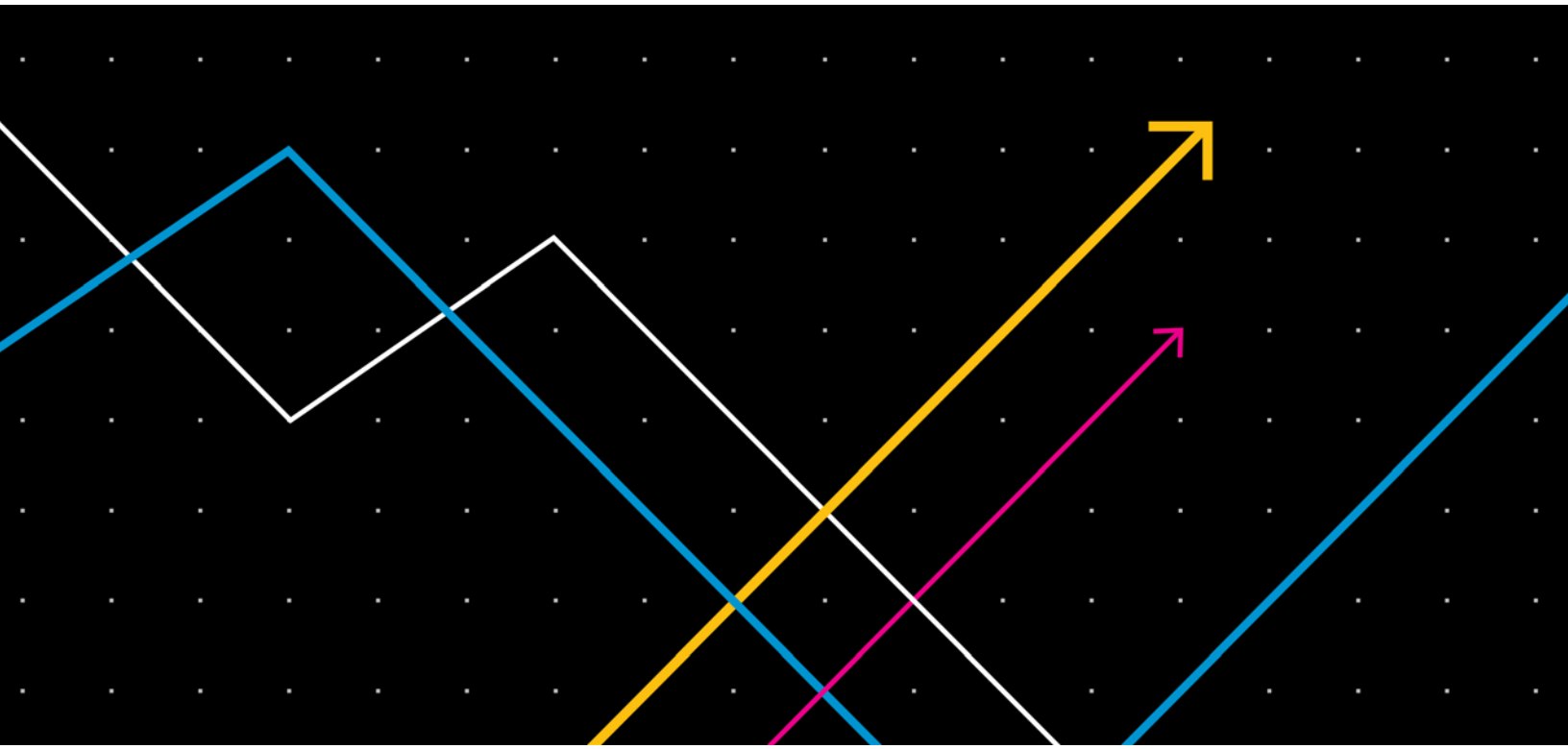

RESEARCH REPORT

# 3.7 Million People Would Gain Health Coverage in 2023 If the Remaining 12 States Were to Expand Medicaid Eligibility

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URBAN INSTITUTE

Robert Wood Johnson Foundation


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# Executive Summary

Under the Affordable Care Act, states have the option to expand Medicaid eligibility to nonelderly people with incomes up to 138 percent of the federal poverty level. As of the time of writing, only 12 states have not done so: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Eleven of the 13 states with the highest uninsurance rates nationwide have not expanded Medicaid. Governors, legislators, and other stakeholders in many of these states are actively debating Medicaid expansion. At the federal level, some in Congress have recently proposed legislation that would extend financial assistance for purchasing health coverage to people who are ineligible for Medicaid because their states have not expanded eligibility.

We estimated the following outcomes if the 12 nonexpansion states were to fully implement a Medicaid expansion in 2023 and all else were to stay the same:

- Medicaid enrollment would increase by 6.4 million people.
- In the current nonexpansion states, 3.7 million fewer people would be uninsured, a reduction of 29.1 percent.
- Groups with the largest gains in coverage due to Medicaid expansion would include non-Hispanic Black people, young adults, and women, particularly women of reproductive age.
- Federal spending on Medicaid and the Marketplaces in the current nonexpansion states would increase by about $34.5 billion, or 26.6 percent. This would be partially offset by $2.6 billion in federal government savings on uncompensated care.
- State spending on Medicaid in the current nonexpansion states would increase by $2.7 billion, or 5.2 percent. This would be partially offset by $1.7 billion in state and local government savings on uncompensated care.
- New state spending in the current nonexpansion states would be fully or largely offset by savings in other areas and potential new revenue. Several comprehensive analyses of the states that have expanded Medicaid have found that savings and new revenue outweigh any new spending due to Medicaid expansion.
- For the first two years after Medicaid expansion, the federal government would pay a higher share of the costs of Medicaid enrollees who were eligible before expansion.

Growing evidence shows that increased health coverage lowers mortality and increases the financial security of families with low incomes. It can also decrease the number of unwanted pregnancies and increase access to effective contraception, which is particularly important after the

Supreme Court's decision revoking the constitutional right to an abortion. Medicaid expansion also improves hospital finances and can boost state economies.

# 3.7 Million People Would Gain Health Coverage in 2023 If the Remaining 12 States Were to Expand Medicaid Eligibility

## Introduction

States have the option to expand Medicaid eligibility to nonelderly people with incomes up to 138 percent of the federal poverty level (FPL) under the Affordable Care Act (ACA).[1] At the time of writing, only 12 states have not done so: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Among adults in nonexpansion states, except for Wisconsin, only parents with very low incomes can be eligible Medicaid with full benefits.[2] Wisconsin is unique in that it extended Medicaid eligibility to adults with incomes up to 100 percent FPL in 2014, without accepting the ACA's Medicaid expansion. Among the nonexpansion states, the highest eligibility thresholds for parents are in Tennessee (88 percent of FPL) and South Carolina (67 percent of FPL).[3] The remaining nine expansion states have thresholds at or below 50 percent of FPL; the lowest thresholds are in Texas (16 percent of FPL) and Alabama (18 percent of FPL).

People with incomes below 100 percent of FPL are also ineligible for Marketplace premium tax credits (PTCs).[4] Thus, many uninsured adults with incomes below 100 percent of FPL in nonexpansion states are caught in a coverage gap, qualifying for neither Medicaid nor PTCs to purchase Marketplace coverage. They generally have no affordable health insurance options. Additionally, people with incomes between 100 and 138 percent of FPL may fall into an assistance gap and be ineligible for tax credits if they have an affordable offer of other coverage.[5] Medicaid has no such requirement for eligibility, so these people would gain eligibility for assistance if their states were to expand Medicaid.

This report updates a series of analyses that used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the impact of Medicaid expansion, most recently Buettgens (2021) and Simpson (2020). Here we assume states have fully resumed normal Medicaid eligibility processing after the expiration of the US Department of Health and Human Services' COVID-19 public health emergency (Buettgens and Green 2022) and that enhanced Marketplace PTCs under the American Rescue Plan Act (ARPA) expire in 2023 (Buettgens, Banthin, and Green 2022), as they are

slated to under current law. We estimate new Medicaid enrollment, as well as the resulting decline in the number of uninsured people, assuming all nonexpansion states were to expand eligibility. We show how this would affect different age, gender, and racial and ethnic groups. We also consider the costs of Medicaid expansion.

