U.S. Health Reform—Monitoring and Impact

With New Marketplaces Created by the Affordable Care Act, Is It Still Less Expensive to Serve Low-Income People in Medicaid Than in Private Coverage?

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

Many believe that low-income people with private insurance have considerably higher health care spending than those with Medicaid, because commercial insurance payments for hospitals and physicians are much higher than such Medicaid payments.[1,2,3,4,5] On average, commercial insurers pay hospitals about 89 percent above Medicare levels,[6] and Medicaid payments to hospitals, counting supplemental payments and disproportionate share hospital payments, are about equal to Medicare payments.[7,8] Commercial insurers typically pay physicians above Medicare levels,[9] and Medicaid physician fees average about 60 percent of Medicare levels.[5,10] However, differences in total spending by payer type are also driven by factors beyond provider payment rates, such as administrative costs, patient health status, and the settings in which care was received. For example, many Medicaid enrollees receive care at hospital emergency rooms (ERs) and federally qualified health centers, which is considerably costlier than care provided in a physician's office.

In the wake of the Affordable Care Act's (ACA's) Medicaid expansion and new Marketplaces—in which competition between private insurers has placed downward pressure on costs—premiums have been lower than expected. Thus, it is important to reassess the cost of Medicaid relative to private insurance within this new health insurance landscape. Cost differences will especially affect states interested in partial Medicaid expansions to adults with incomes up to 100 percent of the federal poverty level (FPL), which would leave most adults with incomes between 100 and 138 percent of FPL eligible for subsidized Marketplace coverage.[11]

Using 2014–16 data from the Medical Expenditure Panel Survey (MEPS) Household Component, we assess differences in the total per capita cost of care (for insurance and households) for those who purchase Marketplace coverage versus those who enroll in Medicaid. We also assess differences in costs between those with private Marketplace coverage versus those with private group (i.e., employer-based) insurance and those with Medicaid versus those with group insurance. Using unadjusted and regression-adjusted models that control for differences in socioeconomic characteristics and health status, we evaluate whether differences in health expenditures by service type are driven by differences in utilization, price, or both. Though average total per capita expenditures for Marketplace enrollees are higher than those for Medicaid enrollees, the difference in expenditures between the two groups is not statistically significant. However, the regression-adjusted models show that Marketplace enrollees, compared with Medicaid enrollees, have significantly higher expenses for physician and hospital outpatient visits and ER services. These models also show that Marketplace enrollees generally consume less hospital care than Medicaid enrollees, but expenditures per unit of care consumed (e.g., expenditures per office visit, inpatient stay, and ER visit)—which capture differences in reimbursement levels but may also reflect differences in treatment intensity—are higher for those with Marketplace coverage than for those with Medicaid.

There are fewer significant differences in expenditures and utilization (overall and by service type) between Marketplace enrollees and those with private group coverage. Regression-adjusted health expenditures for those enrolled in private group plans is around $800 higher (13.5 percent) than for those with Medicaid. Compared with people with private group coverage, Medicaid enrollees typically use more care, but their utilization costs less per visit (i.e., for physician/outpatient, hospital inpatient, and ER visits).

BACKGROUND

Several years after ACA implementation, we now know that Marketplace plans differ from typical commercial plans. The ACA ties income-related tax credits to the premiums of the second-lowest-cost silver plan offered in an enrollee's area of residence. Anyone who chooses a costlier plan, either a costlier silver plan or in a different metal tier, must pay the full marginal cost of the difference in premiums. This structure has resulted in intense competition in many insurance markets. In competitive markets, health insurers can gain market share by negotiating lower provider payments than their competitors and lowering premiums; this is often accomplished by insurers limiting their networks of hospitals and physicians. A recent study found that premiums in Marketplaces with one insurer were about 35 percent higher than in Marketplaces in rating regions with five or more insurers.[12]

Several insurers that only provided coverage through public programs before the ACA, called Medicaid insurers, have participated in many Marketplaces. These insurers, which include large national chains like Centene, Molina, and CareSource, have lower premiums and higher market shares than their competitors.[13] These insurers have taken advantage of the low provider payment rates they negotiated for their Medicaid products, sometimes increasing them for their Marketplace business but still likely paying below commercial rates in most areas. In contrast, commercial insurers often charge significantly higher premiums for Marketplace coverage, and some of the largest (e.g., United, Aetna, Humana, and Cigna) have drastically scaled back their participation in the Marketplaces or exited many markets entirely. Consequently, Marketplace plans in many rating regions have proven to be much less expensive than they would be if Medicaid insurers did not participate. In this study, we use post-ACA implementation data (2014–16) to examine whether, on average, it is less expensive to cover an individual in Medicaid than in Marketplace coverage.

