



Medicaid Expansion Would Have a Larger Impact Than Ever during the COVID-19 Pandemic

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As of December 2020, 36 states and the District of Columbia had expanded Medicaid eligibility under the Affordable Care Act (ACA). We find that if the remaining 14 states had expanded eligibility in 2020, 4.4 million fewer people would have been uninsured that year. Absent the COVID-19 pandemic, the difference would have been 3.8 million. Thus, Medicaid expansion in the remaining states would increase health coverage even more under the pandemic. We also find young adults have the highest uninsurance rates under current law and would gain more coverage from Medicaid expansion than any other age group. And though further expansion would not increase the already high Medicaid eligibility thresholds for children, more children would be enrolled as their parents seek such coverage.

A growing body of literature shows Medicaid expansion has benefits beyond increasing health coverage, such as saving lives and increasing financial security. Expanded Medicaid eligibility has also resulted in net savings to many of the states that have expanded, which is even more important now given the strain the pandemic has placed on state and local budgets. And because states that have recently expanded Medicaid have often done so relatively quickly, it is not too late to expand eligibility during this time of increased need.

Introduction

Medicaid expansion to nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL) has been the most important ACA-related state policy decision since the Supreme Court made it an option in 2011. As of December 2020, 36 states and the District of Columbia had expanded Medicaid eligibility, whereas the remaining 14 states had not. These nonexpansion states are Alabama, Georgia, Florida, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Voters in two of these states, Missouri and Oklahoma, approved Medicaid expansion through referenda in 2020, but the expansions have not yet been implemented. In other states that have passed similar referenda, opposition from the governor and/or the state legislature delayed implementation by up to two years. Thus, it is unclear when eligible Missouri and Oklahoma residents can start enrolling in an expanded Medicaid program.

In other work, we estimated Medicaid expansion in these states would have reduced the number of uninsured people by 3.8 million in 2020, absent the pandemic (Simpson 2020). Nebraska expanded Medicaid after that brief was published, so we treat it as an expansion state here. However, the pandemic has led to job losses and substantial changes in health coverage and eligibility for Medicaid (Banthin et al. 2020). In this brief, we update our earlier estimates, accounting for the impact of the pandemic. We now find Medicaid expansion in the 14 remaining states could have reduced the number of uninsured people by 4.4 million in 2020, 600,000 more than we estimated absent the pandemic. Here, we also focus for the first time on how Medicaid expansion affects young adults, finding they currently have the highest uninsurance rates of any age group and would gain the most health coverage under expansion.

Methods

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) for our analysis (Buettgens and Banthin 2020). 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*.¹ HIPSM is based on two years of the American Community Survey, and the population is aged to future years using projections from the latest available American Community Survey and the Urban Institute's Mapping America's Futures program.² 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.

For this analysis, we estimate the impact of pandemic-related job losses on health coverage and eligibility for Medicaid in 2020, using the same methodology we used in our earlier report on health coverage during the pandemic (Banthin et al. 2020). We then simulate the resulting changes in Medicaid enrollment had the remaining states expanded Medicaid last year. Based on Medicaid

enrollment data from 2019, released by the US Department of Health and Human Services, enrollment experiences in previous Medicaid expansions varied across states;³ using these enrollment data and HIPSM simulation, we estimate slightly more than 72 percent of uninsured people and 13 percent of people with employer-sponsored insurance who gained eligibility under Medicaid expansion had enrolled in the program by 2019.

In this brief, we simulate Medicaid enrollment in 2020 had the remaining 14 states expanded eligibility that year. We limit our analysis to the last three quarters of 2020, since the start of pandemic-related job losses in March. We use 2020 as shorthand for this period. Our estimates account for pandemic-related changes and assume a uniform take-up rate across the new expansion states. As indicated above, we expect 72 percent of the uninsured and 13 percent of those with employer-sponsored insurance who gained Medicaid eligibility in 2020 would have enrolled in the program.

Limitations

In our estimates, we assume the Medicaid take-up rate for new expansion states is the average such rate among current expansion states. However, take-up may vary depending on state decisions we cannot predict: On one hand, newly expanding states could seek waivers for work requirements and lifetime-benefit limits that reduce Medicaid enrollment. On the other hand, such states could be more successful than earlier expansion states with outreach and enrollment assistance. In addition, the pandemic may increase the demand for coverage among those gaining eligibility.

