

The Implications of Medicaid Expansion in the Remaining States: 2020 Update

Michael Simpson

Timely Analysis of Immediate Health Policy Issues

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In Brief

Under the Affordable Care Act (ACA), states have the option to expand Medicaid eligibility for nonelderly people up to 138 percent of the federal poverty level (FPL). As of January 2020, 35 states and the District of Columbia had expanded and 15 states had not. One additional state, Nebraska, is poised to expand later in the year, the outcome of a ballot initiative. Amidst congressional efforts to repeal the ACA and recent administrative actions encouraging states to experiment with work requirements, time limits, and other previously prohibited modifications to the Medicaid program, nonetheless, political efforts to expand Medicaid continue in some of the states that have yet to do so.

Using our pre-COVID-19 current-law baseline, we estimated the following outcomes if the remaining 15 states were to have fully implemented a Medicaid expansion in 2020 and all else stayed the same:

- 3.9 million fewer people would be uninsured, a reduction of 28 percent.
- Another 185,000 people would gain more comprehensive insurance by dropping short-term limited-duration plans and enrolling in Medicaid. In all, 4.1 million more people would have coverage meeting ACA standards; this would constitute a 27 percent drop in the number of people without minimum essential coverage.
- Federal spending on health care for

nonelderly people in these states would increase by about \$30.4 billion, a 23 percent increase taking Medicaid acute care, Children's Health Insurance Program, and marketplace subsidies into account.

- State spending on Medicaid in those states would increase by \$4.7 billion, or nine percent.
- This additional state spending would fully or largely be offset by savings in other areas. Several comprehensive analyses of current expansion states have found that Medicaid expansion had a net positive impact on state budgets.

Given the COVID-19-related job losses, the largest number since the Great Depression, employer-sponsored insurance is lower than the current law estimates presented here and is likely to fall significantly further. As a consequence, these estimates of the implications of Medicaid expansions in the remaining states understate the increase in coverage and government spending that would occur, at least in the near term.

Introduction

Under the Affordable Care Act (ACA), states have the option to expand Medicaid eligibility for nonelderly people up to 138 percent of the federal poverty level (FPL).¹ So far, 35 states and the District of Columbia have taken that option, and 15 states have not, although one more,

Nebraska, is expected to expand eligibility in October 2020. In the nonexpansion states, Medicaid eligibility is extremely limited for nondisabled, nonpregnant adults, particularly those who do not have dependent children. In all of these states except Wisconsin, nondisabled nonparents are not eligible for Medicaid at all, and nondisabled parents are eligible for Medicaid only at very low incomes—below half of the poverty line in 10 of the 15 states. In nonexpansion states, uninsured people with incomes between 100 and 138 percent of FPL can qualify for tax credits to purchase coverage in the marketplaces if no member of their family has access to affordable employer-sponsored coverage, but tax credits are available to very few uninsured people with incomes below the FPL.² Thus, many uninsured people with incomes below 138 percent of FPL in these states are caught in an assistance gap, qualifying for neither Medicaid nor tax credits to purchase marketplace coverage.

Not all states took up the Medicaid expansion in the early years of the ACA's implementation, and efforts to expand Medicaid have continued in some additional states. Most recently, Maine and Virginia expanded Medicaid in 2019, and Idaho and Utah began Medicaid expansion starting in January 2020.³ Voters in Nebraska passed a ballot initiative in November 2018, but the state delayed expansion as it sought a waiver for state-specific provisions. The Centers for Medicare & Medicaid Services (CMS) will not complete the waiver before

the planned start date, so enrollment will begin without the state provisions on October 1, 2020, with enrollment applications beginning on August 1, 2020. For the purposes of this brief, only states that have expanded Medicaid eligibility by January of 2020 are considered expansion states.

In this report, we estimate the effects of expanding Medicaid on health insurance coverage and government costs in each of the nonexpansion states in 2020. The report is based on our current-law baseline estimated *without* the effects of the COVID-19 pandemic. Estimates of the effects of the expansion also exclude any coverage or spending changes attributable to COVID-19.⁴ The pandemic has created huge job and income losses, which in turn have led to losses in employer-sponsored insurance and changes in eligibility for ACA-marketplace premium and cost-sharing subsidies and Medicaid. However, the extent and duration of these effects are still very uncertain, and changes from a normal employment baseline will reflect changes that would occur as we recover from the pandemic and associated economic distress. Consequently, we do not estimate the evolving COVID-related changes here. Other work has looked at the role Medicaid expansion could play in extending insurance coverage during the pandemic.⁵

Our current-law scenario reflects the latest available data on Medicaid and marketplace enrollment in each state, as well as the elimination of individual mandate penalties which began with the 2019 plan year as a consequence of the Tax Cuts and Jobs Act of 2017. We assume that each nonexpansion state would see enrollment equal to the average rate experienced across all expansion states as of 2019. In practice, Medicaid expansion enrollment rates have varied across states, although, on average, states that expanded Medicaid after 2014 have seen enrollment rates at least as high as those in states that expanded right away.

Methods

The estimates in this report were produced using the Health Insurance

Policy Simulation Model (HIPSM), a detailed microsimulation model of the health insurance system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides a representative sample of families that is large enough for us to produce estimates for individual states. The population is reweighted to reflect later survey information and is aged to future years using projections from the Urban Institute's Mapping America's Futures program. HIPSM is designed to incorporate timely, real-world data when they are available. As described below, we regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives.