If all 12 remaining states were to expand eligibility in 2023, we find that Medicaid enrollment would increase by 6.4 million people. In addition, 3.7 million fewer people in the current nonexpansion states would be uninsured, a reduction of 29.1 percent. Groups with the largest gains in coverage due to Medicaid expansion would be Black people, young adults, and women, particularly women of reproductive age. The federal government would pay 90 percent of the costs of newly eligible Medicaid enrollees. Although states would have to pay the remaining 10 percent, Medicaid expansion gives states opportunities to reduce current spending and increase revenue. Several comprehensive analyses of states that have expanded Medicaid have found that expansion had a net positive impact on many state budgets. In addition, for the first two years after new Medicaid expansion, the federal government would pay a higher share of the costs of currently eligible Medicaid enrollees. This new federal funding would outweigh any additional state spending.

**About US Health Reform—Monitoring and Impact**

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

# Methods

We produced our estimates using HIPSM, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—

from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

We updated the model using state-level Marketplace enrollment from the 2022 open enrollment period snapshot released by the Centers for Medicare & Medicaid Services.[6] By comparing those enrollment estimates with estimated Marketplace enrollment before the enhanced PTCs under the ARPA, we measured how the demand for Marketplace coverage increased in each state as a result of the enhanced PTCs. We found substantial variation across states that has important implications for our results.

We estimated the increase in Marketplace coverage as a result of losses of Medicaid enrollment after the public health emergency expires using our recently updated estimates of Medicaid enrollment in 2022 and 2023 (Buettgens and Green 2022). We describe the details of our methodology in a separate brief (Buettgens and Banthin 2022).

In this report, we simulate Medicaid enrollment in 2023 if the remaining 12 states were to expand eligibility that year. Based on Medicaid enrollment data from 2019 released by the US Department of Health and Human Services, enrollment experiences in previous Medicaid expansions varied across states;[7] using these enrollment data and HIPSM simulation, we estimate slightly more than 72 percent of uninsured people and 13 percent of people with employer-sponsored insurance who gained Medicaid eligibility under expansion had enrolled in the program by 2019.[8] We assume the Medicaid take-up rate for new expansion states is the average such rate among current expansion states. However, take-up may vary depending on state decisions we cannot predict, such as those related to outreach and enrollment assistance efforts. Also, states could combine Medicaid expansion with Medicaid waivers that introduce other changes in the program.

Our estimates further assume that the COVID-19 public health emergency has expired and states have had time to fully resume income eligibility processing (Buettgens and Banthin 2022). We assume the enhanced PTCs established under the ARPA have expired in 2023 (Buettgens, Banthin, and Green 2022). At the time of writing, Congress is still considering whether to extend them. However, the focus of this paper is Medicaid, not Marketplace PTCs. Without the enhanced PTCs, Medicaid enrollment would be unchanged because eligibility for Medicaid and PTCs is mutually exclusive. However, the impact on the uninsured population would be smaller. See the Connections with Other Current Health Policy Issues section for more details.

# Results

In this section, we examine changes in Medicaid enrollment, uninsurance, spending by the federal government and state governments, and uncompensated care in 2023 under Medicaid expansion in the remaining states.

## Changes in Health Coverage in Nonexpansion States

We estimate that if the 12 remaining nonexpansion states were to expand Medicaid in 2023, Medicaid enrollment would increase by 6.4 million people, or 35.9 percent (table 1). In the nonexpansion states, 3.7 million fewer people would be uninsured, a decline of 29.1 percent. Also, 172,000 people currently enrolled in unregulated health coverage that does not comply with ACA standards would gain comprehensive Medicaid coverage.

TABLE 1

**Health Insurance Coverage Distribution of the Nonelderly Population in the Current Nonexpansion States, 2023**

| | Current Law, ACA PTCs | | Medicaid Expansion, ACA PTCs | | Change | |
|---|---|---|---|---|---|---|
| | 1,000s of people | % of population | 1,000s of people | % of population | 1,000s of people | % |
| **Insured (MEC)** | **72,777** | **83.6** | **76,684** | **88.1** | **3,906** | **5.4** |
| Employer | 46,150 | 53.0 | 45,312 | 52.1 | -838 | -1.8 |
| Private nongroup | 5,534 | 6.4 | 3,903 | 4.5 | -1,631 | -29.5 |
| Marketplace with PTC | 4,013 | 4.6 | 2,270 | 2.6 | -1,742 | -43.4 |
| Full-pay Marketplace | 278 | 0.3 | 268 | 0.3 | -9 | -3.4 |
| Other nongroup | 1,244 | 1.4 | 1,364 | 1.6 | 121 | 9.7 |
| Medicaid/CHIP | 17,737 | 20.4 | 24,113 | 27.7 | 6,376 | 35.9 |
| Disabled | 2,953 | 3.4 | 2,978 | 3.4 | 24 | 0.8 |
| Medicaid expansion | | 0.0 | 7,348 | 8.4 | 7,348 | 100.0 |
| Traditional nondisabled adult | 3,691 | 4.2 | 2,534 | 2.9 | -1,157 | -31.4 |
| Nondisabled Medicaid/CHIP child | 11,093 | 12.7 | 11,253 | 12.9 | 160 | 1.4 |
| Other public | 3,355 | 3.9 | 3,355 | 3.9 | 0 | 0.0 |
| **Uninsured (no MEC)** | **14,250** | **16.4** | **10,343** | **11.9** | **-3,906** | **-27.4** |
| Uninsured | 12,841 | 14.8 | 9,106 | 10.5 | -3,735 | -29.1 |
| Noncompliant nongroup | 1,409 | 1.6 | 1,237 | 1.4 | -172 | -12.2 |
| **Total** | **87,027** | **100.0** | **87,027** | **100.0** | **0** | **0.0** |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** ACA = Affordable Care Act; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program; PTC = premium tax credit.

About 1.7 million current Marketplace enrollees in the nonexpansion states with incomes below 138 percent of FPL would become eligible for Medicaid and would receive more comprehensive

coverage with lower premiums. Finally, 838,000 low-income working families would transition from employer-sponsored health insurance to Medicaid, again receiving coverage that is generally more comprehensive and lacks premiums.

## Changes in Medicaid Enrollment

Medicaid enrollment in nonexpansion states would increase by 35.9 percent if these states were to expand eligibility in 2023 (table 2). States that would see the largest increases in Medicaid enrollment under expansion include Wyoming (65.4 percent), Florida (42.6 percent), and Kansas (42.2 percent). The nonexpansion state with the lowest increase in enrollment would be Wisconsin (14.1 percent), which has already expanded Medicaid eligibility to adults with incomes up to 100 percent of FPL.

TABLE 2

**Medicaid/CHIP Enrollment in Nonexpansion States, 2023**

| | Current Law, ACA PTCs | | Medicaid Expansion, ACA PTCs | | Change | |
|---|---|---|---|---|---|---|
| State | 1,000s of people | % of population | 1,000s of people | % of population | 1,000s of people | % |
| Alabama | 971 | 23.7 | 1,336 | 32.7 | 365 | 37.5 |
| Florida | 3,431 | 19.8 | 4,894 | 28.2 | 1,463 | 42.6 |
| Georgia | 1,970 | 20.7 | 2,708 | 28.4 | 739 | 37.5 |
| Kansas | 375 | 15.0 | 534 | 21.3 | 159 | 42.2 |
| Mississippi | 619 | 25.0 | 843 | 34.0 | 224 | 36.2 |
| North Carolina | 2,114 | 23.2 | 2,767 | 30.4 | 653 | 30.9 |
| South Carolina | 947 | 22.3 | 1,298 | 30.5 | 351 | 37.1 |
| South Dakota | 114 | 15.7 | 159 | 21.9 | 45 | 39.0 |
| Tennessee | 1,371 | 24.0 | 1,727 | 30.2 | 356 | 25.9 |
| Texas | 4,795 | 18.5 | 6,644 | 25.7 | 1,849 | 38.6 |
| Wisconsin | 975 | 20.2 | 1,113 | 23.1 | 138 | 14.1 |
| Wyoming | 54 | 10.4 | 90 | 17.2 | 36 | 65.4 |
| **Total** | **17,737** | **20.4** | **24,113** | **27.7** | **6,376** | **35.9** |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** CHIP = Children's Health Insurance Program; ACA = Affordable Care Act; PTCs = premium tax credits.

