $1.4 billion. [10] The improvement in uncompensated care in expansion states has continued to increase (Figure 8).

Figure 8

Percent Change in the Uninsured Rate and In Uncompensated Care, 2013-15



Source: Center on Budget and Policy Priorities [11]

Medicaid expansion has improved the health of low-income Americans through the increased access to primary care, expanded use of prescription medications, and increased rates of diagnosis of chronic conditions for new enrollees. Low-income individuals living in

expansion states generally had a greater increase in the use of preventive services recommended by the United States Preventive Services Task Force than low-income individuals living in non-expansion states. [8]

Collectively, these studies indicate that the ACA has reduced the number of uninsured, is improving access to appropriate care and preventive services, is having a substantial positive impact on provider revenue, and is reducing the difficulties that families have in paying medical bills.

The ACA Changes the Healthcare Environment in Non-Expansion States

The writers of the ACA anticipated that the legislation would reduce the number of all uninsured by 30 million through the nationwide expansion of Medicaid. Accordingly, the ACA includes cost-containment provisions anticipating that the number of uninsured would decrease. Thus, the ACA significantly changes the fiscal environment for providers in both expansion and non-expansion states because it includes permanent reductions to reduce other federal healthcare spending by an estimated $196.3 billion over ten years. The ACA also included lower reimbursements to disproportionate-share hospitals (DSH), facilities which provide care for low-income populations. Federal payments to hospitals were further reduced as part of the "fiscal cliff" sequestration budget cuts. In the American Taxpayer Relief Act of 2012 (ATRA), Congress required CMS to make adjustments to payments made in FYs 2010-2013 in response to coding and documentation impacts from the move to a more detailed Diagnostic Related Group (DRG) system in 2008. Nationally, this adjustment pushed an additional cut of $11 billion onto hospitals. These cuts create real financial challenges, the Office of the Actuary – Centers for Medicare & Medicaid (CMS) estimates that the cuts in federal payments will result in 15 percent of all American hospitals being unprofitable by 2020. [12]

As a result of these federal changes, Nebraska's hospitals have seen a variety of reimbursement reductions from both legislative and regulatory actions. The Nebraska Hospital Association estimates that the existing cuts will reduce hospital revenue by $2.7 billion between 2013 and 2027. There is another $815 million in proposed cuts over that time period. Using this information in an IMPLAN model, the direct and indirect economic impacts of the collective cuts from 2013 to 2027 were used to calculate the total effects on Nebraska's economy and tax collections. The enacted cuts, and the proposed cuts if they occur, will decrease state-wide employment, labor income, tax revenue and industry output. These economic headwinds exist regardless of the state decision on Medicaid expansion.

Figure 9

Medicare Cuts to Nebraska Hospitals

Cuts Enacted (2013-2027): Legislative	
ACA Marketbasket Cuts	($1,282,452,600)
Sequestration	($463,942,900)
Medicare DSH Cuts	($317,164,900)
ATRA Coding	($166,453,200)
PAMA CLFS Adjustment	($36,347,300)
Bad Debt at 65%	($9,508,100)
MACRA Post Acute MB Cut	($5,223,000)
Total Legislative Cuts	**($2,281,092,000)**

Cuts Enacted (2013-2027): Regulatory	
Coding Cuts	($353,763,500)
LTCH SN Adjustment	($118,732,900)
340B Reduction	$47,433,600
Total Regulatory Cuts	**($425,062,800)**

Quality Based Payment Reform (2013-2027)	
Quality	($45,570,400)
Total Cuts Enacted	**($2,751,725,200)**

Cuts Under Consideration (2018-2027)	
Rural Hospital Program Cuts (SCH,CAH)	($314,425,500)
Graduate Medical Education Cuts	($264,787,225)
Post-Acute Care Payments Cuts	($47,867,600)
Elimination of Bad Debt Payments	($43,820,700)
Site-Neutral Payment Cuts	($56,376,700)
Extension of 2% Sequestration	($88,348,000)
Total Cuts Under Consideration	**($815,625,725)**

Source: Nebraska Hospital Association, September 2018

Figure 10

Total Cumulative Economic Impact of Currently Enacted Medicare Cuts in Nebraska, (2013 – 2027)

Impact Type	Total Effect
Employment**	(34,300)
Labor Income	($1,931,000,000)
Output	($5,024,000,000)

**Employment is cumulative job years and not on a year-by-year basis

Figure 11

Total Cumulative Tax Impact of Currently Enacted Medicare Cuts in Nebraska, (2013 – 2027)

State and Local Taxes	
NE Income Tax	($38,646,000)
NE Sales Tax	($39,052,000)
NE Property Tax	($48,269,000)
NE Motor Vehicle	($3,231,000)
NE Corporate Taxes	($7,619,000)
Other Nebraska Taxes	($10,126,000)
Total Nebraska Tax	**($146,943,000)**

Federal Taxes	
US Personal Income Tax	($122,514,000)
US Corporate Profit Tax	($53,863,000)
Other US Taxes	($239,777,000)
Total Federal Tax	**($416,154,000)**

The enacted cuts are substantial but are not the end of the story. Cost containment pressures are not going to end in the near future. The sheer size of healthcare spending in the federal budget makes it an attractive target for a variety of future cuts.

Figure 12

Total Cumulative Economic Impact of Medicare Cuts Under Consideration in Nebraska, (2018 – 2027)

Impact Type	Total Effect
Employment	(10,200)
Labor Income	($572,000,000)
Output	($1,489,000,000)

**Employment is cumulative job years and not on a year-by-year basis

Figure 13

Total Cumulative Tax Impact of Medicare Cuts Under Consideration in Nebraska, (2018 – 2027)

State and Local Taxes	
NE Income Tax	($11,445,000)
NE Sales Tax	($11,575,000)
NE Property Tax	($14,307,000)
NE Motor Vehicle	($958,000)
NE Corporate Taxes	($2,258,000)
Other Nebraska Taxes	($3,001,000)
Total Nebraska Tax	**($43,554,000)**

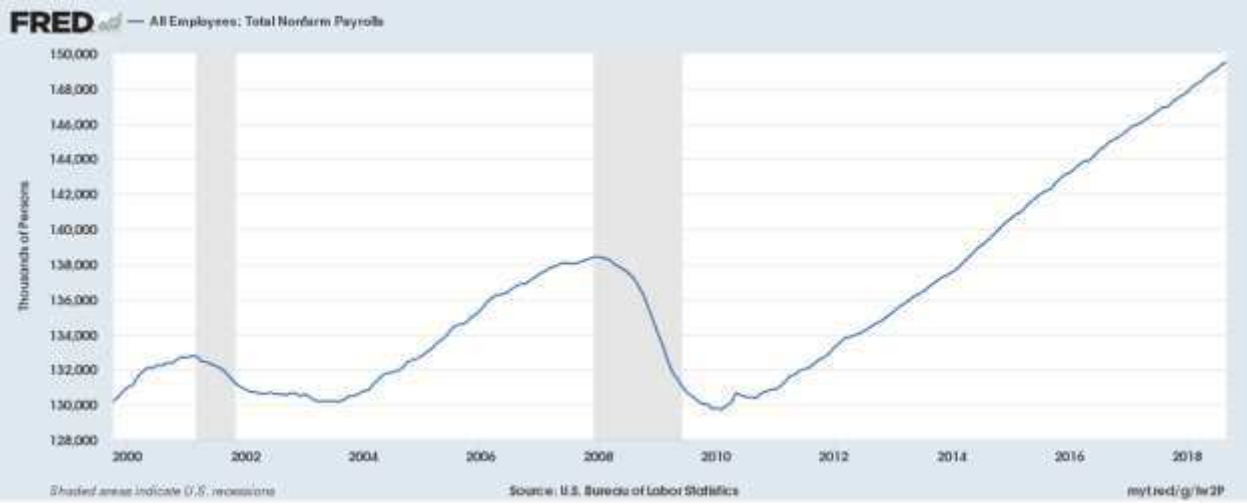
Federal Taxes	
US Personal Income Tax	($36,314,000)
US Corporate Profit Tax	($15,965,000)
Other US Taxes	($71,071,000)
Total Federal Tax	**($123,350,000)**

III. ACA Economic Impacts Beyond Healthcare

The ACA economic impacts are occurring against the backdrop of a slow but steady national recovery from the sharp recession stemming from the financial crisis of 2008 (Figure 14). Medicaid expansion states are seeing generally robust economic growth. Nine of the ten states with the largest percentage decrease in the unemployment rate between 2013 and 2017 had expanded Medicaid by January 1, 2014. Likewise, eight of the ten states with the greatest decrease in Chapter 7 bankruptcies over this period were states that had expanded Medicaid in 2014. Even in the non-expansion states, the ACA insurance subsidies have helped more modest income families obtain insurance at a reduced cost. While there are many factors influencing the economy, the strong showing made by the Medicaid expansion states on employment gains and reduction of bankruptcy presents evidence that the overall economic effect of expansion is positive.

