

RESEARCH REPORT

Reducing Federal Support for Medicaid Expansion Would Shift Costs to States and Likely Result in Coverage Losses

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Executive Summary

Leadership in the House of Representatives has proposed substantial federal funding cuts to the Medicaid program over the next 10 years.¹ This paper focuses on the proposal to reduce the 90 percent federal matching rate that states receive for the expansion population covered under the Affordable Care Act (ACA), known as enhanced Federal Medical Assistance Percentage or FMAP.

Under the ACA, 41 states (including DC) expanded Medicaid eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level. Most of the historic gains in coverage under the ACA were because of the Medicaid expansion (Freaun, Gruber, and Sommers 2017). Studies have found that the increased health coverage because of Medicaid expansion has had a range of benefits, including improved access to and utilization of health care, increased affordability of care, improvements in certain health outcomes, decreased mortality, reduced unintended pregnancies, and improved financial well-being. Positive impacts on states and health care providers include increased state revenue, improved payer mixes and lower uncompensated care costs, improved provider revenue, and fewer hospital closures (see the discussion on page 15).

This paper uses the Urban Institute's Health Insurance Policy Simulation Model to estimate the potential state budget shortfalls and coverage losses that could result from reducing enhanced FMAP. State responses are hard to predict, so we show results at two extremes: no states change eligibility, and all states drop Medicaid expansion. Actual state responses will be between these two. We find the following (table ES.1):

- **If all states keep their Medicaid expansions in place:**
 - » If the enhanced FMAP were eliminated in 2026 and the 41 expansion states kept their Medicaid expansions in place, they would need \$44.3 billion in state budget cuts or additional revenues that year to replace reductions in federal spending. This amounts to an average increase of about 25.6 percent in expansion state spending on Medicaid acute care for the nonelderly. Eight states would have to increase spending by more than 30 percent: North Dakota, Indiana, Montana, Nebraska, Oregon, Colorado, Washington, and New York.
 - » To offset such large reductions in federal spending, states would be forced to consider making cuts to their Medicaid programs, including limiting Medicaid eligibility, further reducing already low provider reimbursement rates, or eliminating optional benefits, raising new revenues, and cutting state spending in other areas.

- **If all states drop Medicaid expansion in response to the loss of enhanced FMAP:**
 - » Medicaid/Children's Health Insurance Program enrollment would decline by 15.9 million people, or 21.8 percent (table ES.1). This projection includes lower Medicaid enrollment among expansion enrollees losing coverage and the family members of Medicaid expansion enrollees losing coverage. The number of uninsured people would rise by 10.8 million or 37.9 percent. Thus, just over two-thirds of those losing Medicaid would become uninsured. We estimate that the remainder would enroll in Marketplace premium tax credits or employer coverage.
 - » The following states would see the highest percent increases in nonelderly uninsurance (over 87 percent): New York, the District of Columbia, Kentucky, Michigan, Pennsylvania, West Virginia, Iowa, Louisiana, and New Mexico.
 - » People who would see the largest increases in uninsurance without the ACA expansion include adults ages 19 to 34 and those older than 55, non-Hispanic white people, non-Hispanic Black people, and people in fair or poor health.
 - » Federal spending would decline even more because of lower enrollment than if states retained expansion, reaching a decline of \$109.0 billion.
 - » State Medicaid spending on acute care for the nonelderly would decline, but that does not mean that dropping Medicaid expansion would necessarily improve state budgets because many expansion states noted other sources of savings and additional revenue because of expansion that would be lost without it (see the discussion on page 4).

In sum, while eliminating the enhanced FMAP for the Medicaid expansion population would reduce federal spending, it would shift those costs to the states, which would have to cover the shortfall by cutting Medicaid enrollment, provider payment rates or optional benefits, or by raising taxes or cutting non-Medicaid spending. Subsequent analyses will assess implications for provider revenues as well as for other Medicaid spending cuts that may be proposed in 2025.

TABLE ES.1

Estimated Changes in Health Insurance Coverage Among the Nonelderly and Federal and State Spending in Response to the Elimination of Enhanced Medicaid Expansion FMAP, 2026

| | No states drop Medicaid expansion | 12 states with legislative triggers drop Medicaid expansion* | All states drop Medicaid expansion |
|--|-----------------------------------|--|------------------------------------|
| Health coverage of the nonelderly | | | |
| Change in Medicaid enrollment | | | |
| Number (millions of people) | 0 | -3,431 | -15,852 |
| Percent change | 0.0% | -4.7% | -21.8% |
| Change in uninsurance | | | |
| Number (millions of people) | 0 | 2,204 | 10,803 |
| Percent change | 0.0% | 7.7% | 37.9% |
| <i>Share of enrollees losing Medicaid becoming uninsured</i> | | | |
| | | -64.2% | -68.1% |
| Government spending on acute care for the nonelderly | | | |
| Federal | | | |
| Amount (billions of dollars) | -44.3 | -60.7 | -109.0 |
| Percent change | -8.8% | -12.0% | -21.6% |
| State | | | |
| Amount (billions of dollars) | 44.3 | 32.1** | -13.9** |
| Percent change in expansion states | 25.6% | 18.7%** | -8.1%** |

Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM). 2025.

Notes: FMAP= federal medical assistance percentage. *The 12 states with legislative triggers to drop Medicaid expansion if enhanced FMAP is lowered are Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia. ** Spending on acute care for the nonelderly does not reflect the net impact on the budget of states that drop Medicaid expansion. Medicaid expansion states realized additional savings and new revenue that could not be estimated (see the report for details). These would be lost if a state drops expansion and would offset all or part of any declines in state spending.

Reducing Federal Support for Medicaid Expansion Would Shift Costs to States and Likely Result in Coverage Losses

Introduction

Leadership in the House of Representatives has proposed substantial federal funding for the Medicaid program over the next 10 years.² One of those proposals would reduce the federal Medicaid matching rate for the Affordable Care Act (ACA) expansion population to each state's general matching rate. Under the ACA, 41 states (including the District of Columbia) have taken the option to expand Medicaid eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL).³ Medicaid expansion is the single provision that contributed the most to the historic gains in health coverage under the ACA (Frean, Gruber, and Sommers 2017). At the time of writing, only 10 states have not chosen to expand eligibility: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.⁴

We estimate that in 2026, under current law, more than 15 million people will be covered under Medicaid expansion, close to what is currently estimated by the Congressional Budget Office. Studies have found that Medicaid expansion had various benefits for enrollees, including improved health care access, utilization, affordability, and financial well-being, and reduced unintended pregnancies and mortality. For states and health care providers, benefits include increased state revenue, improved payer mixes and lower uncompensated care costs, improved provider revenue, and fewer hospital closures (see the discussion on page 15). Many states that conducted a comprehensive analysis of the impact of expansion on state budgets found that additional savings and revenue made possible by Medicaid expansion offset additional state spending on the care of new enrollees (see the discussion on page 12).

Medicaid is jointly funded by federal and state governments. In general, the share of costs paid by the federal government (known as Federal Medicaid Assistance Percentage, or FMAP) varies by state from 50 to just under 74 percent.⁵ However, the federal government pays 90 percent of the costs for

enrollees who qualify as newly eligible under the ACA's Medicaid expansion in all states choosing to expand eligibility (known as enhanced FMAP). Lawmakers are considering policies to eliminate the enhanced FMAP and reduce the federal share of expansion enrollee costs to a state's standard FMAP.⁶ The Congressional Budget Office included this policy among the budget option estimates it presented in late 2024 and found that it would reduce the federal deficit by \$561 billion between 2025 and 2034 (CBO 2024).

This report examines the potential impact of eliminating the Medicaid expansion enhanced FMAP on health coverage and state and federal spending on acute care for the nonelderly. Although some proposals would phase out the enhanced FMAP over several years, we simulate the ultimate impact after the enhanced FMAP has been eliminated and its impacts have been fully phased in. It is unclear how states would respond to the loss of federal funding, so we present health coverage and government costs for hypothetical scenarios that bracket the possible impact on health coverage. We go beyond the Congressional Budget Office estimates by showing the potential impact of eliminating the enhanced FMAP state-by-state.

In the first scenario we model, states would maintain their Medicaid expansions and replace the reductions in federal funding with state funds. This scenario represents the maximum fiscal impact on states regarding new Medicaid spending states would have to take on. Conversely, scenario two would have all states drop Medicaid expansion completely. The enhanced FMAP was enacted along with Medicaid expansion in the ACA, and states that took up expansion because of the enhanced FMAP might be unable or unwilling to bear a higher share of the cost. This scenario represents the maximum loss of coverage. In a third scenario, all states would maintain their ACA's Medicaid expansion except for twelve states that have legislation that will trigger dropping expansion if the federal government lowers enhanced FMAP: Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia. Although it is possible that some of these states could attempt to modify the legislation, these states may be more likely to drop the ACA's Medicaid expansion.

Methods

We produced our estimates using the Urban Institute's Health Insurance Policy Simulation Model (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 show simulated results for 2026. As of the time of writing, enhanced Marketplace premium tax credits (PTCs) are set to expire after 2025, and there is no mention of renewing them in recent budget proposals such as those of the House leadership, so we assume that standard PTCs would be in effect (Banthin et al. 2024). Under standard PTCs, premiums would be higher, so fewer people becoming eligible for PTCs after losing Medicaid would enroll. The “unwinding” of Medicaid enrollment after the COVID-era continuous coverage requirement will also have finished by this time, so we project the eventual impact of the unwinding on Medicaid enrollment (Buettgens and Green 2022). We project the size of the expansion population in 2026 based on what enrollment levels were in 2020 in states that had expanded before that year—which we benchmarked to historical CMS monthly enrollment data—plus historical growth in enrollment over time and new enrollment in states that expanded Medicaid since 2020. The result is just over 15 million Medicaid expansion enrollees in 2026, which agrees closely with Congressional Budget Office projections. Using projections of future Medicaid enrollment is particularly important because administrative data from 2024 do not reflect the end of unwinding and thus overstate Medicaid enrollment and the size of the expansion population. Also, different administrative sources count enrollment differently. In particular, the 2024 Medicaid Budget and Expenditure System, used in Orris and Lukens (2024) and Williams et al. (2025), gives a much higher number than the corresponding CMS monthly enrollment data.⁷ In addition to the higher estimate of the expansion population, Williams et al. (2025) does not project the type of coverage that people losing Medicaid would obtain.