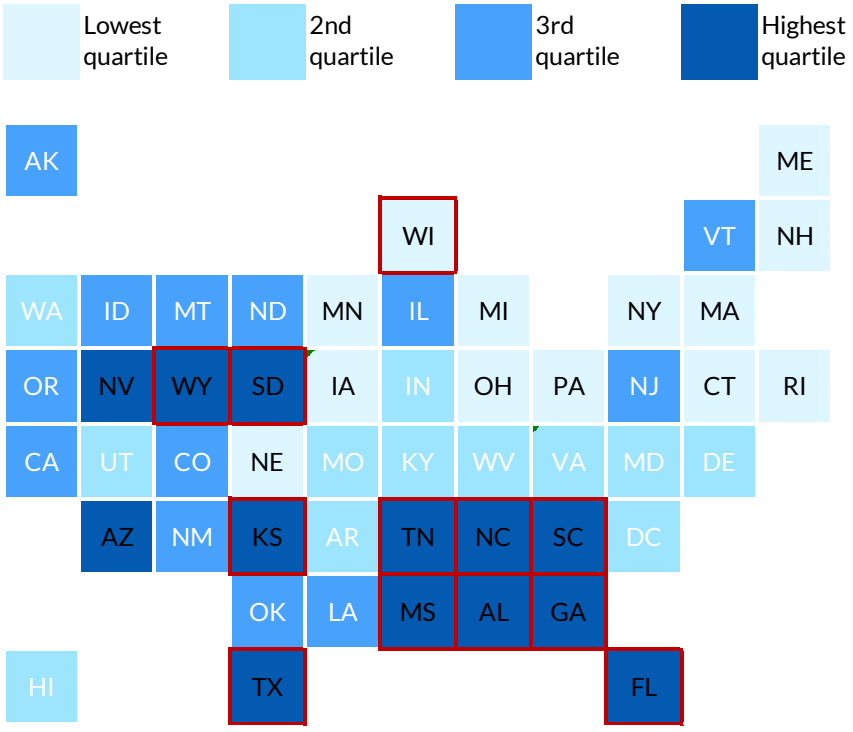
These estimates assume the share of people gaining Medicaid eligibility who choose to enroll is the same in each state, based on the average take-up rate observed across states that have already expanded Medicaid (see the Methods section). However, take-up varies across existing expansion states. Enrollment could be higher than projected in states that conduct more effective outreach and application assistance. Conversely, it could be lower than projected if states impose premiums for Medicaid or additional restrictions such as work requirements.

## Changes in the Uninsured Population

Among the 12 nonexpansion states, all will have uninsurance rates of around 12 percent or higher in 2023. The exception is Wisconsin, which has already extended Medicaid eligibility to all adults with incomes up to 100 percent of FPL. In fact, nonexpansion states make up 11 of the 13 states with the highest uninsurance rates (figure 1). If these states expand Medicaid eligibility in 2023, however, we estimate the number of uninsured people will decline by 29.1 percent (table 3). States with the largest reductions include Alabama (45.0 percent), Mississippi (42.0 percent), and South Carolina (36.6 percent). Wisconsin would have the smallest reduction (16.5 percent) because of its relatively high current Medicaid eligibility threshold for adults. After expanding Medicaid, only four states would have an uninsurance rate of 10 percent or higher: Texas (14.2 percent), Wyoming (11.6 percent), Florida (10.3 percent), and Georgia (10.0) percent. Six nonexpansion states would have uninsurance rates below the national median if they were to expand Medicaid eligibility (figure 2).

FIGURE 1

**Uninsurance Rate for the Nonelderly Population under Current Law, by State, 2023**

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**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Note:** The current nonexpansion states are outlined in red.

TABLE 3

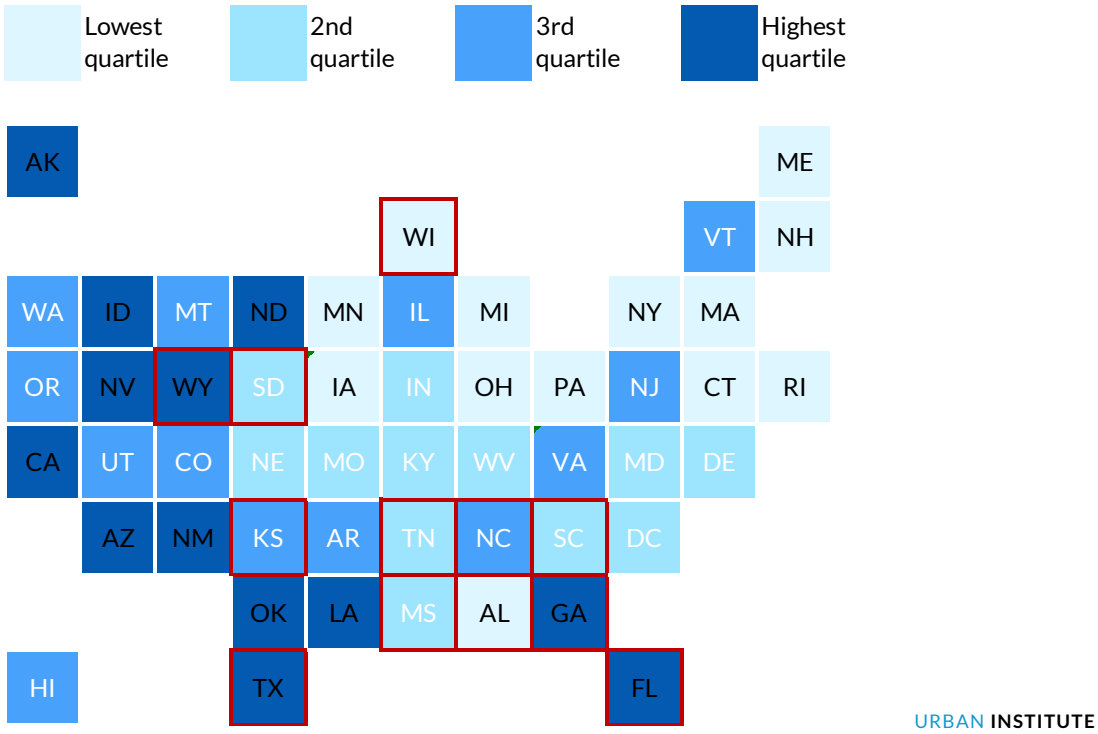
**Uninsurance in Nonexpansion States, 2023**

| State | Current Law, ACA PTCs | | Medicaid Expansion, ACA PTCs | | Change | |
|---|---|---|---|---|---|---|
| | 1,000s of people | Uninsurance rate (%) | 1,000s of people | Uninsurance rate (%) | 1,000s of people | % |
| Alabama | 482 | 11.8 | 265 | 6.5 | -217 | -45.0 |
| Florida | 2,583 | 14.9 | 1,785 | 10.3 | -799 | -30.9 |
| Georgia | 1,397 | 14.7 | 948 | 10.0 | -448 | -32.1 |
| Kansas | 320 | 12.8 | 219 | 8.7 | -101 | -31.6 |
| Mississippi | 350 | 14.1 | 203 | 8.2 | -147 | -42.0 |
| North Carolina | 1,134 | 12.5 | 789 | 8.7 | -346 | -30.5 |
| South Carolina | 546 | 12.8 | 346 | 8.1 | -200 | -36.6 |
| South Dakota | 87 | 12.0 | 61 | 8.5 | -25 | -29.2 |
| Tennessee | 709 | 12.4 | 489 | 8.6 | -220 | -31.0 |
| Texas | 4,826 | 18.6 | 3,668 | 14.2 | -1,158 | -24.0 |
| Wisconsin | 325 | 6.8 | 272 | 5.6 | -54 | -16.5 |
| Wyoming | 81 | 15.4 | 61 | 11.6 | -20 | -24.8 |
| **Total** | **12,841** | **14.8** | **9,106** | **10.5** | **-3,735** | **-29.1** |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** ACA = Affordable Care Act; PTCs = premium tax credits.

