The Hilltop Institute

explainer

Mississippi Medicaid Expansion Policy Option Analysis

April 2024

As part of the Affordable Care Act, states have had the option to expand their Medicaid programs since 2014 by increasing the income eligibility limit to 138% of the federal poverty level (FPL). As of March 2024, 40 states and the District of Columbia had expanded their programs.[1] Mississippi is actively considering expanding its Medicaid program. As of April 2024, the Mississippi House and Senate both passed Medicaid expansion bills (HB 1725).[2]

A successful Medicaid expansion for Mississippi will display careful **fiscal stewardship** of Mississippi's resources by maximizing federal funding and minimizing cost to the state; **support the development of a healthy, productive workforce** by improving access to health care and encouraging labor force participation and economic independence; **minimize administrative burden on the state**; and **strengthen Mississippi's health system** by supporting Mississippi's hospitals and insurance marketplace. This document presents an overview of each bill, as well as a third policy option (the "Mississippi MarketPlus" hybrid plan) representing a pro-market compromise that combines elements of both bills. We evaluate each policy option and present enrollment and fiscal impact estimates based on Hilltop's economic model of expansion.[3] We present summary results in Table 1, with additional detail below.

Table 1. Success Characteristic Assessment and Annual Net Fiscal Cost (Years 1 and 2)

Characteristic	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Fiscal Stewardship (overall)	Moderate	Low/Moderate	Moderate
Support the development of a healthy, productive workforce (overall)	Moderate/High	Low	High
Minimize administrative burden on the state	Low	Low	Moderate/High
Strengthen Mississippi's health system (overall)	Moderate	Low	High
Annual Net Fiscal Cost to Mississippi (Years 1 and 2)	$400.7 million – $404.5 million in savings	$43.4 million in savings	$356.3 million in savings

This study was commissioned by the Center for Mississippi Health Policy.

[1] Kaiser Family Foundation, Status of State Medicaid Decisions. https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

[2] The House version passed 98-20 on February 28, 2024. The Senate version passed 36-13 on March 28, 2024. https://billstatus.ls.state.ms.us/2024/pdf/history/HB/HB1725.xml

[3] Henderson, M., Betley, C., Stockwell, I., Middleton, A., Clark, M., & Woodcock, C. (2022, January 11). *The economic impact of Medicaid expansion in Mississippi, 2023–2028: Summary report*. Baltimore, MD: The Hilltop Institute, UMBC. https://www.hilltopinstitute.org/wp-content/uploads/publications/EconomicImpactMedicaidExpansionMississippi-SummaryReport-Jan2022.pdf

Expansion Options Overview

This section presents an overview of three expansion options: the House and Senate versions of HB 1725 and a third (hybrid) option, "Mississippi MarketPlus". For a tabular view, see Table A1 in the Appendix.

House Bill 1725 (House Version – "Healthy Mississippi Works")

This bill would provide for expansion up to 138% of the FPL and would impose work requirements: participants would need to work 20 hours per week or be enrolled full-time as either a student or in a workforce training program. The bill does not explicitly specify exemptions to the work requirement. The bill also requires MississippiCAN (MSCAN) care coordination organizations (CCOs) to provide employment supports and financial literacy training.

This bill contains a prior coverage restriction: income-eligible individuals who voluntarily left employer-sponsored or private coverage are prohibited from enrolling within 12 months. Funding for this bill would be derived from a 4% assessment on capitated payments for MSCAN CCOs, excluding supplemental payments. If CMS fails to approve work requirements, this bill will go into effect without work requirements. The program would be approved to operate January 1, 2025, to January 31, 2029.

For the purposes of this analysis, we assume that this version would draw down the 90% federal match for the expansion population.[4]

House Bill 1725 (Senate Version)

This bill would provide for expansion up to 100% of the FPL and would impose work requirements: participants would need to work 120 hours per month or be enrolled full-time as either a student or in a workforce training program. This bill specifies exemptions to the work requirement: part-time students are required to work only 60 hours per month. Additionally, the following groups are exempt: parents or guardians of children under 6 years old; individuals who are mentally, physically, or intellectually unfit to work; and individuals who are primary caregivers to disabled family members who also have Medicaid coverage.

Like the House version, this bill contains a prior coverage restriction: income-eligible individuals who voluntarily left employer-sponsored or private coverage are prohibited from enrolling within 12 months. Funding for this bill would be derived from a 3% assessment on total paid capitation to MSCAN CCOs. The program would be approved to operate January 1, 2025, to January 31, 2029.

Since this version would not provide for expansion up to 138% of the FPL, this would not qualify for the 90% federal match for the expansion population.

Mississippi MarketPlus Hybrid Plan

This compromise hybrid plan would offer expansion through MSCAN, the state's Medicaid managed care program, for the population under 100% of the FPL (as in the Senate version), and then use **premium**

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[4] It is unclear whether CMS would approve the prior coverage restriction; if not, then this version would not qualify for the 90% federal match. However, we believe that this issue can be successfully resolved through negotiation with CMS.

assistance to enable coverage for the 100% - 138% FPL population through Mississippi's marketplace. While this would be considered Medicaid expansion for the 100-138% group, service delivery would not be through the MSCAN program and would instead be delivered by qualified health plans (QHPs) through the exchange. As with the Senate plan, this would be funded through a 3% assessment on total paid capitation for CCOs.

This version would also require MSCAN CCOs to provide employment supports (as in the House version), as well as a mandatory referral to a workforce training program and a requirement that individuals with marketplace coverage pay marketplace co-pays. However, it would not include a work requirement or prior coverage restrictions to help ensure federal approval.

Other states have experience using premium assistance to fund Medicaid expansion: notably, Arkansas implemented expansion using premium assistance in 2014, and New Hampshire used premium assistance until 2018.[5] Additionally, Iowa conducted planning for a "MarketPlus"-style plan in 2015, in which marketplace coverage would be purchased for individuals from 100-138% FPL.[6]

We believe that this plan would be approved by CMS, and thus would qualify for the 90% federal match.