HIPSM is unique among microsimulation models of health coverage and costs because it combines the two most common types of microsimulation decision-making in individual and family decisions: elasticity and expected utility. Decision-making follows an expected-utility framework that captures factors such as individual health risk, but we add a latent preference term for each observation that represents factors involved in observed choices that the expected-utility approach alone could not capture. These terms are set so that the model leads to each person in the data making the choice they reported in the survey, and the distribution of latent preference terms is set so that the model replicates premium elasticity targets from the literature. This approach makes it easier to simulate novel policies consistently, while calibrating the model to a wide range of real-world data, such as Medicaid and marketplace enrollment.

Our current-law ACA simulation for 2020 is based on data for the Medicaid program in 2019 and marketplace enrollment in each state from the end of the 2020 open enrollment period. Consistent with current law, no individual mandate penalties are simulated.⁶ As of May 2020, no data were available on recent nongroup enrollment outside the marketplaces,

so this was simulated by HIPSM based on the increases in nongroup premiums from 2017 to 2020 and the elimination of individual mandate penalties in the 2019 plan year.

We simulated the changes in Medicaid enrollment that would result if the remaining states that have not expanded Medicaid were to do so. Based on enrollment data from 2019 released by the Department of Health and Human Services, enrollment experiences appear to have been heterogeneous across states that have expanded Medicaid.^{7,8} Based on enrollment data and HIPSM simulation, we estimate that slightly more than 72 percent of uninsured people in Medicaid expansion states who gained eligibility, and almost 13 percent of people who had employer sponsored insurance before gaining eligibility, had enrolled in Medicaid by 2019.

For this report, we simulate enrollment under Medicaid expansion, assuming a uniform take-up rate across the new expansion states. We expect that 72 percent of the uninsured and 13 percent of those with employer sponsored insurance who gain Medicaid eligibility would enroll. Thus, our estimates assume that new expansion states would have the same take-up rates as current expansion states. However, take-up is uncertain. Because newly expanding states could seek waivers for work requirements and lifetime benefit limits that reduce Medicaid enrollment, or those states could be more successful than earlier expanding states with outreach and enrollment assistance, we present low- and high-takeup scenarios in an appendix.

Medicaid costs per person are based on updated data from the 2014–2016 Medicaid Statistical Information System and data published online by state Medicaid agencies. Medicaid spending in our model is calibrated based on the most recent available state-specific estimates of per capita spending for people with disabilities, adults without disabilities, and children without disabilities.

There are several important sources of uncertainty surrounding the impact of Medicaid expansion. First, HIPSM

is based on the American Community Survey, which, like all household surveys, contains some error in measuring reported income and health coverage. Second, the baseline for this analysis is pre-COVID-19 law in 2020. This must be simulated because it involves policy changes that happened within the past year or have not happened yet. In particular, individual mandate penalties were eliminated in 2019, a change that we projected would only be fully realized in 2020. The most recent survey data do not reflect these changes. Simulating the ongoing impact of the elimination of individual mandate penalties involves

additional uncertainty. Third, outreach and assistance activities and work requirements, lifetime benefit limits, and other conditions of Medicaid eligibility can affect enrollment. Because we cannot foresee what decisions each state would make, we produced additional estimates using higher and lower than expected take-up rates that reflect the range of take-up observed in states that have already expanded Medicaid; again, these are presented in the appendix.

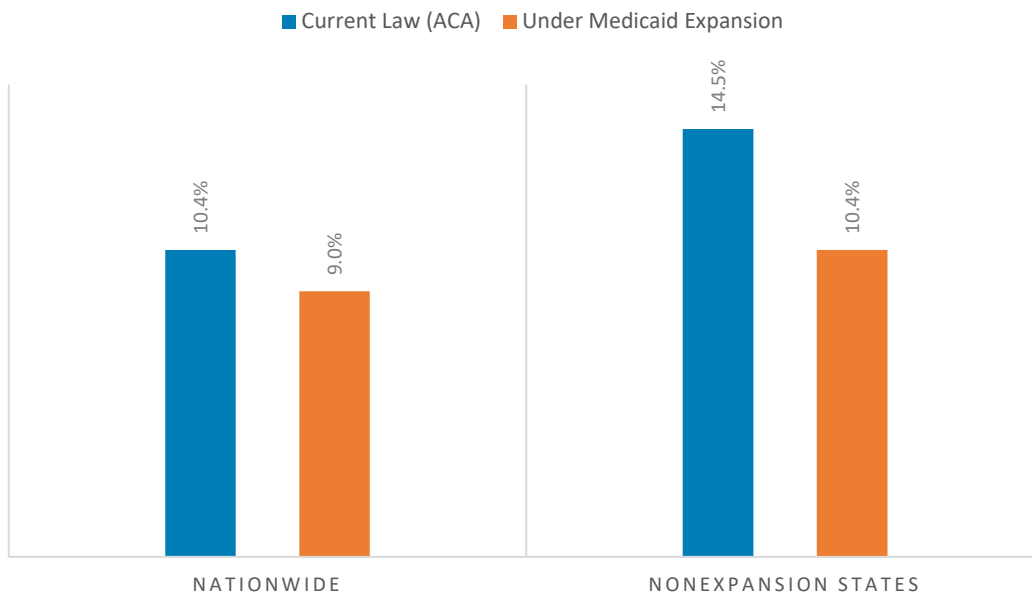
Results

All results are present for the year 2020 and reflect expected annual coverage

and spending absent the COVID-19 pandemic.