Several recent studies have also examined differences in costs of coverage in Medicaid versus commercial insurance, and some specifically examine Marketplace coverage. This research shows that Medicaid reimbursements to providers are significantly lower than those of Marketplace plans. This differential makes Medicaid less costly, but low reimbursement rates may translate to poor access to health care services for some Medicaid beneficiaries.[14,15,16]

Other studies have assessed payment differentials between private insurance and Medicaid in more limited contexts. A regression-adjusted analysis of MEPS data found that Medicaid has the lowest office-based physician payment rates among all the insurance types studied, including employer-sponsored insurance, Marketplace coverage, other nongroup coverage, and Medicare.[17] Medicaid payment rates averaged only 64.5 percent of total Marketplace payment levels, and average out-of-pocket costs per office-based visit for Medicaid patients were only $4, compared with $51 for Marketplace patients. In addition, compared with Marketplace enrollees, Medicaid enrollees have significantly lower third-party and out-of-pocket payments for all office-based visits. Another analysis, using data predating ACA implementation, found that private insurance payment rates have grown significantly higher than Medicaid rates since 2001.[18]

DATA

The Medical Expenditure Panel Survey is a nationally representative survey of household members drawn from the respondent pool from the prior year's National Health Interview Survey. We rely on 2014–16 pooled estimates, representing the period immediately following the creation of subsidized coverage in the Marketplaces and Medicaid expansion. We compare spending and utilization between enrollees in Marketplace insurance plans, Medicaid, and private group insurance.

The MEPS full-year consolidated data files provide detailed information on spending by public and private payers and out-of-pocket spending on various health care services used during the year. The survey also collects data on each individual's monthly health insurance status. Based on this information, we create health insurance categories for those with full-year Marketplace, Medicaid, and private group coverage. In the private group coverage category, we include those with employer-sponsored insurance, TRICARE and other military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage. We exclude those reporting multiple insurance sources during the year from these full-year coverage groups.

Adults who stay enrolled in one coverage type for a full year may have different characteristics and utilization and spending patterns than those who enroll for only part of the year. This primarily pertains to Marketplace plans, which often provide temporary coverage for adults between jobs. We restrict our sample to those with the same full-year coverage,

but as a robustness check, we also create insurance groups for those with any Marketplace coverage during the year, those with any Medicaid coverage and no months of Marketplace coverage, and those with any private group coverage and no months of Marketplace or Medicaid coverage.

The MEPS contains detailed utilization and cost information for each medical event reported during the year. Using this information for events with both imputed and nonimputed expenditures, we classify utilization and spending into physician and outpatient hospital, inpatient hospital, ER, prescription drug, and other services (namely dental, home health, medical equipment, and visits to non-physician providers).

To address underestimated national health expenditures in MEPS, we inflate expenditures of service and payer categories using the respective adjustment factors provided by MEPS researchers.[19] We adjust reported expenditures from all payment sources except out-of-pocket spending, because it is one of the MEPS's strongest features, and no administrative data source exists to which out-of-pocket spending might be benchmarked. Even after these adjustments, the MEPS expenditure data do not equal National Health Expenditure Accounts (NHEA) data because MEPS does not collect data on spending on long-term services and supports, the institutionalized population, over-the-counter drugs, public health, and insurance administration. Overall, these adjustment factors increase MEPS Medicaid expenditures by 54 percent and MEPS private health insurance expenditures by 26 percent to match adjusted NHEA averages (excluding services not collected on the MEPS). Differences in expenditures between Medicaid and Marketplace enrollees would be even larger without these adjustments.

All spending estimates have been put in real terms, adjusted for general price inflation. We use the Centers for Medicare & Medicaid Services personal health care indices,[20] by service type, to inflate expenditure amounts to 2016 dollars, our most recent year of data. We also use MEPS survey weights to produce nationally representative estimates and adjust standard errors to account for the MEPS's cluster design.

METHODS

We restrict our sample to adults ages 18 to 64 with modified adjusted gross income (based on the health insurance unit) at or below 400 percent of FPL, excluding those who have any Supplemental Security Income or Medicare coverage and are therefore likely eligible for public coverage because of a disability. We then compare spending and utilization among those with full-year Marketplace coverage with (1) those with full-year Medicaid coverage and (2) those with full-year employer coverage.[21] We also compare spending and utilization between those with full-year Medicaid coverage and those with full-year employer coverage.

We first conduct a descriptive analysis that compares unadjusted outcomes between people with Marketplace coverage and people in the two comparison groups (Medicaid and private group coverage). We compare per capita expenditures by service type and payer and estimate the differences in three components of per capita expenditures—the fraction of the sample using specific services, the average number of utilization events per user of each service, and the average expenditure per event.

