

The Implications of Medicaid Expansion in the Remaining States: 2018 Update

Matthew Buettgens

Timely Analysis of Immediate Health Policy Issues

MAY 2018

In Brief

Under the Affordable Care Act (ACA), states can expand Medicaid eligibility for nonelderly people up to 138 percent of the federal poverty level (FPL). As of March 2018, 31 states and the District of Columbia had expanded and 19 states had not. 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, political efforts to expand Medicaid continue in some of the states that have not done so.

We estimate the following outcomes if the remaining 19 states were to fully implement a Medicaid expansion in 2019 and all else stayed the same:

- Between 4.3 and 4.7 million fewer people would be uninsured, a reduction of between 24 and 26 percent.
- Federal spending on health care would increase by between \$32.1 billion and \$37.8 billion, while
- State spending on Medicaid would increase by between \$2.3 billion and \$3.0 billion.
- 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.

Introduction

Under the Affordable Care Act (ACA), states can expand Medicaid eligibility for nonelderly people up to 138 percent of the federal poverty level (FPL). So far, 31 states and the District of Columbia have taken that option, and 19 states have not. In the nonexpansion states, Medicaid eligibility is very limited for nondisabled, nonpregnant adults, particularly those who do not have dependent children. 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 federal poverty level.¹ 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.

After Congress failed to repeal the ACA in 2017, efforts to expand Medicaid have continued in some nonexpansion states.² Maine voters approved Medicaid expansion in a November 2017 referendum, but Governor LePage has so far resisted implementation. The Virginia legislature concluded its scheduled session in March 2018 without passing a budget because of a deadlock on Medicaid expansion; as of this writing, the legislature was in a special session to resolve the deadlock.

In this report, we estimate the effects of expanding Medicaid on health care coverage and government costs in each of the nonexpansion states in 2019. 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 starting in the 2019 plan year under the Tax Cuts and Jobs Act of 2017. We assume that each nonexpansion state will see enrollment equal to the average rate expected across all current expansion states in 2019. In practice, Medicaid expansion enrollment rates have varied across states, although states that expanded Medicaid after 2014 have generally seen strong enrollment.

Our new estimates of the impact of Medicaid expansion on the number of uninsured people are different from what we published last year^{3,4} and higher than estimates of the “coverage gap” published last year by the Kaiser Family Foundation.⁵ The main reason for this difference is that we compare full expansion with estimates of coverage under current law in 2019. We anticipate that more people will be uninsured in 2019 than in 2016 or 2017 because of the repeal of the individual mandate penalties and because of administrative decisions that have already affected the marketplaces.⁶ Kaiser’s estimates of the “coverage gap” differ for three additional reasons. First, their results are based on data from a different household survey.⁷ All surveys have uncertainty and measurement error, so

some differences are inevitable. Second, Kaiser only counted uninsured adults, but some uninsured children currently eligible for Medicaid would newly enroll as their parents seek coverage. Third, the “coverage gap” can be used to assess the potential impact of Medicaid expansion on the number of uninsured, it is not suited to estimates of new Medicaid enrollment resulting from expansion because not all new enrollees would otherwise be uninsured. Based on marketplace enrollment data, we project that roughly 2 million marketplace enrollees with incomes between 100 and 138 percent of FPL would become eligible for Medicaid under expansion.

Methods

The estimates in this report were produced using the Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. 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 aged to future years using projections from the Urban Institute’s Mapping America’s Futures project. 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 2019 is based on real-world information on Medicaid and marketplace enrollment in each state from the end of the 2018 open enrollment period. The current-law simulation also eliminates the ACA’s individual mandate penalties.⁸ As of March 2018, no data were available on 2018 nongroup enrollment outside the marketplaces, so this was simulated by HIPSM based on the increases in nongroup premiums from 2017 to 2018 and the elimination of individual mandate penalties. Estimates for 2018 are then adjusted to 2019 for projected medical inflation and sociodemographic changes.

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 the end of 2017 released by the Department of Health and Human Services, enrollment experiences appear to have been heterogeneous across states that have expanded Medicaid.⁹ Based on enrollment data and HIPSM simulation, we estimate that around 76 percent of uninsured adults in Medicaid expansion states who gained eligibility had enrolled in Medicaid by 2017, and that this rate would decline to 73 percent by 2019 because of the elimination of individual mandate penalties.