Fiscal Impact Analysis

In this section, we present high-level modeling estimates for each of the proposed plans. We focus on enrollment, total state spending, cost offsets, and revenue generated by proposed funding mechanisms. We use the following assumptions in the model: MSCAN capitation of approximately $2.3 billion excluding supplemental payments; MSCAN total capitation of $4.0 billion including supplemental payments; and annual capitation payments for new enrollees of $7,998 in MSCAN and $11,357 in the marketplace (reflecting 42% higher cost). Additional details for these assumptions can be found in the Data Appendix.

While the MarketPlus plan would likely cost more than the other plans, it would cover a significantly larger population and help to ensure that the dollars that are invested are spent on health services and go to Mississippi providers rather than to administrative costs.

It is important to note that this is a preliminary analysis and does not include several sources of cost offsets or economic impacts. Additionally, we present results for years 1 and 2 following expansion (which include ARPA funding, as applicable) and then years 3 and up. Results of the fiscal impact analysis are in Table 2, below.

[5] For additional information about New Hampshire, see https://nhfpi.org/resource/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes/
[6] https://www.vox.com/policy-and-politics/2018/8/31/17806656/medicaid-private-insurance-states-work-requirements-voxcare

Table 2. Fiscal Impact Analysis Summary

Cost Center	House Version		Senate Version	Mississippi MarketPlus Hybrid Plan
	No work requirement	With work requirement		
Enrollment Estimate	134,000[a]	67,000	54,000[b]	197,000[c]
Gross costs to state (before offsets)[d]	$107.2 million	$53.6 million[e]	$99.3 million	$174.1 million
Administrative costs and other (state)[f]	$8 million	$15 million	$15 million	$5 million + $7 million (work supports program)
Cost Offsets and Revenue				
Premium tax for expansion population[g]	$32.2 million	$16.1 million	$13.0 million	$32.2 million
State tax revenue due to economic stimulus of expansion[h]	$25.8 million	$12.9 million	$10.4 million	$28.4 million
Assessment of existing capitation[i]	$93.9 million	$93.9 million	$121.4 million	$121.4 million
Assessment of capitation for expansion population[j]	$42.9 million	$21.4 million	$13.0 million	$35.5 million
ARPA funding[k]	$325 million	$325 million	Would not qualify.	$325 million
Annual net cost to the state (years 1 & 2)[l]	$404.5 million in savings	$400.7 million in savings	$43.4 million in savings	$356.3 million in savings
Annual net cost to the state (years 3 and up)	$79.5 million in savings	$75.7 million in savings	$43.4 million in savings	$31.3 million in savings

a. We assume 178,000 uninsured individuals under 138% FPL in 2025 (returning to pre-COVID levels) and apply a 75% takeup rate. Due to the prior coverage restriction, we assume that no income-eligible individuals with private coverage or employer-sponsored coverage will enroll. We estimate that the imposition of work requirements will further reduce enrollment by 50%.
b. We assume 144,000 uninsured individuals under 100% FPL in 2025 (returning to pre-COVID levels) and apply a 75% takeup rate. Due to the prior coverage restriction, we assume that no income-eligible individuals with private coverage or employer-sponsored coverage will enroll. We estimate that the imposition of work requirements will further reduce enrollment by 50%.
c. We assume 162,000 individuals with employer-sponsored coverage under 138% FPL, 42,000 with private coverage, and 178,000 uninsured individuals in 2025 (returning to pre-COVID levels). We apply takeup rates of 13% for employer-sponsored coverage, 100% for private coverage, and 75% for the uninsured.
d. Calculated as the state's share multiplied by enrollment and expected per-enrollee cost estimates. We assume the state's share for HB 1725 House Version and the "MarketPlus" plans are 10%; for the senate version, 23%. For the MarketPlus plan, we assume that 25% of new enrollees will be in the 100-138% FPL range and thus be covered through a marketplace plan.
e. We assume that the state would receive the 90% FMAP if work requirements are approved.
f. We assume that state-funded administrative costs for the prior coverage restrictions would be $8 million and work requirements would be $7 million.
g. For the MarketPlus option, we only included individuals who were previously uninsured. This is an underestimate, since certain individuals who had employer-sponsored coverage are likely to have been in self-funded plans, and thus not contribute premium tax revenue to the state.
h. The prior Hilltop study estimated this at approximately $55 million across state and local funding. The state portion is approximately 70% and was used in this calculation. We scale this against projected MSCAN enrollment for each plan.
i. We apply a 4% assessment for the House plan and 3% assessment for Senate plan and the MarketPlus plan. We use capitation excluding supplemental payments for the House plan (approximately $2.3 billion), and capitation including supplemental payments for the Senate and MarketPlus plans (approximately $4.0 billion).
j. For the MarketPlus option, we only included individuals projected to be under 100% FPL and thus join MSCAN.
k. We assume that the House plan with work requirements would qualify for ARPA funding because it would be approved by CMS. If it is not approved, the House plan without work requirements will go into effect, which will also qualify for ARPA funding.
l. Includes ARPA funding of $325 million per year.

Expansion Options Analysis

Fiscal Stewardship

A successful Medicaid expansion in Mississippi would display careful stewardship of Mississippi's fiscal resources. This has two components: maximizing federal funding and minimizing the costs to Mississippi.

Maximize Federal Funding

The House version and MarketPlus would both likely effectively maximize federal funding along three dimensions.