Next, we estimate regression models for several measures of spending and utilization by service type. We run two sets of these regression models: one with the combined full-year Marketplace coverage and Medicaid enrollee sample and one with the combined full-year Marketplace and private group coverage enrollee sample, using Marketplace enrollment as our main independent variable of interest. To adjust for underlying differences in the population composition, we control for age, race and ethnicity, sex, self-reported health status, family income, education level, work status, average firm size, marital status, region, presence of diagnosed chronic health conditions,[22] pregnancy, number of health conditions, limitations on instrumental activities of daily living and activities of daily living, functional and activity limitations, cognitive limitations, number of limitations, and survey year.

Outcome variables for the regression models include total health spending (overall and conditional on any spending), the probability of having any spending, and expenditures per unit consumed. These models are repeated for expenditures by service type.

We also estimate these regression models for total spending, limiting the sample to those with priority condition diagnoses[23] to examine the differences between Marketplace coverage, Medicaid, and private group coverage for those with chronic conditions.

Some seemingly large differences in expenditures between Marketplace and Medicaid enrollees and between Marketplace enrollees and those with private group coverage

are not statistically significant. This is largely due to the relatively small sample of nonelderly, nondisabled adults with full-year Marketplace coverage and incomes below 400 percent of FPL (n = 877) in the MEPS and the large variation in spending associated with this group. Marketplace sample sizes are even smaller among those with any utilization by service type and those with chronic conditions.[24]

RESULTS

Descriptive Findings

Compared with full-year Medicaid enrollees, full-year Marketplace enrollees are more likely to be male, older, highly educated, higher income, non-Hispanic white, employed full time, and married. Marketplace enrollees are more likely to live in the Midwest and less likely to live in the Northeast (Table 1).

Table 1. Descriptive Statistics, by Coverage Type of Nonelderly Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, 2014–16

	Marketplace Full year	Medicaid Full year	ESI/Private Group Full year
Unweighted sample size	**877**	**6,182**	**14,189**
Average nonelderly population (millions)	**8,437,807**	**38,328,833**	**145,228,935**
Sex			
Female	55.3%	63.0%***	51.4%*†††
Age			
18–24	9.4%	26.3%***	20.0%†††
25–29	9.4%	12.7%**	13.1%**
30–34	7.5%	14.0%***	11.1%**†††
35–39	8.5%	10.7%	10.6%
40–44	8.6%	9.0%	9.9%
45–49	11.9%	8.0%**	8.9%*
50–54	13.6%	8.0%***	9.8%**††
55–59	14.0%	6.2%***	8.7%***†††
60–64	17.1%	5.3%***	7.8%***†††
Race/ethnicity			
White, non-Hispanic	61.9%	42.6%***	61.9%†††
Black, non-Hispanic	11.1%	21.3%***	13.2%†††
Asian, non-Hispanic	11.6%	6.2%**	5.5%***
Hispanic	14.5%	26.7%***	16.4%†††
Other	1.0%	3.1%***	3.0%***
Education			
Less than high school	7.5%	31.1%***	9.8%**†††
High school graduate	31.3%	37.4%**	31.4%†††
Some college	30.6%	25.1%*	34.5%†††
Completed college or more education	30.7%	6.4%***	24.4%**†††

Table 1. Descriptive Statistics, by Coverage Type of Nonelderly Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, 2014–16

	Marketplace Full year	Medicaid Full year	ESI/Private Group Full year
Work status			
Employed full time, full year	43.3%	18.1%***	63.9%***†††
Employed less than full time, part year	38.6%	39.9%	22.4%***†††
Not employed, full year	18.2%	42.0%***	13.8%**†††
Average firm size	39.9	59.1***	135.9***†††
Martial status			
Married	50.7%	28.7%***	50.1%†††
Widowed/divorced/separated	17.9%	18.6%	12.3%***†††
Never married	31.4%	52.7%***	37.5%**†††
Income			
<50% FPL	7.3%	42.4%***	6.1%†††
50–99%	10.8%	21.7%***	5.2%***†††
100–149%	19.2%	16.4%	8.4%***†††
150–199%	19.5%	9.3%***	12.3%***†††
200–249%	14.2%	4.5%***	16.0%†††
250–299%	12.9%	2.8%***	17.2%**†††
300%+	16.1%	2.8%***	34.8%***†††
Region			
Northeast	9.3%	25.6%***	15.5%***†††
South	16.9%	19.5%	22.9%**†
Midwest	48.9%	22.1%***	39.1%***†††
West	25.0%	32.9%*	22.4%†††
% Self-reported fair or poor physical health	9.9%	19.8%***	7.6%†††
% Self-reported fair or poor mental health	4.8%	14.2%***	4.6%†††
Health conditions			
Hypertension	29.4%	26.2%	22.8%***†††
Heart disease	8.4%	9.9%	8.2%††
Stroke	2.4%	3.1%	1.4%†††
Emphysema	0.4%	1.9%***	0.6%†††
Chronic bronchitis	2.1%	4.4%**	1.6%†††
High cholesterol	30.2%	19.7%***	20.8%***
Cancer	7.3%	5.1%	5.0%
Diabetes	9.1%	7.5%	5.9%**†††
Joint pain	46.7%	42.2%*	39.5%***††
Arthritis	22.2%	20.0%	16.3%***†††
Asthma	8.2%	13.9%***	9.1%†††