FIGURE 2

**Uninsurance Rate for the Nonelderly Population If the Remaining States Expand Medicaid, by State, 2023**




**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Note:** The current nonexpansion states are outlined in red.

Immigration status is a major barrier to Medicaid eligibility (Broder, Moussavian, and Blazer 2015). Undocumented immigrants are ineligible for Medicaid. Legally present adult immigrants who have resided in the US fewer than five years are also ineligible for Medicaid; legally present immigrant children who have resided fewer than five years are eligible for Medicaid and the Children's Health Insurance Program (CHIP) in some states. In Texas and a few other states, legally present immigrants are ineligible for Medicaid regardless of length of residency. Consequently, Texas, which has the highest uninsurance rate in the country (18.6 percent), would see a decline in the number of uninsured people (24.0 percent) below the average for all nonexpansion states. However, even this relatively small decline would still represent a substantial gain in health coverage.

### THE UNINSURED POPULATION BY AGE GROUP

Young adults (ages 19 to 34) in nonexpansion states have the highest uninsurance rate of any age group, 25.2 percent in 2023 without Medicaid expansion (table 4 and figure 3). They would also see the greatest decline in the number of people uninsured under Medicaid expansion, 35.2 percent. Adults ages 35 to 54 have the next highest uninsurance rate (17.4 percent) and would see a 26.1 percent reduction under Medicaid expansion. Adults ages 55 to 64 have a lower uninsurance rate (10.4 percent) because they tend to have higher incomes and to value health coverage more because of their greater health care needs. The number of uninsured adults in this age group would decline by 31.0 percent if the remaining states were to expand Medicaid.

Medicaid and CHIP eligibility thresholds for children are already well above 138 percent of FPL, so they would not gain eligibility under ACA Medicaid expansion. However, the number of uninsured children would still fall by 10.8 percent under expansion. As more parents become eligible for and enroll in Medicaid, their already-eligible children would be more likely to be enrolled as well.

TABLE 4

**Changes in the Nonelderly Uninsured Population in Nonexpansion States, by Age, Race, and Gender, 2023**

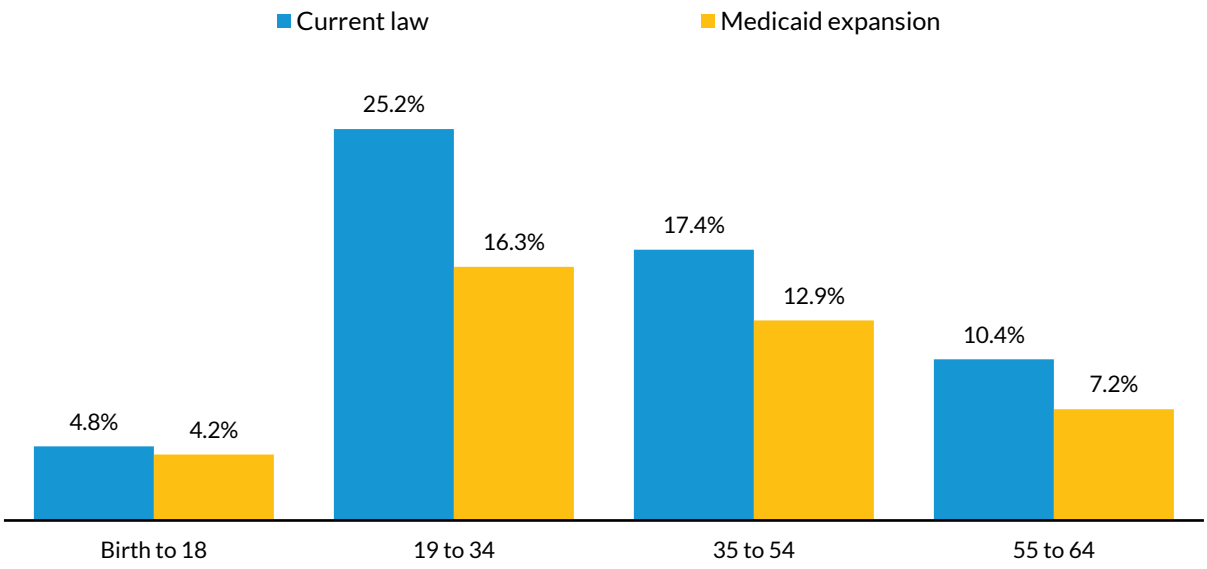
| | Current Law, ACA PTCs | | Medicaid Expansion, ACA PTCs | | Change | |
|---|---|---|---|---|---|---|
| Uninsured population | 1,000s of people | Uninsurance rate (%) | 1,000s of people | Uninsurance rate (%) | 1,000s of people | % |
| **Age** | | | | | | |
| Birth to 18 | 1,195 | 4.8 | 1,066 | 4.2 | -130 | -10.8 |
| 19–34 | 5,527 | 25.2 | 3,581 | 16.3 | -1,947 | -35.2 |
| 35–54 | 4,864 | 17.4 | 3,595 | 12.9 | -1,269 | -26.1 |
| 55–64 | 1,255 | 10.4 | 866 | 7.2 | -389 | -31.0 |
| *Total* | *12,841* | *14.8* | *9,106* | *10.5* | *-3,735* | *-29.1* |
| **Race** | | | | | | |
| White | 5,174 | 10.6 | 3,464 | 7.1 | -1,710 | -33.1 |
| Hispanic | 4,908 | 27.5 | 3,995 | 22.4 | -912 | -18.6 |
| Black | 2,006 | 13.2 | 1,080 | 7.1 | -926 | -46.1 |
| Other | 753 | 14.9 | 567 | 13.3 | -186 | -24.7 |
| *Total* | *12,841* | *14.8* | *9,106* | *10.5* | *-3,735* | *-29.1* |
| **Gender** | | | | | | |
| Men | 7,088 | 16.4 | 5,228 | 12.1 | -1,860 | -26.2 |
| Women | 5,753 | 13.1 | 3,878 | 8.8 | -1,875 | -32.6 |
| *Total* | *12,841* | *14.8* | *9,106* | *10.5* | *-3,735* | *-29.1* |
| **Women** | | | | | | |
| White | 2,270 | 9.3 | 1,413 | 5.8 | -857 | -37.8 |
| Hispanic | 2,187 | 25.0 | 1,711 | 19.6 | -476 | -21.7 |
| Black | 945 | 11.7 | 493 | 6.1 | -452 | -47.9 |
| Other | 351 | 13.4 | 261 | 10.0 | -90 | -25.6 |
| *Total* | *5,753* | *13.1* | *3,878* | *8.8* | *-1,875* | *-32.6* |
| **Women of reproductive age (19–44)** | | | | | | |
| White | 1,252 | 13.0 | 696 | 7.2 | -556 | -44.4 |
| Hispanic | 1,431 | 37.4 | 1,103 | 28.9 | -328 | -22.9 |
| Black | 590 | 17.0 | 273 | 7.9 | -317 | -53.7 |
| Other | 214 | 19.0 | 152 | 13.5 | -62 | -29.1 |
| *Total* | *3,487* | *19.3* | *2,224* | *12.3* | *-1,263* | *-36.2* |
| **Women of older ages (45–64)** | | | | | | |
| White | 829 | 9.3 | 548 | 6.2 | -281 | -33.9 |
| Hispanic | 489 | 26.9 | 367 | 20.2 | -122 | -25.0 |
| Black | 297 | 13.0 | 171 | 7.5 | -125 | -42.3 |
| Other | 95 | 16.0 | 73 | 12.3 | -22 | -23.1 |
| *Total* | *1,709* | *12.6* | *1,159* | *8.5* | *-550* | *-32.2* |
| **Men of younger ages (19–44)** | | | | | | |
| White | 1,739 | 18.1 | 1,144 | 11.9 | -595 | -34.2 |
| Hispanic | 1,926 | 46.8 | 1,615 | 39.2 | -311 | -16.2 |
| Black | 725 | 25.0 | 365 | 12.6 | -360 | -49.7 |
| Other | 254 | 24.4 | 186 | 17.8 | -69 | -27.1 |
| *Total* | *4,644* | *26.3* | *3,309* | *18.7* | *-1,336* | *-28.8* |

| Uninsured population | Current Law, ACA PTCs: 1,000s of people | Current Law, ACA PTCs: Uninsurance rate (%) | Medicaid Expansion, ACA PTCs: 1,000s of people | Medicaid Expansion, ACA PTCs: Uninsurance rate (%) | Change: 1,000s of people | Change: % |
|---|---|---|---|---|---|---|
| **Men of older ages (45–64)** | | | | | | |
| White | 942 | 11.0 | 706 | 8.3 | -236 | -25.1 |
| Hispanic | 502 | 28.6 | 403 | 23.0 | -99 | -19.7 |
| Black | 268 | 14.5 | 167 | 9.0 | -101 | -37.8 |
| Other | 93 | 18.4 | 73 | 14.4 | -20 | -21.9 |
| *Total* | *1,806* | *14.3* | *1,349* | *10.7* | *-457* | *-25.3* |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** ACA = Affordable Care Act; PTCs = premium tax credits. Black people, White people, and people in the "other" racial group did not identify as Hispanic; people who identified as Hispanic on survey data are counted as Hispanic and excluded from the other groups.