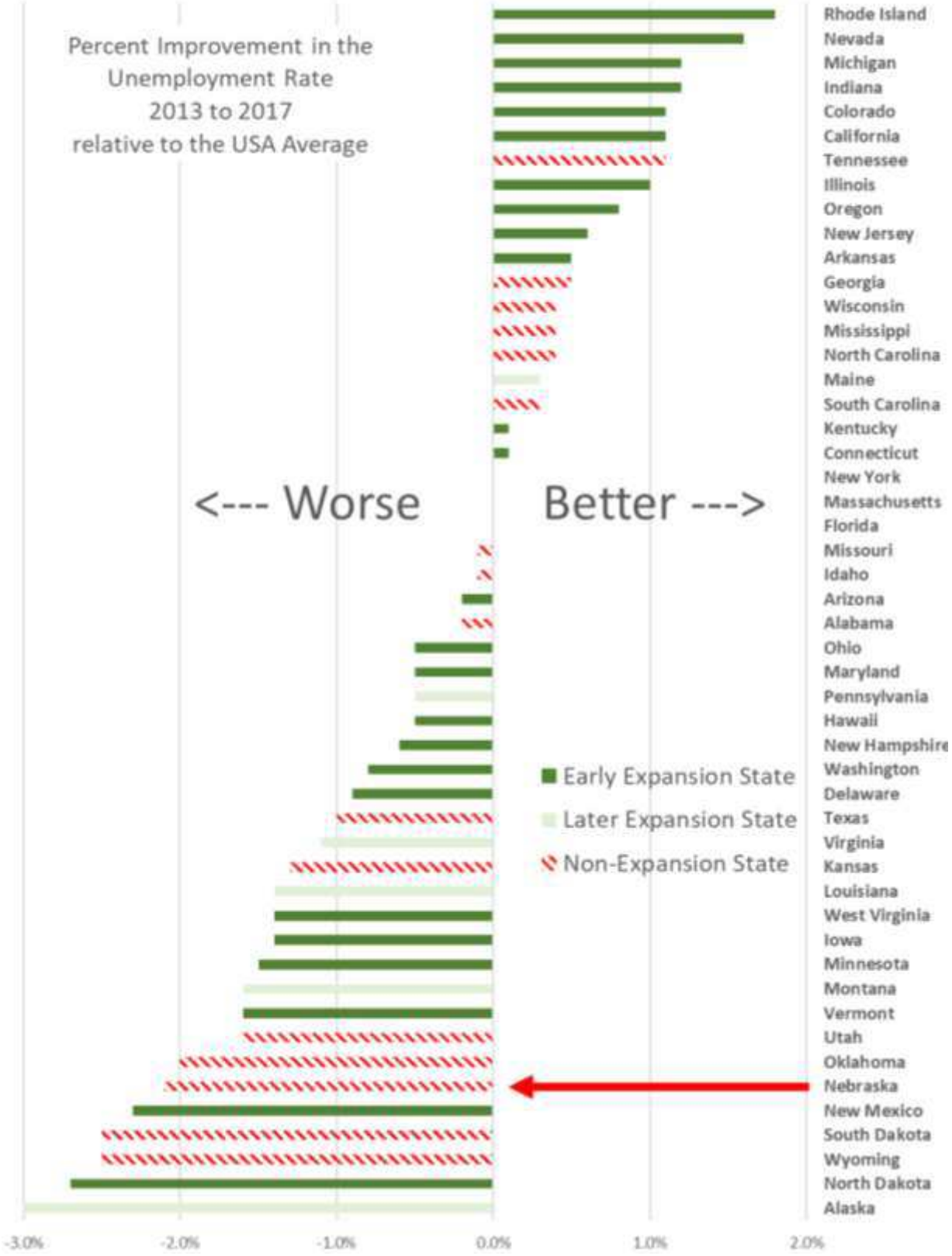
Figure 14

Total Nonfarm Payrolls



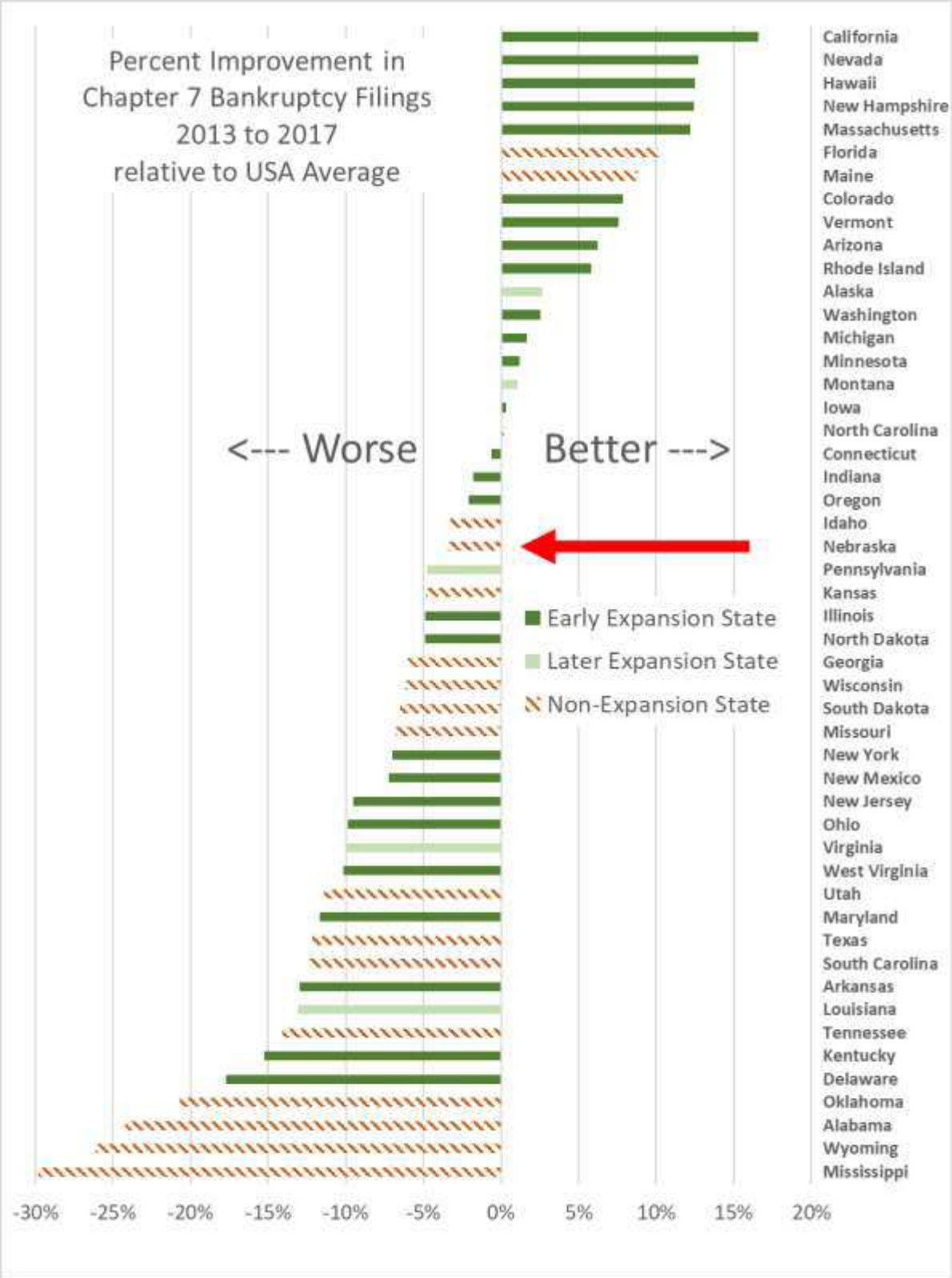
Source: Federal Reserve Bank of St. Louis, 2018

Figure 15



Source: Bureau of Labors Statistics

Figure 16



http://www.uscourts.gov/statistics/table/f/statistical-tables-federal-judiciary/2017/12/31

IV. The Economic Consequences of the Uninsured

The uninsured population, still numbering more than 28 million in 2017, presented three significant economic problems for the healthcare system. First, the uninsured are likely to under consume medical services. This means they defer preventive care, miss recommended screenings, don't buy prescribed pharmaceuticals, or delay needed care for economic reasons. By the time the uninsured seek medical care, they are sicker and require more expensive treatment over the long term. The under-utilization of preventative care, particularly on issues like vaccination, has negative impacts on the wider society. [13]

Second, the uninsured may misuse high-cost emergency services because they lack a developed relationship with a family practice provider. According to Center for Disease Control (CDC) data, 17.6 percent of uninsured adults aged 18 to 64 had one or more emergency department (ED) visits in 2016. [14] This misuse helps create avoidable costs of $38 billion per year nationally. [15] Frequent ED users with four or more visits per year comprise 4.5 to 8.0 percent of all ED patients, but account for 21 to 28 percent of all visits. Though small in number, the "super-users" can account for a large share of costs. For example, in Oregon fifty percent of ED expenses were concentrated in only three percent of the Medicaid population, roughly 16,000 individuals. [16]

Third, the uninsured are often unable to pay for healthcare services received, creating billions of dollars in bad debt/charity care and putting increasing financial pressure on healthcare providers. Charity care is care for which hospitals never expected reimbursement. Bad debt occurs when the provider cannot obtain reimbursement for care provided because patients are unable or unwilling to pay their bills. In 1980, hospitals dealt with $3.9 billion in bad debt/charity care ($11.03 billion in 2013 dollars). By 2013 it had increased to $46.4 billion, thus roughly quadrupling between 1980 and 2013 in real terms. As the number of uninsured fell following passage of the ACA, uncompensated care for hospitals fell to $38.3 billion in 2016.

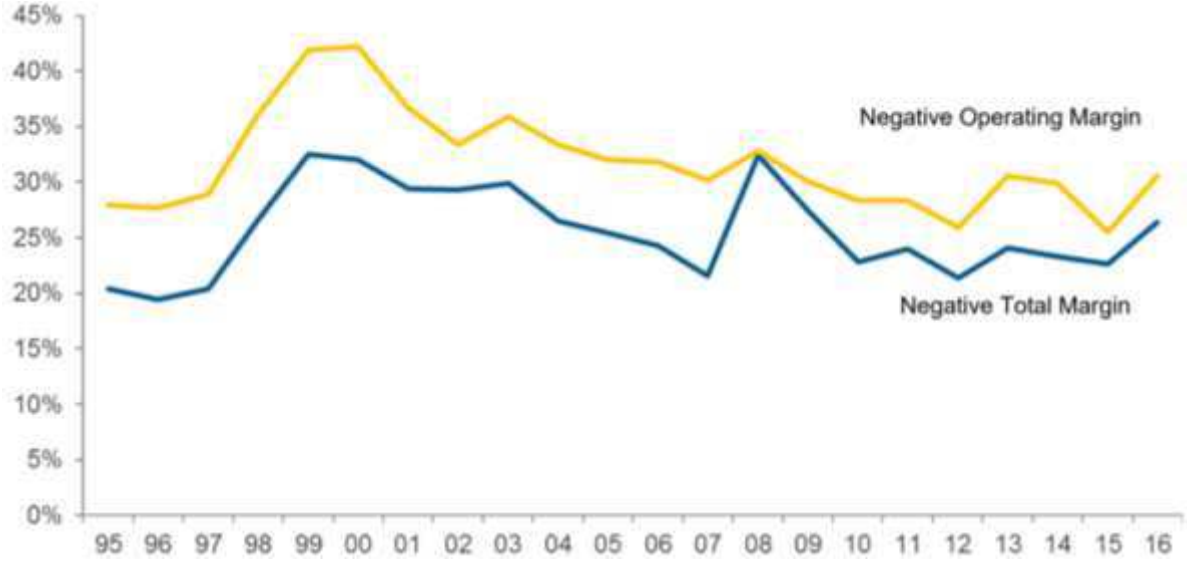
Bad debt/charity care is certainly influenced by unexpected events. In 2015, there were 39 million injury-related visits to emergency departments, accounting for 28 percent of all ED visits. There was no insurance coverage in 20 percent of ED visits. [17] Rural states tend to have high rates of serious motor vehicle accidents. Nearly 2 percent of licensed drivers in Nebraska are involved in a motor vehicle collision each year, with 228 people killed and 17,691 injured in traffic accidents in 2017. Motor vehicle crashes cost Nebraskans over $943 million in 2017. [18]

Events triggering the necessity of medical care are not uniform. An accident or medically-necessary event creating less than $500 in costs can be addressed over time even by families lacking insurance. However, few accidents and interventions are that small - the average medical cost of an accident in 2013 was $4,414 per injured person. [19] There are also

extraordinarily expensive cases. An analysis of South Dakota Medicaid inpatient hospital statistics revealed that 2.7 percent of hospital inpatient stays were responsible for 49 percent of total inpatient payments. [20] For these economically catastrophic events, uninsured families have no realistic chance of paying the bill. Every uninsured single adult or family thus presents an ongoing financial risk to the local community hospital.

Figure 17

Percent of Hospitals with Negative Total Margins,
Percent of Hospitals with Negative Operating Margins,
1995 - 2016



Source: American Hospital Association, Chartbook 2018

All hospitals are operating in an increasingly cost-conscious environment as national policy attempts to slow the growth of healthcare spending. National health expenditures grew at an average annual rate of 9.3 percent between 1960 and 2012. However, between 2010 and 2013 spending only grew at a 3.8 percent annual rate, the lowest rate of growth for any four-year period since 1960. [21] The health spending growth accelerated to 5.1 percent in 2014, up to 5.8 percent in 2015, then dropped to 4.3 percent in 2016. [22]

While this reduction in expenditure growth is good at the macroeconomic level, it places increasing financial stress on individual hospitals. According to the AHA, more than 25 percent of hospitals had a negative operating margin in 2016 (Figure 17). [9]

Financial stress is particularly severe in rural hospitals, but urban hospitals are also feeling the pinch. Since January 2010, 85 rural hospitals have closed nationally. The pace of closure has accelerated, with 64 rural hospitals and 49 urban hospitals closing between 2013 and 2017. A September 2018 Government Accounting Office (GAO) report identifies financial stress as the leading cause of these closures. The GAO also noted that rural hospitals in states which have not expanded Medicaid are particularly at risk. While non-expansion

states had 49 percent of all rural hospitals in 2013, 83 percent of the closures have come from those states. [23] In Nebraska, financial pressure led to the closure of Tilden Community Hospital in 2014.

For the wider society, uncompensated care creates a "silent tax" that is responsible for higher insurance premiums and higher taxes. Hospitals cover a portion of bad debt/charity care by subsidy through higher-than-necessary prices for patients with quality insurance, a hidden tax known as "Cost Shifting" in economics. There is empirical evidence that cost shifting takes place: Zwangziger *et al*. found that both not-for-profit and for-profit hospitals increased private-pay rates in response to Medicare payment rate reductions. [24]

Nationally, Hadley *et al* estimated that 11 percent of uncompensated care is covered though higher insurance premiums and higher copays. [25] Thus, the $38.3 billion in bad debt/charity care provided by hospitals in 2016 created excessive costs of $4.2 billion on privately insured people. Assuming that Nebraska is similar to the national pattern, the state's $433 million in bad debt/charity care would push $47.6 million of unwarranted costs onto insured citizens in 2016.