The ultimate impact of the pandemic on employment and health coverage is still highly uncertain, particularly at the start of 2021. The increasing number of COVID-19 cases and additional state restrictions in the final months of 2020 suggest additional effects on employment and earnings this winter. And though recovery is expected when vaccines become widely available, it is impossible to predict the recovery's timing and magnitude.

Results

We first examine the impact of Medicaid expansion on people of all ages. Later, we focus the analysis on young adults and children.

Medicaid Expansion and Overall Health Coverage

We estimate that 14.7 million people living in nonexpansion states were uninsured in an average month in the last three quarters of 2020 (table 1). This represents 15.7 percent of the nonelderly population in those states in 2020, and uninsurance rates were between 12 and 16 percent for all nonexpansion states but Texas and Wisconsin. Texas has long had the highest uninsurance rate in the nation; we estimate nearly one-fifth of the state's nonelderly population was uninsured in 2020. At the other extreme, Wisconsin has a much lower uninsurance rate, about 8 percent. Though it did not

officially expand Medicaid under the ACA, Wisconsin changed Medicaid eligibility rules so adults with incomes up to the federal poverty level would qualify. Thus, Wisconsin already has a partial Medicaid expansion in place. However, if Wisconsin were to formally expand Medicaid under the ACA, adults with incomes between 100 and 138 percent of FPL would gain eligibility. Further, the federal government would pay 90 percent of the costs of Wisconsin adults gaining Medicaid under the expansion, instead of the 59 percent it currently pays for the health care costs of adults with incomes at or below the federal poverty level. Thus, Wisconsin would pay less to cover more people under Medicaid expansion (Simpson 2020).

TABLE 1
Uninsurance in Nonexpansion States under Current Law and Medicaid Expansion,
Overall and by State, 2020

	Current Law		Medicaid Expansion		Change in uninsurance	
	Uninsured people (1,000s)	Uninsurance rate (%)	Uninsured people (1,000s)	Uninsurance rate (%)	1,000s of people	%
All	14,650	15.7	10,206	10.9	-4,444	-30.3
Alabama	499	12.3	279	6.9	-220	-44.1
Florida	2,692	15.9	1,840	10.8	-852	-31.6
Georgia	1,421	15.4	961	10.4	-461	-32.4
Kansas	336	13.6	229	9.2	-107	-32.0
Mississippi	370	14.9	214	8.6	-156	-42.2
Missouri	689	13.5	427	8.4	-263	-38.1
North Carolina	1,213	13.7	835	9.4	-378	-31.2
Oklahoma	546	16.3	362	10.8	-184	-33.7
South Carolina	589	14.1	372	8.9	-217	-36.8
South Dakota	93	12.9	65	9.0	-29	-30.6
Tennessee	754	13.3	506	9.0	-247	-32.8
Texas	4,983	19.8	3,757	14.9	-1,226	-24.6
Wisconsin	395	8.2	312	6.5	-83	-21.1
Wyoming	69	13.8	48	9.6	-21	-30.4

Source: Urban Institute analysis using the Health Insurance Policy Simulation Model for 2020.

Notes: Reform simulated in the last three quarters of 2020. Missouri and Oklahoma had adopted Medicaid expansion but not yet implemented it.

If all 14 nonexpansion states had expanded Medicaid in 2020, we estimate 4.4 million fewer people would have been uninsured—a nearly 30 percent decline. That would have left 10.2 million uninsured people in those states, and the uninsurance rate would have fallen to 10.9 percent. Not surprisingly, Wisconsin’s uninsurance rate would have had the smallest percent reduction. However, Medicaid expansion would still have decreased the number of uninsured Wisconsinites by about 21 percent. The states with the largest reductions in uninsurance would have been Alabama (44.1 percent) and Mississippi (42.2 percent). Though Texas had the highest uninsurance rate, it would have experienced a smaller percent reduction in uninsurance (24.6 percent) than most other states, largely because of the immigration statuses of many uninsured people; not only are undocumented immigrants ineligible for Medicaid, but—unlike the vast majority of states—Texas excludes legally

present immigrant adults from Medicaid eligibility, regardless of how long they have lived in the US (Broder, Moussavian, and Blazer 2015).

