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The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates

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Introduction

The Supreme Court is set to hear oral arguments in *California v. Texas* (called Texas v. U.S. when heard by the lower courts) on November 10, 2020. In the case, a group of state attorneys general, led by the Texas attorney general, argue the entire Affordable Care Act (ACA) should be found unconstitutional and overturned, given that a 2017 tax law set the ACA's individual mandate penalties to $0 but did not eliminate the now-unenforced individual mandate language along with them. Another group of attorneys general, led by the California attorney general, argue that the law has operated effectively since the penalties were eliminated, the mandate is severable from the rest of the law, and there are no constitutional grounds for overturning it. Here, we update previous analyses of the implications for insurance coverage, federal spending, and health care providers if the ACA is overturned.[1,2] These estimates, computed using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), are based on a newly developed projection of coverage and spending in 2022 that accounts for an anticipated partial economic recovery from the COVID-19 recession. Our estimates of that economic recovery align with employment levels projected by the Congressional Budget Office for 2022.[3]

Using these projections, we estimate that overturning the ACA would have the following effects in 2022:

- An additional 21.1 million people will be uninsured, a 69 percent increase nationally.
- As the marketplace, premium tax credits, and cost-sharing reductions are eliminated, 9.3 million people will lose income-related subsidies for marketplace insurance.
- Medicaid/CHIP coverage (acute care for the nonelderly) will decline by 22 percent nationally, or 15.5 million people.
- The number of people with individually purchased (nongroup) insurance will fall by 7.6 million. In almost all states, the remaining nongroup coverage will have lower value (e.g., lower benefits, higher cost-sharing requirements, higher administrative costs as a percentage of the premium) than the nongroup coverage provided under the ACA's framework.
- Low-income states that expanded Medicaid eligibility under the ACA will see the largest percent increases in uninsurance, such as Maine (197 percent increase, from 5 percent to 15 percent), Kentucky (184 percent increase, from 8 percent to 22 percent), and West Virginia (181 percent increase, from 8 percent to 21 percent). Iowa's uninsurance rate will climb more than 150 percent (from 6 percent to 14 percent), as will Michigan's (from 7 percent to 18 percent). The uninsured population will increase by at least 90 percent in 25 states and the District of Columbia.
- Increases in uninsurance will be spread across all racial and ethnic groups Uninsurance will increase by about 85 percent for both Black people (from 11 percent to 20 percent) and white people (from 8 percent to 15 percent); by about 75 percent for both American Indians/Alaska Natives (from 13 percent to 24 percent) and people who are Asian/Pacific Islander (from 11 percent to 19 percent); and by about 40 percent for Hispanic people (from 21 percent to 30 percent). In addition, the coverage gaps between white people and every other specified racial/ethnic group will increase.
- Uninsurance among the lowest-income population (with incomes below 138 percent of the federal poverty level, or FPL) will more than double, though uninsurance will also increase significantly among the middle class.
- Federal government spending on health care will fall by $152 billion per year, a 35 percent drop relative to current spending on marketplace subsidies and Medicaid acute care for the nonelderly population.
- States that will experience the largest percent decreases in federal funding include Nebraska (56 percent, from $2.1 billion to $0.9 billion), Virginia (56 percent, from $9.5 billion to $4.2 billion), Montana (51 percent, from $2.3 billion to $1.1 billion), and Colorado (47 percent, from $6.3 billion to $3.3 billion).
- Nationally, health care spending by and for nonelderly Americans will fall by $135 billion. This spending decline will be spread across hospitals ($56 billion), pharmaceutical manufacturers ($30 billion), physicians ($17 billion), and other services ($33 billion).

- Relative to current levels, hospital revenues will be hardest hit in California ($10.4 billion decrease), Florida ($3.8 million decrease), Louisiana ($1.7 billion decrease), Kentucky ($1.7 billion decrease), New Mexico ($1.1 billion decrease), Arkansas ($836 million decrease), Idaho ($600 million decrease), and Montana ($503 million decrease).
- Because of the 69 percent increase in uninsurance, the demand for uncompensated care will rise by 74 percent, or $58 billion. The demand for uncompensated care from hospitals alone will increase by $17.4 billion in 2022.

Data and Methods Overview

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) for our analysis. HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed policy options. The model has been used extensively to estimate the cost and coverage implications of health reforms at the national and state levels and has been widely cited, including in the Supreme Court's majority opinion in *King v. Burwell*.[4] HIPSM is based on two years of the American Community Survey, and the population is aged to future years using projections from the Urban Institute's Mapping America's Futures program.[5] HIPSM is designed to incorporate timely, real-world data when they are available. 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. The Appendix contains more information about the model and our methods for this paper.