Governments use a variety of tax-financed programs to mitigate the losses to providers from uninsured patients. For example, in FY 2018, there were Medicaid supplemental payments of $16.5 billion through the Disproportionate Share Program and another $8.5 billion through the Uncompensated Care Pools to help hospitals cover uninsured patients. [26]

V. Nebraska Demographics and Healthcare Sector

Nebraska's settlement pattern, demographics, and healthcare system are generally similar to other Great Plains states. The variation in population density moving east to west and the general demographic profile creates formidable challenges in providing high quality, accessible care. Small business firms are common, which means employees have limited opportunities for employment-based health insurance. While nationally 47 percent of private employers offer the option of health insurance, only 42.6 percent of Nebraska's private employers do so. [27] Rural populations tend to be older and poorer than urban areas, and rural residents are disproportionately involved in dangerous occupations like farming and mining. According to Bureau of Labor Statistics (BLS) data, Nebraska has a higher rate of worker injuries and fatalities than the nation as a whole. There were 60 work related deaths in 2016, increasing by 10 from the previous year. The latest available data indicates that there were 6.3 Nebraska workers fatally injured for every 100,000 full-time workers, the sixth highest state rate for 2016. The worker fatality rate for the US as a whole was 3.6 for every 100,000 full-time workers. [28]

Income is also an issue, with 12.4 percent of Nebraska residents falling below the poverty line in 2016. This is slightly above the national poverty rate of 12.3 percent. Of the state's population of 1,827,191 there are 227 thousand living in poverty. Per capita income in 2016 was $28,596, $1,233 below the national average of $29,829.

Figure 18

2018 Federal Poverty Level Guidelines

Persons in family / household	Annual Income		Hourly Wage (30 hours/wk)		Hourly Wage (40 hours/wk)	
	100% FPL	138% FPL	100% FPL	138% FPL	100% FPL	138% FPL
1	$12,140	$16,753	$7.78	$10.74	$5.84	$8.05
2	16,460	$22,715	$10.55	$14.56	$7.91	$10.92
3	20,780	$28,676	$13.32	$18.38	$9.99	$13.79
4	25,100	$34,638	$16.09	$22.20	$12.07	$16.65
5	29,420	$40,600	$18.86	$26.03	$14.14	$19.52
6	33,740	$46,561	$21.63	$29.85	$16.22	$22.39
7	38,060	$52,523	$24.40	$33.67	$18.30	$25.25
8	42,380	$58,484	$27.17	$37.49	$20.38	$28.12

* For families/households with more than 8 persons, add $4,320 for each additional person

Base on the ACA threshold for classification as a full-time employee (average 30 hours per week) multiplied by 52 weeks.

Source: Office of The Assistant Secretary for Planning and Evaluation [29]

Health care in Nebraska is delivered through a network of hospitals, private practice physician clinics, and rural health clinics. In 2017, there were 27 General Acute Hospitals with 4,659 beds, 64 Critical Access Hospitals (CAHs) with 1,247 beds, and 13 specialty hospitals with 961 beds. [30] Nebraska's health insurance coverage pattern is somewhat similar to neighboring states. As one would expect, the percentage of Medicaid coverage is higher in the two neighboring states, Colorado and Iowa, that have expanded Medicaid.

Figure 19

Health Insurance Coverage of the Total Population (2016)

Location	Employer	Individual	Medicaid	Medicare	Other Public	Uninsured
Colorado	52%	7%	16%	13%	3%	10%
Kansas	53%	9%	14%	13%	n/a	8%
Nebraska	***55%***	***7%***	***13%***	***15%***	***2%***	***7%***
Iowa	54%	6%	18%	15%	1%	5%
South Dakota	49%	10%	15%	17%	2%	8%

Source: Kaiser Family Foundation [31]

For low-income citizens who meet eligibility criteria, the Nebraska Medicaid Program pays for covered medical services. Eligible groups include the elderly, blind, and disabled individuals and low-income pregnant women, children, and parents. CHIP provides medical assistance to children age 18 and younger from modest income households.

Figure 20

Current Nebraska Medicaid Guidelines: Income Limits Relative to FPL

Children				Pregnant Women		Parents	Other Adults
Ages	0-1	1-5	6-18	Medicaid	CHIP		
	213 %	213%	213%	194%	N/A	58%	Not eligible

Source: CMS [32]

The healthcare sector is an important component of Nebraska's economy, accounting for 9.7 percent of all employees in the state. The Bureau of Labor statistics identifies 62,310 current employees (6.4 percent of all Nebraska workers) in the well-paid "Healthcare Practitioners and Technical Occupations" category, with a mean annual wage of $73,150. Another 27,940 employees (3.3 percent of all Nebraska workers) are in the "Healthcare Support Occupations" category, with a mean annual wage of $29,500. [33]

In rural Nebraska, Critical Access Hospitals (CAHs) provide the foundation for health services. CAHs are reimbursed by Medicare for "reasonable costs" plus one percent, a payment structure suited to low-volume facilities. Medicare reimburses larger hospitals at predetermined rates set by Prospective Payment Systems. The annual monitoring report for CAHs provides information on a host of important financial metrics. Data from the latest publicly-available report (2012 numbers) for the 64 Nebraska CAHs found an average Total Margin of 4.56 percent and an average Operating Margin of 2.71 percent. While the median financial values for Nebraska CAHs are good relative to the national numbers, these averages hide important information. As shown in Figure 21, a substantial number of CAHs are plagued by low total margins. The situation is getting worse, and in 2018, 45 percent of Nebraska CAHs are faced with substantial financial stress, with operating margins of less than 2.0 percent. [34] Even not-for-profit hospitals need a total margin above two percent to cover uncompensated care, acquire new technology, and build a capital fund for long-term facility development.

Figure 21

Nebraska CAHs with Low Total Margins

Year	2009	2010	2011	2012
Number of CAHs	19 (29.2 percent)	23 (35.4 percent)	15 (23.1 percent)	23 (35.4 percent)

Source: Nebraska Department of Health & Human Services [35]

The Nebraska ACA Experience

In 2014, Nebraska was one of 26 states opting to use a Federal Marketplace Exchange rather than create a state exchange. By the end of the first open enrollment period in April 2014, 42,975 Nebraskans had enrolled through the exchange and 10,360 had enrolled in ACA-compliant plans off-exchange. An additional 9,546 exchange applicants were found eligible for existing Medicaid in Nebraska (the Woodwork Population). The majority of exchange enrollees, 87 percent, received financial assistance. [36]

Subsequent years saw continued growth in participation. In 2017, 74,582 Nebraskans had coverage through the exchange. In 2018, 84,371 Nebraskans selected a marketplace plan although Medica was the only insurer offering exchange plans this year. Premiums increased substantially for 2018, but premium subsidies also increased, thus mitigating the impact on the 88 percent of consumers who received assistance. [37] If Nebraska voters expand Medicaid, there will be a movement of some marketplace enrollees over to Medicaid. This movement will result in a decrease of total exchange subsidy dollars of approximately $12.4 million.

Figure 22

Impact of Nebraska Medicaid Expansion on ACA Federal Marketplace Exchange

84,371	Number of Consumers Who Selected a Marketplace Plan
74,246	88% of the 84,371 received a subsidy
$507	Average subsidy among consumers receiving APTC
49,800	Consumers continue to receive a subsidy after Medicaid Expansion
$25,265,776	Total NE subsidy remaining after Medicaid Expansion
24,446	Consumers with FPL ≥100% to ≤150% will move to Medicaid
$12,402,434	Total NE subsidy lost with Medicaid Expansion

Source: CMS Annual Report 2018

Figure 23

Total Nebraska Economic Impact for
$12.4 Million Lost ACA Premium Subsidy

Impact Type	Total Effect		Tax Receipts
Employment	(114)	Sales Tax	($231,000)
Labor Income	($4,644,000)	Property Tax	($282,000)
Output	($14,514,000)	Motor Vehicle	($11,000)
		Other Taxes	($170,000)
		Total Tax	**($694,000)**

Source: authors calculation with IMPLAN model, 2018 dataset

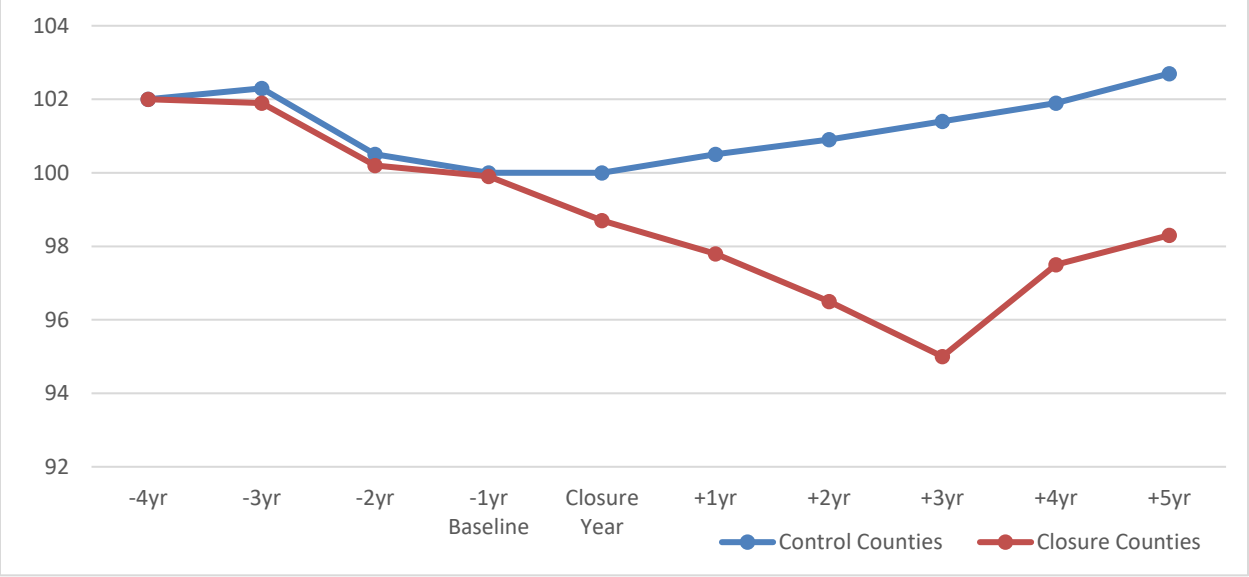
VI. Healthcare is a Critical Infrastructure Component

From an economic development perspective, access to quality healthcare is an essential element. In fact, healthcare facilities should rightly be considered a critical infrastructure component, as central to economic growth as access to transportation, education, and communication. There are at least three important linkages between healthcare and local economic development. High-quality, affordable care facilities help a region attract and maintain business and industry, attract and retain retirees, and create employment. Quality of life factors, which obviously include healthcare, are central to location decisions by businesses, families, and retirees. Further, healthcare brings new money into the community via third party payors.

The direct economic impact of a hospital closure is influenced by the distance to other hospitals. Holmes *et al.* found that the closure of the sole hospital in a community reduces per-capita income by 4 percent and increases the unemployment rate by 1.6 percentage points. Closures in communities with nearby alternative sources of hospital care had no long-term economic impact, although area income decreased for two years following the closure. [38] Studies of rural hospital closures in Oklahoma and Texas found comparable negative impacts. Doeksen, Gerald, and Altobelli (1990) simulated the effect of a hospital closure in rural Oklahoma and estimated that over a 5-year period 78 jobs, $1.7 million in income, $452,100 in retail sales, and $9,100 in sales tax revenue were lost because of the closure. A study of three Texas communities found similar negative impacts. [39] Probst *et al*. looked at the five-year impact of hospital closure on 103 rural counties. The loss of the hospital had a noticeable impact on county employment and income [40].