1) Both would receive the 90% expansion FMAP by expanding coverage in one form or another to individuals up to 138% of the FPL, which will significantly reduce costs for the new enrollees relative to the state's current 77% FMAP that applies to existing Medicaid enrollees.
2) Both would receive the ARPA federal funding incentive for expansion, which has been estimated to exceed $600 million over two years.[7]
3) Both of these proposals (along with the Senate version, as discussed below) would use assessments on CCO capitation to fund the programs. CCO capitated payments are jointly financed through a combination of state and federal funding: for $100 of capitated payments under the current FMAP, Mississippi effectively pays $23, while the federal government pays $77. An assessment of 4% will yield $4 in revenue to the state. Crucially, **the federal match contributes to this state revenue**: the state pays 23% of this assessment, and federal funding will account for the remaining 77%. That $4 in state revenue can then be used to fund future capitation payments, once again with the 77%/23% federal/state match, thus infusing additional federal funds into the system. Moreover, the federal government will cover an even greater share—90% in the long term—of the cost of the CCO assessment on behalf of any individuals enrolled in a CCO plan due to Medicaid expansion.

The Senate version will not qualify for either the 90% FMAP or the ARPA funding. However, it does propose a CCO assessment, which would increase state revenue as described above.

Minimize Costs to Mississippi

Enrollment is projected to be highest for MarketPlus, moderate for the House version, and lowest for the Senate version because both work requirements and prior coverage restrictions will tend to dampen enrollment.[8] While this may result in differing composition of new enrollees by plan, we assume that new enrollees will have similar per-person-per-month expenditures across both the House and Senate plans (roughly $667).[9]

Expansion via the MarketPlus option will entail higher costs on a per-beneficiary basis for those 100-138% of the FPL. Commercial carriers tend to pay physicians and hospitals at higher rates than Medicaid, so marketplace premiums would likely exceed traditional capitated payments for Medicaid CCOs. Research has found that Medicaid rates tend to be 22% - 30% lower than Medicare rates, depending on the type of

[7] http://www.mississippi.edu/urc/downloads/urcmedicaid2021.pdf
[8] For additional details, see the "Fiscal Impact Analysis" section, below.
[9] See the Data Appendix for additional detail.

care.[10,11] Medicare rates, in turn, tend to be approximately half of the rates negotiated by private insurers.[12] The Mississippi Department of Insurance has indicated that commercial reimbursement rates are 40-42% higher than Medicaid reimbursement rates.[13]

These higher per-beneficiary costs, however, will be mitigated by the fact that only individuals with incomes 100-138% of the FPL will be covered through premium assistance. Additionally, as in Arkansas and New Hampshire, this plan could be designed so that high-cost, medically frail enrollees are enrolled in traditional Medicaid.[14] This, in turn, would mitigate the per-enrollee cost of the MarketPlus plan. Further, the MarketPlus plan would enable current state-only funding to be eligible for a 90% federal match, including costs for hospital services for incarcerated individuals, as well as some state-only behavioral health costs.

As noted above, the MarketPlus plan would draw down the 90% federal match, as well as qualify for the ARPA federal funding. However, it is important to note that this plan would replace generous federal advanced premium tax credits (APTCs) for the 100-138% of the FPL population currently on the exchange with Medicaid premium assistance derived from a combination of 10% state and 90% federal funding. However, unless reauthorized by Congress, the enhanced APTC is scheduled to expire at the end of tax year 2025, thus reducing the federal APTC funding that would be "replaced" by the 90% federal share for premium assistance for the 100-138% of the FPL population.[15]

Finally, the FMAP under the Senate version would be 77%; under the House version and MarketPlus, it would be 90%. This implies that each new enrollee under the Senate version would cost Mississippi more than double what a new enrollee would cost under the alternative plans.[16] As such, the Senate version contains high budget risk: if enrollment exceeds estimates, there would be proportionally greater budget overruns in the Senate version than the alternative plans. As a protection to the state, language can be inserted into enabling legislation that rescinds the Medicaid expansion should the federal matching percentage ever be less than 90%.

Table 3. Fiscal Stewardship Summary Assessment

Characteristic	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Fiscal Stewardship (overall)	**Moderate**	**Low/Moderate**	**Moderate**
Federal Funding	*High*	*Low*	*High*
Cost to the state	*Moderate*	*Moderate (with risk)*	*Moderate/High*

[10] Zuckerman, S., Skopec, L., & Aarons, J. (2021). Medicaid physician fees remained substantially below fees paid by Medicare In 2019. *Health Affairs, 40*(2), 343-348.
[11] MACPAC. (2017, April). *Medicaid hospital payment: A comparison across states and to Medicare*. https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf
[12] Lopez, E., Neuman, T., Jacobson, G., & Levitt, L. (2020). *How much more than Medicare do private insurers pay? A review of the literature*. Kaiser Family Foundation, 15. https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/
[13] https://magnoliatribune.com/2024/04/02/state-could-lose-billions-medicaid-expansion/
[14] Arkansas Center for Health Improvement. (2018, June). *Arkansas Health Care Independence Program ('Private Option') Section 1115 Demonstration Waiver final report*. Little Rock, AR: Arkansas Center for Health Improvement. https://achi.net/wp-content/uploads/2017/05/Final-Report-with-Appendices.pdf
[15] For additional detail, see the Data Appendix.
[16] For example, if a new enrollee were to incur $100 in medical expenses, under the Senate version, this would cost Mississippi $23; under the House version and MarketPlus, it would cost Mississippi $10.

Support the Development of a Healthy, Productive Workforce

A key success characteristic is that a Medicaid expansion plan should support the development of a healthy, productive workforce. There are two components to this: improving access to health care and encouraging labor force participation and economic independence.

Improving Access to Health Care

The plans differ significantly in the extent to which they meet this objective, largely due to differences in enrollment projections due to prior coverage restrictions, work requirements, and income eligibility limits.

The **prior coverage restriction** is likely to **significantly dampen enrollment** relative to a "traditional" expansion. Typically, enrollees into Medicaid expansion are either previously uninsured; have employer-sponsored coverage; or have privately purchased individual coverage. This restriction will effectively prevent individuals with employer-sponsored coverage or private purchased coverage from enrolling. It is unclear whether CMS will approve this restriction. It is important to note that if CMS does not approve this restriction, any expansion including this feature will not receive the 90% FMAP. Both House and Senate versions contain the prior coverage restriction.