Results

Changes in Coverage. Table 1 compares the expected current-law distribution of health insurance coverage for the nonelderly population in 2022 with the coverage distribution that same year should the ACA be overturned. We estimate that the number of uninsured people will increase by 21.1 million. The substantially lower insurance rate is attributable to 15.5 million people having lost Medicaid and Children's Health Insurance Program (CHIP) coverage (a 22 percent decrease) and 7.6 million people having lost private nongroup insurance coverage (a 43 percent decrease). The losses of public insurance coverage and nongroup coverage will be offset modestly by 1.9 million more people having employer-based insurance. More than 9 million people will lose marketplace income-related subsidies that help them pay for private nongroup insurance under current law.

Federal regulations of nongroup insurance markets under the ACA will be eliminated if the law is overturned, meaning insurers in almost all states will be expected to revert to pre-2014 practices of denying coverage to people with health problems, offering much more limited benefits, increasing cost-sharing requirements, and setting premiums based on a range of factors often without effective limits (e.g., health status, gender, occupation, health history, age, neighborhood of residence, past health care use). In addition, federal rules requiring that a minimum percentage of premium dollars go toward paying claims (as opposed to insurer administrative cost, including profit) will be eliminated. Combined, this means the coverage sold will be harder for many people to access, particularly those with significant health care needs, and the coverage purchased will be less valuable to the consumer.

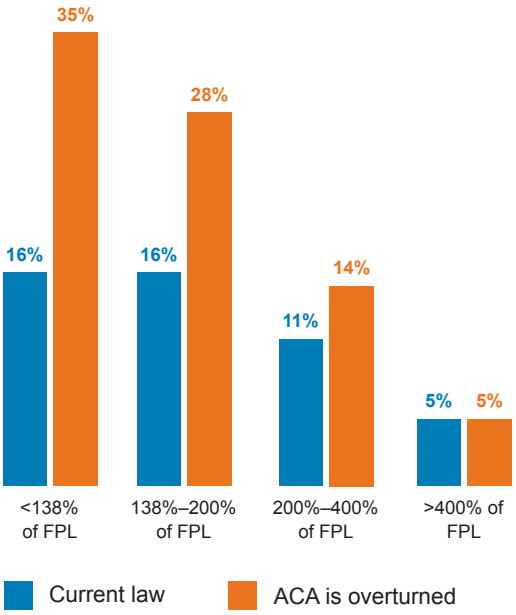
Figure 1 shows that the lowest-income groups will experience the biggest increases in uninsurance if the ACA is overturned. People in families with income below 138 percent of FPL will see their uninsurance rate more than double, from 16 percent under current law to 35 percent. People with incomes between 138 percent and 200 percent of FPL will see their uninsurance rates increase by 71 percent, from 16 percent to 28 percent. Uninsurance rates for people with incomes between 200 and 400 percent of FPL will climb 30 percent, from 11 percent under current law to 14 percent absent the ACA. Those with higher incomes will experience more modest increases in uninsurance.

Table 1. Health Insurance Coverage Distribution of the Nonelderly Population under Current Law and If the ACA Is Overturned, 2022

	Current Law ACA		ACA Is Overturned		Difference	
	1,000s of people	%	1,000s of people	%	1,000s of people	%
Total	**277,446**	**100%**	**277,446**	**100%**	**0**	**0%**
Insured	**246,680**	**89%**	**225,531**	**81%**	**-21,149**	**-9%**
Employer	149,325	54%	151,245	55%	1,920	1%
Nongroup, ACA-compliant	17,528	6%	9,953	4%	-7,575	-43%
ACA nongroup (with tax credits)	9,322	3%	0	0%	-9,322	-100%
ACA nongroup (without tax credits)	5,638	2%	0	0%	-5,638	-100%
Noncompliant nongroup	2,567	1%	9,953	4%	7,385	288%
Medicaid/CHIP	71,162	26%	55,668	20%	-15,494	-22%
Other (including Medicare)	8,665	3%	8,665	3%	0	0%
Uninsured	**30,766**	**11%**	**51,916**	**19%**	**21,149**	**69%**