Table 1. Descriptive Statistics, by Coverage Type of Nonelderly Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, 2014–16

	Marketplace Full year	Medicaid Full year	ESI/Private Group Full year
Pregnancy (out of women ages 18–44)	22.6%	47.4%***	33.3%***†††
Number of conditions			
Zero	31.6%	38.9%**	40.3%***
One	21.5%	22.5%	25.2%*†††
Two	19.1%	14.5%**	15.1%**
Three	14.2%	10.5%**	9.1%***†
Four	5.8%	5.5%	5.2%
Five+	7.7%	8.1%	5.1%*†††
IADL limitations	0.7%	3.2%***	0.6%†††
ADL limitations	1.6%	2.4%	0.8%†††
Functional and activity limitations			
Difficulty lifting 10 pounds	7.1%	11.9%***	3.7%***†††
Difficulty walking up 10 steps	5.6%	12.3%***	4.4%†††
Difficulty walking 3 blocks	8.0%	14.9%***	5.6%*†††
Difficulty walking a mile	8.8%	15.7%***	6.4%*†††
Difficulty standing 20 minutes	6.3%	13.4%***	4.9%†††
Difficulty bending or stooping	9.6%	14.7%***	5.8%***†††
Difficulty reaching over head	6.6%	10.9%***	3.7%**†††
Difficulty using fingers to grasp	3.7%	7.1%***	2.0%*†††
Cognitive limitations	4.2%	11.5%***	2.7%*†††
Number of limitations			
Zero	87.0%	78.2%***	90.7%**†††
One	2.0%	4.7%***	1.9%†††
Two	1.5%	1.1%	1.1%
Three+	9.5%	16.1%***	6.3%**†††

Source: 2014–16 Medical Expenditure Panel Survey Household Component.

Notes:
FPL = federal poverty level.
ESI = employer-sponsored insurance.
IADL = instrumental activity of daily living.
ADL = activity of daily living.
ESI/private group includes military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage.
** p < 0.1; ** p < 0.05; *** p < 0.01 (compared with Marketplace group)*
† p < 0.1, †† p <0.05, ††† p <0.01 (compared with Medicaid group)

Table 1 also highlights some significant differences in health status between those with Medicaid and those with Marketplace coverage: Marketplace enrollees have fewer physical and cognitive limitations and are less likely to report being in fair/poor physical and mental health. Marketplace enrollees are also less likely to have ever been diagnosed with emphysema, chronic bronchitis, and asthma, but consistent with their older age profile, they are more likely to have been diagnosed with high cholesterol and joint pain.

Those with private group coverage are generally more similar to Marketplace enrollees than Medicaid enrollees, but the two groups of privately insured adults differ: generally, those with private group coverage are younger, are more likely to be pregnant, have lower education levels and higher incomes, are more likely to work full time, and are healthier than those with Marketplace coverage.

Table 2. Components of Per Capita Expenditures, by Service Category and Insurance Type, Nonelderly Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, 2014–16

Services	Marketplace Full year	Medicaid Full year	ESI/Private Group Full year
Total			
A. % users	83.9%	80.6%*	82.4%
B. Number of units per user	20.3	27.2***	16.1***†††
C. Expenditures per unit	$361	$271	$354
Per capita expenditures (AxBxC)	$6,139	$5,958	$4,710†††
Hospital outpatient + physician			
A. % users	72.1%	67.8%*	67.3%**
B. Number of visits per user	6.7	8.2***	6.1†††
C. Expenditures per visit	$522	$306**	$411†††
Per capita expenditures (AxBxC)	$2,519	$1,703	$1,679
Hospital inpatient[a]			
A. % users	3.8%	9.9%***	4.6%†††
B. Number of visits per user	3.4	6.9***	4.3†††
C. Expenditures per visit	$7,140	$2,854**	$7,091†††
Per capita expenditures (AxBxC)	$920	$1,970***	$1,378††
Emergency room hospital			
A. % users	10.3%	23.0%***	9.8%†††
B. Number of visits per user	1.4	1.6	1.4†††
C. Expenditures per visit	$2,445	$844***	$2,079†††
Per capita expenditures (AxBxC)	$359	$314	$285
Prescription drugs			
A. % users	63.5%	62.9%	59.5%*†††
B. Number of fills per user	16.3	21.3***	12.6***†††
C. Expenditures per fill	$181	$103	$111
Per capita expenditures (AxBxC)	$1,880	$1,389	$833†††