Even without the prior coverage restriction, it is unlikely that expansion will lead to significant shifting from employer-sponsored coverage to Medicaid. Economic models of expansion typically assume that a small fraction (13% in Hilltop's economic model, or approximately 20,000 individuals) of individuals with prior employer-sponsored coverage will enroll.[17] While most individuals with employer-sponsored coverage do not tend to shift to Medicaid coverage, this may occur for individuals with relatively unaffordable and/or limited employer coverage. Additionally, it is possible that MarketPlus premium assistance could be structured so that Medicaid serves as a secondary payer for individuals with employer-sponsored coverage. This would imply that income-eligible individuals with employer-sponsored coverage would retain their existing coverage, but Medicaid would cover benefits not otherwise covered and/or co-pays.

Additionally, work requirements **significantly dampen enrollment**. The Georgia Pathways experience is relevant: this program mirrors several elements of the Senate version and has experienced both very low enrollment and high administrative costs. Notably, as of the time of writing, over 90% of the cost of this program has been incurred by administrative costs and consulting fees, rather than by medical expenses for covered individuals.[18] These can be mitigated, to a certain extent, by work requirement exemptions, which clearly specify groups for whom work requirements are not binding. Additionally, extensive outreach and participant education over work requirements could potentially moderate enrollment losses due to administrative burden. Given recent decisions, it is unlikely CMS will approve work requirements. Both House and Senate versions contain work requirements, although the House version would go into effect even if work requirements are not approved by CMS.

The MarketPlus option contains neither prior coverage restrictions nor work requirements, though it does propose a mandatory referral to workforce training.

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[17] https://www.urban.org/sites/default/files/2023-10/2.3%20Million%20People%20Would%20Gain%20Health%20Coverage%20in%202024%20if%2010%20States%20Were%20to%20Expand%20Medicaid%20Eligibility_1.pdf
[18] https://kffhealthnews.org/news/article/georgia-medicaid-work-requirements-experiment-high-cost-low-enrollment/

The plans differ in their income eligibility, which will significantly impact enrollment. The House version and MarketPlus plan would allow enrollment up to 138% of the FPL, while the Senate version would cap eligibility at 99%. Enrollment projections presented in the Fiscal Impact Analysis section below indicate that enrollment is projected to be highest under the MarketPlus plan (197,000), followed by the House plan (67,000 – 134,000, depending on whether work requirements are enacted) and then the Senate plan (54,000). The greater the enrollment, the greater the number of individuals able to access health care. Table 4 presents high-level enrollment estimates. For additional detail, see the Fiscal Impact Analysis section.

Table 4. Enrollment Estimates, by Plan

	House Version		Senate Version	Mississippi MarketPlus Hybrid Plan
	No work requirement	With work requirement		
Enrollment Estimate	134,000	67,000	54,000	197,000

The Senate version caps income eligibility to 99% because individuals over 100% of the FPL are able to obtain low-cost health insurance coverage through the state's marketplace. Proponents of this plan have suggested that high enrollment on Mississippi's insurance marketplace by low-income individuals mitigates the need for Medicaid expansion for this population. Three points are relevant.

1) **Current trends in marketplace enrollment for low-income individuals may be unstable.** The population of individuals selecting a marketplace plan was 286,410 in the 2023-2024 open enrollment period; of these, 181,844 were in the 100-138% FPL income range, and 210,749 were in the 100-150% FPL income range. Effectuated enrollment data (column E of Table D2 in the Data Appendix) indicates that, of the individuals selecting plans in open enrollment, approximately 90% continue with coverage.

   The most recently available American Community Survey data indicates that **the total population of Mississippi under age 65 in the 100-138% FPL range is approximately 165,000 – 200,000.**[19] Thus, the 2024 open enrollment data indicate an **implausibly high level of enrollment of individuals from 100-138% FPL** and may contain significant error due to the misrepresentation of income.[20]

2) While marketplace coverage for low-income individuals is low-cost, **it does not provide complete insurance against catastrophic medical expenses**. As of 2024, the maximum out-of-pocket spending for individuals under 150% of the FPL is $3,150 ($6,300 for families).[21] Given that 138% of the 2024 poverty level for a single individual is $20,785, this level of maximum cost sharing constitutes almost two months of salary, or 15.2% of pre-tax income.[22]

[19] See Table D2, column D in the Data Appendix.
[20] It is important to note that individuals under 200% of the FPL who receive a greater amount of APTC than their actual income warrants are required to reimburse their APTC payments up to $375 for an unmarried individual, of $750 for a married individual. See the Data Appendix for additional detail.
[21] See Table D4 in the Data Appendix.
[22] https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

3) Marketplace coverage tends to fluctuate throughout the course of the year, as individuals begin coverage but subsequently drop coverage due to failure to make premium payments. Thus, Marketplace coverage may result in higher levels of churn than either the House version or the MarketPlus plan. Additionally, once disenrolled, individuals typically cannot re-enroll until the next open enrollment period.

Finally, while the MarketPlus plan will likely have a higher per-person-per-month cost due to higher underlying provider rates in the marketplace relative to Medicaid, **these higher underlying provider rates may lead to greater access to care for individuals insured through MarketPlus than traditional Medicaid**. Research from Arkansas finds some evidence to support this: "likely due to markedly higher provider payment rates and more active enrollee management, the network adequacy and clinical performance of the QHPs exceeds that of Medicaid."[11]

Encouraging Labor Force Participation and Economic Independence

Work requirements for Medicaid have not been demonstrated to effectively promote labor force participation.[23] Moreover, the Arkansas experience demonstrates that administrative burden in reporting work status can lead to Medicaid coverage loss for the working poor—thus, hurting the exact individuals designed to be covered under work requirements.[24] The work requirements in the Senate and House versions are unlikely to have the intended effect of increasing labor force participation and economic independence. However, in addition to work requirements, the House version also requires MSCAN CCOs to "assist individuals enrolled in HMW [Healthy Mississippi Works, i.e., the House version] with resources to enhance their workforce opportunities."[25]