Overall health coverage changes (Table 1, Figures 1 and 2). If all 15 nonexpansion states expanded Medicaid, we estimate that 6.5 million more people would be expected to obtain Medicaid coverage. We would expect a decrease in the number of people uninsured of 3.9 million people, which would lower the uninsured rate for nonelderly people in nonexpansion states from 14.5 percent to 10.4 percent. Nationwide, the uninsured rate would decline from 10.4 percent to 9.0 percent. In addition to the uninsured

Figure 1. Uninsurance Rates With and Without Medicaid Expansion, Assuming No Pandemic, 2020



Source: Urban Institute analysis using HIPSM 2020. Reform simulated in 2020.

gaining Medicaid coverage, about 1.4 million of the new Medicaid enrollees would be people with incomes between 100 and 138 percent of FPL who are currently enrolled in the marketplaces with tax credits; this group transfers from marketplace coverage to Medicaid (data not shown). The remainder of the new Medicaid enrollees—1.2 million people—would have had employer coverage or other unsubsidized nongroup coverage, including short-term policies, in the absence of Medicaid expansion (data not shown).

Under current law there are 13.8 million uninsured people in the 15 nonexpansion states as show in Figure 2. Without Medicaid expansion, 9.3 million currently uninsured people have no options for assistance obtaining health insurance, while another 4.4 million have options that they do not use, either Medicaid, Children’s Health Insurance Program (CHIP), or Marketplace subsidies (left panel). Medicaid expansion would increase the number of uninsured people eligible for Medicaid from 2.0

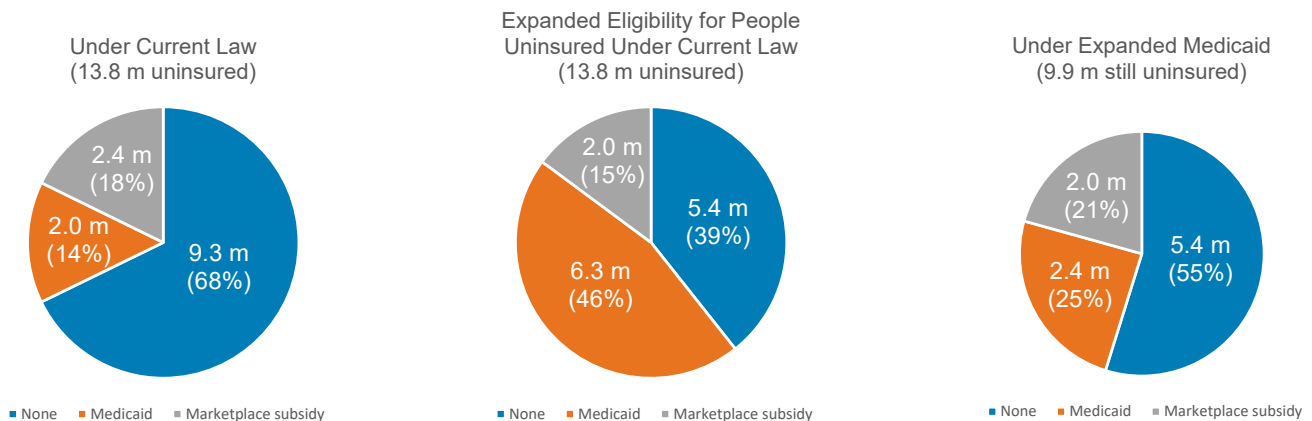
to 6.3 million and reduce the number with no assistance option to 5.4 million people from 9.3 million (center panel). We estimate that under Medicaid expansion 3.9 million of those gaining Medicaid eligibility would enroll, reducing the number uninsured in those states from a total of 13.8 to 9.9 million, leaving 4.4 million eligible for assistance they do not use, and 5.4 million without an assistance option (right panel).

With or without Medicaid expansion, millions of uninsured people will be eligible for but not enrolled in assistance to make health coverage more affordable. Nationwide, if all states expanded

Medicaid eligibility, 7.1 million uninsured people would be eligible for Medicaid or CHIP and 5.0 million would be eligible for marketplace tax credits (data not shown). These uninsured people could be

reached by additional outreach efforts or enrollment assistance programs such as express-lane eligibility,^{9,10} or those eligible for Medicaid could enroll when seeking medical care.

Figure 2. Eligibility for Coverage for Uninsured People in Nonexpansion States Under Current Law and Medicaid Expansion, Assuming No Pandemic, 2020



Source: Urban Institute analysis using HIPSM 2020. Reform simulated in 2020.