For this analysis, Medicaid per capita spending in HIPSM was calibrated to targets set through data from MACPAC tracking disabled individuals, adults, and nondisabled children in each state.⁸ Per capita spending data from 2019 were used for most states because more recent data include the temporary effects of the COVID-19 pandemic and the Medicaid continuous coverage requirement (Buettgens and Green 2022). Idaho, Indiana, Maine, Missouri, Nebraska, North Dakota, and Oklahoma spending was based on 2022 data because of apparent data quality issues in 2019. Targets for Massachusetts, Nevada, New York, North Carolina, South Carolina, Utah, and Virginia were based on state administrative data. All states except North Dakota, South Dakota, and Vermont used separate targets

for Medicaid expansion adults and other nondisabled adults; we used a single target for all nondisabled adults in these three states because of data quality issues. Per capita spending targets were set by aging data forward to 2026 using historical Medicaid growth rates from the National Health Expenditure Accounts.

There are several limitations to our analysis. First, we cannot predict state responses to the elimination of enhanced FMAP, so we present two scenarios showing the smallest and largest coverage impacts. Second, a small number of people who we simulate would lose Medicaid could decide to apply for a disability determination or temporarily retain coverage through pregnancy-related or postpartum eligibility programs. Third, modeling state budget impacts only includes Medicaid spending on acute care for the nonelderly; it does not include savings and additional revenue because of Medicaid expansion (see the discussion on page 12). Fourth, to the extent that the size of the expansion population in 2026 is higher or lower than our projection, the coverage and cost impacts would change as well. Finally, we impute health status based on data from the American Community Survey matched with the Medical Expenditure Panel Survey-Household Component (Buettgens and Banthin 2020). All other detailed characteristics are based on American Community Survey responses, which always involve potential errors and have a time lag between when the survey was fielded and the present time.

Results

We begin by estimating each state's loss of federal Medicaid funding with the elimination of enhanced FMAP, assuming all states maintain Medicaid expansion. We then estimate changes in health coverage and government costs in response to a loss of enhanced FMAP if all states were to drop Medicaid expansion, followed by an intermediate scenario in which all states would maintain their ACA's Medicaid expansion except for 12 states that have legislation that will trigger dropping expansion under FMAP reductions.

State Spending Without Enhanced FMAP If All States Maintain Expansion

We estimate that if enhanced FMAP is eliminated in 2026 and all 41 expansion states (including DC) make no changes to their Medicaid programs, they would spend \$44.3 billion more on acute care for the nonelderly (table 1). On average, expansion states would have to increase spending on acute care for the nonelderly by about 25.6 percent. States with the highest increases in Medicaid spending include North Dakota (46.9 percent, figure 1), Indiana (39.7 percent), Montana (36.2 percent), Nebraska (33.5

percent), Oregon (33.1 percent), Colorado (31.5 percent), Washington (31.0 percent) and New York (30.9 percent). Percent increases differ across states because of differences in standard FMAP, the size of the expansion population relative to other Medicaid eligibility types, and the average cost of the expansion population relative to other types.

TABLE 1

Estimated Changes in Health Insurance Coverage Among the Nonelderly and Federal and State Spending in Response to the Elimination of Enhanced Medicaid Expansion FMAP, 2026

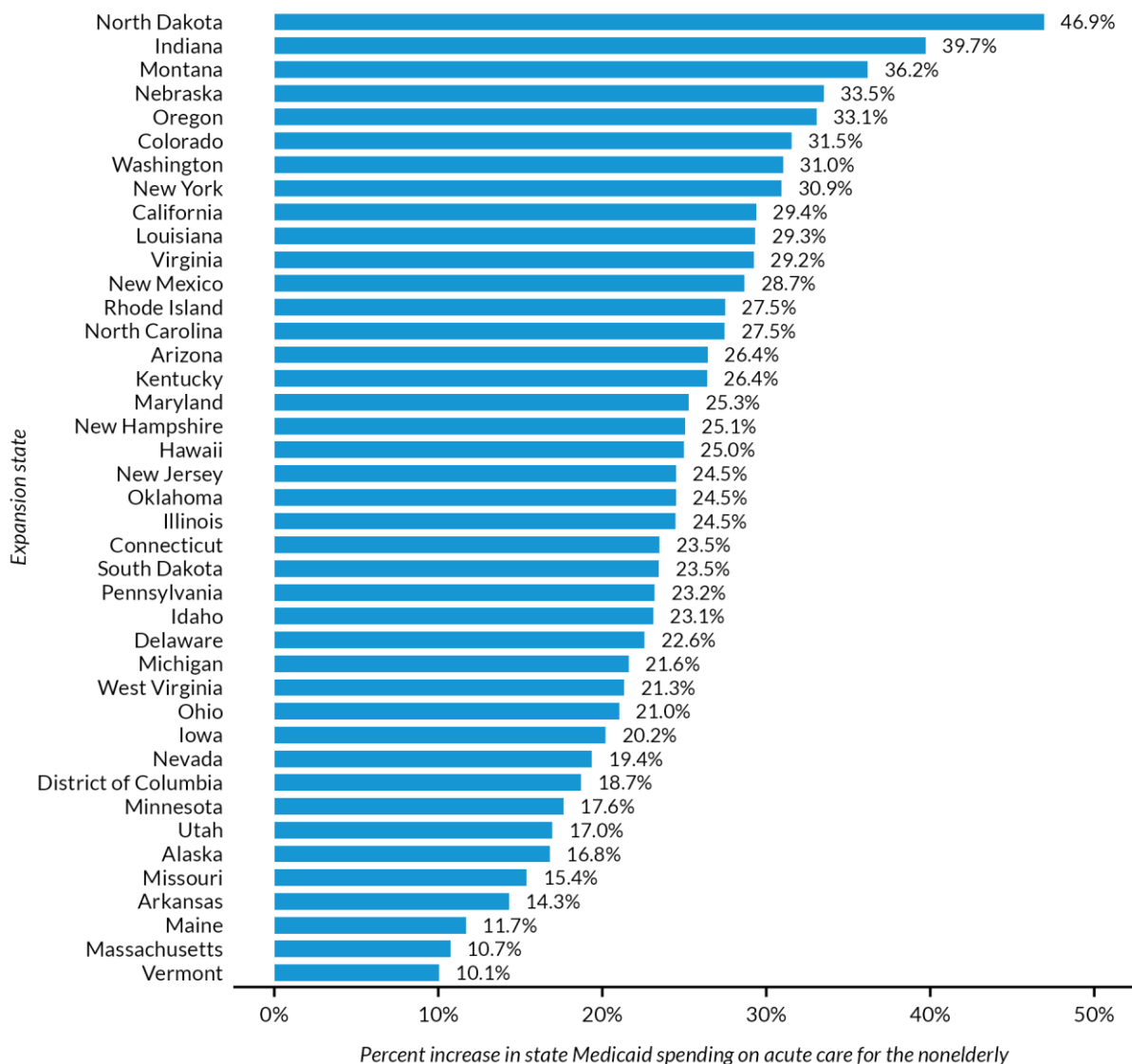
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Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM). 2025.

Notes: FMAP= federal medical assistance percentage. *The 12 states with legislative triggers to drop Medicaid expansion if enhanced FMAP is lowered are Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia. ** Spending on acute care for the nonelderly does not reflect the net impact on the budget of states that drop Medicaid expansion. Medicaid expansion states realized additional savings and new revenue that could not be estimated (see the report for details). These would be lost if a state drops expansion and would offset all or part of any declines in state spending.

FIGURE 1

Percent Increases in State Medicaid Spending on Acute Care for the Nonelderly Without Enhanced FMAP in 2026 If States Do Not Change Eligibility



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Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM). 2025.

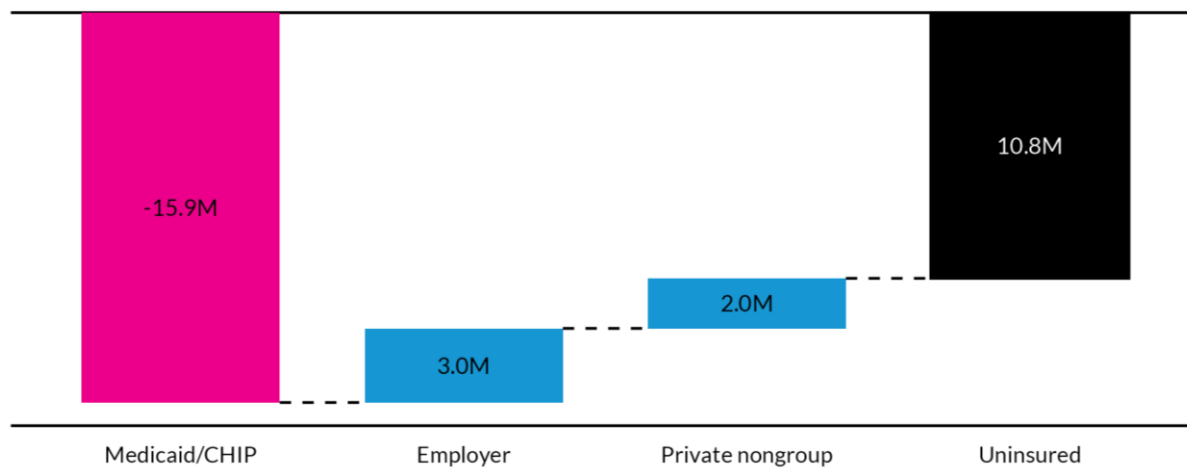
Potential Impacts on Health Coverage Without Enhanced FMAP

We estimate that if all states dropped Medicaid expansion in response to losing the enhanced FMAP, Medicaid enrollment would fall by 15.9 million nationally, a 21.8 percent decline in nonelderly Medicaid and Children's Health Insurance Program (CHIP) enrollment (table 1). This includes 15.1 million

Medicaid expansion adults (Appendix table A.1). However, there would be lower enrollment in other categories as well because family members—mostly children—would be less likely to enroll after family members who are Medicaid expansion adults lose coverage. This would reverse the so-called “welcome mat” or “woodwork effect” that occurred with Medicaid expansion.⁹

Figure 2 shows the type of health coverage—if any—that these 15.9 million people losing Medicaid would find. More than two-thirds—about 10.8 million people—would become uninsured. But smaller numbers would shift to other coverage. We estimate that 3.0 million people losing Medicaid would be enrolled in employer-sponsored health coverage. There is uncertainty about the availability and take-up of employer coverage for this group; our estimates are based on the pre-ACA coverage of those who gained eligibility for Medicaid expansion. Premiums may be burdensome for workers with incomes this low, and many would have plans with high deductibles or out-of-pocket spending limits (Johnston et al. 2020).