FIGURE 3

**Uninsured Population, by Age Group, 2023**

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**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.

## THE UNINSURED POPULATION BY RACE OR ETHNICITY

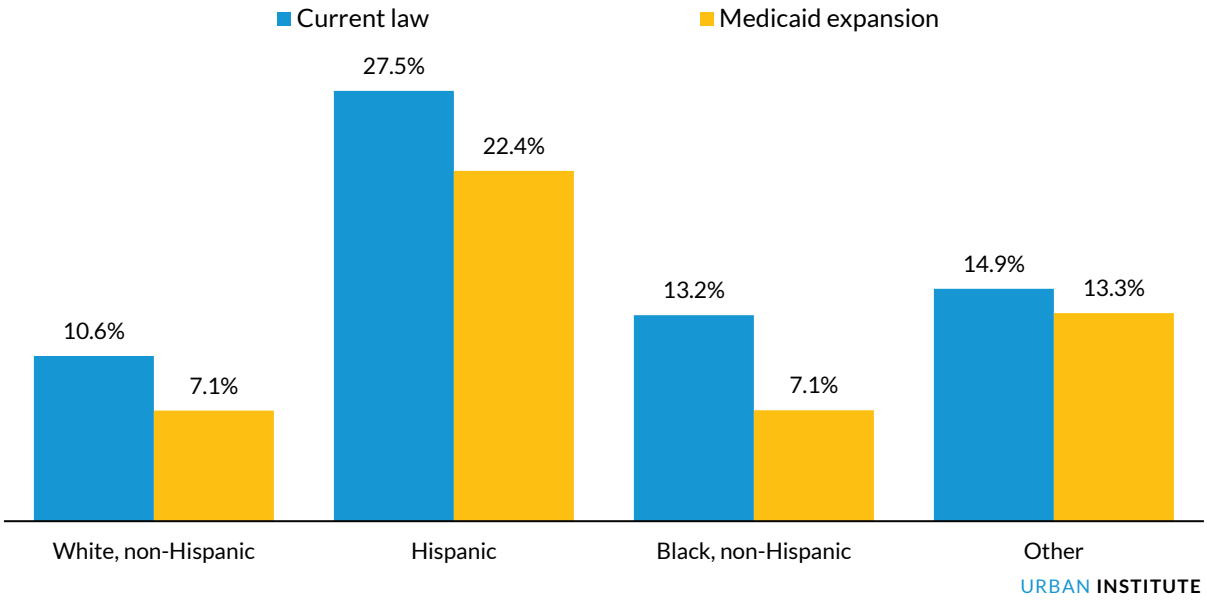
If the remaining 12 states were to expand Medicaid eligibility, the number of uninsured Black people would fall by 46.1 percent (table 4 and figure 4).[9] Uninsurance among White people would fall by 33.1 percent. We estimate that the uninsurance rates for White and Black people would be equal in the nonexpansion states under Medicaid expansion, at 7.1 percent. Thus, Medicaid expansion would eliminate a long-standing inequality in health coverage in these states.

The Hispanic population would see substantial, though smaller, declines in the number of uninsured people (18.6 percent). This is largely because of the restrictions on Medicaid eligibility for immigrants discussed earlier (Broder, Moussavian, and Blazer 2015). Hispanic people would still have the highest uninsurance rate of any racial or ethnic group, 27.5 percent without Medicaid expansion or 22.4 percent with expansion.

Other racial and ethnic groups—specifically people who report being Asian/Pacific Islander, American Indian, or multiple races—would see a 24.7 percent reduction in uninsurance if the remaining states were to expand Medicaid.

FIGURE 4

**Uninsured Population, by Race and Ethnicity, 2023**




**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Note:** "Other" group includes people who report being Asian/Pacific Islander, American Indian, or more than one race.

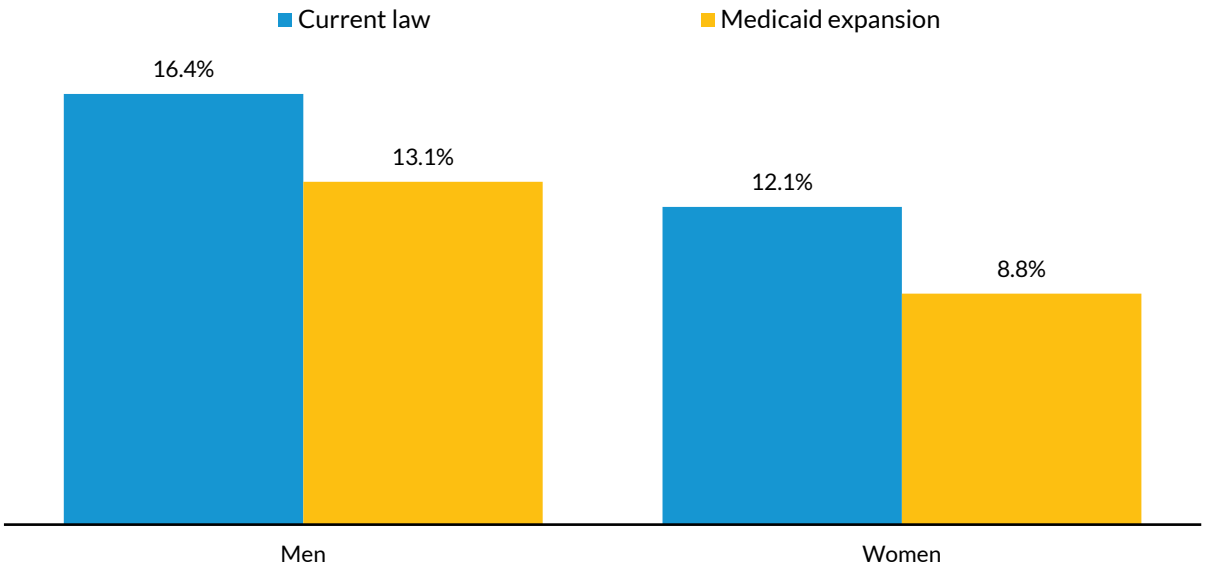
## THE UNINSURED POPULATION BY GENDER

If the remaining 12 states were to expand Medicaid, we estimate that 1.9 million fewer women and 1.9 million fewer men would be uninsured (table 4). However, currently fewer women than men are uninsured in these states (figure 5), so the number of uninsured women would decline by 32.6 percent under Medicaid expansion, compared with a 26.2 percent reduction for men (table 4). The lower uninsurance rate among women in nonexpansion states owes, in part, to the fact that more than half of adult Marketplace enrollees are women.[10] Without expansion, Medicaid is not generally available to

adult men or women, except parents with very low incomes and low-income pregnant women during their pregnancies.

FIGURE 5

**Uninsured Population, by Gender, 2023**

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**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.

## THE INTERSECTION OF RACE, AGE, AND GENDER

That young adults currently have the highest uninsurance rate and would see the greatest reduction in uninsurance due to Medicaid expansion holds when considering women and men separately. Reproductive-age women (19 to 44) would see a 36.2 percent reduction in uninsurance, compared with a 32.2 percent reduction for women ages 45 to 64. By comparison, men ages 19 to 44 would see a 28.8 percent reduction in uninsurance, compared with a 25.3 percent reduction for men ages 45 to 64.