Figure 24

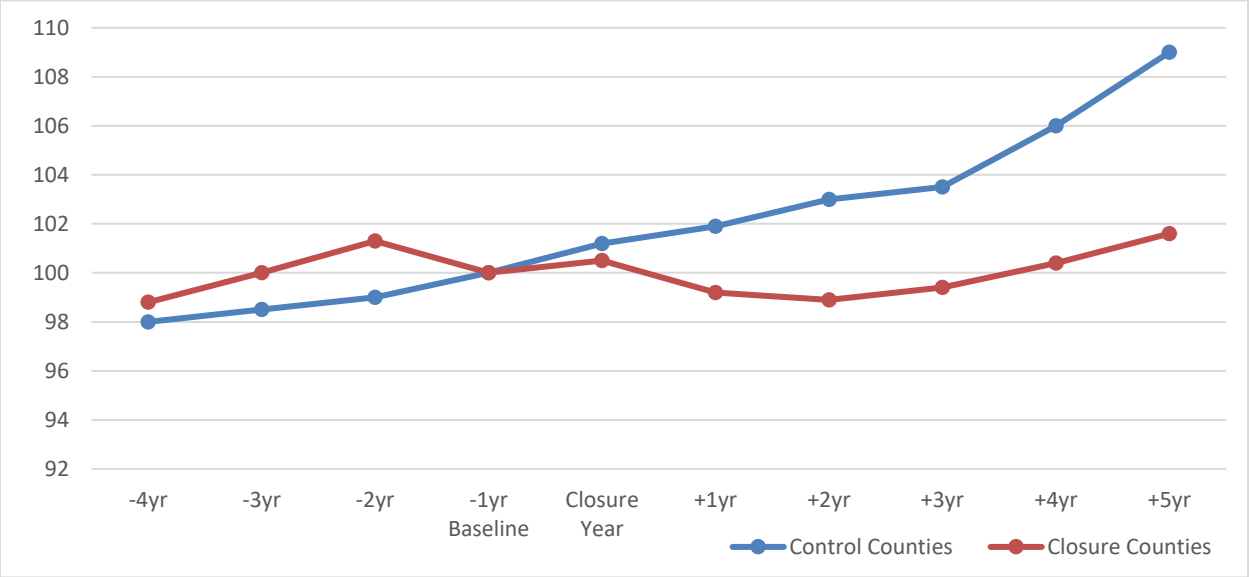
Estimated Percentage Change in Labor Force



Source: Economic Impact of Hospital Closure on Small Rural Counties [40]

Figure 25

Percentage Change in Earned Income (Excluding farming and Mining Incomes)



Source: Economic Impact of Hospital Closure on Small Rural Counties [40]

Viewing healthcare as a critical component of community infrastructure is useful because it provides a basis for thinking about the appropriate role of different levels of government. Infrastructure projects tend to be expensive and long-lasting, so projects often involve a combination of funding sources. For example, all levels of government provide substantial funding for surface transportation. Total federal, state, and local spending on surface transportation averaged $207 billion annually between 2007 and 2011. The federal government provided 25 percent ($51 billion); states contributed 40 percent ($82 billion); and localities (i.e., municipalities, counties, and local transportation authorities) accounted for the remaining 36 percent ($74 billion). These spending figures include both capital investment (construction, rehabilitation, restoration, and reconstruction) and operating expenditures (snow and ice removal, traffic signals, street lights, etc.). [41]

Perhaps the best perspective for viewing the role of government in providing support for healthcare facilities is a comparison with the Rural Electrification Act of 1936 and the subsequent creation of the Rural Electrification Administration (REA). While 90 percent of urban dwellers had electricity by the early 1930s, only 10 percent of rural dwellers and farmers did. Private companies were not interested in building costly electricity lines into the countryside because individual farmers could never cover the marginal cost of installation and upkeep of the lines. The Rural Electrification Act, sponsored by George Norris of Nebraska, created incentives for rural areas to establish electric cooperatives. By 1939, the REA had helped establish 417 electric co-ops, which served 288,000 households. In Nebraska, 34 rural electric co-ops were established. [42]

VII. Cost/Benefit Analysis

Cost/benefit analysis is a powerful tool for evaluating the value of a proposed public policy. One issue that arises in this approach is that short-term costs are generally more readily identifiable than long-term benefits. In discussing healthcare policy, the difficulty in valuing long-term benefits relative to short-term costs is particularly problematic. Providing additional services requires resources, which in turn requires payment. Thus, the short-term costs are readily apparent. The major benefits of better health – higher quality of life and increased productivity – unfold over time and are not easily measured in monetary units. Spending money to save a critically ill infant, for example, creates the possibility of a lifetime of benefits accruing from that initial expenditure. The money spent is easily measured; the intrinsic and economic value of the life saved is inherently difficult to measure.

An example of short-term costs but long-term benefits is found in a National Bureau of Economic Research (NBER) Working Paper by Brown, Kowalski and Lurie: *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?* The study examined the impact of expansions to Medicaid and SCHIP occurring in the 1980s and 1990s. Using data from the IRS, the researchers calculated longitudinal health insurance eligibility from birth to age 18 for children in cohorts affected by these expansions, and linked eligibility to expanded coverage with later economic outcomes as young adults. Increased eligibility was positively related to later economic circumstances. Participating children paid more in cumulative taxes by age 28, collected less in Earned Income Tax Credit payments, and female participants had higher cumulative wages by age 28 than eligible non-participants. The study calculated that the government spent $872 in 2011 dollars for each additional year of Medicaid eligibility induced by the expansions, but also estimated that the government will recoup 56 cents of every dollar spent on childhood Medicaid by the time these cohorts reach age 60. The return on investment does not take into account other benefits that accrue to both the children and the wider society, including estimated decreases in mortality and increases in college attendance. [43]

A. Public Cost: Impact on State Budgets

The true cost of expansion is calculated as the incremental cost, not the total future increase in state Medicaid spending because demographic and economic changes may result in an increase number of enrollees regardless of the expansion status. According to a Kaiser Foundation report from 2013, the projected incremental cost to states if all fifty implemented the Medicaid expansion is $8 billion from 2013-2022. This estimate includes the state share of costs for newly eligible adults and for the additional participation among currently eligible residents, the woodwork population. [44]

This report relies on cost data from the Legislative Fiscal Office (LFO) Medicaid Expansion 2018 Ballot Initiative Cost Projections (September 2018) for two critical reasons: 1) the LFO has the deepest access to state budgetary information; 2) the LFO report is the newest, so has the advantage of the latest possible information. As the LFO spreadsheet makes clear, Nebraska General Fund spending for Medicaid expansion is partially offset by a number of spending reductions in programs currently funded by the state. According to the September report, the net Nebraska General Fund costs are estimated at $19.8 million in FY19-20; $32.2 million in FY 20-21; and $38.8 million in FY 21-22 after taking into consideration both the program cost and the offsets. That estimate was based on an implementation date of July 1, 2019. [2]

B. Public Cost: The Crowd-Out Effect

Medicaid expansion will have a crowd-out effect, reducing the demand for private insurance. Some low-income citizens with existing private insurance will switch to Medicaid to reduce out-of-pocket expenses. The experience from states that have increased Medicaid eligibility in the past indicates that expansion also leads to a small reduction in employer-sponsored insurance. Studies from states that have previously expanded coverage to poor adults find a 10 percent to 20 percent switch from private to public insurance. [45] Gruber, in an extensive review of the literature covering the crowd-out effect, found that studies identified private insurance decreases of 20 percent to 50 percent of the public insurance increase. [46] In the Oregon Health Experiment, Baicker et al. found no statistically significant impact of Medicaid coverage on private health insurance, finding that for the study group "private insurance through an employer is not an option." [47]

C. Woodwork population

The cost of the currently eligible but not enrolled, the so-called "Woodwork Population," is not actually a cost of expanding Medicaid. These individuals are already eligible under existing rules but are now more likely to enroll because of the new ACA rules. The Kaiser Family Foundation had calculated the number of already eligible but not enrolled at 5,500 to 6,000 persons in Nebraska. Official 2014 enrollment numbers identified 9,879 applicants who were already eligible for Medicaid. For perspective, the average Nebraska Medicaid/CHIP enrollment per month in 2014 was 235,497. The 2014 woodwork population thus represented roughly four percent of existing enrollees.

D. Benefit: Supporting Main Street by Increasing Discretionary Income for Low-Wage Workers

The consumption pattern of low-income families is well known – they spend most of their discretionary income on locally-purchased necessities. Because these families have limited savings and financial assets, they are susceptible to unexpected economic/financial shocks stemming from accidents, illness, or job loss. The Great Recession beginning in December

2007 severely strained many families' financial resources. This fragility was exposed in a July 2014 report from the Federal Reserve Board of Governors. Survey respondents were asked how they would pay for an unanticipated emergency expense of $400. Slightly less than half (48 percent) reported that they could handle such an expense, paying for it entirely using cash, money currently in their checking/savings account, or on a credit card that they would pay in full at the next statement. The remainder (52 percent) indicated that such an emergency expense would be challenging to handle: respondents indicated that they could not cover the expense (19 percent); would have to sell something (9 percent); or would have to borrow at least part of the expense, including using a credit card that they would pay off over time (17 percent), borrowing from friends or family (12 percent), or using a payday loan (4 percent). [48]

The poor and near-poor spend a larger percentage of income on healthcare than higher income groups. For low-income families, medical expenses crowd out other discretionary spending. This in turn impacts local retail businesses. Expansion of Medicaid would increase the discretionary income of consumers likely to spend money locally.

Figure 26

Healthcare Expenditure pattern by Income Quintile, 2016

Quintiles of Income before taxes	Amount Spent on Healthcare	Percent of Expenditures	Percent of Income
Lowest 20 percent	$2,156	8.6	18.9
Second 20 percent	$3,528	9.6	12.2
Third 20 percent	$4,266	9.0	8.4
Fourth 20 percent	$5,442	8.4	6.5
Highest 20 percent	$7,677	6.8	3.9

Source: U.S. Bureau of Labor Statistics – Customer Expenditures in 2016, Table 1, April 2018

Figure 27

Increase in Discretionary Income for New Enrollees ($million)

2019-20	2020-21	2021-2022
81.6	105.5	133.7

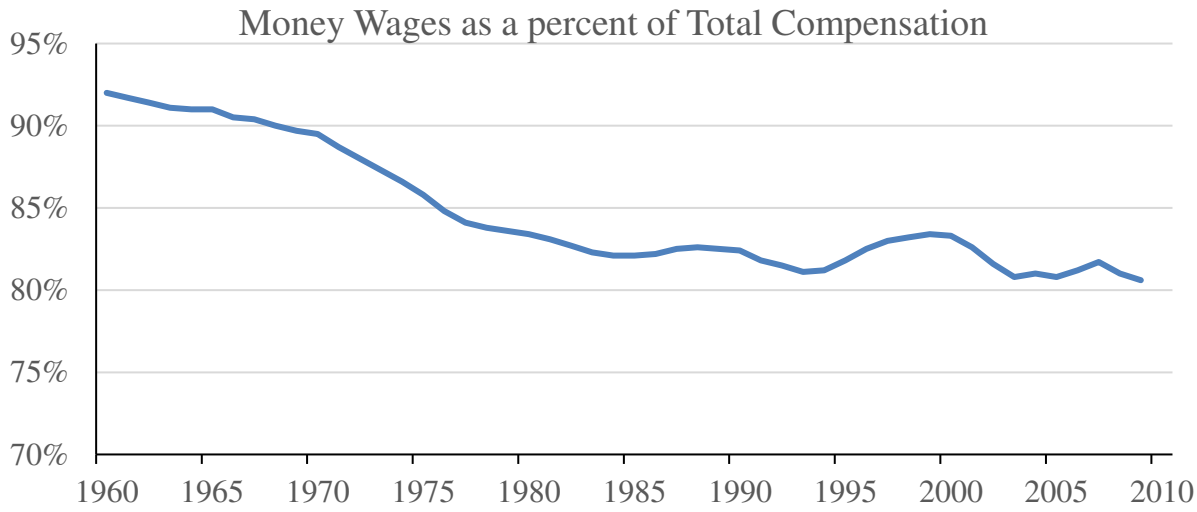
Source: author's calculation with data from Legislative Fiscal Office

The lowest quintile of income spends $2,156 annually on healthcare, or 8.6 percent of their expenditures (Figure 26). Under Medicaid expansion the percent of out-of-pocket spending on healthcare would fall to two and one half percent. A 6.1 percent savings in healthcare spending ($1,533 per enrollee) results in an annual increase in discretionary income of $81.6 million for the 53,201 new enrollees in FY 2019-20. The additional $81.6 million in expenditures supports 748 jobs, creates $30.5 million in additional income and generates

$4.5 million in state and local taxes (Figure 27). As the number of enrollees increase over time, the benefit of increased discretionary income will also increase.