Table 1. Health Insurance Coverage Distribution of the Nonelderly Population in Nonexpansion States, Assuming No Pandemic, 2020

	Current Law		Under Medicaid Expansion			
	Number of people (thousands)	Share of nonelderly population	Number of people (thousands)	Share of nonelderly population	Difference (thousands)	Percent Difference
Insured (Minimum Essential Coverage)	79,952	84.0%	84,023	88.2%	4,072	5.1%
Employer	50,823	53.4%	49,999	52.5%	-824	-1.6%
Nongroup (with tax credits)	4,314	4.5%	2,567	2.7%	-1,747	-40.5%
Nongroup (without tax credits)	1,752	1.8%	1,930	2.0%	178	10.2%
Medicaid and Children's Health Insurance Program (CHIP)	19,400	20.4%	25,864	27.2%	6,465	33.3%
Other (including Medicare)	3,664	3.8%	3,664	3.8%	0	0.0%
No Minimum Essential Coverage	15,275	16.0%	11,203	11.8%	-4,072	-26.7%
Uninsured	13,763	14.5%	9,877	10.4%	-3,886	-28.2%
Short-Term Limited-Duration Policies	1,512	1.6%	1,326	1.4%	-185	-12.3%
Total	95,226	100.0%	95,226	100.0%	0	0.0%

Source: Urban Institute analysis using HIPSM 2020. Reform simulated in 2020.

Notes: Current law and Medicaid expansion are simulated without the effects of the COVID-19 pandemic.

Nonexpansion states are Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Medicaid enrollment by state (Table 2).

Under 2020 pre-COVID-19 law, Medicaid and CHIP covered roughly 20 percent of nonelderly people in the 15 nonexpansion states. However, Medicaid coverage rates vary by state because of differences in the states' income distributions and traditional Medicaid/CHIP program eligibility rules. The states with the highest shares of nonelderly people enrolled in Medicaid (22% or more) are Mississippi, Tennessee, Alabama, North Carolina, and South Carolina. In Tennessee, Medicaid

eligibility extends to parents with incomes up to 94 percent of FPL—much higher than the Medicaid income limits in most other nonexpansion states.¹¹ We estimate that Wyoming, Nebraska, Kansas, and South Dakota have the lowest shares of nonelderly people enrolled in Medicaid or CHIP without eligibility expansion (16% or less).

If all 15 remaining states expand Medicaid eligibility, each state except Wisconsin and Tennessee would see

Medicaid enrollment increase by 25 percent or more. In Wisconsin, all adults with incomes up to 100 percent of FPL are already eligible for Medicaid, and, as noted, Tennessee has high eligibility limits for parents. The highest relative increase in Medicaid enrollment would be in Wyoming, where an unusually low share of the population is currently enrolled.

Table 2. Medicaid Enrollment in Nonexpansion States, Assuming No Pandemic, 2020

State	Current Law - Affordable Care Act (ACA)		Under Expanded Medicaid		
	Number of People (thousands)	Share of Nonelderly Population	Number of People (thousands)	Difference	Percent Difference
Alabama	972	24.0%	1,296	324	33.4%
Florida	3,473	20.5%	4,785	1,312	37.8%
Georgia	1,945	21.1%	2,591	646	33.2%
Kansas	367	14.9%	506	139	37.9%
Mississippi	621	25.0%	828	207	33.3%
Missouri	907	17.8%	1,285	379	41.7%
Nebraska	226	13.9%	316	91	40.1%
North Carolina	2,097	23.7%	2,688	591	28.2%
Oklahoma	641	19.2%	904	263	41.1%
South Carolina	942	22.5%	1,271	329	34.9%
South Dakota	113	15.7%	156	43	37.7%
Tennessee	1,365	24.1%	1,688	323	23.7%
Texas	4,716	18.7%	6,381	1,665	35.3%
Wisconsin	965	20.1%	1,085	120	12.5%
Wyoming	51	10.0%	82	32	62.8%
Total	19,400	20.4%	25,864	6,465	33.3%

Source: Urban Institute analysis using HIPS 2020. Reform simulated in 2020.

Change in uninsurance by state (Table 3).

Absent the pandemic, we project that 14.5 percent of nonelderly people in nonexpansion states would be uninsured in 2020 without policy changes. Uninsurance rates vary across states because of differences in income distribution, Medicaid eligibility rules, prevalence of employers offering insurance, state and other organizational involvement in marketplace outreach and enrollment assistance, health care costs, and other factors. Uninsured rates vary from 6.9 percent in Wisconsin (which has

already expanded Medicaid for adults with incomes up to 100 percent of FPL) to 18.6 percent in Texas. Oklahoma and Wyoming also have uninsured rates exceeding 15 percent.

If all nonexpansion states expanded Medicaid under the ACA, the number of uninsured people in these states would decline by 28 percent. Individual states would see declines ranging from 16 percent in Wisconsin to 43 percent in Alabama. The uninsurance rate across these 15 states would fall from 14.5

percent to 10.4 percent of the nonelderly population. Only three states would have uninsured rates under expansion that exceed the 15-state average: Texas (14.4%), Wyoming (12.3%), and Oklahoma (12.0%). Wisconsin, Alabama, Nebraska, Missouri, and South Carolina would have uninsured rates of 8 percent or lower.