FIGURE 2
Changes in Health Coverage If All States Drop Medicaid Expansion



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Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM). 2025.

Notes: CHIP = Children’s Health Insurance Program.

We estimate that about 2.0 million of those losing Medicaid coverage would newly enroll in nongroup coverage or the Basic Health Plan in Minnesota, New York, and Oregon (Buettgens 2024). Most of those with incomes between 100 and 138 percent of FPL would become eligible for Marketplace coverage with PTCs.¹⁰ Some may not be eligible for PTCs because of an offer of coverage from an employer that is deemed affordable under the ACA. For 2025, that means a worker is offered a single coverage for a premium less than 9.02 percent of annual family income.¹¹ Enhanced PTCs are set

to expire in 2026 unless Congress extends them—and budget proposals that cut enhanced FMAP likely would not extend them—so these new nongroup enrollees will almost certainly pay more in both premiums and cost sharing than they did under Medicaid.

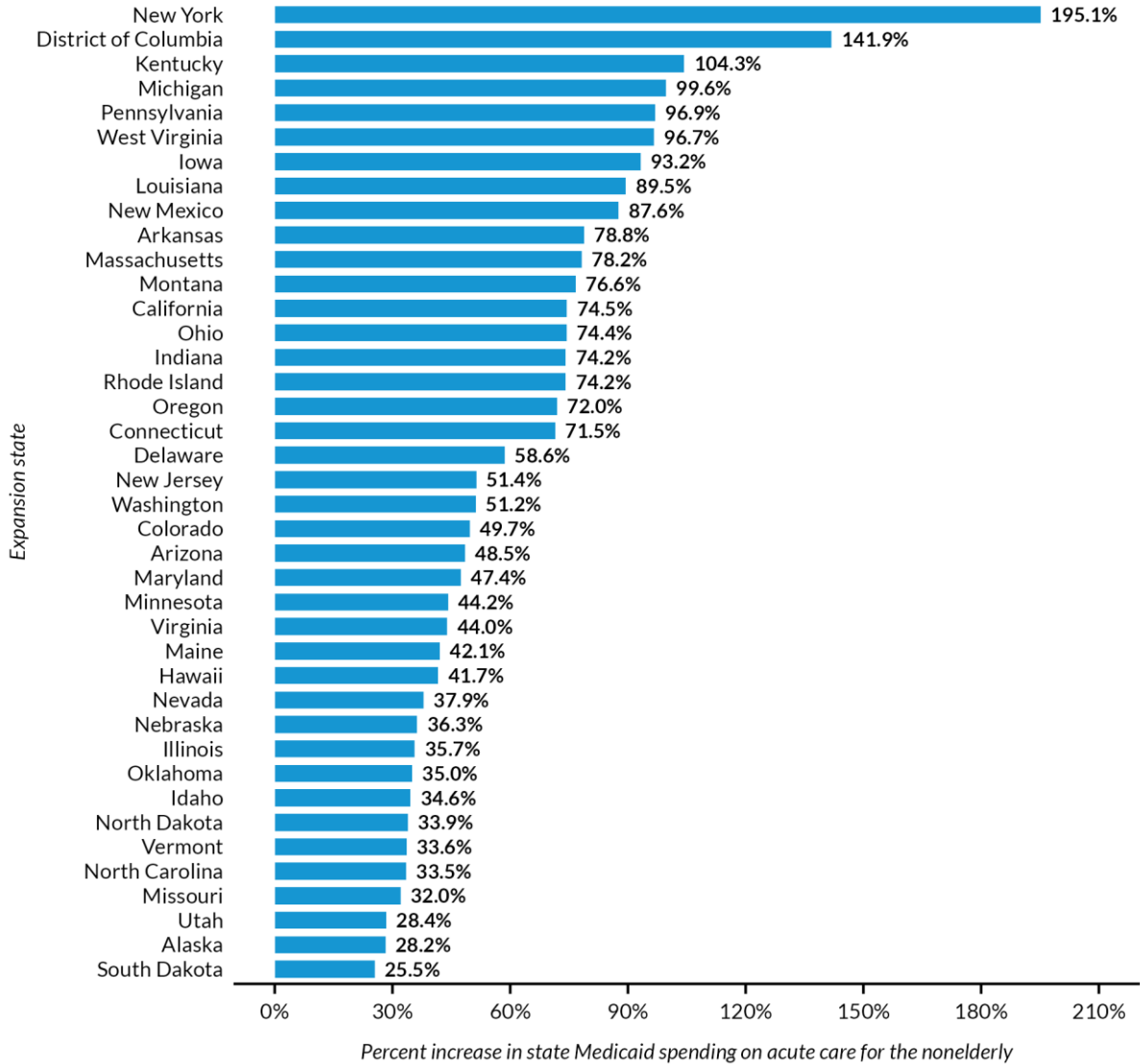
If only the 12 states with legislative triggers dropped Medicaid expansion and the other 29 expansion states maintained the expansion program, the number of expansion enrollees would decline by 3.4 million people, and 2.2 million more people would be uninsured (table 1).

In figure 3, we show percent increases in uninsurance by state if all states drop Medicaid expansion. Half of Medicaid expansion states would see uninsurance increase by about 50 percent or more. New York would see the highest increase (195.1 percent), followed by the District of Columbia (141.9 percent), Kentucky (104.3 percent), Michigan (99.6 percent), Pennsylvania (96.9 percent), West Virginia (96.7 percent), Iowa (93.2 percent), Louisiana (89.5 percent), and New Mexico (87.6 percent). The percent change in New York is so high because the state has a waiver that offers free, comprehensive Essential Plan coverage to people with incomes up to 250 percent of FPL.¹² Similarly, the District of Columbia offers coverage to people at higher incomes through a Medicaid waiver. As a result, they have far fewer uninsured adults above the Medicaid eligibility threshold. The denominator of nonelderly uninsured people under current law is much smaller, so the percent change without expansion is much higher. Percent changes in other states vary with current take-up levels of Medicaid expansion and the number of nonelderly Medicaid enrollees in other eligibility types.

Appendix table A.2 shows how the number of nonelderly uninsured people in each state would increase if they dropped Medicaid expansion.

FIGURE 3

Percent Increases in Uninsurance If All States Drop Medicaid Expansion



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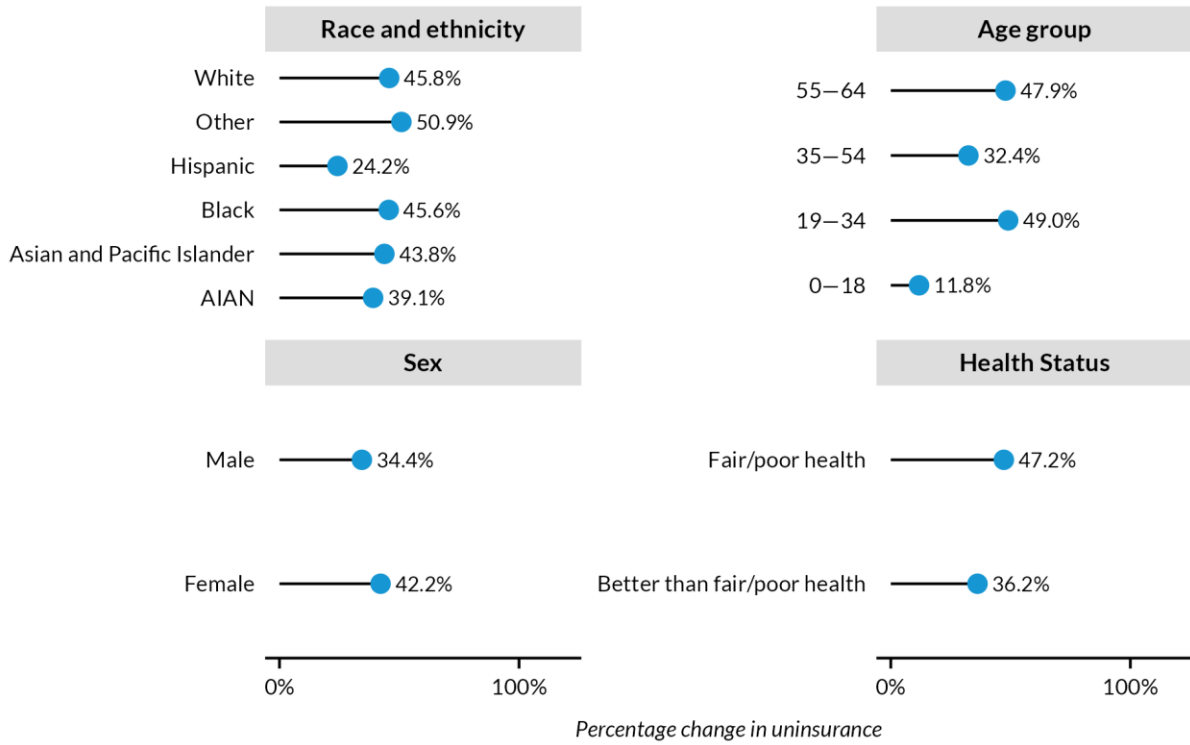
Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM). 2025.