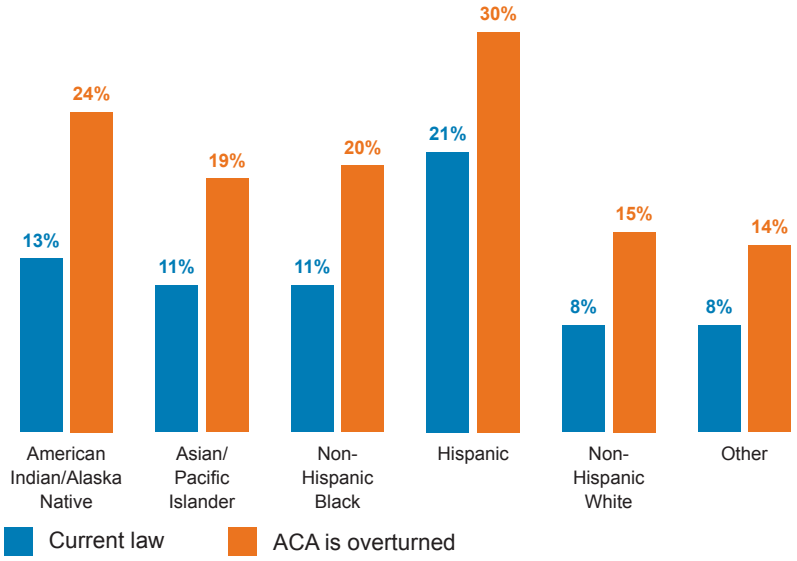
Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program.
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Figure 1. Uninsurance Rates among the Nonelderly Population under Current Law and If the ACA Is Overturned, by Family Income Relative to the Federal Poverty Level, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. FPL = federal poverty level.
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Figure 2. Uninsurance Rates among the Nonelderly Population under Current Law and if the ACA is Overturned, by Race and Ethnicity, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act.
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Figure 2 shows that overturning the ACA will have substantial implications for all racial/ethnic groups. Because the ACA narrowed gaps in coverage between Black people and non-Hispanic white people, overturning the ACA reverses those improvements; uninsurance will increase by roughly 85 percent for Black people and white people, leaving 20 percent of Black people and 15 percent of white people uninsured. Uninsurance will increase by about 75 percent among American Indians/Alaska Natives (from 13 percent to 24 percent) and people who are Asian/Pacific Islander (from 11 percent to 19 percent). Uninsurance among the Hispanic population will rise by more than 40 percent, from 21 percent to 30 percent—the highest uninsurance rate of any racial/ethnic group. Together, people of other races/ethnicities will experience an 80 percent increase in uninsurance (from 8 percent to 14 percent).

If the ACA is invalidated, the largest percent increases in uninsurance will occur in states that experienced the largest coverage gains under the ACA: states that expanded Medicaid eligibility under the law and states that had high pre-ACA uninsurance rates (Table 2). These include Maine (197 percent increase, from 5 percent to 15 percent), Kentucky (184 percent increase, from 8 percent to 22 percent), West Virginia (181 percent increase, from 8 percent to 21 percent), Montana (155 percent increase, from 9 percent to 24 percent), Michigan (152 percent increase, from 7 percent to 18 percent), and Pennsylvania (143 percent increase, from 7 percent to 16 percent). Overall, uninsurance in the 37 states that expanded Medicaid eligibility under the ACA (including the District of Columbia) will more than double. However, even states that did not expand Medicaid will experience large increases in uninsurance as marketplace subsidies are eliminated along with other ACA reforms. On average, uninsurance in those 14 states will increase by 28 percent. Some of the largest increases among these states will be felt in Florida (57 percent increase, or 1.5 million more uninsured people), North Carolina (33 percent increase, or 387,000 people), Wisconsin (30 percent increase, 112,000 people), and Georgia (24 percent increase, or 343,000 people).

Changes in Federal Spending. Table 3 shows ramifications for states' federal health care funding if the ACA is overturned. Nationally, federal investment in health care will decrease by $152 billion in 2022 if the ACA is invalidated. Again, states that gained the most assistance under the ACA will lose the most federal spending. In 21 states, federal funding for marketplace subsidies and Medicaid acute care for the nonelderly will fall by 40 percent or more. Under ACA repeal, Florida's federal funding will drop by $10.7 billion in 2022 (41 percent), and Wyoming's will drop by $311 million (49 percent). These large percent decreases in two states that did not expand Medicaid eligibility reflect their limited traditional Medicaid programs and, in Florida, high marketplace enrollment. Federal spending on health care in California will fall by $25.4 billion, or 47