Total compensation, including all benefits and wages, determines whether each individual hiring is justified. The increase in healthcare cost has substantially impacted compensation. In effect, the increase in employer contribution for healthcare has come at the expense of salary increases. Most labor economists agree that ultimately the cost of any employment benefit is actually paid by the worker in the form of lower wages. The downward trend illustrated by Figure 28 has continued, with money wages now only 68.3 percent of total compensation. [49]

Figure 28

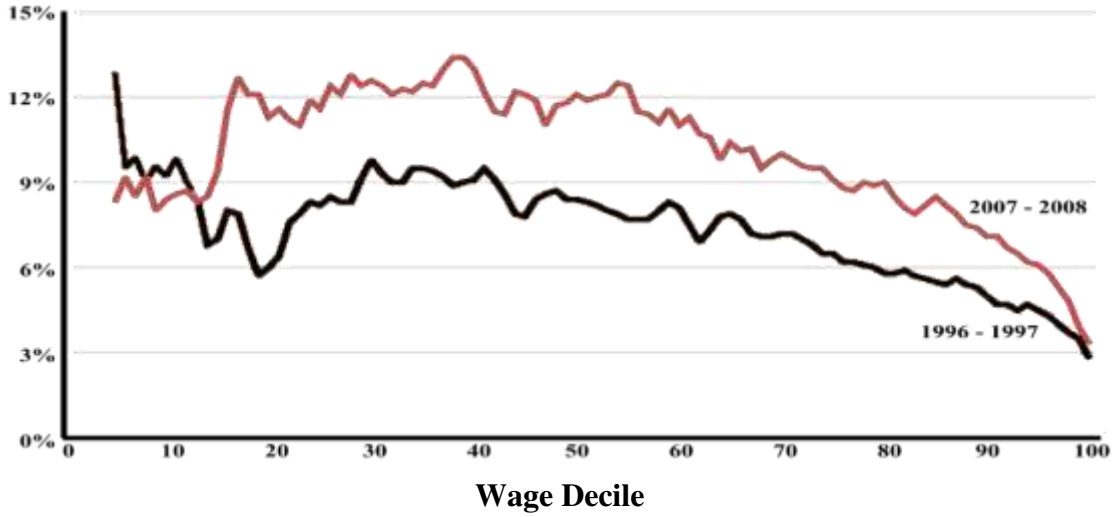


Source: Social Security Administration [50]

The Social Security Administration Office of Retirement and Disability Policy examined the impact of employer-sponsored health insurance. At the bottom of the wage distribution, workers are not likely to have insurance benefits. By reducing the employer's cost (since these low-wage jobs do not provide insurance benefits) changes in real compensation for the lowest-paid workers take the form of increases in money wages. While increasing wages are certainly beneficial for this group, the gains in income are quickly eroded if the uninsured family has to pay out-of-pocket to access the healthcare system. The employer cost of premiums for highly paid workers is only a small part of their compensation; the rapid growth in insurance costs has little impact on employers' ability to give those workers increases in money wages. [50]

Figure 29

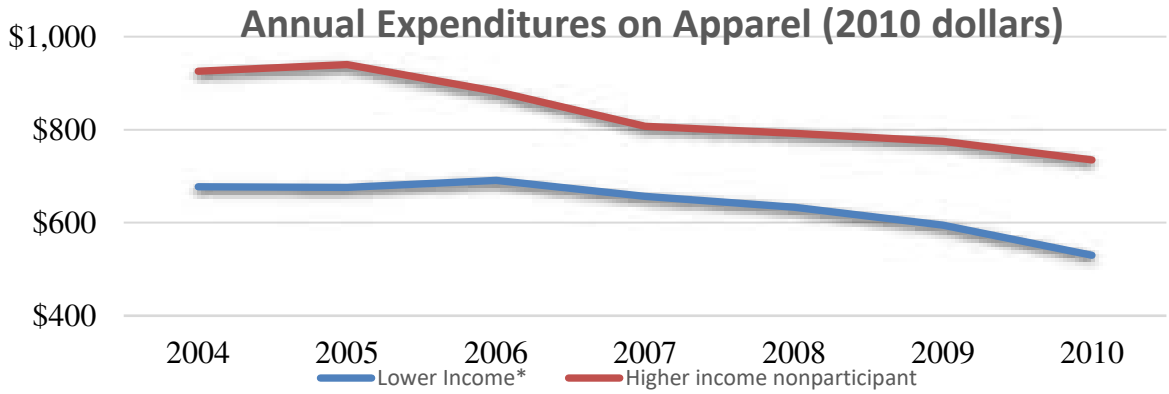
Employer cost of health insurance as a percentage of average annual wage



Source: Social Security Administration [50]

The increase in out-of-pocket spending and rising insurance premium costs has crowded out discretionary spending for low-wage workers. This trend is illustrated by the following graph, created using information from the BLS Consumer Expenditure Survey.

Figure 30



*Lower Income Defined as Supplemental Nutrition Assistance Program Eligible but not participating
Source: BLS Consumer Expenditure Interview Survey, 2004-2010 [51]

A 2017 National Bureau of Economic Research study examined a nationally representative panel of five million credit records and found that Medicaid expansion reduced unpaid medical bills sent to collection by $3.4 billion in its first two years, prevented new payment delinquencies, and improved consumer credit scores. The study also estimated that the newly-acquired access to health insurance helped prevent approximately 50,000 personal bankruptcies over the first two post-reform years. [52]

E. Benefit: Providing Efficient Public Support for Job Creation

Nebraska has a variety of programs providing incentives for job creation. While there were early small-scale programs, LB 775 (The Employment and Investment Growth Act of 1987) signified a new willingness by the state to provide substantial benefits through income tax credits and sales tax refunds. LB 775 also contained provisions allowing the exclusion of capital gains income from sale of corporate stock by a corporate employee. According to Unicameral reports, the cost of this capital gains exclusion benefit varied from $2 million to $50 million per year. By 2007, the cumulative cost of LB 775 since 1987 was $367 million.

In 2005, the Unicameral adopted LB 312 (The Nebraska Advantage Act) to replace LB 775. The Department of Revenue annually publishes a report containing statistics regarding investment, employment, wages and credits and refunds earned and used. From this, Revenue can estimate the annual "cost" of LB 312. The actual value of LB312 is a source of considerable disagreement because it is impossible to know how much activity would have occurred in the absence of the incentives. While some business groups argue that incentives effectively have no long-run cost because the increase in economic activity creates more tax revenue, there is no empirical support that targeted incentives create enough additional activity to pay for themselves.

A special Unicameral Performance Audit Committee report entitled: *Nebraska Department of Revenue: An Examination of Nebraska Advantage Tax Incentive Programs* was completed in February 2013. As noted in the report:

> Tax incentives represent a “cost” to the state in revenue the state would have collected in the absence of the incentives. For 2008 to 2011, the Department reported that 33 businesses used almost $101 million in Advantage Act incentives but acknowledged that the figure underestimates the full state cost. The underestimation is due to (1) additional tax credits the 33 businesses had earned but not used, and (2) additional businesses the Department expects will be found eligible for incentives based on actions taken between 2008 and 2011. [53]

The report estimated that the cost-per-job for jobs created under the centerpiece Nebraska Advantage Act ranged from $42,747, considering only compensation tax credits, to $234,568 considering all earned benefits except the property tax exemption. By comparison, IMPLAN modeling of the healthcare sector in Nebraska finds that each $80,000 increase in healthcare spending creates one new job in the state economy.

F. Benefit: Reduction in Cost-shifting to taxpayers and those who now have insurance

Bad Debt/Charity Care does not solely impact providers. To cover part of the loss, providers shift cost to insurers and private pay patients in the form of higher charges for health services or to taxpayers in the form of government assistance payments to healthcare. Private insurers pass their additional cost to families and businesses in the form of higher premiums. Taxpayers also contribute a substantial amount to cover these costs. In 2013, a Kaiser Family Foundation report estimated that $53.3 billion was paid to help providers offset losses. Other funding ($32.8 billion in 2013) came from the federal government through programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, Community Health Centers block grants, and Ryan White CARE Act. States and localities provided $19.8 billion, and the private sector provided $0.7 billion. [6] The exact amount of cost shifting to the private insured is difficult to estimate at the national level because of regional differences in costs and premiums. A 2008 study by Milliman averaged payments from Medicare, Medicaid, and private carriers without regard to geographic area, physician specialty, or service type. They found that for the same services, Medicare paid 0.89 of the mean payment, Medicaid paid only 0.60 of the mean, and private carriers paid 1.14 more than the mean. [54] Private insurance reimbursement to providers exceeds the actual procedure cost, which provides a subsidy for the bad debt/charity care.

G. Benefit: Supporting Main Street by reducing medical-related bankruptcy

As noted earlier in this report, 16 percent of all families have trouble paying medical bills. Medical expenses have two influences on the circumstances leading to bankruptcy. In some cases, the medical expense itself is the direct cause of the bankruptcy. Other times, a medically-related job loss is the precipitating event. The family's debt load, manageable before the illness or accident, becomes overwhelming with the interruption of income. To the extent that bankruptcy losses are never recouped by the creditors, they represent a second silent tax on local businesses.

Bankruptcies are catastrophic for individual families but are also very damaging to Main Street businesses. The unsecured claims create direct business losses and make it likely that any outstanding medical bills will become bad debt for local providers. Expansion of Medicaid can partially shelter low-income families from bankruptcy. A review of data from the *Annual Report of Statistics Required by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005* reveals that fewer citizens in expansion states are filing for bankruptcy.

Figure 31

Nebraska Bankruptcy 2017

Type of Bankruptcy	Total Filing	Assets ($000)			Liabilities ($000)			
		Total	Real Property	Personal Property	Total	Secured Claims	Unsecured Priority Claims	Unsecured Non-priority Claims
Chapter 7	2,523	117,838	70,620	47,218	243,642	90,635	5,791	147,225
Chapter 11	2	1,376	1,353	23	664	660	4	0
Chapter 13	1,246	101,343	69,082	32,261	140,862	77,022	3,300	60,540
Total	3,771	220,557	141,055	79,502	385,168	168,318	9,085	207,765

Source: 2017 Report of Statistics Required by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 [55], Note: Cases with predominantly non-business debts commenced during the 12-month period ending December 31, 2017.

Declaring bankruptcy has far-reaching impacts on a family's expenditure pattern, particularly during the five years immediately following the filing. It is very difficult to obtain credit during this five-year period, so consumption spending is limited and receiving credit for big ticket purchases like automobiles is practically impossible. Medical debt is treated as a non-priority unsecured debt in bankruptcy. This means that medical debts do not receive priority if the trustee is able to make any partial payments to creditors. Even if a portion of medical debt is paid through bankruptcy, the remainder is erased upon discharge.

Most of Nebraska's bankruptcies are Chapter 7, financially harmful both to creditors and to the effected family's long-term prosperity. In 2013, the Nebraska Appleseed advocacy group examined publicly available data on bankruptcy from three counties: Dawson, Otoe, and Red Willow. This study found that medical bills often played a significant role in the financial stress leading to the decision to file bankruptcy. Importantly, the vast majority of the debt (77 to 97 percent) was held by Nebraska creditors. Thus, these bankruptcies not only devastated individual families, they also pushed substantial losses unto Nebraska-based businesses.