The MarketPlus plan includes the House language requiring that MSCAN CCOs work to promote employment and also includes mandatory referral to a work support program modeled after Montana's HELP-Link program, which has been shown to increase labor force participation for low-income Montanans by 3-6 percentage points.[26] While this would be funded by state-only resources, we assume the cost for this program would be minimal, at approximately $5-$7 million per year.[27] This program would be a collaboration with Division of Medicaid and the Division of Workforce Development & Partnership Management, which already has a successful work support program in place with SNAP which could further mitigate state costs to implement.[28]

[23] https://www.hilltopinstitute.org/wp-content/uploads/publications/MSWorkRequirements-March2024.pdf; https://www.commonwealthfund.org/publications/explainer/2024/apr/work-requirements-medicaid-enrollees
[24] Sommers, B. D., Chen, L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2020). Medicaid work requirements In Arkansas: Two-year impacts on coverage, employment, and affordability of care. *Health Affairs, 39*(9), 1522-1530.
[25] Section 1.d.ii of the House version.
[26] https://mthcf.org/wp-content/uploads/2019/01/Economic-Impact-of-MedEx-in-MT_1.28.19-FINAL.pdf
[27] The first-year cost to Montana was $939,151, for 1,408 individuals served. We assume enrollment will be roughly 5-7 times that of the Montana plan. For additional details, see the 2019 fiscal year-end report: https://leg.mt.gov/content/Committees/Interim/2019-2020/Children-Family/Required-Reports/nov2019-help-link-report.pdf
[28] https://www.mdhs.ms.gov/workforce/

Table 5. Supporting Development of Healthy, Productive Workforce Summary Assessment

Characteristic	House Version	Senate Version	Mississippi MarketPlus Hyrid Plan
Supporting Development of Healthy, Productive Workforce (overall)	**Moderate/High**	**Low**	**High**
Improving access to health care	*Moderate*	*Low (due to low enrollment projections)*	*High*
Encouraging Labor Force Participation and Economic Independence	*Moderate (High if expanded without work requirements)*	*Low*	*High*

Minimize Administrative Burden on the State

Prior research has demonstrated that the implementation of work requirements required significant administrative cost to develop and operationalize the necessary eligibility tracking systems. Arkansas spent at least $26.1 million in administrative costs on work requirements, and Georgia is slated to spend $122 million over four years.[29, 30] Similarly, the implementation of systems necessary to operationalize the prior coverage restrictions could lead to significant administrative costs.

The MarketPlus option would likely require moderate administrative costs; while it contains neither work requirements nor prior coverage restrictions, administrative effort will be required to implement this hybrid system. However, it should be possible to operationalize this expansion using the current eligibility system for those under 100% of the FPL through the creation of a new coverage group. CMS already has extensive experience working with states such as Arkansas and New Hampshire to administer premium assistance through the federal Marketplace.

Table 6. Minimize State Administrative Burden Summary Assessment

Characteristic	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Minimize administrative burden on the state	Low	Low	Moderate/High

Strengthen Mississippi's Health System

A successful Medicaid expansion in Mississippi will strengthen Mississippi's overall health system. This has two components: improving the financial health of Mississippi's hospitals and improving the strength of Mississippi's insurance marketplace.

[29] GAO. (2019). *Medicaid demonstrations: Actions needed to address weaknesses in oversight of costs to administer work requirements*. https://www.gao.gov/assets/gao-20-149.pdf
[30] https://kffhealthnews.org/news/article/georgia-medicaid-work-requirements-experiment-high-cost-low-enrollment/

Strengthening Mississippi's Hospitals

Medicaid expansion has been demonstrated by numerous studies to improve the financial position of hospitals.[31] This is largely due to reductions in uncompensated care. Hospitals with emergency rooms are bound by federal legislation (the Emergency Medical Treatment and Labor Act, or EMTALA) to examine and, if necessary, stabilize any individual with an emergency medical condition.[32] In addition, the Affordable Care Act requires hospitals to have financial assistance policies to provide assistance to uninsured or underinsured individuals, implying that uncompensated care is not concentrated solely on emergent care.[33] As a result, hospitals incur the costs of providing care to individuals without insurance coverage without reimbursement. As of 2019, Mississippi's hospitals incurred $616 million in uncompensated care.[34]

Medicaid expansion significantly reduces the population of uninsured individuals and, as such, reduces the amount of uncompensated care hospitals provide. Research estimates that Medicaid expansion leads to a 28-53% reduction in uncompensated care for hospitals. This impact is in direct proportion to the population of new individuals who otherwise would be uninsured. While the prior coverage restriction does not impact coverage of this population, the work requirements will significantly dampen enrollment of this population. Thus, neither the Senate plan nor the House plan with work requirements effectively strengthen Mississippi's hospitals.

As noted above, the Mississippi MarketPlus plan would purchase marketplace coverage for individuals from 100-138% of the FPL; as such, these individuals would be covered by commercial carriers rather than MSCAN CCOs. Per recent estimates by the Mississippi Insurance Department, commercial carriers pay higher rates to providers than MSCAN CCOs; these higher rates, in turn, would strengthen the financial position of Mississippi's hospitals and providers. The general reduction in hospital uncompensated care and attendant improvement in Mississippi hospitals' financial position may also forestall additional hospital closures or bankruptcies in Mississippi: five Mississippi hospitals have closed since 2010, and four rural Mississippi hospitals declared bankruptcy in 2018.[35]

Strengthening Mississippi's Insurance Marketplace

The MarketPlus option alone has the potential to **strengthen Mississippi's insurance marketplace.** As of 2022, four carriers participated in Mississippi's marketplace; however, one carrier (Ambetter of Magnolia) dominates the marketplace, with over 80% enrollment. This is a precarious position for Mississippi's exchange. Should that carrier pull out of the market, substantial disruption could occur. The MarketPlus plan would insert a large, stabilizing force into the marketplace, which led to significant strengthening of