For this report, we simulated enrollment under full Medicaid expansion for three scenarios, each assuming a uniform take-up rate across the new expansion states. We expect that 73 percent of the uninsured who gain Medicaid eligibility would enroll. Thus, expected take-up assumes that new expansion states will have the same take-up as existing expansion states under current law. We assume this rate would be 76 percent in the expected take-up scenario if new

expansion states are more successful than average with outreach and enrollment assistance. We assume a rate of 70 percent in the low take-up scenario, where the elimination of individual mandate penalties affects enrollment more than expected and/or state waivers for work requirements and lifetime benefit limits reduce Medicaid enrollment. We did not model specific waivers because of the uncertainty about which states will apply, which waivers will be approved, and how waivers will be implemented.

We have recently updated our estimated Medicaid costs per person 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 disabled people, nondisabled adults, and nondisabled children.

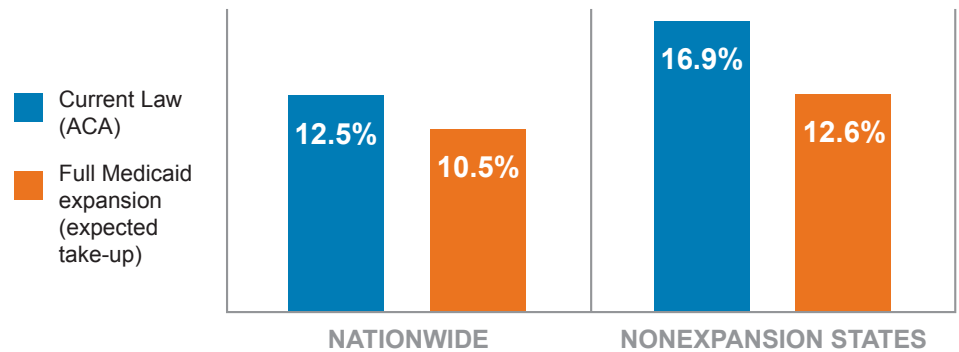
There are several important sources of uncertainty surrounding the impact of Medicaid expansion. First, HIPSM is based on the American Community Survey, which, like all household surveys, contains uncertainty in the accuracy of reported income and health coverage. Second, the baseline for this analysis is current law in 2019. 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 will be eliminated for 2019. The most recent survey data do not reflect these changes. Simulating the 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. We cannot foresee what decisions each state will make, so we produced estimates for each state using the same low, expected, and high take-up assumptions.

Results

Overall health coverage changes (Table 1, Figure 1). If all 19 nonexpansion states expanded Medicaid, 7.4 million more people would be expected to obtain Medicaid coverage. New Medicaid enrollment could range from 7.1 million to 8.0 million, and 4.5 million fewer people would be uninsured. Depending on enrollment, the decline in the number of uninsured people would range from 4.3 million to 4.7 million. The uninsured rate for nonelderly people in nonexpansion states would decline from 16.9 percent to 12.6 percent under expected Medicaid take-up—in other words, consistent with that observed in the current expansion states. Nationwide, the uninsured rate would decline from 12.5 percent to 10.5 percent.

Nearly 2 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 but would be transferred

Figure 1. Uninsured Rates With and Without Full Implementation of Medicaid Expansion 2019



Source: Urban Institute analysis using HIPSIM 2018. Reform simulated in 2019.

to Medicaid. The remainder of the new Medicaid enrollees—1.0 million people with expected take-up, 800,000 with low take-up, and 1.3 million with high take-up—would have had employer coverage or other nongroup coverage without tax credits in the absence of Medicaid expansion (data not shown).

With or without full Medicaid expansion, millions of uninsured people will be eligible for but not enrolled in assistance

to make health coverage more affordable. If all states expanded Medicaid, 6.6 million uninsured people would be eligible for Medicaid or CHIP and 6.1 million would be eligible for marketplace tax credits, under our expected take-up assumptions (data not shown). These uninsured people could be reached by additional outreach efforts or enrollment assistance programs such as express-lane eligibility,¹⁰ or they could enroll when seeking medical care.