Figure 32

Medical Related Bankruptcies in Nebraska – Selected Counties

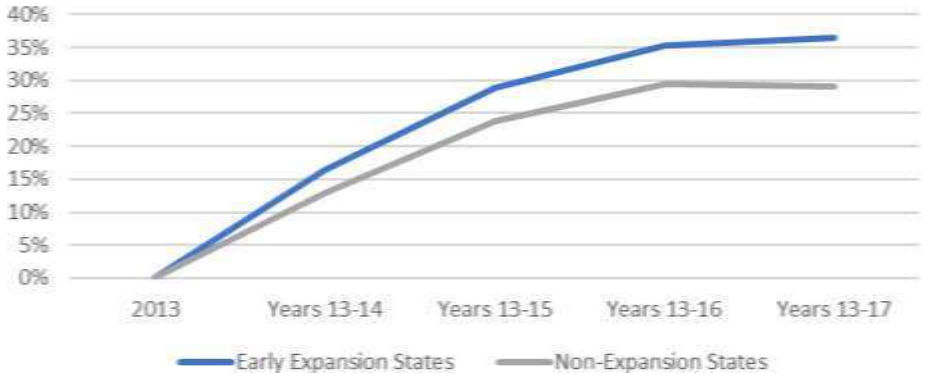
Category	Dawson County	Otoe County	Red Willow County
Number of Chapter 7 bankruptcies in 2013	**48**	**26**	**11**
Medical bankruptcies	**60.42%**	**46.15%**	**54.55%**
Declared medical debt and No health insurance	**31.25%**	**50.00%**	**18.18%**
Unsecured debt from cases with significant medical debt	**$1,177,770**	**$1,047,778**	**$188,495**
Total amount of ALL unsecured debt (of all bankruptcies in the county)	**$4,667,670**	**$2,537,299**	**$2,537,299**

Source: Appleseed Nebraska [56]

Over time, the cumulative impact of expansion has become more pronounced. This is an expected outcome because the longer a family has the protection of health insurance, the less likely there will be a health-related event that pushes them into a financial crisis (Figure 33). While improving national economic conditions have decreased overall bankruptcy rates, the expansion states are seeing the largest reductions (Figure 34).

Figure 33

Percent Improvement in Chapter 7 Bankruptcy from 2013

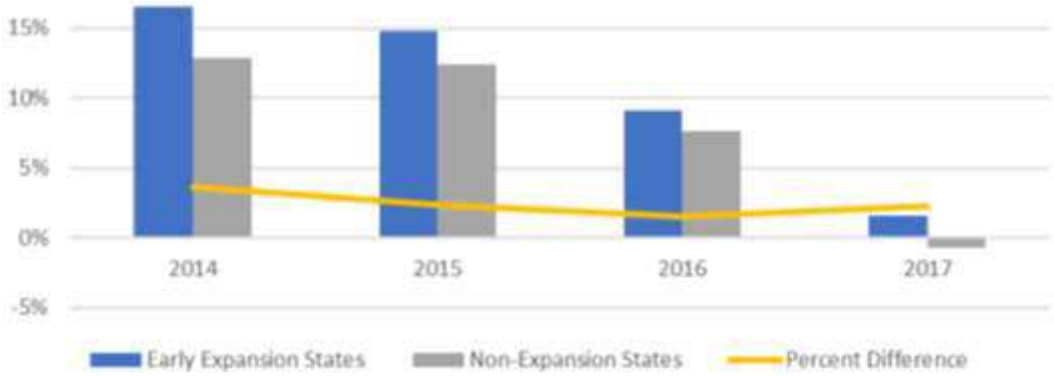


Source: Author's calculations from U.S. Bankruptcy Courts—Business and Nonbusiness Cases Commenced, by Chapter of the Bankruptcy Code data

Using the differences shown by the data from expansion and non-expansion states, one could make an informed estimate of the benefit to Nebraska if it had expanded Medicaid in 2014. Using the actual numbers for the state, then adjusting the data for the difference per year for each group (the yellow line in Figure 34), we estimate that 283 fewer Nebraskans would have filed for Chapter 7 bankruptcy if Nebraska was a 2014 expansion state (Figure 35).

Figure 34

Percent Improvement in Chapter 7 Bankruptcy from Previous Year



Source: Author's calculations from U.S. Bankruptcy Courts—Business and Nonbusiness Cases Commenced, by Chapter of the Bankruptcy Code data

The average Net Scheduled Debt per case is $88,700, so the bankruptcy loss in the state would have been reduced by $25.1 million over this four-year period (Figure 36). Given the difficult economic circumstances now facing Nebraska's agricultural producers, the rate of bankruptcies may increase in the near future. That unfavorable growth rate would be suppressed, though not negated, by expansion.

Figure 35

Averted Bankruptcy Filings in Nebraska

Filings	2014	2015	2016	2017	Total
Actual	3,153	2,825	2,665	2,657	11,333
Adjusted	3,039	2,790	2,624	2,597	11,050
Difference	114	68	41	60	283

Source: authors' estimation

Figure 36

NE reduction in chapter 7 bankruptcy with Medicaid Expansion ($million)

2014	2015	2016	2017	Average
$11.53	$5.57	$3.33	$4.96	$6.35

H. Benefits: Improved health and Increased productivity for low-income workers

The link between income, health, and productivity is well established. For low-income workers, a lack of access to healthcare leads to absenteeism, reduced productivity, and vulnerability to employment termination. Human resource researchers have coined the term "presenteeism" to describe the circumstance in which a worker is at work but cannot perform adequately because of illness or injury. Presenteeism includes: time not on task (in the workplace, but not working); decreased quality of work (increased injury rates, product waste, product defects); decreased quantity of work; unresolved unsatisfactory employee interpersonal factors (personality disorders); and unsatisfactory work culture. [57] Presenteeism costs employers two to three times more than direct medical care. [58]

Programs that improve the health and vitality of workers improve the quality of labor. Access to medical care improves the physical vigor and the emotional stability of the labor force, which enhances worker longevity and contributes to a workforce that is more productive because it is more experienced. A study of U.S. productivity growth found that 12 percent of the increase for the 1959 - 2006 period stemmed from improved labor quality. [59] Even assuming an annual wage increase of 1 percent, the value of enhanced longevity in a particular job is substantial over a career. Reduced turnover reduces recruitment and training costs. Through longevity at work, workers can acquire additional skills that may

protect them from long periods of future unemployment. This in turn, helps control the business cost of unemployment compensation.

To estimate the impact of increased job tenure due to better health, we begin with an identification of the distribution of wages across lower income occupations. The following figure lists the largest low-income worker occupations in Nebraska. The weighted average hourly wage for this group of 160,000 employees is $11.61. Working 30 hours for 50 weeks creates a gross income of $17,400. Workers making less than $11.61 per hour are considered low-income. This is a conservative estimate because it does not consider family size. What is the direct economic impact of improving the health of these 160,000 Nebraskans? Using data from the table, the total income for workers in these occupations (using the average of $11.61 per hour) is $1,856,000 in one hour. Assuming a 30-hour workweek for 50 weeks per year, the total annual income is $1.86 billion for these workers.

Figure 37

Wage Distribution for Major Low-Income Occupations in Nebraska (2018)

		Average	Percentile Distribution				
Occupation	Workers	Hourly Wage	10%	25%	50%	75%	90%
Cashiers	25,450	10.49	9.18	9.30	9.64	11.16	12.67
Combined Food Preparation and Serving Workers	24,330	10.65	9.33	9.50	9.98	11.37	12.82
Waiters and Waitresses	15,640	12.32	9.31	9.41	9.67	12.97	19.74
Janitors and Cleaners, Except Maids and Housekeeping Cleaners	14,430	12.68	9.49	10.15	11.64	14.46	17.77
Stock Clerks and Order Fillers	13,590	13.19	9.49	10.23	12.07	14.73	18.50
Childcare Workers	8,520	11.05	9.33	9.53	10.33	11.83	14.26
Personal Care Aides	7,190	12.42	9.89	10.62	11.83	13.91	16.28
Cooks, Restaurant	6,180	12.93	9.82	11.01	12.63	14.33	16.25
Maids and Housekeeping Cleaners	5,930	10.99	9.34	9.52	10.35	11.84	14.00
Bartenders	5,000	10.52	9.19	9.37	9.58	10.31	13.04
Social and Human Service Assistants	4,180	12.75	9.82	10.73	12.12	14.33	16.63
Cooks, Institution and Cafeteria	3,890	12.44	9.60	10.47	12.10	14.10	15.61
Food Preparation Workers	3,670	11.06	9.35	9.55	10.36	11.82	13.99
Cleaners of Vehicles and Equipment	3,670	12.91	9.52	10.10	11.60	14.30	18.14
Packers and Packagers, Hand	3,650	12.41	9.38	9.59	11.08	15.16	17.85
Home Health Aides	3,450	11.15	9.38	9.92	10.81	11.70	13.71
Counter Attendants, Cafeteria, Food Concession, and Coffee Shop	3,390	10.38	9.23	9.42	9.74	10.97	12.19
Cooks, Fast Food	2,870	10.44	9.26	9.39	9.73	11.13	12.31
Cooks, Short Order	2,660	11.99	9.42	9.94	11.42	13.54	15.46
Dishwashers	2,170	10.71	9.42	9.65	10.37	11.52	12.63

Source: Bureau of Labor Statistics [60]

The majority of the newly eligible Medicaid enrollees work in one of the low-income occupations listed in Figure 37. If, through better health, 25 percent of the new enrollees can remain in their present job long enough to receive a 2 percent wage increase each year, it would generate a substantial amount of additional income. If the eventual number of enrollees plateaus around 90,000, each year on the job with a 2 percent raise for that 25 percent of workers will generate an extra $7.8 million in income for the group. This is important to Nebraska's economy because low-income workers spend their money locally.

The idea that better worker health for low-income workers would have substantial benefits is grounded in reality. Nationally, nearly one quarter of adults report they have lost a job or were threatened with job loss due to their illness or because they missed work to care for a sick child or relative. [61] Further, there is a substantial cost to the wider society from this worker insecurity. Adults without access to paid sick days are twice as likely to go the hospital emergency room because of their inability to miss work to get medical care during regular work hours. [61]

Many employers have recognized the benefit of workplace health programs going beyond the mere provision of health insurance. Companies with successful health and productivity programs have better outcomes and better financial performance. [62] These programs improve the bottom line through enhanced productivity, decreased employee absenteeism, and lower insurance and workers compensation costs. Healthier employees are less likely to call in sick or use vacation time due to illness, so companies that support workplace health have a greater percentage of employees at work every day. Further, employee health frequently carries over into better health behavior that impacts the entire family, so workers miss less work caring for ill family members.

And finally, lack of access to healthcare increases age-adjusted mortality. Multiple large-scale national longitudinal studies have consistently found that the uninsured have a higher age-adjusted mortality. This relationship holds even with adjustments for race/ethnicity, income, education, body mass index, leisure exercise, smoking and moderate drinking. [63] Dickman, et al. estimated the annual number of deaths attributable to the lack of Medicaid expansion in opt-out states at between 7,115 and 17,104 nationally. For Nebraska, they estimate the opt-out decision will result in 67 to 212 unnecessary deaths each year. Medicaid expansion in the opt-out states would have resulted in 422,553 more diabetics receiving necessary medication, 195,492 more mammograms for women age 50-64 years and 443,677 more pap smears for women age 21-64. Further, it would have resulted in 712,037 fewer persons screening positive for depression and 240,700 fewer individuals suffering catastrophic medical expenditures. [64]

I. Benefits: Improved Financial Circumstances for Providers

The impact of the 2014 expansion is now beginning to emerge as data becomes available. On the important issue of bad debt/charity care, multiple studies are showing a 50 - 70 percent decrease in expansion states.

Insurance coverage gains were significant in states with or without Medicaid expansion for those with incomes between 139 percent and 400 percent of the FPL. This is expected since it is consistent with the subsidies provided by the ACA for insurance in this income range, regardless of state decisions regarding Medicaid expansion. In Medicaid expansion states, the uninsured rate for those at or below 138 percent of the FPL decreased twice as much as in non-expansion states. [65] The following table (Figure 38) provides the estimated annual decrease in bad debt/charity care for all Nebraska hospitals. Further, this decrease would continue as more citizens gain insurance over time.