Who Would Lose Health Coverage If States Dropped Medicaid Expansion?

Figures 4 and 5 examine the characteristics of people who would lose health coverage if all states dropped Medicaid expansion. Younger adults aged 19 to 34 would see the largest percent increase in uninsurance of any age group, 49.0 percent (figure 4). Older adults aged 55 to 64 would see the next highest increase, 47.9 percent. Although children would not lose Medicaid or CHIP eligibility without

expansion, some children whose parents lose Medicaid would become uninsured, and we project that uninsurance among children would increase by 11.8 percent.

FIGURE 4
Percent Changes in Uninsurance If All States Eliminate Medicaid Expansion, by Characteristic



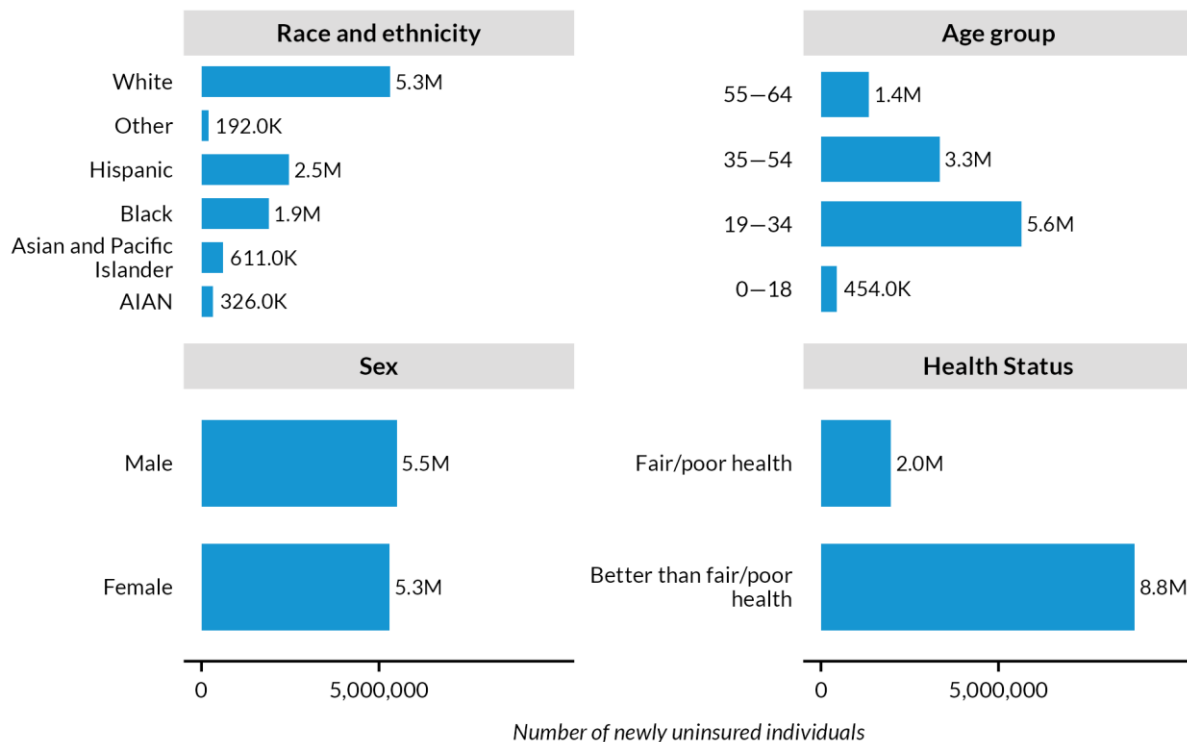
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Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM). 2025.

Notes: AIAN = American Indian and Alaska Native.

FIGURE 5

Increases in Uninsurance If All States Eliminate Medicaid Expansion, by Characteristic



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Source: The Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2025.

Notes: AIAN = American Indian and Alaska Native.

Uninsurance would increase by a higher rate among females (42.2 percent) than males (34.4 percent). However, the number of newly uninsured people would be nearly equal between these groups, 5.3 million females and 5.5 million males.

People reporting fair or poor health would see increases in uninsurance of 47.2 percent, and those reporting better health would see increases of 45.6 percent. Non-Hispanic White and Black people would see high percent increases in uninsurance (45.8 percent and 45.6 percent, respectively). Hispanic people would see the lowest increases of any racial or ethnic group (24.2 percent) because a large share is ineligible for Medicaid because of immigration status.¹³

Non-Hispanic whites would make up nearly half of the newly uninsured (5.3 million out of 10.8 million). Even though many Hispanic people are ineligible for Medicaid, 2.5 million newly uninsured people would be Hispanic. About 1.9 million non-Hispanic Blacks would become uninsured without Medicaid expansion.

Changes in Federal and State Spending Without Enhanced FMAP

Reductions in federal spending without enhanced FMAP depend on state responses. If a state maintains expansion, then federal savings will be determined by the difference between standard and enhanced FMAP. On the other hand, if a state eliminates Medicaid expansion, federal costs overall would be notably lower. The federal government will no longer pay a share of the costs of those losing Medicaid. Some of those losing Medicaid would newly enroll in Marketplace coverage with PTCs, which are completely paid for by the federal government. Thus, federal PTC spending would be higher, partially offsetting the larger decreases in Medicaid spending. Our estimates of federal spending include this.

As a result, the smallest decline in federal spending on acute care for the nonelderly would occur if states maintained their Medicaid expansions despite the loss of enhanced FMAP: \$44.3 billion or 8.8 percent in 2026 (table 1). The largest decline in federal spending would be if all states dropped expansion without any coverage expansions through waivers: \$109.0 billion or 21.6 percent (See Appendix table A.3 for associated reductions in federal dollars for each state). Eleven expansion states would see declines in federal spending of 30 percent or more without Medicaid expansion: Arizona, California, Indiana, Kentucky, Louisiana, New Mexico, New York, North Dakota, Oregon, Rhode Island, and Washington.

State decisions about keeping their Medicaid expansions would lead to even more dramatic differences in state Medicaid spending. If states keep their current programs unchanged, they will necessarily spend more if enhanced FMAP were eliminated. On the other hand, states dropping expansion would no longer pay a share of the costs of people losing Medicaid, so state spending on Medicaid enrollees would decline.

Thus, the greatest increase in state spending on acute care for the nonelderly would occur if Medicaid expansion states did not change eligibility: \$44.3 billion or 25.6 percent among expansion states in 2026. At the other extreme, if all states dropped Medicaid expansion, state spending would decline by \$13.9 billion nationally or 8.1 percent among expansion states. Appendix tables A.2 and A.4 show changes in state spending on acute care for the nonelderly under a range of state responses.

This does not mean that dropping Medicaid expansion would necessarily improve state budgets relative to current policy. Expansion led to other state savings and increased revenue that offset the state's share of the costs of new enrollees. Many states have found that state spending declined because of expansion when these were considered (see the discussion on page 14). These savings and revenue items would be lost if a state terminates expansion, so the actual cost to the state is likely to be

higher than the change in spending on acute care. We could not estimate these because they are highly state-specific and sometimes not computable from publicly available data.

Discussion

Medicaid expansion was responsible for most of the ACA's health coverage gains (Frean, Gruber, and Somers 2017), and, as we have seen, enhanced FMAP is crucial for allowing states to adopt expansion. We now discuss other aspects of expansion in more detail: the documented health and financial benefits that Medicaid expansion has had, the range of possible state responses to the elimination of enhanced FMAP, and a comprehensive view of how Medicaid expansion has affected state budgets.

Benefits of Medicaid Expansion

Studies have found Medicaid expansion has many benefits beyond reducing the number of uninsured people:

- **Medicaid expansion saves lives.** Multiple studies have found that health coverage under the ACA decreased mortality (Goldin, Lurie, and McCubbin 2019; Guth and Ammula 2021; Miller, Johnson, and Wherry 2019).
- **Expansion increases the financial security of those gaining health coverage and reduces barriers to employment.** Multiple studies have 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 2019; Hu et al. 2016). Several studies found that Medicaid expansion reduced barriers to employment (Gehr and Wikle 2017).
- **Expansion has been found to reduce unwanted pregnancies and increase access to effective contraception.** There is evidence that uninsured women are at higher risk than insured women of having an unwanted pregnancy because of their 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-acting and short-acting contraception. Darney et al. (2020) found that Medicaid expansion is associated with an increase in access to the most effective methods of contraception. Johnston and McMorro (2020) found that the ACA's expansion in health coverage significantly increased the use of contraception among Black women. Other studies are summarized in Guth and Diep (2023).

- **Expansion improves hospital finances.** Studies have shown this is achieved through improved payer mixes and lowered uncompensated care costs (Ammula and Guth 2023; Blavin 2017; Dranove, Garthwaite, and Ody 2017).
- **Expansion improves state economies.** For example, a study in Montana found that Medicaid expansion led to an additional \$600 million 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).

State Responses to Losing Enhanced FMAP

Unlike the federal government, state governments are generally prevented by state laws from running budget deficits. Thus, states that want to maintain their Medicaid expansions must respond to the loss of federal funding without enhanced FMAP by reducing Medicaid spending, reallocating state budgets to cover the federal Medicaid revenue loss, or raising taxes. Forecasts of future state revenue are uncertain (Dadayan 2024), so state budgets may be tight even without any major change to Medicaid financing.