Table 3. Uninsurance in Nonexpansion States, Assuming No Pandemic, 2020

State	Current Law - Affordable Care Act (ACA)		Under Medicaid Expansion		
	Number of People Uninsured (thousands)	Uninsurance Rate (percent)	Uninsurance Rate (percent)	Change in Uninsurance Rate (percentage points)	Change in Number of People Uninsured (percent)
Alabama	4,057	11.2%	6.3%	-4.8%	-43.1%
Florida	16,979	14.6%	10.2%	-4.4%	-30.0%
Georgia	9,223	14.1%	9.8%	-4.3%	-30.7%
Kansas	2,473	12.9%	9.2%	-3.8%	-29.1%
Mississippi	2,481	14.3%	8.7%	-5.6%	-39.0%
Missouri	5,104	12.4%	7.9%	-4.5%	-36.4%
Nebraska	1,619	9.6%	7.0%	-2.7%	-27.8%
North Carolina	8,841	12.3%	8.7%	-3.6%	-29.6%
Oklahoma	3,345	17.1%	12.0%	-5.1%	-30.0%
South Carolina	4,184	12.6%	8.0%	-4.6%	-36.3%
South Dakota	722	12.1%	8.6%	-3.4%	-28.4%
Tennessee	5,657	12.0%	8.4%	-3.6%	-30.1%
Texas	25,230	18.6%	14.4%	-4.2%	-22.5%
Wisconsin	4,809	6.9%	5.8%	-1.1%	-16.0%
Wyoming	504	15.9%	12.3%	-3.6%	-22.5%
Total	95,226	14.5%	10.4%	-4.1%	-28.2%

Source: Urban Institute analysis using HIPSIM 2020. Reform simulated in 2020.

Federal spending on Medicaid, CHIP, and marketplaces (Table 4).

Absent the pandemic and without any new Medicaid expansions, the federal government would have spent \$129.9 billion in 2020 on Medicaid, CHIP, and marketplace coverage for nonelderly people in nonexpansion states. If these states had expanded Medicaid eligibility, federal spending would have risen to \$160.3 billion, a 23 percent increase. Nonexpansion states with the smallest relative increases in federal spending under expansion have a few distinguishing features:

- 1. Higher-than-average current Medicaid eligibility limits for parents.** We have already discussed Medicaid eligibility in Wisconsin and Tennessee. Wyoming and Nebraska also have higher-than-average Medicaid eligibility limits for adult parents, covering those with incomes up to 53 percent and 63 percent of FPL, respectively.¹¹

- 2. High marketplace enrollment** (Nebraska, Wyoming, and Florida) leading to a larger federal cost offset, as those with incomes between 100 and 138 percent of FPL transition from marketplace tax credits to Medicaid.

- 3. Low current uninsured rates** (Wisconsin, Nebraska).

The opposite characteristics—lower parent Medicaid eligibility limits, lower marketplace tax credit enrollment (and thus federal cost offsets), and higher current uninsured rates—lead to larger increases in federal spending. For example, Texas has the lowest eligibility for parents (17% of FPL) and the highest uninsured rate and thus would have a large increase in federal spending under expansion.

State spending on Medicaid and CHIP (Table 5). Absent expansion and without the pandemic, nonexpansion states would have spent \$51.6 billion on

Medicaid and CHIP acute care for the nonelderly in 2020. If these 15 states had expanded Medicaid eligibility, state spending on Medicaid would have risen by \$4.7 billion, or 9 percent. The expected percent increase in state Medicaid and CHIP spending is small, despite the projected 33 percent increase in Medicaid enrollment, because the federal government pays 90 percent of the costs for newly eligible Medicaid enrollees (a higher share than that paid for the traditional Medicaid-eligible population). However, this increase overestimates the effect of Medicaid expansion on state budgets because states would see additional savings that would at least partially offset additional spending on the Medicaid program.

Table 4. Federal Spending on Medicaid, CHIP, and Marketplace Tax Credits in Nonexpansion States, Assuming No Pandemic, 2020 (\$ millions)

State	Current Law - Affordable Care Act (ACA)	Under Expanded Medicaid		
	Spending	Spending	Difference	Percent difference
Alabama	\$5,513	\$7,086	\$1,573	28.5%
Florida	\$24,210	\$27,840	\$3,630	15.0%
Georgia	\$10,770	\$13,630	\$2,860	26.6%
Kansas	\$2,087	\$2,662	\$575	27.6%
Mississippi	\$4,747	\$5,955	\$1,208	25.4%
Missouri	\$7,838	\$9,962	\$2,124	27.1%
Nebraska	\$1,724	\$2,005	\$281	16.3%
North Carolina	\$15,500	\$19,430	\$3,930	25.4%
Oklahoma	\$4,822	\$6,089	\$1,267	26.3%
South Carolina	\$5,592	\$7,158	\$1,566	28.0%
South Dakota	\$843	\$1,067	\$224	26.6%
Tennessee	\$8,612	\$9,940	\$1,328	15.4%
Texas	\$32,120	\$41,390	\$9,270	28.9%
Wisconsin	\$4,937	\$5,427	\$490	9.9%
Wyoming	\$578	\$620	\$42	7.3%
Total	\$129,893	\$160,300	\$30,407	23.4%

Source: Urban Institute analysis using HIPSM 2020. Reform simulated in 2020.

Note: Current law and expanded Medicaid costs are based on pre-COVID-19 law.

Table 5. State Spending on Medicaid and CHIP in Nonexpansion States, Assuming No Pandemic, 2020 (\$ millions)

State	Current Law - Affordable Care Act (ACA)	Under Medicaid Expansion		
	Spending	Spending	Difference	Percent difference
Alabama	\$1,535	\$1,784	\$249	16.2%
Florida	\$8,742	\$9,468	\$726	8.3%
Georgia	\$3,796	\$4,220	\$424	11.2%
Kansas	\$987	\$1,085	\$98	9.9%
Mississippi	\$1,149	\$1,326	\$177	15.4%
Missouri	\$3,288	\$3,657	\$369	11.2%
Nebraska	\$756	\$822	\$67	8.8%
North Carolina	\$5,414	\$5,989	\$575	10.6%
Oklahoma	\$1,754	\$1,983	\$229	13.1%
South Carolina	\$1,674	\$1,924	\$250	14.9%
South Dakota	\$397	\$434	\$36	9.1%
Tennessee	\$3,608	\$3,782	\$174	4.8%
Texas	\$15,700	\$17,190	\$1,490	9.5%
Wisconsin	\$2,557	\$2,386	-\$171	-6.7%
Wyoming	\$279	\$308	\$29	10.2%
Total	\$51,636	\$56,358	\$4,721	9.1%

Source: Urban Institute analysis using HIPSM 2020. Reform simulated in 2020.