Figure 38

Reduction in Hospital Bad Debt/Charity Care with Expansion

Bad Debt / Charity Care	2019-20	2020-21	2021-2022
Annual Reduction (millions)	$87.2	$112.7	$142.9
New eligible enrollees	53,201	68,789	87,214

J. Businesses and individuals paying tax penalties stemming from the ACA

The ACA contains provisions designed to encourage employers to offer affordable insurance plans. Employers with low-income workers will not face penalties if their employees qualify to enroll in Medicaid. In states deciding to expand Medicaid to 138 percent of FPL this safe haven provides protection for all businesses. For the Nebraska economy, any ACA tax penalty paid by individuals or businesses is a financial leakage.

Recent changes at the national level makes it difficult to predict the amount of tax penalties in the future. The Tax Cuts and Jobs Act of 2017 did not repeal the individual mandate, but it did remove any financial penalties for being uninsured. This has prompted some individuals to drop coverage, so the national uninsured rate is beginning to rise. According to CBO projections, for 2026 the number of people obtaining subsidized coverage through the ACA marketplace will be 4 million fewer, and the projected number of uninsured people will be 3 million larger, than they were in CBO's March 2016 baseline projections. Congress has not repealed the requirement that firms with at least 50 full-time and/or full-time equivalent employees offer affordable health care coverage that provides a minimum level of coverage, or pay a penalty. The business penalty was not collected through the 2017 tax year as the IRS argued that it needed time to create enforcement procedures, but the IRS has declared the agency will begin enforcing the employer mandate in 2018. The number of Nebraska firms impacted by this decision is not known at this time. [66]

K. State Program Cost Savings

As identified in the September 2018 Legislative Fiscal Office Ballot Initiative Cost Projections, the state can shift some state-aid funding to Medicaid. Shifts include: the elimination of the State Disability Program; replacement of state provided prescription drugs for low income individuals who are HIV positive or have AIDS; replacement funding for behavioral health assistance to the mental health regions; assistance for pregnant women; assistance for women with cancer; CHIP 599 funds; and Corrections funding. LFO estimates program savings of $13.1 million in FY 2019-20, rising to $18.3 million in FY 2020-21, and $26.1 million in FY 2021-22.

VIII. Economic Input/Output Modeling of Fiscal Impact - IMPLAN

As part of the cost/benefit calculation for Medicaid expansion, there is a fiscal impact arising from the increased federal spending in Nebraska. The impacts are modeled with the IMPLAN 3.1 software using data from the MIG 2018 Nebraska data package. Direct spending is the federal money funding care to the expanded Medicaid population. The healthcare industry will use these funds to hire healthcare workers and to purchase goods and services in order to meet the demand for health services. The suppliers in turn will purchase supplies and hire employees, thus generating an indirect and induced economic impact. IMPLAN is a powerful analytic tool because it can track the inter-industry flow of money within an identified region. This allows researchers to identify the multiplier effects originating from an external injection of funds. Currently, more than 1,500 academics and government agencies use IMPLAN.

Benefits Modeled

1. *Increased Discretionary Spending*: The impact resulting from the increase in family discretionary income through the replacement of private spending on healthcare with publicly funded insurance.

2. *Healthcare Cost Shifting*: The impact resulting from the decrease in individual hidden cost stemming from increased insurance premiums and higher tax payments required to mitigate bad debt/charity care.

3. *Averted Bankruptcy*: The impacts stemming from the reduction in medical related bankruptcies.

4. *Better Worker Health*: The increase in income for low-wage workers who see an increase in employment hours and tenure because of better health.

5. *Medicaid Provider Payments*: Payments to providers for patient services. This is used instead of a direct federal injection to avoid any possible double counting of impacts.

Multiple states have used IMPLAN to assess the potential impact of Medicaid expansion, generally focusing on the state level impact of the injection of new federal money. IMPLAN can estimate the overall economic impacts in Nebraska arising from the direct benefits discussed in the earlier cost/benefit analysis. The following table (Figure 39) summarizes the initial financial values associated with Nebraska Medicaid expansion.

Figure 39

Inputs into IMPLAN Model
Costs per LFO Report
(Millions of Nominal Dollars)

	2019-20	2020-21	2021-22	Total
Medicaid Cost (Federal & State)	375.7	494.2	637.8	1,507.7
Aid Costs for New Eligibles	373.1	491.5	635.0	1,499.6
Other Costs	2.7	2.7	2.8	8.2

	2019-20	2020-21	2021-22	Total
Healthcare Cost Shifting	21.3	27.5	34.9	83.7
Increased Discretionary Spending	81.6	105.5	133.7	320.8
Averted Bankruptcy	6.4	6.4	6.4	19.1
Better Worker Health	4.5	5.8	7.3	17.5

Source: Author's calculation

The flow of funds diagram for FY 2021-22 illustrates how the state and federal funds flow through the system to provide healthcare to the expanded Medicaid population. The values for the Nebraska General Fund expenditures, Federal Funds expenditures, Medicaid Expansion Cost, Administration costs, and Program Savings are taken directly from the Nebraska Legislative Fiscal Office Medicaid Expansion Ballot Initiative Cost Projections. All other values are the direct calculations from the authors and results from the IMPLAN model. The diagram helps track the flow of funds because it reinforces the fundamental reality that every dollar has a purpose, that no dollar is forgotten, and that no dollar can be used or counted twice (Figure 45). The authors took great effort to assure that no activity or expenditure was double counted in this cost-benefit analysis,

IX. Conclusion

Examining the issue of Medicaid expansion in Nebraska through a cost/benefit analytical approach finds that expansion will have a strong positive influence on the state's economy with a small net cost to state government general funds. The three-year estimated injection of federal funds is $1.359 billion. These payments have a multiplier effect, they flow from the health sector into supporting services then to additional sectors spread throughout the Nebraska economy. The direct value to the state's retail and financial sectors through the reduction of bankruptcies and the increase in consumer discretionary spending are approximately $340 million dollars over the three years modeled. This benefit will stretch into the future. Businesses will also benefit from improved worker health, which increases attendance, improves productivity, reduces recruitment and training costs, reduces presenteeism, and facilitates worker skill improvement. This will bring another $17.5 million in direct economic benefits from expansion. The currently insured will benefit by $83.7 million as providers no longer need to subsidize uncompensated care. Through the multiplier process, these four factors increase total state output by $571 million over the three-year period.

Relative to other state programs to create employment, Medicaid expansion is a cost-effective approach. The Department of Revenue estimates that the cost to the state budget per job created under the centerpiece Nebraska Advantage Act ranged from $42,747, considering only compensation tax credits, to $234,568 considering all earned benefits except the property tax exemption. By comparison, IMPLAN modeling of the healthcare sector in Nebraska finds that each $80,000 increase in healthcare spending supports one job. Once the program is fully populated (90,000 enrollees) the injection will support 10,800 jobs per year. It is important to recognize that changes in the financial environment in healthcare are creating substantial employment headwinds, independent of the expansion issue. Nebraska providers are facing more than $2 billion in Medicare cuts by 2024, with a potential loss of another $1 billion. The announced cuts alone will reduce state employment by 30,000.

Medicaid expansion will help protect the healthcare infrastructure necessary for local economic vitality. Nearly 45 percent of Nebraska's Critical Access Hospitals are facing severe financial stress, and urban hospitals are struggling to compensate for increasing levels of bad debt/charity care. The loss of a hospital immediately reduces local employment and income, and has a devastating impact on the prospect for future local economic development. Expansion states are seeing dramatic decreases in the number of uninsured and in uncompensated care losses for providers, with numerous studies showing decreases of 50-70 percent in bad debt/charity care. Nebraska's hospitals should see a reduction in uncompensated care by $343 million over the three-year period, providing much needed financial support at a time of considerable pressure.

The net impact on the state budget is estimated at net cost of $25.7 million over three years (Figure 40). However, over the same period local government taxes revenue will increase by $47.35 million, so in total the government sector in Nebraska receives an additional $21.65 million. There was no reduction in federal taxes paid by Nebraskans because the state did not expand Medicaid, and there is no evidence that federal taxes paid in the future will increase if expansion occurs.

Figure 40

Nebraska Fiscal Impact of Medicaid Expansion by Fiscal Year

	FY 2019-20	FY 2020-21	FY 2021-22	Total
General Fund Cost	$32,912,142	$50,511,276	$64,893,524	$148,316,942
Program offset	$13,135,837	$18,284,705	$26,101,892	$57,522,434
Net Cost	$19,776,305	$32,226,571	$38,791,632	$90,794,508
Total Taxes Received	$28,322,000	$36,926,000	$47,194,000	$112,442,000
State Taxes Received	$16,377,400	$21,375,000	$27,339,200	$65,091,600
Local Taxes Received	$11,944,600	$15,551,000	$19,854,800	$47,350,400
Net to General Fund	($3,398,905)	($10,851,571)	($11,452,432)	($25,702,908)
Net to State & Local Govt	$8,545,695	$4,699,429	$8,402,368	$21,647,492

Figure 41

Total Impacts of Medicaid Expansion by Fiscal Year (modeled)

Economic Impacts	FY 2019-20	FY 2020-21	FY 2021-22	Total
Employment	6,444	8,425	10,791	25,660
Labor Income	$344,784,000	$451,236,000	$578,477,000	$1,374,497,000
Output	$815,779,000	$1,066,094,000	$1,365,154,000	$3,247,027,000

State and Local Taxes	FY 2019-20	FY 2020-21	FY 2021-22	Total
Income Tax	$6,925,000	$9,063,000	$11,618,000	$27,606,000
Sales Tax	$7,913,000	$10,300,000	$13,149,000	$31,362,000
Property Tax	$9,758,000	$12,703,000	$16,216,000	$38,677,000
Motor Vehicle	$604,000	$788,000	$1,009,000	$2,401,000
Corporate Taxes	$1,153,000	$1,504,000	$1,920,000	$4,577,000
Other Taxes	$1,969,000	$2,568,000	$3,282,000	$7,819,000
Total Nebraska Tax	**$28,322,000**	**$36,926,000**	**$47,194,000**	**$112,442,000**
Nebraska StateTax	$16,377,400	$21,375,000	$27,339,200	$65,091,600
Local Tax	$11,944,600	$15,551,000	$19,854,800	$47,350,400

Federal Taxes	FY 2019-20	FY 2020-21	FY 2021-22	Total
Personal Income Tax	$21,951,000	$28,731,000	$36,831,000	$87,513,000
Corporate Profit Tax	$8,158,000	$10,627,000	$13,573,000	$32,358,000
Other Taxes	$41,935,000	$54,870,000	$70,328,000	$167,133,000
Total Federal Tax	$72,044,000	$94,228,000	$120,732,000	$287,004,000

What will the state's taxpayers receive for this $25.7 million general fund expenditure? Expansion will support increased employments; will help Main Street by increasing discretionary income and reducing bankruptcy; and will help Nebraska businesses now struggling with an on-going labor shortage in the state by improving employee health and productivity. The reduction in provider uncompensated care will help protect the healthcare system, a critical infrastructure absolutely essential for any future economic development. Increased insurance coverage will reduce the "silent taxes" now paid by insured Nebraskans to subsidize care for the uninsured.

Just as the $435 million spent to originally construct Interstate 80 has proven to be a remarkable good investment of taxpayer funds, General Fund spending of a net $25.7 million for hundreds of millions of dollars in yearly benefits stemming from Medicaid expansion is an eminently efficient of scarce tax dollars.