State Medicaid spending on the expansion program could be reduced by cutting eligibility and/or reducing per-person spending. Although states have historically been reluctant to reverse previous expansions in coverage even under financial pressures, that may not hold in this instance.¹⁴ As our estimates show, eliminating the Medicaid expansion group would substantially increase the number of uninsured people. States could cut eligibility for smaller optional Medicaid populations to maintain the expansion, but these often cover particularly vulnerable groups such as the medically needy and children above federal minimum levels.¹⁵

A more indirect way that states could cut enrollment is by creating barriers to maintenance of coverage so that fewer eligible people stay continuously enrolled in the program. This would reverse major recent policy initiatives over the past several years that have, among other things, increased the use of automatic (ex parte) renewals based on data matches¹⁶ and expanded continuous eligibility policies that reduce churn in enrollment (Buettgens 2023a, 2023b).

States could try to offset the loss of federal funding without reducing eligibility by reducing program costs per enrollee, such as by reducing provider reimbursement rates or limiting benefits. These changes could be applied to all Medicaid enrollees, not just the expansion population, but already low Medicaid provider reimbursement rates and federal benefit requirements limit the extent to which

further reductions are possible (Zuckerman, Skopec, and Aarons 2021), but it is unlikely that spending on existing enrollees could be cut enough to cover the elimination of enhanced FMAP.

Section 1115 Medicaid waivers are potentially another important part of state policy responses. Six expansion states used these waivers to expand coverage before the ACA: Arizona, Delaware, Hawaii, Massachusetts, New York, and Vermont. For example, Massachusetts used a waiver to provide Medicaid and subsidized private coverage to people with incomes up to 300 percent of FPL in a landmark program that, in many ways, was the prototype for the ACA. We estimate that if these states were to resume their pre-ACA waivers, the number of nonelderly people becoming uninsured would be 9.0 million, or 1.9 million fewer than if they eliminated Medicaid expansion (data not shown).¹⁷ It is possible that some states would seek new waivers or modify existing waivers to provide more limited expansions of coverage, but such programs would be matched at the regular state match rate and would be subject to federal approval.

Medicaid Expansion Brought Savings and New Revenue to States Beyond What We Could Estimate

Finally, as noted above, this analysis considers the drop in state Medicaid spending on acute care for the nonelderly but not for other offsetting increases in state spending or adverse effects on state revenues. Medicaid expansion did not necessarily increase overall state spending when offsetting budgetary impacts were included. Though spending on Medicaid claims increased because of higher caseloads, expansion states often saw both substantial savings and new revenue. Offsets identified in state analyses (summarized in the next paragraph) varied considerably by state but included the following:

- State and local governments saved on uncompensated care.
- States received 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.¹⁸
- As the federal government spent more on a state's health care, its economic activity increased, thereby increasing tax revenue.¹⁹
- State taxes on health care providers and/or health coverage premiums increased revenue.
- Demand decreased for non-Medicaid state-funded programs for uninsured people with low incomes (separate from uncompensated care).

Most states with comprehensive analyses projected net fiscal gains from expansion, even after states began paying 10 percent of 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 2016); Kentucky (Deloitte 2015); Louisiana (Louisiana Department of Health 2017); Maryland (Sommers and Gruber 2017); Michigan (Ayanian et al. 2017); New Jersey;²⁰ 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 the calendar year 2020 and beyond, when federal funding for Medicaid expansion will reach its final and lowest matching rate (90 percent). Eight 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.²¹

States that drop Medicaid expansion in response to the loss of enhanced FMAP will lose these savings and revenue. This would offset any reductions in state spending on acute care for the nonelderly, as shown in Appendix table A.5. States that experienced net budget savings because of expansion would see their total spending increase without expansion.

Conclusion

Reducing the share of federal spending for the ACA expansion population is one of several recently proposed policies that proponents say would substantially reduce Medicaid spending over the next 10 years. We estimate that if enhanced FMAP for Medicaid expansion is repealed in 2026, expansion states would have to increase their spending on acute care for the nonelderly by an average of 25.6 percent to maintain current eligibility. Twelve states have legislation that would trigger dropping Medicaid expansion if the enhanced FMAP is reduced, substantially increasing uninsurance. The remaining 29 expansion states would be faced with a difficult choice. Raising taxes would likely be highly unpopular, and options to reduce spending without cutting enrollment—such as reducing already low Medicaid provider payment rates—would be limited. States would likely be forced to cut Medicaid eligibility in response to reductions in federal spending.

Dropping Medicaid expansion would seriously impact health coverage, with up to 10.8 million more people becoming uninsured if all states drop expansion. Half of expansion states would see uninsurance rise by about 50 percent or more without Medicaid expansion, with nine states seeing increases of more than 87 percent. People who would see the largest increases in uninsurance without Medicaid expansion include adults ages 19 to 34, non-Hispanic white people, non-Hispanic Black people, and people in fair or poor health. Further analysis of the consequences of this policy proposal, such as analysis of how this loss of health coverage would reduce the revenue of health care providers and analyses of other policies that are being considered, is forthcoming.

In sum, while eliminating enhanced FMAP would reduce federal spending, it would force all 41 states that expanded Medicaid to make more people uninsured, cut already low Medicaid provider payment rates, drop benefits, reduce state spending in other areas, and/or raise taxes.

Appendix A. Data Tables

APPENDIX TABLE A.1

Health Insurance Coverage Distribution of the Nonelderly Without Expansion Enhanced FMAP, 2026

| | Current law | | No Expansion FMAP, Trigger States Drop Expansion | | Change | Percent difference | All States Drop Expansion, No Pre-ACA Expansions | | Change | Percent difference |
|---------------------------------|----------------|---------------|--|---------------|----------|--------------------|--|---------------|----------|--------------------|
| | | | | | | | | | | |
| Insured (MEC) | 250,317 | 89.0% | 248,075 | 88.2% | -2,242 | -0.9% | 239,453 | 85.1% | -10,865 | -4.3% |
| Employer | 151,688 | 53.9% | 152,269 | 54.1% | 582 | 0.4% | 154,701 | 55.0% | 3,013 | 2.0% |
| Private nongroup | 17,092 | 6.1% | 17,698 | 6.3% | 606 | 3.5% | 19,066 | 6.8% | 1,974 | 11.5% |
| Basic health program | 1,458 | 0.5% | 1,458 | 0.5% | 0 | 0.0% | 1,630 | 0.6% | 173 | 11.8% |
| Marketplace with PTC | 10,222 | 3.6% | 10,206 | 3.6% | -15 | -0.1% | 11,906 | 4.2% | 1,684 | 16.5% |
| Full-pay Marketplace | 1,360 | 0.5% | 1,363 | 0.5% | 3 | 0.2% | 1,354 | 0.5% | -6 | -0.5% |
| Other nongroup | 4,053 | 1.4% | 4,672 | 1.7% | 619 | 15.3% | 4,177 | 1.5% | 124 | 3.1% |
| Medicaid/CHIP | 72,781 | 25.9% | 69,350 | 24.6% | -3,431 | -4.7% | 56,929 | 20.2% | -15,852 | -21.8% |
| Disabled | 9,439 | 3.4% | 9,425 | 3.3% | -14 | -0.2% | 9,394 | 3.3% | -45 | -0.5% |
| Medicaid Expansion | 15,094 | 5.4% | 11,810 | 4.2% | -3,284 | -21.8% | 0 | 0.0% | -15,094 | -100.0% |
| Traditional Nondisabled Adult | 11,578 | 4.1% | 11,561 | 4.1% | -17 | -0.1% | 11,516 | 4.1% | -62 | -0.5% |
| Nondisabled Medicaid/CHIP child | 35,431 | 12.6% | 35,325 | 12.6% | -107 | -0.3% | 34,985 | 12.4% | -446 | -1.3% |
| State-funded program | 1,238 | 0.4% | 1,229 | 0.4% | -9 | -0.7% | 1,033 | 0.4% | -204 | -16.5% |
| Other public | 8,757 | 3.1% | 8,757 | 3.1% | 0 | 0.0% | 8,757 | 3.1% | 0 | 0.0% |
| Uninsured (No MEC) | 31,073 | 11.0% | 33,316 | 11.8% | 2,242 | 7.2% | 41,938 | 14.9% | 10,865 | 35.0% |
| Uninsured | 28,541 | 10.1% | 30,745 | 10.9% | 2,204 | 7.7% | 39,344 | 14.0% | 10,803 | 37.9% |
| Noncompliant nongroup | 2,533 | 0.9% | 2,571 | 0.9% | 38 | 1.5% | 2,594 | 0.9% | 62 | 2.4% |
| Total | 281,391 | 100.0% | 281,391 | 100.0% | 0 | 0.0% | 281,391 | 100.0% | 0 | 0.0% |

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: FMAP = Federal Medical Assistance Percentage; ACA = Affordable Care Act; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program.

* The 12 states with legislative triggers to drop expansion of enhanced FMAP is lowered are Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia.

** The six states with pre-ACA coverage expansions that could resume without the ACA's Medicaid expansion are Arizona, Delaware, Hawaii, Massachusetts, New York, and Vermont.