Table 2. Components of Per Capita Expenditures, by Service Category and Insurance Type, Nonelderly Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, 2014–16

Services	Marketplace Full year	Medicaid Full year	ESI/Private Group Full year
All other services[b]			
A. % users	46.6%	40.0%***	51.7%**†††
B. Number of units per user	3.4	5.3**	2.7†††
C. Expenditures per unit	$293	$274**	$378††
Per capita expenditures (AxBxC)	$461	$582	$535
Unweighted sample size	**877**	**6,182**	**14,189**

Source: 2014–16 Medical Expenditure Panel Survey Household Component.

Notes:
ESI = employer-sponsored insurance.
ESI/private group includes military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage.
** p < 0.1; ** p < 0.05; *** p < 0.01 (compared with Marketplace group)*
† p < 0.1, †† p <0.05, ††† p <0.01 (compared with Medicaid group)
[a]Includes zero-night hospital stays.
[b]Other services = other providers + dentist + home health + medical equipment expenditures.

Table 2 compares per capita expenditures (for insurance and households) by service category and their components among those with full-year Marketplace, Medicaid, and private group coverage. Marketplace enrollees' spending levels were generally higher than those of Medicaid enrollees, but we find no significant differences in per capita expenditures overall and for hospital outpatient/physician services, ER visits, and prescription drugs between the two groups.

In contrast, per capita hospital inpatient expenditures for Medicaid enrollees ($1,970) are significantly higher than per capita expenditures for those with Marketplace coverage ($920). This difference is driven by Medicaid enrollees' greater likelihood of using any inpatient services (9.9 versus 3.8 percent) and higher average number of visits per user (6.9 versus 3.4). However, expenditures per inpatient stay are significantly lower for Medicaid enrollees ($2,854 versus $7,140), which is consistent with higher reimbursement per inpatient stay for Marketplace enrollees but may also reflect differences in treatment intensity.

These differences in the components of per capita expenditures are consistent across the other service categories. We find the following:

- Medicaid enrollees are significantly more likely to have any ER visit than those with Marketplace coverage (23.0 versus 10.3 percent) but are less likely to have any hospital outpatient/physician visit (67.8 versus 72.1 percent) or any use of other services (40.0 versus 46.6 percent).[25]
- Medicaid enrollees generally consume more units of care per user than those with Marketplace coverage (e.g., 8.2 versus 6.7 hospital outpatient/physician visits per user, 21.3 versus 16.3 prescription fills per user, and 5.3 versus 3.4 units of other services per user).
- Marketplace enrollees' expenditures per unit of care consumed are significantly higher than those of Medicaid enrollees for hospital outpatient/physician services ($522 versus $306) and ER visits ($2,445 versus $844).

In contrast, we find no significant differences in per capita expenditures (overall and by service type) and few differences in the components of expenditures between those with Marketplace coverage and those with private group coverage.

Per capita expenditures for Medicaid enrollees ($5,958) are 26 percent higher than per capita expenditures for those with private group coverage ($4,710). This difference is completely driven by Medicaid enrollees' greater number of units of care per user (27.2 versus 16.1), because Medicaid enrollees are slightly less likely to use any care and have lower expenditures per unit of care than those with private group coverage. This pattern is generally consistent across service type, except for prescription drugs.

Multivariate Results

The regression-adjusted results in Tables 4, 5, and 6 are generally consistent with these descriptive findings. The first data column (A) compares total spending for those with full-year Marketplace coverage with that for people with full-year Medicaid coverage (Table 3). After controlling for socioeconomic characteristics and an array of health status measures, we find that Marketplace enrollment, compared with Medicaid, is not associated with significantly higher total health expenditures ($1,450; p-value = 0.19) and prescription drug expenditures ($742; p-value = 0.30), despite the large estimated magnitudes. The significantly higher unadjusted per capita hospital inpatient spending among Medicaid enrollees is also not statistically significant after controlling for observable differences between the two groups. However, we find that full-year Marketplace enrollment, relative to full-year Medicaid coverage, is associated with significantly higher expenditures on physician/outpatient ($757) and ER services ($214), though the latter association is estimated with less precision.