Table 2 shows the uninsured population in nonexpansion states by age in 2020. Children had the lowest uninsurance rate by far, at about 6 percent. This largely owes to the already high eligibility thresholds for child Medicaid and the Children’s Health Insurance Program (CHIP) predating the ACA. Young adults (ages 19 to 24) had the highest uninsurance rate, 27.5 percent. They tend to have lower incomes and less access to health coverage through a job than older nonelderly adults (ages 25 to 64), who had an uninsurance rate of about 18 percent in 2020.

TABLE 2
Uninsurance in Nonexpansion States under Current Law and Medicaid Expansion,
by Age Group, 2020

	Current Law		Medicaid Expansion		Change in number of uninsured people	
	Uninsured people (1,000s)	Uninsurance rate (%)	Uninsured people (1,000s)	Uninsurance rate (%)	1,000s of people	%
0-18	1,659	6.1	1,405	5.2	-253	-15.3
19-24	2,479	27.5	1,345	14.9	-1,134	-45.8
25-64	10,513	18.3	7,456	13.0	-3,057	-29.1

Source: Urban Institute analysis using the Health Insurance Policy Simulation Model for 2020.

Note: Reform simulated in the last three quarters of 2020.

Medicaid Expansion and Young Adults

Without further Medicaid expansion, young adults have the highest uninsurance rate of any age group, and they would see the greatest reductions in uninsurance under expansion. If nonexpansion states had expanded Medicaid eligibility in the last three quarters of 2020, uninsurance among young adults in those states would have decreased by 45.8 percent (table 2). In addition, uninsurance would have dropped by 29.1 percent for older nonelderly adults and 15.3 percent for children.

In 2020, the uninsurance rates for young adults in each nonexpansion state were similar to overall uninsurance rates, but their magnitudes were larger. As shown in table 3, Wisconsin had the lowest uninsurance rate for this age group without expansion, 13.1 percent, and Texas the highest, 34.3 percent. Uninsurance rates for young adults in the other nonexpansion states were clustered between 23 and 28 percent. Under Medicaid expansion, Alabama and Mississippi would have had the largest declines in the number of uninsured adults, 59.7 percent and 57.2 percent.

Table 4 shows some demographic and economic characteristics of uninsured young adults and young adults who would gain coverage under further Medicaid expansion. Under current law in 2020, a majority (59 percent) of uninsured young adults were men. And 2020 Marketplace enrollment data show most of those enrolled were women.⁴ In our model, the estimated population eligible for

Marketplace premium tax credits has a roughly equal sex distribution, meaning women are more likely to enroll in Marketplace coverage, whereas men are more likely to go uninsured. Most uninsured young adults (56 percent) were single, and 90 percent did not have children. After gaining Medicaid eligibility, women and families with children would have been more likely to take up coverage than men and single people, who are more likely to remain uninsured. Take-up of Medicaid, which would be free or nearly free, would have been high among all groups. Thus, the distribution of uninsured young adults by sex and family structure would not have differed much under Medicaid expansion in 2020. However, as we have shown, the number of uninsured young adults would have been much lower.

TABLE 3
Uninsurance among Young Adults Ages 19 to 24 in Nonexpansion States under Current Law and Medicaid Expansion, Overall and by State, 2020

	Current Law		Medicaid Expansion		Change in uninsurance	
	Uninsured young adults (1,000s)	Uninsurance rate (%)	Uninsured young adults (1,000s)	Uninsurance rate (%)	1,000s of young adults	%
All	2,479	27.5	1,345	14.9	-1,134	-45.8
Alabama	101	24.8	41	10.0	-60	-59.7
Florida	437	27.3	238	14.9	-199	-45.6
Georgia	246	28.3	128	14.8	-117	-47.8
Kansas	60	24.1	33	13.1	-27	-45.6
Mississippi	70	27.6	30	11.8	-40	-57.2
Missouri	122	24.6	55	11.1	-67	-54.8
North Carolina	206	24.4	121	14.3	-86	-41.5
Oklahoma	94	27.6	49	14.3	-45	-48.1
South Carolina	105	24.4	47	11.0	-58	-55.0
South Dakota	18	24.0	9	12.8	-8	-46.5
Tennessee	118	22.8	56	10.7	-62	-52.9
Texas	832	34.3	494	20.4	-339	-40.7
Wisconsin	58	13.1	37	8.4	-21	-35.7
Wyoming	11	22.7	7	13.9	-4	-38.7