APPENDIX TABLE A.2

Uninsured by State (thousands of people)

| State | Current Law | | No Expansion FMAP, 12 Trigger States Drop Expansion* | | | | All States Drop Expansion, No Pre-ACA Expansions | | | |
|---|---------------|---|--|---|--------------|-------------------------------------|--|---|---------------|-------------------------------------|
| | Number | As percent of state's nonelderly population | Number | As percent of state's nonelderly population | Difference | Percent change from the current law | Number | As percent of state's nonelderly population | Difference | Percent change from the current law |
| All states | 28,541 | 72.5% | 30,745 | 78.1% | 2,204 | 7.7% | 39,344 | 7.0% | 10,803 | 37.9% |
| Expansion states without trigger | | | | | | | | | | |
| Total | 11,307 | 57.7% | 11,307 | 57.7% | 0 | 0.0% | 19,598 | 13.2% | 8,291 | 73.3% |
| Alaska | 93 | 77.8% | 93 | 77.8% | 0 | 0.0% | 119 | 16.1% | 26 | 28.5% |
| California | 2,788 | 57.3% | 2,788 | 57.3% | 0 | 0.0% | 4,863 | 14.0% | 2,076 | 74.5% |
| Colorado | 458 | 66.8% | 458 | 66.8% | 0 | 0.0% | 686 | 13.6% | 228 | 49.7% |
| Connecticut | 182 | 58.3% | 182 | 58.3% | 0 | 0.0% | 312 | 10.5% | 130 | 71.5% |
| Delaware | 69 | 63.0% | 69 | 63.0% | 0 | 0.0% | 110 | 13.4% | 41 | 58.6% |
| DC | 29 | 41.3% | 29 | 41.3% | 0 | 0.0% | 71 | 11.4% | 42 | 141.9% |
| Hawaii | 140 | 70.6% | 140 | 70.6% | 0 | 0.0% | 198 | 15.7% | 58 | 41.7% |
| Kentucky | 270 | 48.9% | 270 | 48.9% | 0 | 0.0% | 552 | 14.7% | 282 | 104.4% |
| Louisiana | 377 | 52.8% | 377 | 52.8% | 0 | 0.0% | 714 | 18.5% | 337 | 89.5% |
| Maine | 60 | 70.4% | 60 | 70.4% | 0 | 0.0% | 86 | 8.4% | 25 | 42.1% |
| Maryland | 393 | 67.8% | 393 | 67.8% | 0 | 0.0% | 580 | 10.8% | 187 | 47.4% |
| Massachusetts | 261 | 56.1% | 261 | 56.1% | 0 | 0.0% | 465 | 8.5% | 204 | 78.2% |
| Michigan | 493 | 50.1% | 493 | 50.1% | 0 | 0.0% | 985 | 13.2% | 492 | 99.7% |
| Minnesota | 312 | 69.4% | 312 | 69.4% | 0 | 0.0% | 449 | 9.4% | 138 | 44.2% |
| Missouri | 461 | 75.7% | 461 | 75.7% | 0 | 0.0% | 609 | 11.7% | 148 | 32.0% |
| Nebraska | 121 | 73.5% | 121 | 73.5% | 0 | 0.0% | 164 | 10.1% | 44 | 36.0% |
| Nevada | 426 | 72.5% | 426 | 72.5% | 0 | 0.0% | 588 | 19.1% | 162 | 37.9% |
| New Jersey | 751 | 66.1% | 751 | 66.1% | 0 | 0.0% | 1,137 | 15.1% | 386 | 51.4% |
| New York | 676 | 33.9% | 676 | 33.9% | 0 | 0.0% | 1,994 | 12.2% | 1,318 | 195.1% |
| North Dakota | 67 | 74.7% | 67 | 74.7% | 0 | 0.0% | 90 | 14.9% | 23 | 33.9% |
| Ohio | 625 | 57.3% | 625 | 57.3% | 0 | 0.0% | 1,089 | 11.9% | 465 | 74.4% |
| Oklahoma | 412 | 74.1% | 412 | 74.1% | 0 | 0.0% | 555 | 16.1% | 144 | 35.0% |
| Oregon | 319 | 58.2% | 319 | 58.2% | 0 | 0.0% | 549 | 15.7% | 230 | 72.0% |
| Pennsylvania | 645 | 50.8% | 645 | 50.8% | 0 | 0.0% | 1,271 | 12.2% | 626 | 97.0% |
| Rhode Island | 52 | 57.4% | 52 | 57.4% | 0 | 0.0% | 91 | 11.0% | 39 | 74.2% |
| South Dakota | 75 | 79.7% | 75 | 79.7% | 0 | 0.0% | 95 | 13.0% | 19 | 25.5% |
| Vermont | 47 | 74.9% | 47 | 74.9% | 0 | 0.0% | 63 | 13.1% | 16 | 33.6% |
| Washington | 598 | 66.1% | 598 | 66.1% | 0 | 0.0% | 904 | 13.8% | 306 | 51.2% |

| State | Current Law | | No Expansion FMAP, 12 Trigger States Drop Expansion* | | | | All States Drop Expansion, No Pre-ACA Expansions | | | |
|--------------------------------------|-------------|---|--|---|------------|-------------------------------------|--|---|------------|-------------------------------------|
| | Number | As percent of state's nonelderly population | Number | As percent of state's nonelderly population | Difference | Percent change from the current law | Number | As percent of state's nonelderly population | Difference | Percent change from the current law |
| West Virginia | 105 | 50.9% | 105 | 50.9% | 0 | 0.0% | 206 | 14.6% | 101 | 96.7% |
| Expansion states with trigger | | | | | | | | | | |
| Total | 5,194 | 67.4% | 7,398 | 96.0% | 2,204 | 42.4% | 7,706 | 14.3% | 2,512 | 48.4% |
| Arizona | 752 | 67.4% | 827 | 74.0% | 74 | 9.9% | 1,117 | 17.2% | 365 | 48.5% |
| Arkansas | 215 | 55.9% | 384 | 100.0% | 169 | 78.8% | 384 | 14.8% | 169 | 78.8% |
| Idaho | 177 | 74.3% | 238 | 100.0% | 61 | 34.6% | 238 | 14.8% | 61 | 34.6% |
| Illinois | 1,197 | 73.7% | 1,624 | 100.0% | 427 | 35.7% | 1,624 | 15.0% | 427 | 35.7% |
| Indiana | 494 | 57.4% | 859 | 100.0% | 366 | 74.2% | 859 | 15.2% | 366 | 74.1% |
| Iowa | 135 | 51.8% | 261 | 100.0% | 126 | 93.2% | 261 | 10.2% | 126 | 93.2% |
| Montana | 68 | 56.6% | 121 | 100.0% | 52 | 76.6% | 121 | 14.0% | 52 | 76.6% |
| New Hampshire | 70 | 60.6% | 115 | 100.0% | 46 | 65.1% | 115 | 10.7% | 46 | 65.1% |
| New Mexico | 230 | 51.3% | 432 | 96.3% | 202 | 87.6% | 449 | 24.0% | 219 | 94.8% |
| North Carolina | 894 | 74.9% | 1,194 | 99.9% | 299 | 33.5% | 1,194 | 12.7% | 300 | 33.6% |
| Utah | 267 | 77.9% | 343 | 100.0% | 76 | 28.4% | 343 | 11.3% | 76 | 28.4% |
| Virginia | 694 | 69.4% | 999 | 100.0% | 305 | 44.0% | 999 | 12.9% | 305 | 44.0% |
| Nonexpansion states | | | | | | | | | | |
| Total | 12,040 | 100.0% | 12,040 | 100.0% | 0 | 0.0% | 12,040 | 15.3% | 0 | 0.0% |
| Alabama | 520 | 100.0% | 520 | 100.0% | 0 | 0.0% | 520 | 12.6% | 0 | 0.0% |
| Florida | 2,684 | 100.0% | 2,684 | 100.0% | 0 | 0.0% | 2,684 | 15.1% | 0 | 0.0% |
| Georgia | 1,397 | 100.0% | 1,397 | 100.0% | 0 | 0.0% | 1,397 | 14.2% | 0 | 0.0% |
| Kansas | 343 | 100.0% | 343 | 100.0% | 0 | 0.0% | 343 | 13.5% | 0 | 0.0% |
| Mississippi | 373 | 100.0% | 373 | 100.0% | 0 | 0.0% | 373 | 15.0% | 0 | 0.0% |
| South Carolina | 562 | 100.0% | 562 | 100.0% | 0 | 0.0% | 562 | 13.0% | 0 | 0.0% |
| Tennessee | 708 | 100.0% | 708 | 100.0% | 0 | 0.0% | 708 | 12.2% | 0 | 0.0% |
| Texas | 4,960 | 100.0% | 4,960 | 100.0% | 0 | 0.0% | 4,960 | 18.7% | 0 | 0.0% |
| Wisconsin | 411 | 100.0% | 411 | 100.0% | 0 | 0.0% | 411 | 8.5% | 0 | 0.0% |
| Wyoming | 83 | 100.0% | 83 | 100.0% | 0 | 0.0% | 83 | 15.1% | 0 | 0.0% |

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: FMAP = Federal Medical Assistance Percentage; ACA = Affordable Care Act; DC = District of Columbia.

* The 12 states with legislative triggers to drop expansion of enhanced FMAP is lowered are Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia.

** The six states with pre-ACA coverage expansions that could resume without the ACA's Medicaid expansion are Arizona, Delaware, Hawaii, Massachusetts, New York, and Vermont.