Table 1. Health Insurance Coverage Distribution of the Nonelderly Population in Nonexpansion States, 2019

	Current Law (ACA)		Full Implementation of Medicaid Expansion								
			Lower Take-Up			Expected Take-Up			Higher Take-Up		
	Number of people (thous.)	Share of nonelderly population	Number of people (thous.)	Share of nonelderly population	Difference (thous.)	Number of people (thous.)	Share of nonelderly population	Difference (thous.)	Number of people (thous.)	Share of nonelderly population	Difference (thous.)
Insured	88,387	83.1%	92,736	87.2%	4,349	92,925	87.4%	4,538	93,123	87.5%	4,737
Employer	56,311	52.9%	55,658	52.3%	-653	55,487	52.2%	-823	55,144	51.8%	-1,166
Nongroup (with tax credits)	3,878	3.6%	1,990	1.9%	-1,888	1,990	1.9%	-1,888	1,990	1.9%	-1,888
Nongroup (without tax credits)	2,355	2.2%	2,188	2.1%	-167	2,187	2.1%	-168	2,186	2.1%	-169
Medicaid/CHIP	21,646	20.3%	28,703	27.0%	7,057	29,064	27.3%	7,418	29,606	27.8%	7,960
Other (including Medicare)	4,196	3.9%	4,196	3.9%	0	4,196	3.9%	0	4,196	3.9%	0
Uninsured	17,991	16.9%	13,642	12.8%	-4,349	13,453	12.6%	-4,538	13,255	12.5%	-4,737
Total	106,378	100.0%	106,378	100.0%	0	106,378	100.0%	0	106,378	100.0%	0

Source: Urban Institute analysis using HIPSIM 2018. Reform simulated in 2019.

Notes: Higher take-up = 2017 take-up rate across all current expansion states. Expected take-up = HIPSIM-simulated take-up across current expansion states in 2019 without the individual mandate. Lower take-up = lower enrollment because of greater effect of the loss of the mandate and/or state waivers.

Medicaid enrollment by state (Table 2). Under current law, Medicaid and CHIP would cover roughly 20 percent of nonelderly people in the 19 nonexpansion states in 2019, and Medicaid enrollment rates would vary by state because of differences in the states' income distributions and Medicaid eligibility rules. The states with the highest shares of nonelderly people enrolled in Medicaid (22 percent or more) would be Maine, Mississippi, Tennessee, North Carolina, South Carolina, Alabama, and Florida. In Maine and Tennessee, Medicaid

eligibility extends to parents with incomes up to 105 percent and 98 percent of FPL, respectively—much higher than the Medicaid income limits in most other nonexpansion states.¹¹ We project that Virginia, Wyoming, Utah, Nebraska, and Kansas will have the lowest shares of nonelderly people enrolled in Medicaid or CHIP (less than 15 percent).

If all 19 remaining states expanded Medicaid, each state except Wisconsin, Maine, and Tennessee would see Medicaid enrollment increase by 30 percent or

more in the expected take-up scenario. In Wisconsin, all adults with incomes up to 100 percent of FPL are already eligible for Medicaid, and Maine and Tennessee have high eligibility limits for parents. The two highest percent increases in Medicaid enrollment would be in states where an unusually low share of the population is currently enrolled: Wyoming and Utah.

Table 2. Medicaid Enrollment in Nonexpansion States, 2019

State	Current Law (ACA)		Full Implementation of Medicaid Expansion		
	Number of people (thousands)	Share of nonelderly population	Expected Take-Up		
			Number of people (thousands)	Difference	Percent difference
Alabama	928	22.7%	1,242	314	33.8%
Florida	3,639	22.5%	5,001	1,362	37.4%
Georgia	1,873	19.9%	2,599	726	38.8%
Idaho	299	20.5%	418	119	40.0%
Kansas	383	15.3%	512	129	33.7%
Maine	259	25.1%	314	56	21.5%
Mississippi	664	26.7%	874	210	31.6%
Missouri	1,028	20.1%	1,380	352	34.2%
Nebraska	234	14.7%	320	86	36.6%
North Carolina	2,079	23.8%	2,705	626	30.1%
Oklahoma	695	20.5%	927	233	33.5%
South Carolina	906	22.5%	1,218	312	34.5%
South Dakota	125	17.3%	168	43	34.5%
Tennessee	1,435	25.8%	1,817	381	26.6%
Texas	4,726	19.4%	6,412	1,685	35.7%
Utah	371	13.2%	529	158	42.6%
Virginia	983	13.0%	1,406	423	43.0%
Wisconsin	956	19.9%	1,132	176	18.4%
Wyoming	63	12.7%	91	27	43.1%
Total	21,646	20.3%	29,064	7,418	34.3%