Table 2. The Uninsured Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022

	Current Law		ACA Is Overturned		Difference	
	1,000s of people	%	1,000s of people	%	1,000s of people	%
Total	**30,766**	**11%**	**51,916**	**19%**	**21,149**	**69%**
Expansion States	**16,229**	**9%**	**33,368**	**18%**	**17,139**	**106%**
Alaska	95	13%	143	20%	48	51%
Arizona	755	12%	978	16%	223	30%
Arkansas	230	9%	579	23%	349	152%
California	3,682	11%	8,004	23%	4,323	117%
Colorado	484	10%	966	20%	482	100%
Connecticut	203	7%	442	15%	239	118%
Delaware	67	8%	92	11%	26	38%
District of Columbia	43	7%	84	14%	40	94%
Hawaii	114	9%	143	12%	29	25%
Idaho	161	11%	356	23%	195	121%
Illinois	1,073	10%	1,810	17%	737	69%
Indiana	499	9%	1,085	19%	586	118%
Iowa	144	6%	365	14%	221	153%
Kentucky	294	8%	836	22%	542	184%
Louisiana	381	10%	935	24%	554	145%
Maine	54	5%	159	15%	105	197%
Maryland	420	8%	816	16%	395	94%
Massachusetts	248	4%	488	9%	241	97%
Michigan	552	7%	1,395	18%	842	152%
Minnesota	291	6%	608	13%	317	109%
Montana	79	9%	202	24%	123	155%
Nebraska	135	8%	260	16%	125	93%
Nevada	397	14%	710	25%	313	79%
New Hampshire	74	7%	166	15%	91	123%
New Jersey	731	10%	1,392	19%	662	91%
New Mexico	216	12%	534	29%	318	147%
New York	1,106	7%	2,075	13%	969	88%
North Dakota	75	12%	115	18%	39	52%
Ohio	724	8%	1,496	16%	772	107%
Oregon	346	10%	753	22%	407	118%
Pennsylvania	693	7%	1,687	16%	994	143%
Rhode Island	60	7%	156	18%	97	162%
Utah	299	10%	559	19%	260	87%
Vermont	44	9%	59	12%	16	36%
Virginia	755	10%	1,433	19%	678	90%
Washington	597	9%	1,180	18%	583	98%
West Virginia	109	8%	307	21%	198	181%
Nonexpansion States	**14,537**	**15%**	**18,547**	**20%**	**4,010**	**28%**
Alabama	486	12%	608	15%	122	25%
Florida	2,641	15%	4,140	24%	1,499	57%
Georgia	1,401	15%	1,745	19%	343	24%
Kansas	341	14%	399	16%	58	17%
Mississippi	371	15%	448	18%	77	21%
Missouri	676	13%	804	16%	128	19%
North Carolina	1,179	13%	1,565	17%	387	33%
Oklahoma	597	18%	726	21%	129	22%
South Carolina	572	14%	733	17%	161	28%
South Dakota	95	13%	112	15%	17	18%
Tennessee	731	13%	901	16%	171	23%
Texas	4,996	19%	5,784	23%	788	16%
Wisconsin	366	8%	478	10%	112	30%
Wyoming	85	16%	104	20%	19	22%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Table 3. Federal Spending on Marketplace Subsidies and Medicaid/CHIP Acute Care for the Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022

	Current Law	ACA Is Overturned	Difference	
	Millions of $	Millions of $	Millions of $	%
Total	**435,704**	**283,743**	**-151,962**	**-35%**
Expansion States	**299,012**	**179,548**	**-119,464**	**-40%**
Alaska	1,462	950	-512	-35%
Arizona	12,639	10,102	-2,537	-20%
Arkansas	5,652	3,563	-2,090	-37%
California	53,748	28,338	-25,410	-47%
Colorado	6,309	3,347	-2,962	-47%
Connecticut	5,268	3,228	-2,040	-39%
Delaware	1,551	1,211	-340	-22%
District of Columbia	1,559	1,303	-257	-16%
Hawaii	1,236	892	-345	-28%
Idaho	2,763	1,268	-1,495	-54%
Illinois	9,697	6,175	-3,522	-36%
Indiana	9,111	5,355	-3,757	-41%
Iowa	4,059	2,637	-1,423	-35%
Kentucky	9,356	4,996	-4,360	-47%
Louisiana	8,669	4,570	-4,099	-47%
Maine	2,173	1,427	-746	-34%
Maryland	8,142	4,736	-3,406	-42%
Massachusetts	9,124	7,363	-1,761	-19%
Michigan	14,774	8,754	-6,020	-41%
Minnesota	7,309	4,962	-2,347	-32%
Montana	2,266	1,119	-1,148	-51%
Nebraska	2,079	912	-1,167	-56%
Nevada	3,471	2,047	-1,424	-41%
New Hampshire	1,068	629	-439	-41%
New Jersey	7,564	4,131	-3,433	-45%
New Mexico	5,844	3,072	-2,772	-47%
New York	34,812	22,447	-12,365	-36%
North Dakota	560	310	-250	-45%
Ohio	15,202	10,376	-4,826	-32%
Oregon	6,599	3,654	-2,944	-45%
Pennsylvania	16,853	11,086	-5,767	-34%
Rhode Island	1,368	880	-488	-36%
Utah	4,121	2,114	-2,006	-49%
Vermont	1,297	1,071	-226	-17%
Virginia	9,455	4,177	-5,278	-56%
Washington	8,597	4,237	-4,360	-51%
West Virginia	3,254	2,112	-1,142	-35%
Nonexpansion States	**136,693**	**104,195**	**-32,498**	**-24%**
Alabama	5,837	4,538	-1,298	-22%
Florida	25,939	15,257	-10,683	-41%
Georgia	11,562	8,992	-2,569	-22%
Kansas	2,211	1,671	-540	-24%
Mississippi	5,016	4,303	-712	-14%
Missouri	8,289	7,064	-1,225	-15%
North Carolina	16,518	12,622	-3,896	-24%
Oklahoma	5,166	3,920	-1,246	-24%
South Carolina	5,967	4,521	-1,446	-24%
South Dakota	887	650	-237	-27%
Tennessee	9,102	7,509	-1,593	-18%
Texas	34,205	28,572	-5,633	-16%
Wisconsin	5,358	4,250	-1,108	-21%
Wyoming	637	326	-311	-49%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated decreases in federal health care spending conservative.

percent, reflecting the size of the state and the importance of the Medicaid expansion there. Virginia will lose $5.3 billion in federal funding (a 56 percent decrease) with the law overturned, Michigan will lose $6.0 billion (41 percent), and Pennsylvania will lose $5.8 billion (34 percent).