Note: Current law and expanded Medicaid costs are based on pre-COVID-19 law.

Potential reductions in uncompensated care spending (Table 6). Uncompensated care has declined in Medicaid expansion states.^{12,13,14} However, the financing of uncompensated care is very complex and varies widely across states. Reductions in spending on uncompensated care may require changes to state law, which means that reduced demand for uncompensated care may not automatically translate into lower state spending, just as increases in demand (due to increases in the number of people uninsured) may not trigger more spending. Because of this uncertainty, we focus on estimating the overall differences

in demand for uncompensated care resulting from increased enrollment in Medicaid and fewer uninsured people, instead of forecasting the savings for each state.

Without Medicaid expansions and absent the pandemic, uncompensated care for uninsured people in nonexpansion states would have totaled \$27.7 billion in 2020. We estimate that the federal government would have funded \$11.1 billion of this total, state and local governments \$6.9 billion, and health care providers \$9.7 billion.¹⁵

If all the nonexpansion states expanded Medicaid, the demand for uncompensated care in these 15 states would have declined by \$6.4 billion. This decrease in demand could translate into federal government savings of \$2.6 billion, state and local government savings of \$1.6 billion, and provider savings of \$2.3 billion, if distributed proportionately to prior spending. This is only one of several state cost offsets for Medicaid expansion.

Table 6. Uncompensated Care in Nonexpansion States by Payer, Assuming No Pandemic, 2020 (\$ millions)

	Current Law - Affordable Care Act (ACA)	Under Medicaid Expansion	
		Spending	Difference
Federal government	\$11,084	\$8,505	\$-2,579
State/local government	\$6,927	\$5,315	\$-1,612
Health care providers	\$9,698	\$7,441	\$-2,257
Total	\$27,709	\$21,261	\$-6,448

Source: Urban Institute analysis using HIPSM 2020. Reform simulated in 2020.

Note: Nonexpansion states are Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Differences from other studies. Our new estimates of the impact of Medicaid expansion on the number of uninsured people are different from what we published in 2018. The difference from our 2018 estimates comes from two main sources. First, there are fewer nonexpansion states in 2020 than there were when we produced the 2018 analysis. Idaho, Maine, Virginia, and Utah were nonexpansion states at that time and have since expanded Medicaid eligibility. Second, we compare expansion with estimates of coverage under current law in 2020 pre-pandemic. We anticipated that a smaller proportion of people in nonexpansion states would be uninsured in 2020 than we did in 2018, the result of a strong pre-pandemic economy, inclusion of ACA noncompliant insurance (short-term and limited-duration), and updates to the model's population weights.

Our estimates also differ from estimates of the coverage gap published in January

by the Kaiser Family Foundation for four significant reasons. First, Kaiser only counts uninsured adults, but our estimates include counts of some uninsured children currently eligible for Medicaid who we predicted (based on past experience in other states) would newly enroll as their parents sought coverage. Second, their coverage gap measures eligibility for Medicaid, but not enrollment in coverage for which people are eligible. Even when made eligible, only a portion of the uninsured will enroll in Medicaid. Third, their coverage gap includes only new eligibility for the uninsured, so does not address new Medicaid enrollment of people who currently have other forms of insurance coverage (e.g., employer insurance, nongroup insurance) absent Medicaid expansion. For example, based on marketplace enrollment data, we project that roughly 1.4 million marketplace enrollees with incomes between 100 and 138 percent of FPL would become

eligible for Medicaid under expansion, simultaneously losing their eligibility for marketplace premium tax credits. Last, their results include Nebraska, which will expand late in 2020, as an expansion state, whereas we exclude states from the expansion category until they actually begin to provide coverage through an expansion of eligibility.

Discussion

Under our central assumptions, if all 15 nonexpansion states had implemented the Medicaid expansion in 2020, 4.1 million more people would have been insured with minimum essential coverage in 2020 (absent the pandemic), reducing the nonelderly uninsured rate in those states from 14.5 percent today to 10.4 percent, and reducing the national uninsured rate from 10.4 percent to 9.0 percent. With expansion, 7.1 million uninsured people nationwide would be eligible for but not enrolled in Medicaid, and 5.0 million uninsured people would

be eligible for marketplace premium tax credits, leaving substantial room for additional outreach and enrollment activities to lower the uninsurance rate further.