For all ages and genders, Black people would see the highest reductions in uninsurance; White people would see lower reductions, and Hispanic people would see the lowest reductions. In particular, Black women of reproductive age would see a 53.7 percent reduction in uninsurance, the largest decrease of any group considered. Reductions in uninsurance among other women of reproductive age would be 44.4 percent for those who are White, 22.9 percent for those who are Hispanic, and 29.1 percent for those in other racial groups.

## Changes in Federal Costs

The federal government would pay 90 percent of the costs of Medicaid enrollees who newly become eligible under expansion. This would apply to the large majority of new Medicaid enrollees, but enrollment would also increase among those who were already eligible, particularly children. As more parents enroll in coverage, more of their eligible children will also be enrolled in Medicaid and CHIP. For enrollees who were eligible before expansion, the federal government pays the state's standard matching rate, which is much lower than 90 percent.[11]

Consequently, if the remaining 12 states were to expand Medicaid eligibility, the federal government would spend $34.5 billion more on health care in those states in 2023, a 26.6 percent increase (table 5). States with the largest increases would be Kansas (33.9 percent), Texas (32.5 percent), Alabama (32.0 percent), and South Carolina (31.3 percent). As we have seen, Wisconsin would have the smallest enrollment increases, so the increase in federal spending would be smallest there as well (8.4 percent).

TABLE 5

**Federal Spending on Medicaid, CHIP, and Marketplace PTCs in Nonexpansion States, 2023**

| | | | Change | |
|---|---|---|---|---|
| State | Current law, ACA PTCs ($million) | Medicaid expansion, ACA PTCs ($million) | $million | % |
| Alabama | 6,159 | 8,132 | 1,972 | 32.0 |
| Florida | 27,204 | 32,251 | 5,047 | 18.6 |
| Georgia | 12,321 | 15,951 | 3,631 | 29.5 |
| Kansas | 2,336 | 3,128 | 791 | 33.9 |
| Mississippi | 5,230 | 6,747 | 1,518 | 29.0 |
| North Carolina | 17,176 | 22,245 | 5,069 | 29.5 |
| South Carolina | 6,202 | 8,146 | 1,944 | 31.3 |
| South Dakota | 962 | 1,230 | 268 | 27.8 |
| Tennessee | 9,423 | 11,261 | 1,838 | 19.5 |
| Texas | 36,668 | 48,581 | 11,913 | 32.5 |
| Wisconsin | 5,696 | 6,175 | 479 | 8.4 |
| Wyoming | 647 | 713 | 66 | 10.2 |
| **Total** | **130,024** | **164,560** | **34,536** | **26.6** |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; PTCs = premium tax credits.

In addition to benefitting the people gaining better access to health care, this additional federal spending can lead to improved hospital finances, new jobs, and additional state revenue. See the Discussion section for more information and citations.

Under the ARPA, states that newly expand Medicaid will receive a 5 percentage-point increase in their federal Medicaid matching rates for two years. In other words, the federal government will pay more for Medicaid enrollees who were eligible before Medicaid expansion. We excluded this temporary addition to federal spending from our estimates to give an accurate picture of long-term spending under Medicaid expansion.

## Changes in State Costs

If the remaining 12 states were to expand Medicaid eligibility in 2023, these states would spend $2.7 billion more on new Medicaid enrollees, a 5.2 percent increase (table 6). States with the largest increases in spending include Mississippi (11.1 percent), Alabama (11.0 percent), and Wyoming (9.8 percent).

TABLE 6

**State Spending on Medicaid, CHIP, and Marketplace PTCs in Nonexpansion States, 2023**

| | | | Change | |
|---|---|---|---|---|
| State | Current law, ACA PTCs ($million) | Medicaid expansion, ACA PTCs ($million) | $million | % |
| Alabama | 1,765 | 1,959 | 194 | 11.0 |
| Florida | 9,906 | 10,281 | 374 | 3.8 |
| Georgia | 4,402 | 4,757 | 356 | 8.1 |
| Kansas | 1,149 | 1,211 | 62 | 5.4 |
| Mississippi | 1,325 | 1,472 | 147 | 11.1 |
| North Carolina | 6,346 | 6,765 | 420 | 6.6 |
| South Carolina | 1,909 | 2,092 | 183 | 9.6 |
| South Dakota | 445 | 471 | 25 | 5.7 |
| Tennessee | 4,116 | 4,171 | 56 | 1.4 |
| Texas | 18,408 | 19,512 | 1,104 | 6.0 |
| Wisconsin | 2,926 | 2,713 | -213 | -7.3 |
| Wyoming | 327 | 359 | 32 | 9.8 |
| **Total** | **53,023** | **55,764** | **2,740** | **5.2** |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; PTCs = premium tax credits.

Wisconsin would spend less under Medicaid expansion because it currently extends Medicaid coverage to adults with incomes up to 100 percent of FPL, with the federal government covering only 60.1 percent of the cost. If Wisconsin were to expand Medicaid, the federal government would cover 90 percent of the cost of the same enrollees. In other words, by not accepting the ACA's Medicaid expansion, Wisconsin is spending more to cover fewer people.

Table 6 does not represent the net impact of Medicaid expansion on state budgets. Medicaid expansion brings many opportunities for state savings and additional state revenue. We estimate state savings on uncompensated care in the next section and discuss the impact on state budgets more fully below. Most expansion states that have conducted comprehensive analyses have concluded that Medicaid expansion reduced total state spending.

Again, these estimates exclude the two-year increase in federal funding after a new Medicaid expansion under the ARPA. During that time, new federal funding would outweigh state spending on Medicaid expansion enrollees.

## Changes in Uncompensated Care

When the number of uninsured people declines, the demand for uncompensated care among uninsured people also declines. However, because of the complexities of how uncompensated care is financed, a reduction in demand will not necessarily result in comparable government savings. For the federal government, we estimate that half of the change in demand will be realized as savings in Medicare disproportionate share hospital payments. That results in $2.6 billion in federal government savings for 2023 (table 7), which partially offsets the $34.5 billion in new federal Medicaid spending (table 5).

Financing by state and local governments is more complicated. We assume that half of the change in demand for uncompensated care will be realized as savings. That results in $1.7 billion in savings that would offset more than 60 percent of the $2.7 billion in new state Medicaid spending (table 6). We did not estimate these savings by state because considerable variation would be likely.

TABLE 7

**Uncompensated Care Spending in Nonexpansion States, by Payer, 2023**

*Millions of dollars*

| | Current law, ACA PTCs | Medicaid expansion, ACA PTCs | Difference |
|---|---|---|---|
| Federal government | 10,940 | 8,295 | -2,645 |
| State/local government | 6,837 | 5,184 | -1,653 |
| Health care providers | 9,572 | 7,258 | -2,314 |
| **Total** | **27,349** | **20,737** | **-6,612** |

**Source:** Urban Institute analysis using the Health Insurance Policy Simulation Model, 2022.
**Notes:** ACA = Affordable Care Act; PTCs = premium tax credits.

# Discussion

More than a decade after the Supreme Court made Medicaid expansion a state option under the ACA, expansion remains one of the most important health policy questions for states that have not already expanded eligibility. Earlier this year, the governor of Kansas proposed Medicaid expansion in the state's annual budget, the North Carolina Senate passed a bill for Medicaid expansion, and South Dakota validated two ballot initiatives on Medicaid expansion.[12]

In addition to state policy debates, some in Congress have proposed federal policies to offer health coverage to people ineligible for assistance purchasing coverage because their states have not expanded Medicaid. The most recent proposal was in the Build Back Better Act considered in 2021, which Congress ultimately did not pass (Holahan et al. 2021). At the time of writing, it is unclear whether this provision could be considered in new legislation containing some parts of the Build Back Better Act. The results of such a proposal could differ from our estimates of Medicaid expansion. Most importantly, the federal government would bear the full cost of such a policy proposal. If premiums and cost sharing are higher than Medicaid costs under such a proposal, take-up will be lower than what we estimate. If the affordable offer test currently in place for Marketplace PTC eligibility also applies to such a proposal, fewer people will gain eligibility for assistance than under Medicaid expansion. Finally, using the Marketplace as a substitute for Medicaid expansion could have a major impact on nongroup premiums, depending on how cost-sharing reductions for the new enrollees are funded.