Implications for Providers. Table 4 highlights the financial implications of decreased spending on health care (both public and private) to different types of health care providers. As the number of insured people falls under ACA repeal, so will spending on various types of medical care. We estimate that health care spending will fall by $135 billion nationally. Of that, $56 billion is attributable to lower spending on hospitals, $17 billion owes to lower spending on physician care, $30 billion owes to lower spending on pharmaceuticals, and $33 billion owes to lower spending on other medical services. These decreases will be spread across the country, but some of the largest percent decreases will be seen in New Mexico, a very low–income state that has benefited considerably from the ACA's Medicaid expansion, as well as Montana, Louisiana, Kentucky, and Idaho. These states all expanded Medicaid under the ACA and had high pre-ACA uninsurance rates.

Given a 69 percent increase in the number of uninsured people in the United States, overturning the ACA will greatly increase the demand for uncompensated medical care, or care provided without payment from the patient or an insurer. How much of this increased need for uncompensated care would be met is unclear, particularly given increasing financial pressures on state governments due to the pandemic that will likely last years. Health care providers cannot feasibly meet all or even most of this increased need. We estimate that the demand for uncompensated care will increase by $58 billion in 2022, or 74 percent, should the ACA be overturned (Table 5). This increased demand would be distributed across different health care providers: $17 billion for hospitals, $7 billion for physicians, $12 billion for pharmaceutical manufacturers, and $22 billion for other provider types.

Conclusion

The Supreme Court can invalidate the entire ACA via *California v. Texas.* If the court sides with Texas and eliminates the ACA, the consequences will be felt throughout the U.S. health care system. Many of these implications are beyond our ability to measure. Here, we estimate the impact of overturning the law on health insurance coverage and federal spending on health care. We also show how a 69 percent increase in the number of uninsured Americans would affect spending on health care providers of different types, as well as the demand for uncompensated care. The implications of reduced federal spending and an additional 21 million uninsured people would be particularly pronounced as the recession abates. In addition, higher levels of demand for an array of public services and lower state and local tax revenues will continue for some time, making it difficult for state and local governments to increase funding enough to meet these demands, let alone support replacing lost coverage.

Thus, invalidating the ACA will have massive financial consequences for health care providers and households, and millions of people will experience reduced access to necessary medical care. However, some legislative mechanisms could help eliminate these eventualities before a Supreme Court decision is issued: Congress can pass and the president can sign legislation eliminating the now-toothless individual mandate while explicitly retaining the remainder of the law. Alternatively, a law could reinstate a more modest individual mandate penalty, a step that could also make the case moot.

Methodology Appendix

Given uncertain economic conditions in 2020, owing to the COVID-19 pandemic and consequent recession and its rapid evolution, we opted to simulate the consequences of overturning the ACA using a 2022 current-law baseline, a year when conditions should be more stable. In doing so, we assume, consistent with Congressional Budget Office projections,[3] that the economy will have partly recovered from the pandemic recession by that time. We assume the characteristics of people who remain unemployed at that time are largely consistent with the distribution identified in U.S. Department of Labor data from August 2020, which showed clearly that higher-wage jobs had recovered to a much greater extent than had lower-wage jobs.

The simulations account for relevant state regulations, such as banning short-term, limited-duration plans.[6] Our current-law estimates account for the federal individual mandate penalties being set to $0 beginning in plan year 2019, as well as the fact that California, the District of Columbia, Massachusetts, and New Jersey have their own individual mandate penalties. We treat Missouri and Oklahoma, where the ACA Medicaid expansion has been approved by ballot initiative but not yet implemented, as nonexpansion states. We do this because the political environments surrounding expansion, even once ballot initiatives are passed, remain uncertain, and the timing and implementation of these expansions are therefore still unknown.

The current version of HIPSM is calibrated to state-specific targets for marketplace enrollment following the 2020 open enrollment period, 2020 marketplace premiums, and late 2019 Medicaid enrollment from the Centers for Medicare & Medicaid Services monthly enrollment snapshots. Aging our projections to 2022 involved several steps. First, we aged the 2020 population to 2022 using projections from the Urban Institute's Mapping America's Futures program. We then inflated incomes and health costs to 2022. Because the pandemic has reduced use of expensive care, we assume costs for private nongroup health insurance and Medicaid are flat in 2021 but return to default inflation assumptions in 2022.[7,8] Under our default assumptions, we estimate Medicaid will grow at 5 percent annually, private premiums will grow at 6 percent, and out-of-pocket spending and uncompensated care will grow at 3 percent.