Source: Urban Institute analysis using the Health Insurance Policy Simulation Model for 2020.

Notes: Reform simulated in the last three quarters of 2020. Missouri and Oklahoma had adopted Medicaid expansion but not yet implemented it.

TABLE 4

Characteristics of Uninsured Young Adults Ages 19 to 24 in Nonexpansion States under Current Law and Medicaid Expansion, 2020

	Uninsured under Current Law		Gaining Coverage under Medicaid Expansion		Remaining Uninsured under Medicaid Expansion	
	1,000s of young adults	% of total	1,000s of young adults	% of total	1,000s of young adults	% of total
Total	2,479	100	1,134	100	1,345	100
Sex						
Male	1,459	59	666	59	793	59
Female	1,020	41	468	41	552	41
Race and ethnicity						
American Indian/Alaska Native	51	2	27	2	24	2
Asian/Pacific Islander	75	3	25	2	50	4
Non-Hispanic Black	842	34	278	24	564	42
Hispanic	469	19	292	26	177	13
Non-Hispanic white	1,008	41	499	44	509	38
Other race/ethnicity, non-Hispanic	34	1	14	1	20	1
Education						
Less than high school	262	11	94	8	168	12
High school graduate	1,109	45	555	49	554	41
Some college	823	33	389	34	434	32
College graduate	286	12	97	9	189	14
Family structure						
Single	1,377	56	611	54	766	57
Multiple adults, no children	853	34	408	36	446	33
Parent(s) with children	248	10	115	10	133	10
Family work status						
Family affected by pandemic-related job loss	329	13	213	19	116	9
No worker in the family	423	17	237	21	186	14
Worker(s) in the family but not affected by pandemic-related job loss	1,727	70	685	60	1,042	78
Citizenship status						
Citizen	2,025	82	1,117	99	907	67
Noncitizen	454	18	17	1	437	33

Source: Urban Institute analysis using the Health Insurance Policy Simulation Model for 2020.

Notes: Reform simulated in the last three quarters of 2020. Missouri and Oklahoma had adopted Medicaid expansion but not yet implemented it.

We estimate 70 percent of uninsured young adults either worked or had a worker in their family in 2020, and an additional 13 percent had experienced a pandemic-related job loss in their family. Employment by no means guarantees access to health coverage for young adults. Under Medicaid expansion, about 19 percent of young adults gaining Medicaid coverage would have been affected by a pandemic-related job loss, highlighting Medicaid's increased importance during the crisis.

We estimate most uninsured young adults (82 percent) were US citizens in 2020. Medicaid is not available to undocumented immigrants and most legally present immigrants who have resided in the US for fewer than five years. So, nearly all of those who would have gained coverage under Medicaid expansion would have been citizens.⁵ Consequently, the nearly one-third of young adults remaining uninsured would have been noncitizens.

Medicaid Expansion and Children

Medicaid and CHIP eligibility thresholds for children (from birth to age 18) are already above 138 percent of FPL in all states, so children do not directly gain eligibility under expansion.⁶ However, many of their parents would gain eligibility, and the more parents seek coverage, the more children get covered. Thus, child Medicaid and CHIP participation rates are higher in expansion states than nonexpansion states (Haley et al. 2020).

Examining children’s uninsurance rates by state in 2020 (table 5) shows a different pattern than such rates for young adults (table 3). We estimate 253,000 children would have gained coverage if the remaining states expanded Medicaid in the last three quarters of 2020. These rates largely owe to different eligibility thresholds and participation rates across states (Haley et al. 2020).