## Gains in and Benefits of Health Coverage

We estimate that 3.7 million fewer people in the 12 current nonexpansion states would be uninsured if those states were to expand Medicaid eligibility in 2023. In addition, 172,000 people who currently have unregulated, non-ACA-compliant health coverage would be enrolled in Medicaid. Expansion would benefit many groups who are historically underinsured or vulnerable to high health care costs:

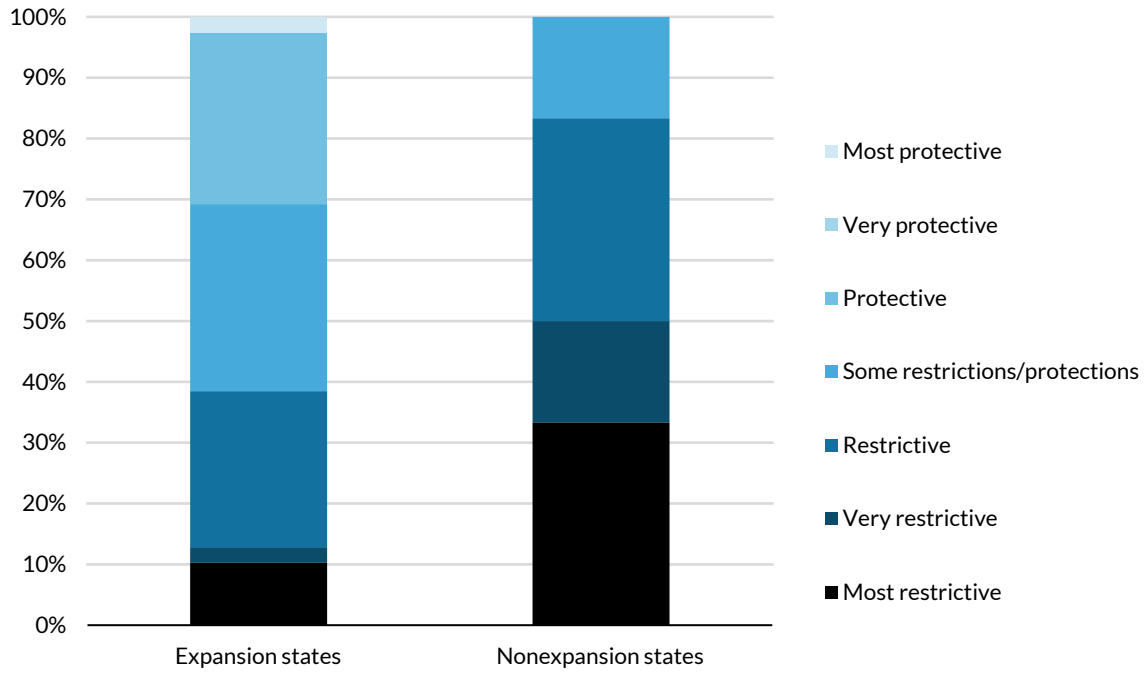
- The Black population would see the largest reduction in uninsurance of any racial or ethnic group we considered (46.1 percent); Medicaid expansion would equalize the uninsurance rates of Black and White people in the 12 nonexpansion states (7.1 percent).
- Young adults currently have the highest uninsurance rate of any age group (25.2 percent) and would see the greatest reduction in uninsurance (35.2 percent).
- Reproductive-age women would see a larger reduction in uninsurance (36.2 percent) than either older women (32.2 percent) or men (26.2 percent). Health coverage in general and Medicaid expansion in particular are associated with a reduction in unwanted pregnancies and

greater access to the most effective contraceptive methods (see below). This is particularly relevant in the wake of *Dobbs v. Jackson Women's Health Organization*, in which the Supreme Court eliminated the constitutional right to an abortion.13 According to data from the Guttmacher Institute,[14] abortion access in 10 of the 12 nonexpansion states is considered restrictive, whereas the remaining 2 states are rated as having some abortion restrictions and protections (figure 6). By contrast, among the 39 states and the District of Columbia which have expanded Medicaid, abortion access is considered restrictive in only 15 states.

- Black women of reproductive age would see a 53.7 percent reduction in uninsurance, the largest change of any group we considered.
- Restrictions on Medicaid eligibility for immigrants, both legally present and undocumented, limit potential gains in health coverage, particularly in states like Texas and Florida. Under expansion, Hispanic people would see the smallest reduction in uninsurance of any racial or ethnic group (18.6 percent) and would continue to have the highest uninsurance rate (22.4 percent).

FIGURE 6

**State Abortion Access, by Medicaid Expansion Status**

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**Source:** "Interactive Map: US Abortion Policies and Access after Roe," Guttmacher Institute, accessed July 11, 2022, https://states.guttmacher.org/policies/.

In addition, studies have found Medicaid expansion has many benefits beyond reducing the number of uninsured people:

- **Medicaid expansion saves lives.** At least two studies have found that health coverage under the ACA decreased mortality, and one found a statistically significant reduction in mortality in expansion states compared with nonexpansion states (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2019).
- **Expansion increases the financial security of people gaining health coverage.** Two studies found that Medicaid expansion improved financial security measures, such as credit scores, while reducing financial insecurity measures, such as medical debt collection balances (Caswell and Waidmann 2017; Hu et al. 2016).
- **Expansion can reduce unwanted pregnancies and increase access to effective contraception.** Evidence shows that uninsured women are at higher risk than insured women of having an unwanted pregnancy due to an inability to access free or low-cost reproductive health services, including contraception (Grindlay and Grossman 2016). Kavanaugh and Pliskin (2020) found that access to health care was strongly associated with the use of nearly all methods of long- and short-acting contraception. Darney and colleagues (2020) found that Medicaid expansion is associated with an increase in access to the most effective methods of contraception. Johnston and McMorrow (2020) found that the ACA's expansion in health coverage significantly increased the use of contraception among Black women. This last result is particularly striking given that we estimate that reproductive-age Black women would see the largest reduction in uninsurance of any group we considered.
- **Expansion improves hospital finances.** Studies have shown this is achieved through lowered uncompensated care costs (Blavin 2017; Dranove, Garthwaite, and Ody 2017).
- **Expansion improves state economies.** A study in Montana found Medicaid expansion led to an additional $600 million circulating in the state's economy each year, supporting 5,900 to 7,500 jobs and $350 to $385 million in personal income (Ward and Bridge 2019).

## Potential Net Savings to State Budgets

If the remaining 12 states were to expand Medicaid eligibility in 2023, we estimate that federal spending would increase by $34.5 billion, or 26.6 percent, that year. This would be partially offset by $2.6 billion in savings on uncompensated care paid for by Medicare disproportionate share hospital payments. State spending on Medicaid would increase by $2.7 billion, or 5.2 percent. We estimate that state and local government spending on uncompensated care could decrease by $1.7 billion, offsetting part of this increase.

However, this does not mean that Medicaid expansion would necessarily increase overall state spending. Though spending on Medicaid claims would increase because of higher caseloads, states could see both substantial savings and new revenue. These offsets vary considerably by state but include the following:

- State and local governments save on uncompensated care.
- States receive higher federal matching rates for some beneficiaries who, without expansion, would have been covered through pre-ACA Medicaid eligibility categories. We include this to the extent that we can estimate it, though we may understate potential savings in some states.[15]
- As the federal government spends more on a state's health care, the state's economic activity increases, thereby increasing tax revenue.[16]
- State taxes on health care providers and/or health coverage premiums increase revenue.
- Demand decreases for non-Medicaid state-funded programs for uninsured people with low incomes (which are separate from uncompensated care).