Source: Urban Institute analysis using HIPSIM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSIM-simulated take-up across current expansion states in 2019 without the individual mandate.

Change in the number of uninsured people by state (Table 3, Table 4). We project that 16.9 percent of nonelderly people in nonexpansion states will be uninsured in 2019 under current law. Uninsurance rates vary across states because of differences in income distribution, Medicaid eligibility rules, prevalence of employers offering employer-based insurance, state and other organizational involvement in marketplace outreach and enrollment assistance, health care costs, and other

factors. Uninsured rates under current law will vary from 9.1 percent in Wisconsin (which has already expanded Medicaid for adults with incomes up to 100 percent of FPL) to 21.8 percent in Texas. Texas, Oklahoma, Georgia, and Mississippi would have the highest uninsured rates (18 percent or higher).

If all nonexpansion states expanded Medicaid under the ACA, the number of uninsured people would decline by 25.2 percent with expected take-up. Individual

states would see declines ranging from 19.7 percent in Wyoming to 33.9 percent in Mississippi. The uninsurance rate across these 19 states would fall from 16.9 percent to 12.6 percent of the nonelderly population with expected take-up. Only three states would have uninsured rates above the 19-state average: Texas (17.2 percent), Oklahoma (15.2 percent), and Georgia (13.8 percent). Wisconsin, Maine, Tennessee, Missouri, Nebraska, and Idaho would have uninsured rates in the single digits.

Table 3. Uninsured Rate in Nonexpansion States, 2019

State	Current Law (ACA)	Full Implementation of Medicaid Expansion	
		Expected Take-Up	
		Number	Percentage Point Difference
Alabama	17.5%	12.5%	-5.0%
Florida	15.7%	11.1%	-4.5%
Georgia	18.9%	13.8%	-5.0%
Idaho	14.6%	9.9%	-4.7%
Kansas	14.5%	11.2%	-3.3%
Maine	11.6%	8.3%	-3.3%
Mississippi	18.0%	11.9%	-6.1%
Missouri	14.1%	9.8%	-4.3%
Nebraska	12.4%	9.6%	-2.8%
North Carolina	16.3%	12.2%	-4.2%
Oklahoma	19.7%	15.2%	-4.5%
South Carolina	16.4%	11.6%	-4.8%
South Dakota	15.1%	11.5%	-3.5%
Tennessee	13.8%	9.9%	-3.9%
Texas	21.8%	17.2%	-4.6%
Utah	13.3%	10.5%	-2.7%
Virginia	14.2%	10.9%	-3.3%
Wisconsin	9.1%	6.9%	-2.2%
Wyoming	15.7%	12.6%	-3.1%
Total	16.9%	12.6%	-4.3%

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Table 4. Uninsured People in Nonexpansion States, 2019 (thousands of people)

State	Current Law (ACA)	Full Implementation of Medicaid Expansion		
		Expected Take-Up		
		Number	Difference	Percent difference
Alabama	715	510	-205	-28.7%
Florida	2,532	1,798	-734	-29.0%
Georgia	1,778	1,305	-473	-26.6%
Idaho	213	144	-69	-32.3%
Kansas	363	280	-83	-23.0%
Maine	120	86	-34	-28.1%
Mississippi	448	296	-152	-33.9%
Missouri	723	503	-220	-30.4%
Nebraska	197	152	-45	-22.7%
North Carolina	1,430	1,065	-365	-25.5%
Oklahoma	668	515	-153	-22.9%
South Carolina	660	466	-194	-29.3%
South Dakota	109	83	-25	-23.3%
Tennessee	769	552	-216	-28.1%
Texas	5,304	4,180	-1,124	-21.2%
Utah	373	297	-76	-20.4%
Virginia	1,069	823	-247	-23.1%
Wisconsin	441	333	-108	-24.5%
Wyoming	78	63	-15	-19.7%
Total	17,991	13,453	-4,538	-25.2%