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[31] For a summary, see page 34 of Hilltop's technical report on Medicaid expansion in Mississippi: https://hilltopinstitute.org/wp-content/uploads/publications/EconomicImpactMedicaidExpansionMississippi-TechnicalReport-Jan2022.pdf

[32] https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/emtala.pdf

[33] https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/

[34] https://www.legislature.ms.gov/media/1148/20201026mshospassn.pdf

[35] https://mrha34.wildapricot.org/resources/Documents/Governors%20Rural%20Health%20Task%20Force%20Report%20-%20Final.pdf

Arkansas's exchange: in 2014, only three of seven market regions had more than two carrier options. By 2016, however, "five carriers were offering coverage across all seven market regions."[36]

Additionally, the increased competition may lead to slower premium growth for all marketplace participants, not just those under 138% of the FPL. Evidence indicates that this occurred in Arkansas: since 2018, Arkansas has had the lowest "benchmark premium" among TN, OK, TX, MO, LA, and MS.[37] Notably, in 2016, the average benchmark premium was 6.4% **lower** in Mississippi than Arkansas; as of 2024, benchmark premiums are 14.4% **higher** in Mississippi than Arkansas.

Table 7. Strengthening Mississippi's Health System Summary Assessment

Characteristic	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Strengthening Mississippi's health system (overall)	**Moderate**	**Low**	**High**
Strengthening Mississippi's Hospitals	*High (assuming no work requirements)*	*Moderate/Low*	*High, due to wide coverage and higher payment rates*
Improving the Strength of Mississippi's Marketplace	*Low*	*Low*	*High*

[36] Arkansas Center for Health Improvement. (2018, June). *Arkansas Health Care Independence Program ('Private Option') Section 1115 Demonstration Waiver final report*. Little Rock, AR: Arkansas Center for Health Improvement. https://achi.net/wp-content/uploads/2017/05/Final-Report-with-Appendices.pdf
[37] https://achi.net/library/data-watch-arkansas-individual-marketplace-health-insurance-premiums/. Average benchmark premiums were calculated using the second-lowest-cost silver plan for a 40-year-old.

Appendix

Table A1. Policy Option Comparison Table

Policy Element	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Maximum income eligibility	138% of the FPL	99% of the FPL	Under 100% of the FPL through MSCAN Premium assistance for the 100% - 138% of the FPL population through Mississippi's marketplace
Work Requirements?	Yes	Yes	No (mandatory referral to work training and development program)
Work Requirement Details	• 20 hours/week without employer insurance • Enrolled full-time as a student • Enrolled in full-time workforce training (section 1.a) • CCOs to provide employment support (section 2.d.ii)	• 120 hours/month (30 hours/week) without employer insurance • Enrolled full-time as a student • Enrolled in full-time workforce training • Combination of 60 hours/month (15 hours/week) employment and education/workforce training (section 1.a)	N/A
Work Requirement Exemptions	*Not specified*	• Parent of guardian of child under six • Physically, mentally, or intellectually incapable of meeting work requirements • Primary caregiver for disabled family member on Medicaid (section 1.a.v-vii)	N/A

Policy Element	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Prior Coverage Restriction	Individuals who voluntarily disenroll from employer-sponsored or private coverage must wait 12 months before enrolling in Medicaid (section 1.a)	Individuals who voluntarily disenroll from employer-sponsored or private coverage must wait 12 months before enrolling in Medicaid (section 1.a)	N/A
Co-Pays	$10 for nonemergency use of the emergency room (Section 1c)	May establish copays or co-insurance for services as allowable under federal law or regulation (Section 10(49))	Co-pays for 100-138%
Key Funding Details	4% assessment on total paid capitation, **excluding supplementals** capitated payments for MCOs (Section 1e)	3% assessment on total paid capitation for MCOs (Section 1e; section 2.1)	3% assessment on total paid capitation for MCOs
Timing	If 1115 waiver is not approved by CMS before September 30, 2024, then expansion would go into effect without work requirements. Enabling legislation will be repealed on January 31, 2029 (Section 1f)	Repealed on date of CMS rejection of work request waiver or hospital assessment, or court nullification of work requirement or hospital assessment (Section 3) Enabling legislation will be repealed on January 31, 2029 (Section 1f)	Enabling legislation will be repealed on January 31, 2029, or if federal government lowers federal match rate below 90%

Table A2. Policy Option Key Considerations

Policy Element	House Version	Senate Version	Mississippi MarketPlus Hybrid Plan
Work Requirements?	Unclear whether CMS will permit; will **substantially** reduce projected enrollment if enacted as proposed	Unclear whether CMS will permit; will **very substantially** reduce projected enrollment if enacted as proposed.	No requirements, but mandatory referral to workforce training and development.
Prior Coverage Restriction	Unclear whether CMS will permit; unclear whether enforceable by the Mississippi Division of Medicaid.	Unclear whether CMS will permit; unclear whether enforceable by the Mississippi Division of Medicaid.	None
Other	Federal regulations limit cost sharing based on household family income[38]	Quarterly eligibility redetermination will likely not be permitted under federal regulations.[39]	

[38] https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html

[39] 42 CFR § 435.916 states that "the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months."

Data Appendix

Income and Insurance Status, 2019-2022

Table D1 presents data on income levels and insurance status from 2019-2022 from the American Community Survey for Mississippi. The overall population (row A) and the population of individuals aged 19-64 (row B) are shrinking slowly. The population of individuals aged 19-64 and under 138% of the federal poverty level (FPL) (row C) shrank moderately from 2019 to 2022. Within that population, the subset not on Medicaid or some other form of private coverage (row D) displayed a similar pattern, as did the subset of that population not Medicaid eligible under existing eligibility limits (row E).