In addition to reducing the number of uninsured, expanding Medicaid under the ACA to low-income people improves health and reduces mortality in the enrolled population. Two recent studies provide strong evidence that expansions of coverage under the ACA have reduced mortality rates in older adults by meaningful amounts. While health economists have studied the issue for decades, the implementation of the ACA afforded new opportunities to study the effects of insurance on health. Taking advantage of certain features of the ACA, both of the recent papers apply an experimental or quasi-experimental research design with extremely large samples of people and link administrative data from death records to other data sources such as tax records and survey collected information on income and education to strengthen their analyses. One paper takes advantage of a random experiment that occurred when the Internal Revenue Service (IRS) sent letters to a random portion of taxpayers who had paid a tax penalty for failing to show proof of insurance coverage as required under the ACA's individual responsibility provision.¹⁹ Researchers found that taxpayers who had received the letters had higher rates of coverage and lower mortality rates in subsequent years. The random nature of the experiment bolsters their findings that insurance coverage improves health as measured by statistically significant declines in mortality rates. A second paper compares changes in mortality for near-elderly adults in states with and without Affordable Care Act Medicaid expansions.²⁰ The researchers identify adults aged 55 to 64 in years prior to the ACA who would most likely be eligible for expanded Medicaid and follow them over time. They find a 9.4 percent reduction in annual mortality associated with the Medicaid expansion for 2014 to 2017. The reduced mortality is the result of a drop in disease-related deaths and grows over time. They estimate there

were approximately 19,200 fewer deaths in their study population (of about 3.7 million people) over the first four years of the ACA.

The resulting growth in Medicaid enrollment would have increased federal spending on health care financial assistance by an estimated \$30.4 billion in 2020 absent the pandemic. Such an increase in federal spending could have positive impacts on the economies of the affected states, particularly in states running at less than full employment. For example, a study in Montana found that 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.²¹

If all the nonexpansion states expanded Medicaid, these states' spending on Medicaid would have increased by \$4.7 billion, or 9 percent—but that entire amount would not translate into a budgetary impact. Medicaid expansion is likely to yield savings in other areas:

- \$1.6 billion in potential savings on state and local spending on uncompensated care;
- Higher federal matching rates for beneficiaries who, without expansion, would have been covered through pre-ACA Medicaid eligibility categories;
- Increased tax revenue from increased economic activity produced by increased federal Medicaid spending on health care within the state;
- Increased revenue from state taxes on health care providers and/or health coverage premiums;
- Lower demand for non-Medicaid state-funded programs for uninsured low-income people (not counted as uncompensated care).

A study covering all expansion states found that as of 2015, “there were no significant increases in spending from state funds as a result of the expansion.”²⁴

Comprehensive analyses of the budget impact of Medicaid expansion concluded that, on balance, Medicaid expansion yielded net state budget gains in the following states: Arkansas,²⁵ Alaska,²⁶ California,²⁵ Colorado,²⁷ the District of Columbia,²⁵ Kentucky,²⁸ Louisiana,²⁹ Maryland,²⁵ Michigan,³⁰ New Jersey,³¹ New Mexico,³² Oregon,²⁵ Pennsylvania,²⁵ Virginia,³³ Washington State,³⁴ and West Virginia.²⁵ Ten of these studies covered calendar year 2020 and beyond, when federal Medicaid funding for expansion will reach its final (and lowest) 90 percent matching rate. Eight of the ten studies found that the impact on the state budget would be positive throughout this period. Two analyses projected eventual net budget losses, but these results may not be generalizable to other states.³⁵

Several states are seeking changes to their Medicaid programs such as work requirements, premiums, and time limits on coverage.³⁶ There is tremendous uncertainty about which states will ultimately submit such waivers, what the proposals will look like, what will be approved, and how the policies will be implemented. However, such waivers would reduce Medicaid enrollment, making our low take-up scenario more likely in those states obtaining them.

The research shows that, compared with nonexpansion states, Medicaid expansion states have seen larger declines in the number of uninsured people, lower uncompensated care, improvements in hospital finances,¹⁴ economic benefits from additional health care spending, and net gains to state budgets. There is also evidence that for many states, government cost increases resulting from higher Medicaid caseloads are outweighed by state savings and revenue growth caused by expansion. Most states with relevant analyses expect net fiscal gains, even after states begin paying 10 percent of expansion costs. Our estimates suggest that the remaining 15 nonexpansion states would see similar benefits if they expanded Medicaid eligibility.

The COVID-19 pandemic means the estimates of coverage increases

presented here understate the implications of Medicaid eligibility expansions in 2020. As we have shown elsewhere, workers most likely to lose their employer-based insurance due to the virus-driven economic crash are substantially more likely to be eligible for financial assistance-maintaining health insurance coverage if they live in a Medicaid expansion state.³⁷ Even for those receiving assistance, workers in nonexpansion states are substantially more likely to be eligible for partial-premium assistance for marketplace coverage that carries greater out-of-pocket costs compared to workers in expansion states who are more likely to be eligible for no-premium Medicaid coverage with little-to-no associated out-of-pocket costs. The current situation highlights the more robust safety net in place for those facing crisis circumstances in states that have implemented Medicaid expansions.

Appendix – Lower and Higher Takeup Scenarios

Because of the inherent uncertainty in projections of the effects of Medicaid expansion, we have produced lower and higher take-up scenarios than our central estimates presented in the body of the paper. We did not model specific waivers because of the uncertainty about which states would apply, which waivers would be approved, and how waivers would be implemented. High and low take-up rate assumptions are based on variation among states that had expanded Medicaid as of 2019. We assume the take-up rate for new expansion states would be 79 percent of those currently uninsured and 16 percent of those with employer-sponsored insurance (compared to 72 percent and 13 percent in our central estimates) if new expansion states are more successful than average with outreach and enrollment assistance, our higher take-up rate scenario. We assume a rate of 66 percent of those currently uninsured and 9 percent of those with employer sponsored insurance in the lower take-up scenario, where state waivers for work requirements and lifetime benefit limits reduce Medicaid enrollment.