Table 3. Regression-Adjusted Differences in Spending and Utilization Outcomes, Full-Year Marketplace Coverage Compared with Full-Year Medicaid Coverage

SAMPLE 1: Marketplace versus Medicaid Full-Year Marketplace Coverage Compared with Full-Year Medicaid Coverage					
Services	Outcome				
	Total spending	Probability of any spending	Total spending conditional on any spending	Number of units (utilization)	Expenditures per unit (of those with any utilization)
	A	B	C	D	E
Total expenditures	1450	0.009	1726	-2.588*	166
Physician/outpatient	757**	0.020	979*	-0.213	203*
Hospital inpatient	-103	-0.023**	8878	-0.046***	9971*
Emergency room	214*	-0.058***	2485***	-0.095***	1824***
Prescription drugs	742	-0.016	1133	-1.762	33
Other services	- 160	0.037	-416**	-0.597	-191*

Source: 2014–16 Medical Expenditure Panel Survey Household Component.

Notes:
ESI = employer-sponsored insurance.
ESI/private group includes military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage.
** p < 0.1; ** p < 0.05; *** p < 0.01 (compared with Marketplace group)*

Table 4. Regression-Adjusted Differences in Spending and Utilization Outcomes, Full-Year Marketplace Coverage Compared with Full-Year ESI/Private Group Coverage

Services	Outcome				
	Total spending	Probability of any spending	Total spending conditional on any spending	Number of units (utilization)	Expenditures per unit (of those with any utilization)
	A	B	C	D	E
Total expenditures	156	-0.007	189	0.694	30
Physician/outpatient	366	0.014	334	-0.139	111
Hospital inpatient	-840**	-0.009	-5840	-0.014	-3945
Emergency room	79	0.009	371	0.016	312
Prescription drugs	689	-0.004	1090	0.807	37
Other services	-138**	-0.069***	-135	-0.014	-48

Source: 2014–16 Medical Expenditure Panel Survey Household Component.

Notes:
ESI = employer-sponsored insurance.
ESI/private group includes military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage.
** p < 0.1; ** p < 0.05; *** p < 0.01 (compared with Marketplace group)*

Table 5. Regression-Adjusted Differences in Spending and Utilization Outcomes, Full-Year Medicaid Coverage Compared with Full-Year ESI/Private Group Coverage

Services	Outcome				
	Total spending	Probability of any spending	Total spending conditional on any spending	Number of units (utilization)	Expenditures per unit (of those with any utilization)
	A	B	C	D	E
Total expenditures	-804*	-0.009	-$968*	3.619***	31
Physician/outpatient	-595***	0.002	-$903***	0.289	-131***
Hospital inpatient	-374	0.024***	-$8,753***	0.031***	-8557***
Emergency room	-75**	0.089***	-$1,537***	0.142***	-1104***
Prescription drugs	283***	0.015	$488***	2.820***	8
Other services	-43	-0.076***	$76	0.283	87

Source: 2014–16 Medical Expenditure Panel Survey Household Component.

Notes:
ESI = employer-sponsored insurance.
ESI/private group includes military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage.
** p < 0.1; ** p < 0.05; *** p < 0.01 (compared with Marketplace group)*

We observe similar patterns for expenditures (overall and by service type), conditional on having any utilization (Table 3, column C); Marketplace enrollment is associated with significantly higher physician/outpatient spending ($979) and ER spending ($2,485), conditional on any spending, but lower spending on other services ($416).

Consistent with the descriptive data, we also find that relative to Medicaid enrollment, Marketplace enrollment is associated with higher expenditures per physician/outpatient visit ($203), inpatient stay ($9,971),[26] and ER visit ($1,824; Table 3, column E). These findings suggest that greater Marketplace spending per unit is driven by higher reimbursement levels and higher treatment intensity, or higher reimbursement levels and similar or lower treatment intensity, which may vary across care settings. For instance, Medicaid enrollees may be more likely than Marketplace enrollees to visit the ER for low-intensity primary care services, but given their worse health status on average, they may also receive more complex care in other settings.

Finally, though Marketplace enrollment is associated with higher per unit spending, Marketplace enrollees consume less health care in hospital emergency and inpatient settings than Medicaid enrollees. We find that Marketplace enrollees are 2.3 percentage points less likely to have any hospital inpatient spending and 5.8 percentage points less likely to have any ER spending than those with Medicaid (Table 3, column B). Marketplace enrollees also consume fewer units of health care, on average, than those with Medicaid coverage (e.g., 2.59 fewer units overall, 0.05 fewer inpatient stays, and 0.10 fewer ER visits; Table 3, column D).