Other ACA provisions that affect Medicare, payment and delivery system reform, support for community health centers, and preventive care initiatives will be eliminated if the ACA is fully invalidated. As with our prior analyses, we do not analyze elimination of those provisions here. We estimate the impacts of the ACA coverage provisions being overturned, comparing them with insurance coverage and health care spending under current law at the national and state levels.

Table 4. Health Care Spending by Insurers (Public and Private) and Households on Acute Care for the Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022

	Current Law				
	Total health care spending (millions of $)	Hospitals (millions of $)	Physician services (millions of $)	Prescription drugs (millions of $)	Other services (millions of $)
Total	**1,925,293**	**678,397**	**308,464**	**431,903**	**506,528**
Expansion States	**1,302,043**	**457,631**	**207,581**	**292,574**	**344,257**
Alaska	4,801	1,694	756	1,052	1,299
Arizona	42,215	14,913	6,662	9,538	11,101
Arkansas	17,819	6,375	2,789	4,041	4,614
California	226,374	78,800	36,020	51,207	60,347
Colorado	33,830	11,657	5,548	7,521	9,105
Connecticut	24,335	8,346	3,843	5,604	6,542
Delaware	6,367	2,256	1,006	1,444	1,661
District of Columbia	4,828	1,763	749	1,064	1,252
Hawaii	7,178	2,563	1,145	1,611	1,859
Idaho	10,361	3,701	1,621	2,331	2,707
Illinois	71,159	24,657	11,652	15,868	18,982
Indiana	41,227	14,644	6,540	9,271	10,772
Iowa	20,115	7,012	3,273	4,462	5,368
Kentucky	28,037	10,039	4,330	6,412	7,256
Louisiana	26,855	9,737	4,098	6,136	6,884
Maine	8,347	2,926	1,306	1,943	2,172
Maryland	36,876	12,841	5,897	8,297	9,840
Massachusetts	43,679	15,432	7,035	9,691	11,521
Michigan	59,331	21,009	9,311	13,505	15,506
Minnesota	39,475	13,777	6,366	8,770	10,563
Montana	6,727	2,410	1,056	1,511	1,749
Nebraska	11,626	4,046	1,894	2,567	3,120
Nevada	17,134	6,072	2,760	3,846	4,455
New Hampshire	8,195	2,783	1,348	1,861	2,203
New Jersey	52,002	17,642	8,627	11,668	14,064
New Mexico	13,205	4,811	1,985	3,013	3,396
New York	121,564	44,183	18,962	26,991	31,428
North Dakota	4,352	1,518	722	937	1,175
Ohio	70,564	24,928	11,168	15,966	18,501
Oregon	25,876	9,049	4,097	5,871	6,859
Pennsylvania	82,747	29,049	13,323	18,515	21,860
Rhode Island	6,141	2,141	990	1,382	1,628
Utah	20,024	6,997	3,258	4,278	5,492
Vermont	4,756	1,706	732	1,085	1,232
Virginia	48,923	17,021	7,913	10,968	13,022
Washington	44,676	15,406	7,221	9,976	12,074
West Virginia	10,324	3,728	1,579	2,369	2,648
Nonexpansion States	**623,250**	**220,766**	**100,883**	**139,330**	**162,271**
Alabama	26,271	9,348	4,210	5,898	6,816
Florida	107,615	37,905	17,301	24,620	27,789
Georgia	58,199	20,500	9,510	12,978	15,211
Kansas	16,522	5,743	2,747	3,629	4,403
Mississippi	16,802	6,152	2,639	3,772	4,239
Missouri	38,215	13,743	6,130	8,545	9,797
North Carolina	63,372	22,604	10,182	14,164	16,422
Oklahoma	21,820	7,821	3,478	4,873	5,648
South Carolina	26,559	9,450	4,266	5,997	6,846
South Dakota	5,139	1,812	838	1,130	1,358
Tennessee	39,550	14,042	6,331	8,916	10,261
Texas	163,857	58,005	26,803	36,002	43,047
Wisconsin	35,739	12,380	5,860	8,012	9,487
Wyoming	3,591	1,261	588	794	949

continued

Table 4. Health Care Spending by Insurers (Public and Private) and Households on Acute Care for the Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022 (continued)