APPENDIX TABLE A.3

Changes in Federal Spending on Acute Care for the Nonelderly Without Expansion Enhanced FMAP (millions of dollars)

| State | Current Law | No Expansion FMAP, 12 Trigger States Drop | | All States Drop Expansion | | | |
|---|------------------------|---|----------------|---------------------------|------------------------|-----------------|----------------|
| | Total federal spending | Total federal spending | Difference | Percent change | Total federal spending | Difference | Percent change |
| All States | 504,112 | 443,402 | -60,710 | -12.0% | 395,136 | -108,976 | -21.6% |
| Expansion states without trigger | | | | | | | |
| Total | 289,922 | 255,065 | -34,857 | -12.0% | 209,652 | -80,270 | -27.7% |
| Alaska | 2,024 | 1,888 | -136 | -6.7% | 1,716 | -309 | -15.3% |
| California | 60,268 | 51,140 | -9,128 | -15.1% | 42,060 | -18,209 | -30.2% |
| Colorado | 7,539 | 6,408 | -1,131 | -15.0% | 5,313 | -2,226 | -29.5% |
| Connecticut | 5,704 | 4,949 | -755 | -13.2% | 4,159 | -1,545 | -27.1% |
| Delaware | 1,796 | 1,621 | -175 | -9.8% | 1,328 | -468 | -26.1% |
| DC | 2,103 | 1,972 | -130 | -6.2% | 1,546 | -557 | -26.5% |
| Hawaii | 1,554 | 1,351 | -203 | -13.1% | 1,102 | -452 | -29.1% |
| Kentucky | 8,743 | 8,110 | -633 | -7.2% | 6,032 | -2,711 | -31.0% |
| Louisiana | 9,139 | 8,287 | -853 | -9.3% | 6,330 | -2,809 | -30.7% |
| Maine | 2,615 | 2,498 | -118 | -4.5% | 2,314 | -301 | -11.5% |
| Maryland | 9,476 | 8,173 | -1,303 | -13.8% | 6,760 | -2,716 | -28.7% |
| Massachusetts | 8,939 | 8,312 | -627 | -7.0% | 7,566 | -1,372 | -15.4% |
| Michigan | 14,070 | 12,957 | -1,113 | -7.9% | 10,470 | -3,600 | -25.6% |
| Minnesota | 8,972 | 7,975 | -997 | -11.1% | 6,818 | -2,154 | -24.0% |
| Missouri | 11,608 | 10,975 | -633 | -5.5% | 9,681 | -1,927 | -16.6% |
| Nebraska | 3,062 | 2,656 | -405 | -13.2% | 2,156 | -905 | -29.6% |
| Nevada | 4,380 | 4,055 | -324 | -7.4% | 3,440 | -940 | -21.5% |
| New Jersey | 11,296 | 9,834 | -1,462 | -12.9% | 8,051 | -3,245 | -28.7% |
| New York | 44,270 | 37,478 | -6,791 | -15.3% | 30,776 | -13,493 | -30.5% |
| North Dakota | 894 | 726 | -168 | -18.8% | 520 | -374 | -41.9% |
| Ohio | 16,552 | 15,200 | -1,352 | -8.2% | 12,522 | -4,031 | -24.4% |
| Oklahoma | 8,075 | 7,455 | -620 | -7.7% | 5,974 | -2,101 | -26.0% |
| Oregon | 9,634 | 8,549 | -1,084 | -11.3% | 6,368 | -3,266 | -33.9% |
| Pennsylvania | 18,887 | 16,600 | -2,287 | -12.1% | 13,725 | -5,162 | -27.3% |
| Rhode Island | 1,709 | 1,466 | -243 | -14.2% | 1,168 | -540 | -31.6% |
| South Dakota | 1,125 | 1,014 | -111 | -9.9% | 928 | -197 | -17.5% |
| Vermont | 1,152 | 1,089 | -63 | -5.5% | 1,006 | -146 | -12.7% |

| State | Current Law | No Expansion FMAP, 12 Trigger States Drop Expansion* | | | All States Drop Expansion | | |
|--------------------------------------|------------------------|--|------------|----------------|---------------------------|------------|----------------|
| | Total federal spending | Total federal spending | Difference | Percent change | Total federal spending | Difference | Percent change |
| Washington | 10,913 | 9,064 | -1,849 | -16.9% | 7,042 | -3,871 | -35.5% |
| West Virginia | 3,424 | 3,262 | -162 | -4.7% | 2,782 | -641 | -18.7% |
| Expansion states with trigger | | | | | | | |
| Total | 102,677 | 76,825 | -25,852 | -25.2% | 73,972 | -28,705 | -28.0% |
| Arizona | 14,365 | 12,612 | -1,754 | -12.2% | 9,893 | -4,473 | -31.1% |
| Arkansas | 6,378 | 5,346 | -1,032 | -16.2% | 5,346 | -1,032 | -16.2% |
| Idaho | 3,194 | 2,496 | -698 | -21.9% | 2,496 | -698 | -21.9% |
| Illinois | 12,166 | 9,019 | -3,147 | -25.9% | 9,022 | -3,144 | -25.8% |
| Indiana | 11,674 | 6,805 | -4,869 | -41.7% | 6,807 | -4,868 | -41.7% |
| Iowa | 4,412 | 3,358 | -1,054 | -23.9% | 3,358 | -1,054 | -23.9% |
| Montana | 2,088 | 1,549 | -539 | -25.8% | 1,550 | -538 | -25.7% |
| New Hampshire | 1,362 | 998 | -364 | -26.7% | 998 | -364 | -26.7% |
| New Mexico | 5,203 | 3,620 | -1,583 | -30.4% | 3,474 | -1,729 | -33.2% |
| North Carolina | 26,534 | 19,553 | -6,981 | -26.3% | 19,552 | -6,982 | -26.3% |
| Utah | 5,451 | 4,548 | -903 | -16.6% | 4,551 | -900 | -16.5% |
| Virginia | 9,849 | 6,921 | -2,928 | -29.7% | 6,925 | -2,924 | -29.7% |
| Nonexpansion states | | | | | | | |
| Total | 111,513 | 133,560 | 22,047 | 19.8% | 111,513 | 0 | 0.0% |
| Alabama | 6,199 | 6,988 | 789 | 12.7% | 6,199 | 0 | 0.0% |
| Florida | 27,746 | 32,389 | 4,643 | 16.7% | 27,746 | 0 | 0.0% |
| Georgia | 11,293 | 15,148 | 3,855 | 34.1% | 11,293 | 0 | 0.0% |
| Kansas | 2,859 | 2,786 | -73 | -2.6% | 2,859 | 0 | 0.0% |
| Mississippi | 4,786 | 6,047 | 1,261 | 26.4% | 4,786 | 0 | 0.0% |
| South Carolina | 7,243 | 7,243 | 0 | 0.0% | 7,243 | 0 | 0.0% |
| Tennessee | 8,409 | 11,282 | 2,873 | 34.2% | 8,409 | 0 | 0.0% |
| Texas | 35,708 | 44,386 | 8,677 | 24.3% | 35,708 | 0 | 0.0% |
| Wisconsin | 6,576 | 6,509 | -67 | -1.0% | 6,576 | 0 | 0.0% |
| Wyoming | 694 | 781 | 88 | 12.7% | 694 | 0 | 0.0% |

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: FMAP = Federal Medical Assistance Percentage; ACA = Affordable Care Act; DC = District of Columbia.

* The 12 states with legislative triggers to drop expansion of enhanced FMAP is lowered are Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia.

** The six states with pre-ACA coverage expansions that could resume without the ACA's Medicaid expansion are Arizona, Delaware, Hawaii, Massachusetts, New York, and Vermont.

APPENDIX TABLE A.4

Changes in State Spending on Acute Care for the Nonelderly Without Expansion Enhanced FMAP (millions of dollars)

| State | No Expansion FMAP, No Changes in Eligibility | | | No Expansion FMAP, 12 Trigger States Drop Expansion* | | | All States Drop Expansion, No Pre-ACA Expansions | | |
|---|--|---------------|------------------|--|---------------|------------------|--|----------------|------------------|
| | Total | Amount | Percent of total | Total | Amount | Percent of total | Total | Amount | Percent of total |
| All States | 258,211 | 44,256 | 20.7% | 246,103 | 32,148 | 15.0% | 200,015 | -13,940 | -6.5% |
| Expansion states without trigger | | | | | | | | | |
| Total | 171,605 | 34,806 | 25.4% | 171,605 | 34,807 | 25.4% | 126,730 | -10,068 | -7.4% |
| Alaska | 943 | 136 | 16.8% | 943 | 136 | 16.8% | 761 | -47 | -5.8% |
| California | 40,128 | 9,112 | 29.4% | 40,128 | 9,112 | 29.4% | 28,726 | -2,290 | -7.4% |
| Colorado | 4,836 | 1,130 | 30.5% | 4,836 | 1,130 | 30.5% | 3,422 | -285 | -7.7% |
| Connecticut | 3,961 | 754 | 23.5% | 3,961 | 754 | 23.5% | 3,012 | -195 | -6.1% |
| Delaware | 986 | 175 | 21.6% | 986 | 175 | 21.6% | 752 | -60 | -7.4% |
| DC | 828 | 130 | 18.7% | 828 | 130 | 18.7% | 631 | -66 | -9.5% |
| Hawaii | 1,016 | 203 | 25.0% | 1,016 | 203 | 25.0% | 755 | -58 | -7.1% |
| Kentucky | 3,031 | 633 | 26.4% | 3,031 | 633 | 26.4% | 2,050 | -348 | -14.5% |
| Louisiana | 3,757 | 852 | 29.3% | 3,757 | 852 | 29.3% | 2,517 | -387 | -13.3% |
| Maine | 1,148 | 117 | 11.4% | 1,148 | 117 | 11.4% | 987 | -44 | -4.3% |
| Maryland | 6,601 | 1,302 | 24.6% | 6,600 | 1,302 | 24.6% | 4,958 | -340 | -6.4% |
| Massachusetts | 6,452 | 625 | 10.7% | 6,452 | 625 | 10.7% | 5,668 | -159 | -2.7% |
| Michigan | 6,251 | 1,111 | 21.6% | 6,251 | 1,111 | 21.6% | 4,600 | -540 | -10.5% |
| Minnesota | 7,099 | 996 | 16.3% | 7,099 | 996 | 16.3% | 5,836 | -268 | -4.4% |
| Missouri | 4,730 | 631 | 15.4% | 4,730 | 631 | 15.4% | 3,839 | -260 | -6.3% |
| Nebraska | 1,623 | 407 | 33.5% | 1,623 | 407 | 33.5% | 1,099 | -117 | -9.6% |
| Nevada | 1,995 | 324 | 19.4% | 1,995 | 324 | 19.4% | 1,528 | -144 | -8.6% |
| New Jersey | 7,896 | 1,460 | 22.7% | 7,896 | 1,460 | 22.7% | 5,937 | -499 | -7.7% |
| New York | 28,702 | 6,782 | 30.9% | 28,702 | 6,782 | 30.9% | 20,884 | -1,037 | -4.7% |
| North Dakota | 577 | 168 | 41.0% | 577 | 168 | 41.0% | 359 | -50 | -12.2% |
| Ohio | 7,768 | 1,350 | 21.0% | 7,768 | 1,350 | 21.0% | 5,849 | -568 | -8.9% |
| Oklahoma | 3,140 | 618 | 24.5% | 3,141 | 619 | 24.5% | 2,261 | -261 | -10.4% |
| Oregon | 4,499 | 1,083 | 31.7% | 4,499 | 1,083 | 31.7% | 3,019 | -398 | -11.6% |
| Pennsylvania | 12,508 | 2,284 | 22.3% | 12,508 | 2,284 | 22.3% | 9,322 | -902 | -8.8% |
| Rhode Island | 1,140 | 242 | 27.0% | 1,140 | 242 | 27.0% | 832 | -66 | -7.3% |
| South Dakota | 583 | 111 | 23.5% | 583 | 111 | 23.5% | 437 | -35 | -7.4% |
| Vermont | 687 | 63 | 10.1% | 687 | 63 | 10.1% | 607 | -17 | -2.8% |
| Washington | 7,801 | 1,848 | 31.0% | 7,801 | 1,848 | 31.0% | 5,441 | -513 | -8.6% |
| West Virginia | 919 | 162 | 21.3% | 919 | 162 | 21.3% | 642 | -115 | -15.2% |
| Expansion states with trigger | | | | | | | | | |
| Total | 45,311 | 9,450 | 26.4% | 33,202 | -2,659 | -7.4% | 31,989 | -3,872 | -10.8% |