Table D1. Mississippi Income and Insurance Status, 2019-2022

Row		2019	2021	2022
A	Total Population (thousands)	2,919	2,900	2,887
B	*Aged 19-64*	1,698	1,678	1,669
C	*… **and** under 138% FPL*[a]	605	560	523
D	*…. **and** not currently on Medicaid or other public coverage*[b]	404	352	329
E	*… **and** not Medicaid-eligible under existing eligibility limits*[c]	382	327	310
	Of this population (row E)[d]			
F	*With Employer-Sponsored Coverage*	162	130	132
G	*With Purchased Private Coverage*	42	49	55
H	*Uninsured*	178	155	128
	Of the uninsured population (row H)			
I	*100 % FPL – 138% FPL*	34	32	20
J	*Under 100% FPL*	144	123	108
	Of the uninsured population under 100% FPL (row J)			
K	*Employed*	55	43	37
L	*Unemployed (but in labor force)*	24	20	15
M	*Not in labor force*	65	60	55
	Of the uninsured population under 138% FPL (row H)			
N	*Employed*	82	64	50
O	*Unemployed (but in labor force)*	26	23	17
P	*Not in labor force*	71	69	61

Source: American Community Survey 1-year data files, 2019-2022 (except 2020). Institutional inmates ("relate" = 13) are excluded from all tabulations. IPUMS-USA, University of Minnesota, www.ipums.org. Columns may not total due to rounding.

a. This analysis uses the "health insurance unit" variable developed by the State Health Access Data Assistance Center (SHADAC) to calculate income levels as a fraction of the federal poverty level (https://www.shadac.org/publications/SHADAC-HIU). This identifier was developed with the specific purpose of analyzing health insurance coverage. We restrict attention to the universe of individuals in the "HIU poverty universe" (hiupovuniv = 1) and use the variable "hiuhhspov" for this calculation.

b. This retains individuals without public coverage at the time of the ACS interview (hcovpub = 1)

c. We identify individuals who are Medicaid-eligible under existing eligibility limits and those adults who live in a health insurance unit with children and who earn under 28% of the FPL. Additionally, we exclude individuals born outside of the United States without at least five years of residency.

d. Due to overlapping coverage, these totals may not add exactly to row (E).

Individual Marketplace Open Enrollment, 2016-2024

Mississippi Marketplace enrollment has experienced tremendous growth in open enrollment applications in recent years. The number of individuals with marketplace selections was steady at approximately 85,000 – 90,000 from 2017-2019; this has grown sharply starting in 2020 and, as of 2024, was 286,410. The portion of this population consisting of individuals from 100-138% of the FPL has also grown significantly: first measured in 2022, this population has grown from 78,462 to 181,844.

Two points are noteworthy. First, individuals with a marketplace plan selection (column A) do not necessarily receive coverage for the entire year; instead, a more accurate measure of marketplace coverage is “effectuated enrollment” (column E), which calculates the average monthly population of individuals with an active policy in a given year. As of 2022, the most recent year available, this count was approximately 11.3% lower than the total population with marketplace selections. Second, as of 2022, the population within Mississippi of individuals under age 64 with income from 100-138% of the FPL was approximately 165,000 (column C). Thus, to the extent that that population holds steady, **recent open enrollment data indicate that significantly more individuals reported this income amount to the Mississippi marketplace than exist in the state.** Table D2 below presents additional details.

Table D2. Mississippi Individual Marketplace Exchange Data, 2016-2022

	CMS Open Enrollment Public-Use Data			American Community Survey (ACS)	
Year	Total with a Marketplace plan selection (A)	100-150% FPL (B)	100-138% FPL (C)	Population under age 65 in 100-138% FPL[j] (D)	Effectuated Enrollment[k] (E)
2016[a]	108,672	62,904	Not available	Not available	Not available
2017[b]	88,483	49,076	Not available	Not available	61,519
2018[c]	83,649	48,771	Not available	Not available	65,644
2019[d]	88,542	53,009	Not available	200,000	74,304
2020[e]	98,892	62,046	Not available	Excluded	86,736
2021[f]	110,966	73,059	Not available	186,000	101,706
2022[g]	143,014	90,717	78,462	165,000	126,731
2023[g]	183,478	124,404	101,882	Not available	Not available
2024[i]	286,410	210,749	181,844	Not available	Not available

a: 2016 Final Enrollment Report – State-Level Excel Data Tables, https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report. 108,672 (Column J) individuals selected marketplace coverage, but only 104,840 (Column BQ) have available data on household income. Of these, 60% are from 100-150% FPL (Column BS).
b. 2017 Marketplace Open Enrollment Period Public Use Files, State-Level file. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2017-marketplace-open-enrollment-period-public-use-files
c. 2018 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2018-marketplace-open-enrollment-period-public-use-files
d. 2019 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2019-marketplace-open-enrollment-period-public-use-files
e. 2020 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2020-marketplace-open-enrollment-period-public-use-files. Total is from Column H (Cnsmr). 100-150% FPL from Column BJ (FPL_100_150).
f. 2021 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files. Total is from Column H (Cnsmr). 100-150% FPL from Column BI (FPL_100_150).
g. 2022 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-

research/statistics-trends-and-reports/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files
h. 2023 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products/2023-marketplace-open-enrollment-period-public-use-files
i. 2024 Marketplace Open Enrollment Period Public Use Files, State-Level public use file. https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files
j. Population under age 65 with 100-138% FPL from American Community Survey 1 Year Samples, 2016-2022 (excluding 2020). This figure excludes institutional inmates and uses the same poverty level calculation as in Data Appendix Table D1. https://usa.ipums.org/usa/index.shtml
k. Kaiser Family Foundation "Marketplace Effectuated Enrollment and Financial Assistance." This represents the average monthly number of individuals who had an active policy in a given year. Source: https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/.