	Change if ACA is Overturned									
	Total health care spending		Hospitals		Physician services		Physician services		Other services	
	Millions of $	%	Millions of $	%	Millions of $	%	Millions of $	%	Millions of $	%
Total	**-135,460**	**-7%**	**-55,934**	**-8%**	**-17,214**	**-6%**	**-29,681**	**-7%**	**-32,632**	**-6%**
Expansion States	**-108,839**	**-8%**	**-44,862**	**-10%**	**-13,119**	**-6%**	**-24,235**	**-8%**	**-26,623**	**-8%**
Alaska	-470	-10%	-190	-11%	-59	-8%	-105	-10%	-116	-9%
Arizona	-1,804	-4%	-674	-5%	-252	-4%	-431	-5%	-447	-4%
Arkansas	-1,968	-11%	-836	-13%	-221	-8%	-434	-11%	-477	-10%
California	-25,436	-11%	-10,361	-13%	-3,056	-8%	-5,781	-11%	-6,237	-10%
Colorado	-2,825	-8%	-1,218	-10%	-344	-6%	-612	-8%	-651	-7%
Connecticut	-1,929	-8%	-776	-9%	-219	-6%	-445	-8%	-489	-7%
Delaware	-232	-4%	-90	-4%	-35	-4%	-55	-4%	-52	-3%
District of Columbia	-249	-5%	-100	-6%	-25	-3%	-56	-5%	-68	-5%
Hawaii	-166	-2%	-62	-2%	-22	-2%	-40	-2%	-41	-2%
Idaho	-1,489	-14%	-600	-16%	-180	-11%	-345	-15%	-364	-13%
Illinois	-3,483	-5%	-1,472	-6%	-429	-4%	-739	-5%	-842	-4%
Indiana	-3,734	-9%	-1,574	-11%	-431	-7%	-829	-9%	-899	-8%
Iowa	-1,183	-6%	-504	-7%	-144	-4%	-256	-6%	-279	-5%
Kentucky	-4,167	-15%	-1,714	-17%	-469	-11%	-964	-15%	-1,021	-14%
Louisiana	-4,027	-15%	-1,682	-17%	-453	-11%	-921	-15%	-972	-14%
Maine	-776	-9%	-309	-11%	-101	-8%	-177	-9%	-189	-9%
Maryland	-3,283	-9%	-1,337	-10%	-400	-7%	-750	-9%	-797	-8%
Massachusetts	-901	-2%	-414	-3%	-146	-2%	-133	-1%	-207	-2%
Michigan	-6,109	-10%	-2,480	-12%	-709	-8%	-1,392	-10%	-1,528	-10%
Minnesota	-2,105	-5%	-924	-7%	-248	-4%	-417	-5%	-516	-5%
Montana	-1,225	-18%	-503	-21%	-148	-14%	-280	-19%	-294	-17%
Nebraska	-989	-9%	-390	-10%	-119	-6%	-232	-9%	-248	-8%
Nevada	-1,368	-8%	-566	-9%	-165	-6%	-300	-8%	-338	-8%
New Hampshire	-421	-5%	-172	-6%	-53	-4%	-95	-5%	-102	-5%
New Jersey	-3,748	-7%	-1,514	-9%	-467	-5%	-835	-7%	-933	-7%
New Mexico	-2,792	-21%	-1,107	-23%	-304	-15%	-670	-22%	-711	-21%
New York	-5,174	-4%	-2,279	-5%	-728	-4%	-916	-3%	-1,250	-4%
North Dakota	-237	-5%	-106	-7%	-30	-4%	-48	-5%	-53	-5%
Ohio	-4,682	-7%	-1,945	-8%	-533	-5%	-1,071	-7%	-1,134	-6%
Oregon	-2,921	-11%	-1,214	-13%	-355	-9%	-648	-11%	-704	-10%
Pennsylvania	-5,594	-7%	-2,284	-8%	-686	-5%	-1,222	-7%	-1,403	-6%
Rhode Island	-460	-7%	-195	-9%	-54	-5%	-98	-7%	-114	-7%
Utah	-2,039	-10%	-814	-12%	-259	-8%	-460	-11%	-506	-9%
Vermont	-145	-3%	-58	-3%	-23	-3%	-27	-2%	-36	-3%
Virginia	-5,268	-11%	-2,145	-13%	-626	-8%	-1,223	-11%	-1,274	-10%
Washington	-4,358	-10%	-1,801	-12%	-499	-7%	-994	-10%	-1,064	-9%
West Virginia	-1,081	-10%	-452	-12%	-125	-8%	-237	-10%	-266	-10%
Nonexpansion States	**-26,621**	**-4%**	**-11,072**	**-5%**	**-4,096**	**-4%**	**-5,445**	**-4%**	**-6,009**	**-4%**
Alabama	-952	-4%	-405	-4%	-144	-3%	-190	-3%	-213	-3%
Florida	-9,364	-9%	-3,771	-10%	-1,446	-8%	-1,959	-8%	-2,186	-8%
Georgia	-2,026	-3%	-863	-4%	-310	-3%	-404	-3%	-449	-3%
Kansas	-421	-3%	-174	-3%	-63	-2%	-93	-3%	-91	-2%
Mississippi	-482	-3%	-207	-3%	-74	-3%	-97	-3%	-104	-2%
Missouri	-962	-3%	-415	-3%	-149	-2%	-187	-2%	-211	-2%
North Carolina	-3,226	-5%	-1,334	-6%	-488	-5%	-680	-5%	-724	-4%
Oklahoma	-921	-4%	-383	-5%	-139	-4%	-194	-4%	-205	-4%
South Carolina	-1,126	-4%	-474	-5%	-172	-4%	-228	-4%	-252	-4%
South Dakota	-128	-2%	-57	-3%	-19	-2%	-22	-2%	-29	-2%
Tennessee	-1,318	-3%	-558	-4%	-196	-3%	-268	-3%	-295	-3%
Texas	-4,523	-3%	-1,935	-3%	-704	-3%	-894	-2%	-990	-2%
Wisconsin	-916	-3%	-388	-3%	-149	-3%	-177	-2%	-202	-2%
Wyoming	-255	-7%	-107	-8%	-40	-7%	-51	-6%	-57	-6%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. Estimates assume that Medicaid coverage expansion waivers in place in 7 states prior to the ACA are reinstated. It is likely that at least some of thes waivers will not be reinstated, however, making our estimated decreases in federal health care spending conservative.