| State | No Expansion FMAP, No Changes in Eligibility | | | No Expansion FMAP, 12 Trigger States Drop Expansion* | | | All States Drop Expansion, No Pre-ACA Expansions | | |
|----------------------------|--|--------|------------------|--|--------|------------------|--|--------|------------------|
| | Total | Amount | Percent of total | Total | Amount | Percent of total | Total | Amount | Percent of total |
| Arizona | 4,994 | 1,044 | 26.4% | 4,580 | 630 | 16.0% | 3,422 | -528 | -13.4% |
| Arkansas | 2,115 | 265 | 14.3% | 1,700 | -150 | -8.1% | 1,700 | -150 | -8.1% |
| Idaho | 1,067 | 183 | 20.8% | 790 | -94 | -10.6% | 790 | -94 | -10.6% |
| Illinois | 8,053 | 1,584 | 24.5% | 6,011 | -458 | -7.1% | 6,011 | -458 | -7.1% |
| Indiana | 4,751 | 1,351 | 39.7% | 2,752 | -648 | -19.1% | 2,752 | -648 | -19.1% |
| Iowa | 2,155 | 362 | 20.2% | 1,632 | -161 | -9.0% | 1,632 | -161 | -9.0% |
| Montana | 745 | 179 | 31.6% | 496 | -71 | -12.5% | 496 | -71 | -12.5% |
| New Hampshire | 952 | 178 | 22.9% | 724 | -50 | -6.5% | 724 | -50 | -6.5% |
| New Mexico | 1,568 | 349 | 28.7% | 1,061 | -158 | -13.0% | 1,008 | -211 | -17.3% |
| North Carolina | 10,442 | 2,250 | 27.5% | 7,213 | -979 | -12.0% | 7,211 | -981 | -12.0% |
| Utah | 1,691 | 245 | 17.0% | 1,324 | -121 | -8.4% | 1,325 | -121 | -8.4% |
| Virginia | 6,777 | 1,461 | 27.5% | 4,919 | -397 | -7.5% | 4,918 | -398 | -7.5% |
| Nonexpansion states | | | | | | | | | |
| Total | 41,295 | 0 | 0.0% | 41,295 | 0 | 0.0% | 41,295 | 0 | 0.0% |
| Alabama | 1,635 | 0 | 0.0% | 1,635 | 0 | 0.0% | 1,635 | 0 | 0.0% |
| Florida | 8,559 | 0 | 0.0% | 8,559 | 0 | 0.0% | 8,559 | 0 | 0.0% |
| Georgia | 3,398 | 0 | 0.0% | 3,398 | 0 | 0.0% | 3,398 | 0 | 0.0% |
| Kansas | 1,397 | 0 | 0.0% | 1,397 | 0 | 0.0% | 1,397 | 0 | 0.0% |
| Mississippi | 1,137 | 0 | 0.0% | 1,137 | 0 | 0.0% | 1,137 | 0 | 0.0% |
| South Carolina | 2,169 | 0 | 0.0% | 2,169 | 0 | 0.0% | 2,169 | 0 | 0.0% |
| Tennessee | 3,232 | 0 | 0.0% | 3,232 | 0 | 0.0% | 3,232 | 0 | 0.0% |
| Texas | 16,182 | 0 | 0.0% | 16,182 | 0 | 0.0% | 16,182 | 0 | 0.0% |
| Wisconsin | 3,301 | 0 | 0.0% | 3,301 | 0 | 0.0% | 3,301 | 0 | 0.0% |
| Wyoming | 284 | 0 | 0.0% | 284 | 0 | 0.0% | 284 | 0 | 0.0% |

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: FMAP = Federal Medical Assistance Percentage; ACA = Affordable Care Act; DC = District of Columbia.

* The 12 states with legislative triggers to drop expansion of enhanced FMAP is lowered are Arizona, Arkansas, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia.

** The six states with pre-ACA coverage expansions that could resume without the ACA's Medicaid expansion are Arizona, Delaware, Hawaii, Massachusetts, New York, and Vermont.

*** Spending on acute care for the nonelderly does not reflect the net impact on the budget of states that drop Medicaid expansion. Medicaid expansion states realized additional savings and new revenue that could not be estimated (see the report for details). These would be lost if a state drops expansion and would offset all or part of any declines in state spending.

Notes

- ¹ “Chairman’s Mark 10 Year Balance,” House Budget Committee, accessed February 5, 2025; and Ben Leonard, Meredith Lee Hill, and Kelsey Tamborrino, “House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block,” *Politico*, January 10, 2025, <https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541>.
- ² “Chairman’s Mark 10 Year Balance,” House Budget Committee, accessed February 5, 2025; and Leonard, Lee Hill, and Tamborrino, “House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block.”
- ³ The Supreme Court’s decision in *National Federation of Independent Business v. Sebelius* (2012) effectively made the ACA’s Medicaid expansion voluntary for states.
- ⁴ Wisconsin changed a Medicaid waiver in 2014 to cover adults up to 100 percent FPL, but this does not qualify its program for enhanced FMAP. As a result, Wisconsin is in some ways more like an expansion state but spends more state funds to cover fewer people than it would under an ACA expansion to 138 percent of FPL (Buettgens and Ramchandani 2023).
- ⁵ “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier,” KFF, accessed February 5, 2025, <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.
- ⁶ “Chairman’s Mark 10 Year Balance,” House Budget Committee, accessed February 5, 2025; and Leonard, Lee Hill, and Tamborrino, “House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block.”
- ⁷ Both are available at “Medicaid & CHIP Enrollment Data,” Medicaid.gov, accessed February 5, 2025, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/index.html>.
- ⁸ For 2021 spending, see page 68 in “MACStats: Medicaid and CHIP Data Book,” MACPAC, December 2021.
For 2021 enrollment, see page 56 in “MACStats: Medicaid and CHIP Data Book.”
For 2021 spending per capita, see page 71 in “MACStats: Medicaid and CHIP Data Book.”
For 2022 spending, see “EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2022 (millions),” MACPAC, accessed February 5, 2025.
For 2022 enrollment, see “EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2022 (thousands),” MACPAC, accessed February 5, 2025.
For 2022 spending per capita, see “EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group,” MACPAC, accessed February 5, 2025.
- ⁹ “Medicaid Enrollment Changes Following the ACA,” MACPAC, March 31, 2022, <https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/>.
- ¹⁰ PTC applicants must estimate what their income will be over the coming year, which is difficult to predict for many low-income workers. Those who believe their income will be above 100 percent of FPL will not have to pay back PTCs if their income falls below this level.
- ¹¹ “26 CFR 601.105: Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability,” IRS, accessed February 5, 2025.
- ¹² Eligibility rules are the same as for Marketplace coverage with PTCs. In particular, there would be an income eligibility floor of 100 percent FPL without Medicaid expansion.

- ¹³ The “other” category is small and groups people reporting multiple racial and ethnic identities, so it is difficult to draw conclusions about this group.
- ¹⁴ For example, see Nellie Bristol, “Kaiser: State Medicaid, CHIP Eligibility, Enrollment Policies Steady Despite Strained Budgets,” The Commonwealth Fund, January 18, 2012, <https://www.commonwealthfund.org/publications/newsletter-article/kaiser-state-medicaid-chip-eligibility-enrollment-policies-steady>.
- ¹⁵ “HHS Guidance on Optional Eligibility Groups,” HHS, accessed before January 20, 2025, appears to be currently unavailable.
- ¹⁶ Anne Marie Costello, CMCS Informational Bulletin, SUBJECT: Medicaid and Children’s Health Insurance Program (CHIP) Renewal Requirements,” CMS, December 4, 2020.
- ¹⁷ More than 1 million would be in New York, with most of the remainder in Massachusetts.
- ¹⁸ 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 those with disabilities and parents with low incomes. We incorporate current beneficiaries who would receive the new eligible match 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.
- ¹⁹ Michael Chernew, “The Economics of Medicaid Expansion,” *Health Affairs Forefront*, March 21, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20160321.054035/full/>.
- ²⁰ In this analysis, we find net reductions in state spending because of expansion; we did not consider revenue effects. See NJ DHS (2016).
- ²¹ New Mexico’s analysis projects net state budget gains until state FY 2020–21, when a small net adverse budget impact is anticipated. Reynis (2016) notes its revenue estimates are conservative. In Alaska, net state budget losses are forecasted to start in federal FY 2017. Alaska does not have sales taxes or individual income taxes, so Evans et al. (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 et al. (2015). Lastly, even Alaska collects corporate income tax, but Evans et al. (2016) did not estimate the impact of expansion on such tax revenues.

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