Most states with comprehensive analyses project net fiscal gains from Medicaid expansion, even after states begin paying 10 percent of the costs for Medicaid expansion enrollees. A study of all expansion states found "no significant increases in spending from state funds as a result of the expansion" by 2015 (Sommers and Gruber 2017). Comprehensive analyses of the budget impact of Medicaid expansion have concluded that, on balance, Medicaid expansion has yielded net gains to state budgets in the following states and the District of Columbia (Sommers and Gruber 2017): Alaska (Evans et al. 2016); Arkansas (Bachrach et al. 2016); California (Sommers and Gruber 2017); Colorado (Brown, Fisher, and Resnick 2015); Kentucky (Deloitte 2015); Louisiana (Louisiana Department of Health 2017); Maryland (Sommers and Gruber 2017); Michigan (Ayanian et al. 2017); New Jersey;[17] New Mexico (Reynis 2016); Oregon (Sommers and Gruber 2017); Pennsylvania (Sommers and Gruber 2017); Virginia (VA DMAS 2018); Washington (Dorn et al. 2015); and West Virginia (Sommers and Gruber 2017). Ten of these studies covered calendar year 2020 and beyond, when federal funding for Medicaid expansion will reach its final and lowest matching rate (90 percent). Eight of them found Medicaid expansion's impact on the state budget would be positive over that period. Two analyses projected eventual net budget losses, but these results may not be generalizable to other states.[18]

Under the ARPA, the federal government will pay a higher share of the costs of nonexpansion Medicaid enrollees for the first two years after a state newly expands Medicaid. During this time, the new federal funding would greatly outweigh any additional state spending on the Medicaid expansion population (Straw et al. 2021). Our focus in this report is to show the long-term impacts of Medicaid

expansion, so we excluded this temporary funding from our estimates. It is also excluded from all of the state analyses cited in this section; many expansion states were able to save money by expanding Medicaid even without this provision.

### Connections with Other Current Health Policy Issues

In 2020, the Families First Coronavirus Response Act prevented states from disenrolling people from Medicaid during the public health emergency, unless they specifically ask to be disenrolled. Consequently, Medicaid enrollment has reached record levels (Buettgens and Green 2022). The public health emergency is currently set to expire in October 2022 but could be extended further. After the public health emergency expires, states have up to 14 months to resume normal eligibility processing. This will likely result in more than 16 million enrollees losing Medicaid coverage. In our Medicaid expansion estimates, we assume these large but temporary enrollment changes have already settled. They will not affect the eventual level of Medicaid enrollment if the remaining states were to expand eligibility.

We also assume the ARPA enhanced PTCs will expire in 2023. Eligibility for Medicaid and Marketplace PTCs is mutually exclusive, so our estimates of Medicaid enrollment and costs would be virtually the same with or without the enhanced PTCs. What would be different if Congress decides to extend the enhanced PTCs is that more people with incomes below 138 percent of FPL would be enrolled in the Marketplace with enhanced PTCs than would be the case without the enhanced PTCs (Buettgens, Banthin, and Green 2022). Consequently, with the enhanced PTCs, about 1 million fewer people would be transitioning from being uninsured to having Medicaid (data not shown). Instead, they would transition from Marketplace coverage to Medicaid.

## Conclusion

As of this writing, 12 states have not expanded Medicaid eligibility under the ACA. Eleven of these are among the 13 states with the highest uninsurance rates nationwide. Expanding Medicaid in the remaining 12 states would reduce the number of uninsured people by 3.7 million. Having health coverage leads to reduced mortality and increased financial security. Young adults currently have the highest uninsurance rate of any age group and would benefit the most from expansion. Women would see a larger increase in health coverage due to Medicaid expansion than men, and women of reproductive age would see greater gains than older women. As far as racial and ethnic groups, the

Black population would see the largest increase in coverage, followed by the White population. Increases in health coverage among Hispanic people would be smaller, but still substantial, mainly because of restrictions on Medicaid eligibility by immigration status.

In addition to benefitting people who gain coverage, Medicaid expansion improves hospital finances and creates jobs. Many expansion states have found that savings and new revenue due to Medicaid expansion outweigh the state's share of the cost of new Medicaid enrollees. The ARPA added another financial incentive for states newly expanding Medicaid by raising the share of the costs of currently eligible Medicaid enrollees paid for by the federal government for the first two years after expansion. Expanding Medicaid eligibility would thus provide substantial health and economic benefits at little or no cost to state governments.

# Notes

[1] The Supreme Court's decision in *National Federation of Independent Business v. Sebelius* in 2012 effectively made the ACA's Medicaid expansion voluntary for states.

[2] Some may be eligible for limited benefit programs. For example, pregnant women with low incomes can qualify for certain benefits during their pregnancies.

[3] "Medicaid Income Eligibility Limits for Parents, 2002-2022," Kaiser Family Foundation, accessed July 21, 2022, https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Legal immigrants who are ineligible for Medicaid because they have resided in the US fewer than five years are eligible even if their incomes are below the FPL. Evidence also shows that some nonimmigrants with lower incomes are enrolled in Marketplace coverage with tax credits—particularly with the enhanced tax credits under the ARPA—largely because income is particularly volatile for low-income workers, who are protected from having to repay tax credits if their annual incomes end up below the FPL (Buettgens and Banthin 2022).

[5] The Biden administration has issued a draft change to administrative guidance that would limit the number of people disqualified in this way. This issue is often called the "family glitch" (Buettgens and Banthin 2021).

[6] Centers for Medicare & Medicaid Services, "Marketplace 2022 Open Enrollment Period Report: Final National Snapshot," news release, January 27, 2022, https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot.

[7] "Medicaid and CHIP: June 2017 Monthly Applications and Eligibility Determinations Updated August 2017," Centers for Medicare & Medicaid Services, accessed January 7, 2021, https://www.medicaid.gov/medicaid/downloads/updated-june-2017-enrollment-data.pdf; and "Filtered State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data," Data.Medicaid.gov, accessed July 25, 2022, https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data?conditions[0][property]=report_date&conditions[0][value]=2021-10-01&conditions[0][operator]=%3D&conditions[1][property]=preliminary_updated&conditions[1][value]=U&conditions[1][operator]=%3D.

[8] Take-up rates during the public health emergency will be artificially high and unusable for this purpose.

[9] The racial and ethnic terms used in this analysis are from the American Community Survey, the data on which HIPSM is built. Black people, White people, and people in the "other" racial group did not identify as Hispanic; people who identified as Hispanic on survey data are counted as Hispanic and excluded from the other groups. The "other" racial group is people who identify as Asian/Pacific Islander, American Indian, or multiple races on survey data. We acknowledge this language may not reflect how people describe themselves. We remain committed to employing respectful and inclusive language.

[10] Data on plan selections at the end of the open enrollment period for all years since 2014 show that 54 percent or more of Marketplace enrollees of all ages have been female; see "Affordable Care Act Indicators 2022 Marketplace Open Enrollment Period," Kaiser Family Foundation, accessed July 21, 2022, https://www.kff.org/state-category/affordable-care-act/2022-marketplace-open-enrollment-period/

[11] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, Timeframe: FY 2023" Kaiser Family Foundation, accessed July 21, 2022, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[12] "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, July 21, 2022, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

[13] Dobbs v. Jackson Women's Health Organization, No. 19-1392, slip op. (Sup. Ct. 2022).

[14] "Interactive Map: US Abortion Policies and Access after Roe," Guttmacher Institute, accessed July 8, 2022, https://states.guttmacher.org/policies/.

[15] The largest such population is adults in Wisconsin with incomes up to 100 percent of FPL, who are not part of mandatory Medicaid categories, such as people with disabilities and parents with low incomes. We incorporate current beneficiaries who would receive the new eligible matching rate into our estimates to the extent they could be identified. Some eligibility groups, such as the medically needy, are difficult to identify using survey data.

[16] Michael Chernew, "The Economics of Medicaid Expansion," *Health Affairs Blog*, March 21, 2016, https://www.healthaffairs.org/do/10.1377/hblog20160321.054035/full/.

[17] In this analysis, we find net reductions in state spending because of expansion; we did not consider revenue effects. See NJ DHS (2016).

[18] New Mexico's analysis projects net state budget gains until state fiscal year 2020–21, when a small net adverse budget impact is anticipated. Reynis (2016) noted its revenue estimates are conservative. In Alaska, net state budget losses were forecasted to start in federal fiscal year 2017. Alaska does not have sales taxes or individual income taxes, so Evans and colleagues (2016) concluded state general revenue would not be affected by expansion-generated economic activity. Every other state collects sales taxes, individual income taxes, or both, so Alaska's fiscal conditions do not apply to other nonexpansion states; see Lee and colleagues (2015). Lastly, even Alaska collects corporate income tax, but Evans and colleagues did not estimate the impact of expansion on such tax revenues.

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**Matthew Buettgens** is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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