Changes in Coverage and Uninsurance (Appendix Table 1) Medicaid enrollment would be larger than without expansion by between 5.9 and 7.1 million people, with increases of 30 to 37 percent. The uninsurance rate in the 15 newly expanding states would fall from 14.5 percent to 10.7 percent under lower take-up and to 10.0 percent with higher take-up.

Changes in Federal and State Spending and the Demand for Uncompensated Care Under our lower and higher take-up assumptions, the increase in federal spending could range from \$26.2 billion to \$34.8 billion, or from 20 percent to 27 percent of federal marketplace credits and Medicaid and CHIP acute care for the non-elderly in the 15 states (data not shown). State costs could increase from \$4.1 billion to \$5.5 billion, which is an increase of 9 to 11 percent respectively (data not shown). If all the nonexpansion states expanded Medicaid, the demand for uncompensated care in these 15 states would have declined by \$5.7 billion to \$7.2 billion (Appendix Table 2).

Appendix Table 1. Health Insurance Coverage Distribution of the Nonelderly Population in Nonexpansion States: Low and High Takeup Assumptions, Assuming No Pandemic, 2020

	Current Law (ACA)		Full Implementation of Medicaid Expansion								
			Lower Take-Up			Expected Take-Up			Higher Take-Up		
	Number of People (thousands)	Share of Nonelderly Population	Number of People (thousands)	Share of Nonelderly Population	Difference (thousands)	Number of People (thousands)	Share of Nonelderly Population	Difference (thousands)	Number of People (thousands)	Share of Nonelderly Population	Difference (thousands)
Insured (Minimum Essential Coverage)	79,952	84.0%	83,669	87.9%	3,717	84,023	88.2%	4,072	84,388	88.6%	4,436
Employer	50,823	53.4%	50,239	52.3%	-584	49,999	52.5%	-824	49,692	51.8%	-1,131
Nongroup (with tax credits)	4,314	4.5%	2,567	1.9%	-1,747	2,567	2.7%	-1,747	2,567	1.9%	-1,747
Nongroup (without tax credits)	1,752	1.8%	1,939	2.1%	187	1,930	2.0%	178	1,921	2.1%	169
Medicaid and CHIP	19,400	20.4%	25,260	27.0%	5,861	25,864	27.2%	6,465	26,544	27.8%	7,144
Other (including Medicare)	3,664	3.8%	3,664	3.9%	0	3,664	3.8%	0	3,664	3.9%	0
Uninsured (no MEC)	15,275	16.0%	11,558	12.8%	-3,717	11,203	11.8%	-4,072	10,839	12.5%	-4,436
Uninsured	13,763	14.5%	10,230	10.7%	-3,533	9,877	10.4%	-3,886	9,519	10.0%	-4,244
Noncompliant Nongroup	1,512	1.6%	1,328	1.4%	-184	1,326	1.4%	-185	1,320	1.4%	-192
Total	95,226	100.0%	95,226	100.0%	0	95,226	100.0%	0	95,226	100.0%	0

Source: Urban Institute analysis using HIPSIM 2020. Reform simulated in 2020.

Note: Expected take-up reflects the average rate of Medicaid take-up in states that had fully expanded as of 2019. Lower and higher scenarios assume take-up reflect the range of takeup among those states.

Nonexpansion states are Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Appendix Table 2. Uncompensated Care in Nonexpansion States by Payer: Low and High Takeup Assumptions, Assuming No Pandemic, 2020 (\$ millions)

	Current Law (ACA)	Full Implementation of Medicaid Expansion					
		Lower Take-Up		Expected Take-Up		Higher Take-Up	
		Spending	Difference	Spending	Difference	Spending	Difference
Federal government	\$11,084	\$8,804	\$-2,280	\$8,505	\$-2,579	\$8,221	\$-2,863
State/local government	\$6,927	\$5,502	\$-1,425	\$5,315	\$-1,612	\$5,138	\$-1,789
Health care providers	\$9,698	\$7,703	\$-1,995	\$7,441	\$-2,257	\$7,193	\$-2,505
Total	\$27,709	\$22,009	\$-5,700	\$21,261	\$-6,448	\$20,552	\$-7,157

Source: Urban Institute analysis using HIPSIM 2020. Reform simulated in 2020.

Note: Expected take-up reflects the average rate of Medicaid take-up in states that had fully expanded as of 2019. Lower and higher scenarios assume take-up reflect the range of takeup among those states.

Nonexpansion states are Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

NOTES

- 1 The Supreme Court's decision in *National Federation of Independent Business v. Sebelius* (2012) effectively made the ACA's Medicaid expansion voluntary for states.
- 2 The law was written anticipating that all states would expand Medicaid eligibility under the ACA, so it limited premium tax credits to the population above the poverty level. The only adults with incomes below 100 percent of FPL who are eligible for marketplace premium tax credits are lawfully present immigrants who would otherwise be eligible for Medicaid but have not yet completed the requisite five-year waiting period for benefits. Also, people with incomes between 100 and 138 percent of FPL who are ineligible for marketplace premium tax credits because a family member has an offer of affordable coverage would be eligible for Medicaid if their state expanded.
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