Total Impact by Benefit Examined

FY 2019-20

	Medicaid Provider Payments	Discretionary Spending	Healthcare Cost Shifting	Better Worker Health	Averted Bankruptcy	Administration	Total
Economic Impacts							
Employment	5,307	748	265	41	58	25	6,444
Labor Income	$294,162,000	$30,547,000	$14,935,000	$1,669,000	$2,378,000	$1,093,000	$344,784,000
Output	$664,914,000	$95,468,000	$38,853,000	$5,215,000	$7,431,000	$3,898,000	$815,779,000
State and Local Taxes							
Income Tax	$5,908,000	$614,000	$299,000	$34,000	$48,000	$22,000	$6,925,000
Sales Tax	$5,803,000	$1,518,000	$302,000	$83,000	$118,000	$89,000	$7,913,000
Property Tax	$7,177,000	$1,854,000	$373,000	$101,000	$144,000	$109,000	$9,758,000
Motor Vehicle	$490,000	$75,000	$25,000	$4,000	$6,000	$4,000	$604,000
Corporate Taxes	$867,000	$189,000	$59,000	$10,000	$15,000	$13,000	$1,153,000
Other Taxes	$1,519,000	$314,000	$78,000	$17,000	$24,000	$17,000	$1,969,000
Total State & Local Tax	**$21,764,000**	**$4,564,000**	**$1,136,000**	**$249,000**	**$355,000**	**$254,000**	**$28,322,000**
Nebraska StateTax	**$12,936,400**	**$2,331,400**	**$677,600**	**$127,400**	**$181,400**	**$123,200**	**$16,377,400**
Local Tax	**$8,827,600**	**$2,232,600**	**$458,400**	**$121,600**	**$173,600**	**$130,800**	**$11,944,600**
Federal Taxes							
Personal Income	$18,729,000	$1,948,000	$947,000	$106,000	$152,000	$69,000	$21,951,000
Corporate Profit	$6,132,000	$1,338,000	$417,000	$73,000	$104,000	$94,000	$8,158,000
Other Taxes	$35,537,000	$3,879,000	$1,854,000	$212,000	$302,000	$151,000	$41,935,000
Total Federal Tax	$60,398,000	$7,165,000	$3,218,000	$391,000	$558,000	$314,000	$72,044,000

Source: Nebraska Medicaid Expansion, Prepared by Allan Jenkins, Ph.D., Ron Konecny, Ph.D., October, 2018

Cost Data Source: Legislative Fiscal Office Ballot Initiative Cost Projections, September 2018

Figure 42

Total Impact by Benefit Examined

FY 2020-21

	Medicaid Provider Payments	Discretionary Spending	Healthcare Cost Shifting	Better Worker Health	Averted Bankruptcy	Administration	Total
Economic Impacts							
Employment	6,978	967	343	53	58	26	8,425
Labor Income	$386,768,000	$39,498,000	$19,311,000	$2,158,000	$2,378,000	$1,123,000	$451,236,000
Output	$874,239,000	$123,440,000	$50,237,000	$6,743,000	$7,431,000	$4,004,000	$1,066,094,000
State and Local Taxes							
Income Tax	$7,768,000	$795,000	$386,000	$43,000	$48,000	$23,000	$9,063,000
Sales Tax	$7,630,000	$1,963,000	$390,000	$107,000	$118,000	$92,000	$10,300,000
Property Tax	$9,436,000	$2,397,000	$483,000	$131,000	$144,000	$112,000	$12,703,000
Motor Vehicle	$644,000	$97,000	$32,000	$5,000	$6,000	$4,000	$788,000
Corporate Taxes	$1,141,000	$245,000	$76,000	$13,000	$15,000	$14,000	$1,504,000
Other Taxes	$1,997,000	$406,000	$101,000	$22,000	$24,000	$18,000	$2,568,000
Total State & Local Tax	**$28,616,000**	**$5,903,000**	**$1,468,000**	**$321,000**	**$355,000**	**$263,000**	**$36,926,000**
Nebraska StateTax	**$17,010,000**	**$3,016,400**	**$875,000**	**$163,600**	**$181,400**	**$128,600**	**$21,375,000**
Local Tax	**$11,606,000**	**$2,886,600**	**$593,000**	**$157,400**	**$173,600**	**$134,400**	**$15,551,000**
Federal Taxes							
Personal Income	$24,626,000	$2,519,000	$1,225,000	$138,000	$152,000	$71,000	$28,731,000
Corporate Profit	$8,063,000	$1,730,000	$539,000	$95,000	$104,000	$96,000	$10,627,000
Other Taxes	$46,725,000	$5,016,000	$2,398,000	$274,000	$302,000	$155,000	$54,870,000
Total Federal Tax	$79,414,000	$9,265,000	$4,162,000	$507,000	$558,000	$322,000	$94,228,000

Source: Nebraska Medicaid Expansion, Prepared by Allan Jenkins, Ph.D., Ron Konecny, Ph.D., October, 2018

Cost Data Source: Legislative Fiscal Office Ballot Initiative Cost Projections, September 2018

Figure 43

Total Impact by Benefit Examined

FY 2021-22

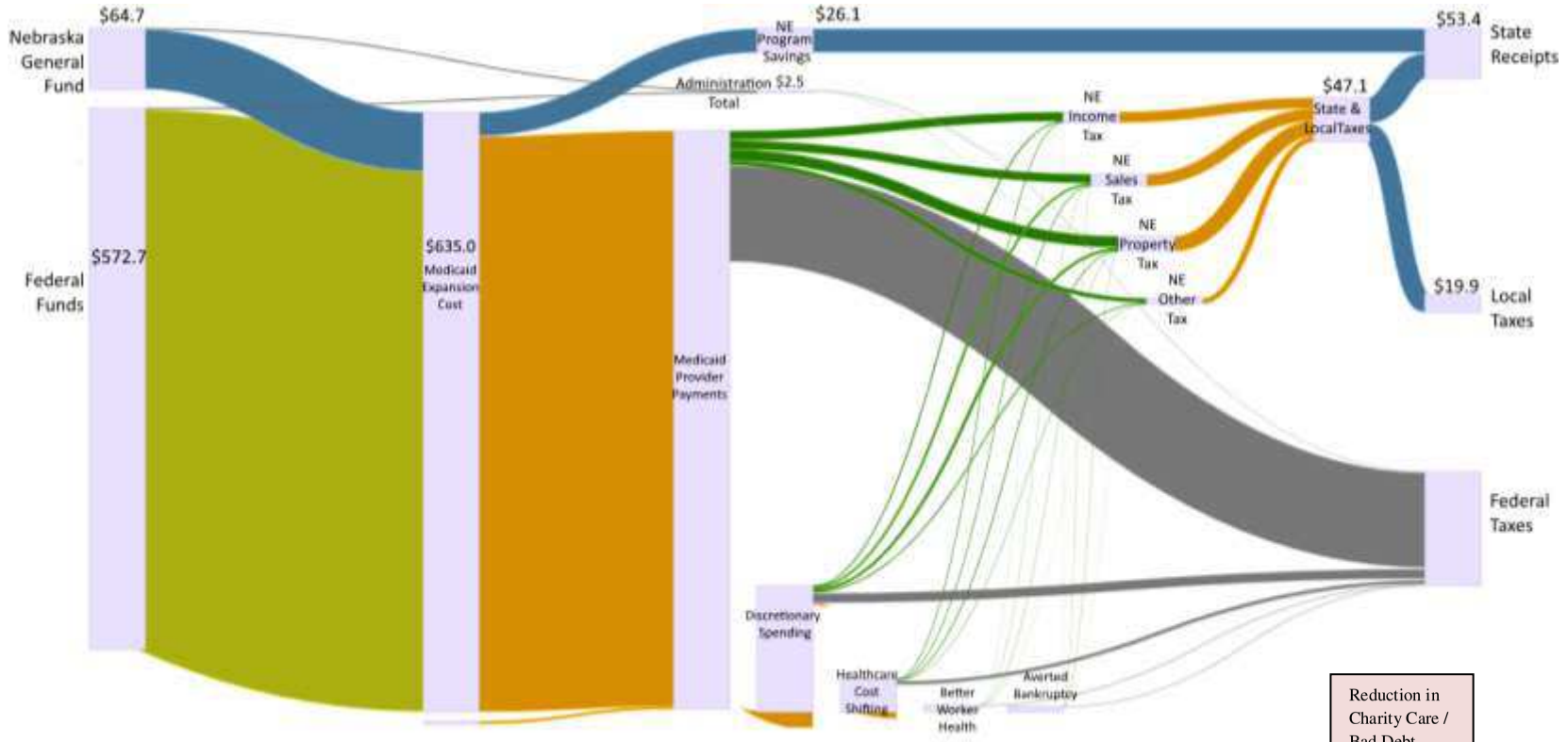
	Medicaid Provider Payments	Discretionary Spending	Healthcare Cost Shifting	Better Worker Health	Averted Bankruptcy	Administration	Total
Economic Impacts							
Employment	8,979	1,226	435	67	58	26	10,791
Labor Income	$497,653,000	$50,077,000	$24,484,000	$2,736,000	$2,378,000	$1,149,000	$578,477,000
Output	$1,124,879,000	$156,504,000	$63,693,000	$8,549,000	$7,431,000	$4,098,000	$1,365,154,000
State and Local Taxes							
Income Tax	$9,995,000	$1,007,000	$490,000	$55,000	$48,000	$23,000	$11,618,000
Sales Tax	$9,817,000	$2,489,000	$495,000	$136,000	$118,000	$94,000	$13,149,000
Property Tax	$12,141,000	$3,039,000	$612,000	$166,000	$144,000	$114,000	$16,216,000
Motor Vehicle	$828,000	$123,000	$41,000	$7,000	$6,000	$4,000	$1,009,000
Corporate Taxes	$1,467,000	$310,000	$97,000	$17,000	$15,000	$14,000	$1,920,000
Other Taxes	$2,569,000	$515,000	$128,000	$28,000	$24,000	$18,000	$3,282,000
Total State & Local Tax	**$36,817,000**	**$7,483,000**	**$1,863,000**	**$409,000**	**$355,000**	**$267,000**	**$47,194,000**
Nebraska StateTax	**$21,884,600**	**$3,823,200**	**$1,111,000**	**$208,800**	**$181,400**	**$130,200**	**$27,339,200**
Local Tax	**$14,932,400**	**$3,659,800**	**$752,000**	**$200,200**	**$173,600**	**$136,800**	**$19,854,800**
Federal Taxes							
Personal Income	$31,686,000	$3,193,000	$1,553,000	$174,000	$152,000	$73,000	$36,831,000
Corporate Profit	$10,374,000	$2,194,000	$683,000	$120,000	$104,000	$98,000	$13,573,000
Other Taxes	$60,121,000	$6,360,000	$3,040,000	$347,000	$302,000	$158,000	$70,328,000
Total Federal Tax	$102,181,000	$11,747,000	$5,276,000	$641,000	$558,000	$329,000	$120,732,000

Source: Nebraska Medicaid Expansion, Prepared by Allan Jenkins, Ph.D., Ron Konecny, Ph.D., October, 2018

Cost Data Source: Legislative Fiscal Office Ballot Initiative Cost Projections, September 2018

Figure 44

Medicaid Expansion Flow of Funds Diagram
FY 2021-22
(all values are in millions of dollars)



Reduction in Charity Care / Bad Debt 2021-2022: $143 million

Benefits Analysis: Jenkins A., Konecny R. Nebraska Medicaid Expansion Update, 2018. Funding: Nebraska Hospital Association

Cost Data Source: Legislative Fiscal Office Ballot Initiative Cost Projections, September 2018

Figure 45

APPENDIX

National Uncompensated Care Based on Cost*: 1990-2016 (in Billions), Registered Community Hospitals

Year	Hospitals	Uncompensated Care Cost
1990	5370	$12.1
1991	5329	$13.4
1992	5287	$14.7
1993	5252	$16.0
1994	5206	$16.8
1995	5166	$17.5
1996	5134	$18.0
1997	5057	$18.5
1998	5015	$19.0
1999	4956	$20.7
2000	4915	$21.6
2001	4908	$21.5
2002	4927	$22.3
2003	4895	$24.9
2004	4919	$26.9
2005	4936	$28.9
2006	4927	$31.2
2007	4897	$34.0
2008	5010	$36.4
2009	5008	$39.1
2010	4985	$39.3
2011	4973	$41.1
2012	4999	$45.9
2013	4974	$46.4
2014	4926	$42.8
2015	4862	$35.7
2016	4840	$38.3

Source: Health Forum, AHA Annual Survey Data, 1990-2016

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