TABLE 5
Uninsurance among Children in Nonexpansion States under Current Law and Medicaid Expansion, 2020

	Current Law		Medicaid Expansion		Change in uninsurance	
	Uninsured children (1,000s)	Uninsurance rate (%)	Uninsured children (1,000s)	Uninsurance rate (%)	1,000s of children	%
All	1,659	6.1	1,405	5.2	-253	-15.3
Alabama	23	2.0	18	1.5	-5	-23.0
Florida	257	5.7	229	5.1	-28	-11.0
Georgia	107	3.9	95	3.5	-12	-11.1
Kansas	49	6.5	38	5.0	-11	-22.2
Mississippi	48	6.3	37	4.8	-11	-23.4
Missouri	86	5.8	63	4.3	-24	-27.2
North Carolina	91	3.6	84	3.3	-7	-7.9
Oklahoma	100	9.8	69	6.8	-31	-30.7
South Carolina	54	4.6	47	4.0	-7	-13.5
South Dakota	13	5.8	11	4.8	-2	-16.2
Tennessee	52	3.2	46	2.9	-5	-10.4
Texas	711	9.1	613	7.8	-98	-13.8
Wisconsin	53	3.8	47	3.4	-6	-11.3
Wyoming	14	9.3	9	5.9	-5	-36.0

Source: Urban Institute analysis using the Health Insurance Policy Simulation Model for 2020.

Notes: Children are from birth to age 18. Reform simulated in 2020. Missouri and Oklahoma had adopted Medicaid expansion but not yet implemented it.

Discussion

We find the COVID-19 pandemic has increased the impact of the ACA's Medicaid expansion. If the 14 states that had not expanded Medicaid eligibility in 2020 had done so, the number of uninsured people would have dropped by 4.4 million in the last three quarters of the year, 600,000 more people than we estimated absent the pandemic. Further, young adults would experience the largest gains in health coverage. In states that have not expanded Medicaid, young adults currently have the highest uninsurance rate, 27.5 percent, compared with 18.4 percent of older adults and 6.1 percent of children in such states. If these states had expanded Medicaid eligibility, the number of uninsured young adults would have fallen 45.8 percent, compared with 29.1 percent for older adults and 15.3 percent for children.

Children would have also benefitted from Medicaid expansion, though they currently enjoy relatively low uninsurance rates. But as more parents seek and obtain coverage with expanded Medicaid eligibility, more children will be covered. We estimate 253,000 children in nonexpansion states would have gained coverage under Medicaid expansion in 2020.

Medicaid Expansion Has Many Benefits

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

- **Medicaid expansion saves lives.** At least two studies have found that health coverage under the ACA decreased mortality, and one found a statistically significant reduction in mortality in expansion states compared with nonexpansion states (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2019).
- **Expansion increases the financial security of the uninsured.** Two studies found that Medicaid expansion improved financial security measures, such as credit scores, while reducing financial insecurity measures, such as medical debt collection balances (Caswell and Waidmann 2017; Hu et al. 2016).
- **Expansion improves hospital finances.** Studies have shown this is achieved through lowered uncompensated care costs (Blavin 2017; Dranove, Garthwaite, and Ody 2017).
- **Expansion improves state economies.** A study in Montana found Medicaid expansion led to an additional \$600 million circulating in the state's economy each year, supporting 5,900 to 7,500 jobs and \$350 to \$385 million in personal income (Ward and Bridge 2019).

Medicaid Expansion May Result in Net Savings to State Budgets

The pandemic has severely strained state and local budgets, so assessing the impact of Medicaid expansion on such budgets is critical. Medicaid expansion would not necessarily increase overall state spending; though spending on Medicaid claims would increase because of higher caseloads, states could see both substantial savings and new revenue. These offsets vary considerably by state but include the following:

- State and local governments save on uncompensated care.
- States receive higher federal matching rates for some beneficiaries who, without expansion, would have been covered through pre-ACA Medicaid eligibility categories.⁷
- As the federal government spends more on a state's health care, its economic activity increases, thereby increasing tax revenue.⁸
- State taxes on health care providers and/or health coverage premiums increase revenue.
- Demand decreases for non-Medicaid state-funded programs for uninsured people with low incomes (separate from uncompensated care).