These findings differ slightly when we compare people with any Marketplace coverage with those with any Medicaid coverage during the year (data not shown). However, we still consistently find that Marketplace enrollees use less care but have higher expenditures per unit of care received than do Medicaid enrollees.

In contrast, we find fewer significant differences in expenditures and utilization between those with full-year Marketplace coverage and those with full-year private group coverage (Table 4). Relative to full-year private group coverage, full-year Marketplace enrollment is associated with significantly lower per capita expenditures for hospital inpatient stays (-$840) and other services (-$138). For utilization, the only significant difference between the two groups is that Marketplace enrollees are significantly less likely to have any spending on other services (Table 4).[27]

Regression-adjusted health expenditures for those enrolled in private group plans is around $800 higher (13.5 percent) than those for Medicaid enrollees (Table 5). After controlling for socioeconomic characteristics and an array of health status measures, we find that Medicaid, compared with private group coverage, is associated with significantly lower total expenditures overall (-$804) and for physician/outpatient (-$595) and emergency room services (-$75), even

though Medicaid enrollees typically utilize more care. This is because expenditures per visit are significantly lower for physician/outpatient (-$131), hospital inpatient (-$8,557), and emergency room services (-$1,104). In contrast, per capita expenditures for those with Medicaid are higher than those with private group coverage ($283) because Medicaid enrollees consume significantly more prescription drugs (2.8 fills) without significant differences in expenditures per fill.

Table 6. Regression-Adjusted Differences in Spending and Utilization Outcomes, by Service Type among Those with Any Priority Conditions

Full-Year Marketplace Coverage Compared with Full-Year Medicaid Coverage					
Conditions	Outcome				
	Total spending	Probability of any spending	Total spending conditional on any spending	Number of units (utilization)	Expenditures per unit (of those with any utilization)
	A	B	C	D	E
Total expenditures					
Any priority condition diagnosis	2122	-0.008	2414	-4.09**	109.05
High blood pressure	4912*	-0.029	5705*	-4.51	664.02
High cholesterol	5086**	-0.007	5398**	-6.86**	185.91**
Diabetes	7959*	0.014	7760*	3.44	149.82
Joint pain	3529*	-0.005	3861*	-5.85**	223.73**
Arthritis	7420**	0.013	7707**	-5.55	142.84

Full-Year Marketplace Coverage Compared with Full-Year ESI/Private Group Coverage					
Conditions	Outcome				
	Total spending	Probability of any spending	Total spending conditional on any spending	Number of units (utilization)	Expenditures per unit (of those with any utilization)
	A	B	C	D	E
Total expenditures					
Any priority condition diagnosis	6	-0.002	-30	0.566	-43.23
High blood pressure	6	0.010	94	-0.983	-48.80
High cholesterol	-70	-0.002	-117	-0.304	28.35
Diabetes	2563	0.017	2439	-0.335	81.46
Joint pain	886	-0.004	1004	-0.084	-49.92
Arthritis	156	0.011	-80	-0.167	-87.57

Table 6. Regression-Adjusted Differences in Spending and Utilization Outcomes, by Service Type among Those with Any Priority Conditions

Full-Year Medicaid Coverage Compared with Full-Year ESI/Private Group Coverage					
Conditions	Outcome				
	Total spending	Probability of any spending	Total spending conditional on any spending	Number of units (utilization)	Expenditures per unit (of those with any utilization)
	A	B	C	D	E
Total expenditures					
Any priority condition diagnosis	-1517**	0.002	-1780**	5.667***	46.97
High blood pressure	-2576	0.039***	-3031*	8.286***	393.19
High cholesterol	-2573	0.011	-2792*	9.634***	-99.15***
Diabetes	-2843	0.015	-2997	11.324**	-105.54**
Joint pain	-1914*	0.003	-2124*	6.805***	-120.34**
Arthritis	-2370	0.022	-2684	7.715***	-109.96**

Source: 2014–16 Medical Expenditure Panel Survey Household Component.

Notes:
ESI = employer-sponsored insurance.
ESI/private group includes military coverage, unknown private coverage, coverage from someone outside the household, and other group coverage.
** p < 0.1; ** p < 0.05; *** p < 0.01 (compared with Marketplace group)*

Table 4 shows differences in total expenditures and utilization among those with priority condition diagnoses. These differences are consistent with the main model findings—across each condition, Marketplace enrollment is generally associated with higher spending (overall and conditional on any spending), less utilization, and higher expenditures per unit consumed.