Table 5. Uncompensated Care Sought under Current Law and If the ACA Is Overturned, by Type of Service, 2022

	Total uncompensated care	Hospitals	Physician services	Prescription drug manufacturers	Other services
Current law (millions of $)	78,501	22,171	10,081	16,033	30,217
ACA is overturned (millions of $)	136,462	39,558	16,962	28,016	51,927
Difference (millions of $)	57,961	17,387	6,881	11,983	21,710
Percent difference	74%	78%	68%	75%	72%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program.
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

We present estimated effects of ACA repeal assuming pre-ACA Medicaid Section 1115 coverage expansion waivers will be reinstated. We therefore likely underestimate the number of people who will become uninsured and the amount of federal health care dollars that will be lost if the law is overturned. Before the ACA, seven states received federal Section 1115 waivers to expand eligibility for Medicaid coverage; most often, these states had demonstrated that their expansion would be budget neutral for the federal government because savings would accrue from moving Medicaid enrollees into managed-care organizations. The seven states were Arizona, Delaware, Hawaii, Massachusetts, New York, Vermont, and Wisconsin. Because the ACA made these waivers obsolete in states that expanded Medicaid, not all waivers, or the coverage aspects of the waivers, have been renewed since 2014. If the ACA is overturned and not all state waivers are reinstated, Medicaid eligibility in the nonrenewed states will shift back to its pre–waiver implementation level. These states would be able to apply to renegotiate their waivers with the federal government, but the outcome would be uncertain. First, states would have to be willing and able to invest the time and expenses involved with the waiver. Second, it is unclear what terms the Trump administration would agree to. And third, it is unclear whether states would be able to show that their new waivers would be budget neutral to the federal government, given changes in circumstances since the waivers' original approval and intervening changes in the administration's calculation of budget neutrality. It is also possible that, if the ACA is overturned and the Trump administration has a second term, invalidation of the law could be used to introduce large-scale changes to Medicaid the current administration now encourages through waivers, such as the imposition of work requirements. We did not simulate any such changes to the program.

Health care spending data used in HIPSM come from the Medical Expenditure Panel Survey Household Component and other sources. We estimate total health care spending for each person represented in HIPSM for each possible health insurance status; these estimates of spending control for a broad array of sociodemographic variables and health statuses. Using the Medical Expenditure Panel Survey Household Component, we then compute the share of individual health expenditures attributable to each type of care (hospital, office-based physician, prescription drugs, other) by individual characteristics (health insurance coverage, age, gender, income, and health status). The percentage of spending assigned to each provider type is then imputed to the individuals represented in HIPSM.

Though the ACA reduced the volume of uncompensated care by reducing the number of uninsured people, uncompensated care is currently funded in several ways:

- Medicaid disproportionate share hospital (DSH) and upper payment limit programs
- Medicare DSH payments
- Veterans Health Administration
- other federal programs
- state and local government programs
- private programs, such as patient assistance programs providing free or reduced-cost prescription drugs to those who qualify
- charity care and bad debt absorbed by health care providers

HIPSM estimates the demand for uncompensated care by people who are uninsured or underinsured based on pre-ACA data. Coughlin and colleagues estimated that, in 2013, the federal government funded about 39 percent of uncompensated care through programs such as Medicaid and Medicare DSH payments, state and local governments funded 24 percent, and health care providers funded 37 percent.[9] It is unclear how willing or able different levels of government and different providers will be to increase funding for such care if the ACA is overturned. Current patterns of uncompensated care use may not persist if, for example, large increases in the number of uninsured people are not met with commensurate increases in government funding or provider contributions of free or reduced-price care. Consequently, we discuss estimated amounts of care (based on recent patterns of uncompensated care use) as the value of care sought by the newly uninsured, not the value of the uncompensated care they would actually receive.

ENDNOTES

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