Most states with comprehensive analyses project net fiscal gains from expansion, even after states begin 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 2015); Kentucky (Deloitte 2015); Louisiana (Louisiana Department of Health 2017); Maryland (Sommers and Gruber 2017); Michigan (Ayanian et al. 2017); New Jersey;⁹ New Mexico (Reynis 2016); Oregon (Sommers and Gruber 2017); Pennsylvania (Sommers and Gruber 2017); Virginia (VA DMAS 2018); Washington State (Dorn et al. 2015); and West Virginia (Sommers and Gruber 2017). Ten of these studies covered calendar year 2020 and beyond, when federal funding for Medicaid expansion will reach its final and lowest matching rate (90 percent). Eight of them found Medicaid expansion's impact on the state budget would be positive over that period. Two analyses projected eventual net budget losses, but these results may not be generalizable to other states.¹⁰

Medicaid Expansion Could Be Done Relatively Quickly

The remaining states still have time to expand Medicaid eligibility during the pandemic. Many states that have expanded Medicaid in recent years have done so relatively quickly, in a few weeks to a few months (Blumberg and Mann 2020). The Centers for Medicare & Medicaid Services has reviewed and approved state expansion plans in as little as three weeks after submission. However, implementing Medicaid expansion also requires the cooperation of the governor and the state legislature's approval of a funding plan.

A considerable body of research has documented the benefits of Medicaid expansion, and we find Medicaid expansion in the remaining states would make a greater difference during the pandemic. Many states that have expanded Medicaid eligibility have found it resulted in net savings to the state, which is especially important given the strain the pandemic has placed on state and local budgets. And as noted, it is not too late to expand eligibility for Medicaid during the current crisis.

Notes

- ¹ King v. Burwell, 576 U.S. 988 (2015).
- ² Nan Marie Astone, Steven Martin, H. Elizabeth Peters, Austin Nichols, Kaitlin Franks Hildner, Allison Stolte, and Pam Blumenthal, “Mapping America’s Futures,” Urban Institute, updated December 1, 2017, <http://apps.urban.org/features/mapping-americas-futures>.
- ³ “Medicaid and CHIP: June 2017 Monthly Applications and Eligibility Determinations Updated August 2017,” Centers for Medicare & Medicaid Services, accessed January 7, 2021, <https://www.medicaid.gov/medicaid/downloads/updated-june-2017-enrollment-data.pdf>; and “2019 10 Updated Applications, Eligibility Determinations, and Enrollment Data,” Centers for Medicare & Medicaid Services, accessed January 7, 2021, <https://data.medicaid.gov/Enrollment/2019-10-Updated-applications-eligibility-determina/m3hz-r9mu/data>.
- ⁴ “2020 Marketplace Open Enrollment Period Public Use Files,” Centers for Medicare & Medicaid Services, April 2, 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files>.
- ⁵ As we have noted for Texas, some legal immigrants in a few states are ineligible for Medicaid regardless of length of residency. See Broder, Moussavian, and Blazer (2015).
- ⁶ “Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level,” Henry J. Kaiser Family Foundation, January 1, 2020, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/>.
- ⁷ 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.
- ⁸ Michael Chernew, “The Economics of Medicaid Expansion,” *Health Affairs Blog*, March 21, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20160321.054035/full/>.
- ⁹ In this analysis, we find net reductions in state spending because of expansion; we did not consider revenue effects. See NJ DHS (2016).
- ¹⁰ New Mexico’s analysis projects net state budget gains until state fiscal year 2020–21, when a small net adverse budget impact is anticipated. Reynis (2016) notes its revenue estimates are conservative. In Alaska, net state budget losses are forecasted to start in federal fiscal year 2017. Alaska does not have sales taxes or individual income taxes, so Evans and colleagues (2016) concluded state general revenue would not be affected by expansion-generated economic activity. Every other state collects sales taxes, individual income taxes, or both, so Alaska’s fiscal conditions do not apply to other nonexpansion states; see Lee and colleagues (2015). Lastly, even Alaska collects corporate income tax, but Evans and colleagues did not estimate the impact of expansion on such tax revenues.

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

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