We observe no significant differences between people with chronic conditions and Marketplace coverage and those with private group coverage. The differences between Medicaid enrollees and private group enrollees with chronic conditions are consistent with the results shown in Table 5.

DISCUSSION

After controlling for differences in Marketplace and Medicaid enrollees' observable socioeconomic and health characteristics, we find that though average total per capita expenditures for Marketplace enrollees are higher than those for Medicaid enrollees, the difference in expenditures between the two groups is not statistically significant. This is likely because of the lack of precision in estimating expenditures among a relatively small sample of Marketplace enrollees. We also find that full-year Marketplace enrollees use significantly less care in hospital emergency room and inpatient settings than full-year Medicaid enrollees. However, Marketplace enrollees have higher total spending for physician/outpatient and emergency room services than Medicaid enrollees, a result of their higher expenditures per unit of care.

These findings have implications for the ongoing debate over approaches for expanding coverage, particularly within states seeking waivers to adopt partial Medicaid expansions to adults with incomes up to 100 percent of FPL, leaving most people with incomes between 100 and 138 percent of FPL eligible to receive subsidized coverage through the Marketplaces. Our findings suggest that higher treatment intensity (e.g., Medicaid enrollees using the emergency room for less intense treatments, such as primary care) or higher provider reimbursement rates drive higher average spending levels per Marketplace enrollee relative to Medicaid levels. Holding other factors constant, relying more on the Marketplace for coverage expansion could increase total expenditures, given Marketplace enrollees' higher per capita spending across some services. However, differences in provider reimbursement rates alone do

not determine differences in the costs of expanding Medicaid versus Marketplace coverage; differences in administrative costs and network quality also play a role. In addition, compared with a full Medicaid expansion, partial Medicaid expansion could increase overall federal costs because the federal government pays the full cost of subsidies in the Marketplace, and Medicaid costs are shared between states and the federal government.[11]

Other policy trade-offs should also be considered. Somewhat higher Marketplace per capita costs may be partially offset by lower take-up of coverage and use of care resulting from larger premium and cost-sharing requirements in the Marketplace than in Medicaid. One study of near-poor nonelderly adults with incomes of 100 to 138 percent of FPL found that living in a Medicaid expansion state was associated with a decreased probability of being uninsured and a large decline in average total out-of-pocket spending, most likely because of lower or no premiums and cost-sharing and less restrictive eligibility requirements in Medicaid, which allow enrollment even if someone has access to an affordable employer-based insurance plan.[28] Another consideration is that though Medicaid could be less costly per capita and would generally make coverage and care more affordable, patients may face limited access to providers willing to accept Medicaid.[16]

We also find that Medicaid enrollment is associated with significantly lower expenditures compared to private group coverage. This suggests that policies that would shift Medicaid enrollees into private plans would likely increase costs, though the exact amount would depend on several factors. For example, Medicaid enrollees might start to use more high-cost care if their provider networks expand with private insurance. In contrast, those who move from Medicaid to private coverage would likely consume less if they face significant cost-sharing requirements.

This analysis has several limitations. First, we cannot separate differences in expenditures per visit due to provider payment rates from differences due to variation in treatment intensity with MEPS data. Second, there may be measurement error in reported coverage type and expenditures among Medicaid and Marketplace populations. For example, Medicaid expenditures in administrative data could differ from the MEPS expenditures adjusted to the NHEA totals for several reasons: administrative data may include social services covered in Medicaid but not reported as health expenditures in MEPS, NHEA may undercount supplemental payments to hospitals and other providers, and NHEA may also not include full managed care and administrative costs. Finally, this analysis period only extends through 2016 and does not capture the most recent dynamics in the Marketplaces; Marketplace payments through 2019 may have declined as more Medicaid plans gained market share and commercial insurers scaled back their participation.

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23 These conditions, selected for their prevalence, expense, or relevance to policy, are: hypertension, heart disease, high cholesterol, emphysema, chronic bronchitis, diabetes, cancer, arthritis, asthma, attention deficit/hyperactivity disorder (ADHD or ADD), and stroke.

24 There are 690 Marketplace enrollees with any utilization, 596 with any physician/outpatient services, 32 with any hospital inpatient services, 99 with any emergency room visit, 513 with any prescription drugs, and 286 with any other services. There are also 565 Marketplace enrollees with any priority condition diagnosis, 244 with high blood pressure, 250 with high cholesterol, 88 with diabetes, 377 with joint pain, and 161 with arthritis.

25 Differences in any use of other services are driven by differences in use of dental services (31.1 percent versus 27.2 percent), other providers (11.7 percent versus 7.4 percent), and medical equipment (18.6 percent versus 15.9 percent).

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