Individual Marketplace Enrollment by Issuer, 2022

Hilltop used issuer-level enrollment data from the Mississippi marketplace to calculate the distribution of enrollment by issuer. As of 2022, Ambetter of Magnolia, Inc (owned by Centene Corporation) covers almost 81% of the individual marketplace, Molina Healthcare covers 10.3%, Cigna covers 8.0%, and Vantage Health Plan covers just 0.9%.

We linked these data to publicly available information on Mississippi's Medicaid managed care organizations (MCOs). The two largest exchange carriers are also MSCAN MCOs, covering over 60% of the MSCAN population as of January 2024. Additional information is available in Table D3.

Table D3. Enrollment by Marketplace Carrier, 2022

Issuer	Average Monthly Enrollment (A)	Percentage of Total Marketplace (B)	Is MSCAN MCO? (C)	MSCAN Enrollment Jan 2024[a] (D)	Percentage of Total MSCAN (E)
Ambetter of Magnolia Inc.	102,464	80.9%	Yes	166,031	39.0%
Molina Healthcare of Mississippi, Inc	13,041	10.3%	Yes	92,251	21.7%
Cigna Health and Life Insurance Company	10,100	8.0%	No	N/A	N/A
Vantage Health Plan of Mississippi, Inc.	1,115	0.9%	No	N/A	N/A

Source: Issuer-level marketplace enrollment, 2022 public use file (https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data).
a: https://medicaid.ms.gov/wp-content/uploads/2024/02/2024-MississippiCAN-Enrollment_January.pdf. Total MSCAN enrollment in January 2024 is 425,966.

Projected Costs per New Enrollee

Hilltop updated our estimates of the annual cost per new enrollee in the Medicaid expansion population. We use a similar method to that of our 2022 technical study: use the capitated payment for the "MA Adult" rate MSCAN rate cell, and then make adjustments for expected acuity and demographic profile of new enrollees.[40]

[40] Henderson, M., Betley, C., Stockwell, I., Middleton, A., Clark, M., & Woodcock, C. (2022, January 11). *The economic impact of Medicaid expansion in Mississippi, 2023–2028: Summary report*. Baltimore, MD: The Hilltop Institute, UMBC.

The SFY 2024 capitated rate per member per month (PMPM) for the "MA Adult" rate cell is $573.42.[41] Using the methodology from our economic model of expansion, we applied a 13.4% correction factor in order to account for the older age—and higher acuity—of the expansion population. Additionally, we trended this forward by 2.5% to reflect rising health costs. This calculation implies that annual cost of new members will be **$7,998** in SFY 2025.

MSCAN Capitated Payment Total

Hilltop identified in SFY 2024 capitated payment report that total statewide capitation dollars for SFY 2024 are expected to be **$2,289,610,272**.[42] We trend this forward by 2.5% to reflect rising health costs.

There are an additional **$1.703** billion in directed and supplemental payments in fiscal year 2024.[43]

APTC Required Premium Contribution, 100-133% FPL

The reduction in required contribution for the low-income group due to the American Rescue Plan Act (ARPA) is set to expire at the end of tax year 2025. Starting in tax year 2026, the required contribution will revert to pre-ARPA statute. Given the volume of research indicating that even small costs deter adoption of health coverage, **marketplace coverage is likely to fall upon the resumption of premium cost-sharing**.[44] Table D4 presents the required contribution for individuals 100-133% FPL in selected years.

Table D4. Required Marketplace Exchange Premium ContributionIndividuals 100-133% FPL

Year	Required Contribution
2018[a]	2.01%
2020[b]	2.06%
2022[c]	0.00%
2023[d]	0.00%
2024[e]	0.00%

a: https://www.irs.gov/pub/irs-drop/rp-17-36.pdf; b. https://www.irs.gov/pub/irs-drop/rp-19-29.pdf;
c. https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36; d. https://crsreports.congress.gov/product/pdf/R/R44425/23;
e. https://crsreports.congress.gov/product/pdf/R/R44425

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https://www.hilltopinstitute.org/wp-content/uploads/publications/EconomicImpactMedicaidExpansionMississippi-SummaryReport-Jan2022.pdf

[41] See Exhibit 3: https://medicaid.ms.gov/wp-content/uploads/2023/07/Molina-MSCAN-FY24-Emergency-Contract_20230701_Fully-Executed.pdf

[42] See Exhibit 4: https://medicaid.ms.gov/wp-content/uploads/2023/07/Molina-MSCAN-FY24-Emergency-Contract_20230701_Fully-Executed.pdf

[43] See slide 4: https://medicaid.ms.gov/wp-content/uploads/2024/02/House-Appropriations-Committee-Presentation.pdf

[44] https://www.brookings.edu/articles/eliminating-small-marketplace-premiums-could-meaningfully-increase-insurance-coverage/

Exchange Out-of-Pocket Spending Maximum, 100-150% FPL

Despite generous premium assistance and cost-sharing reductions for low-income individuals, exchange plans can entail substantial out-of-pocket expenditure for enrollees. Table D5 presents maximum out-of-pocket annual cost sharing limits for low-income individuals in tax year 2024.

Table D5. Maximum Out-of-Pocket Annual Cost-Sharing Limits, 2024

Household Income Tier, by FPL	Self-Only Coverage	Family Coverage
100% - 150%	$3,150	$6,300

Source: https://crsreports.congress.gov/product/pdf/R/R44425, Table 3

Annual Repayment Limit of Excess Premium Tax Credit Payments

The advanced premium tax credit (APTC) is based on an estimate of income; this income estimate is reconciled with the income reported in an individual's tax filing the following year. Individuals who receive a greater amount of APTC than their actual income warrants are required to reimburse their APTC payments. This could occur if an individual's actual income exceeds the estimated income or, for low-income individuals, if estimated income exceeds 100% of the FPL but actual income is below 100% of the FPL.

For tax year 2024, individuals under 200% of the FPL required to repay excess advanced premium tax credits are required to pay up to **$375** for an unmarried individual (**$750** for married).[45]

[45] https://crsreports.congress.gov/product/pdf/R/R44425, Table 2.