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Table 5. Federal Spending on Medicaid, CHIP, and Marketplace Tax Credits in Nonexpansion States, 2019 (\$ million)

State	Current Law (ACA)	Full Implementation of Medicaid Expansion		
		Expected Take-Up		
		Spending	Difference	Percent Difference
Alabama	5,009	6,549	1,540	30.7%
Florida	23,380	27,329	3,949	16.9%
Georgia	10,697	13,711	3,015	28.2%
Idaho	1,981	2,648	667	33.7%
Kansas	1,985	2,505	519	26.2%
Maine	1,939	2,090	151	7.8%
Mississippi	4,411	5,716	1,305	29.6%
Missouri	8,182	10,218	2,036	24.9%
Nebraska	1,864	2,095	231	12.4%
North Carolina	15,155	19,167	4,012	26.5%
Oklahoma	4,724	5,828	1,105	23.4%
South Carolina	5,185	6,524	1,339	25.8%
South Dakota	784	1,022	238	30.3%
Tennessee	9,541	10,327	786	8.2%
Texas	29,219	39,076	9,858	33.7%
Utah	3,618	4,369	751	20.8%
Virginia	6,852	8,961	2,110	30.8%
Wisconsin	5,355	6,099	744	13.9%
Wyoming	567	661	94	16.6%
Total	140,447	174,895	34,448	24.5%

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

Federal spending on Medicaid, CHIP, and marketplaces (Table 5 and Figure 2).

Without any new Medicaid expansions, the federal government would spend \$140.4 billion on Medicaid, CHIP, and marketplace coverage for nonelderly people in nonexpansion states in 2019. If these states expanded Medicaid eligibility, federal spending would rise to \$174.9 billion, a 24.5 percent increase under our expected take-up rate assumptions. But depending on actual take-up, the increase in federal spending could range from \$32.1 billion to \$37.8 billion, or from 22.9 percent to 26.9 percent.

Nonexpansion states with the lowest increases in federal spending have a few distinguishing features:

1. **Higher-than-average current Medicaid eligibility limits for parents.** We have already discussed Medicaid eligibility in Wisconsin, Maine, and Tennessee. Wyoming and Nebraska also have higher-than-average Medicaid eligibility limits for adult parents, covering those with incomes up to 55 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, Maine, Nebraska).

The opposite characteristics—lower parent Medicaid eligibility limits, lower marketplace tax credit savings, and higher current uninsured rates—lead to larger increases in federal spending. For example, Texas has the highest uninsured rate and is tied for the largest increase in federal spending.

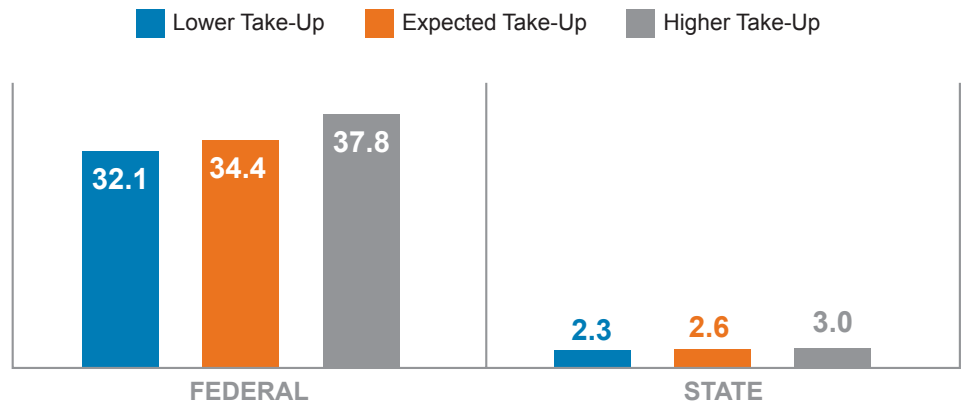
State spending on Medicaid and CHIP (Table 6 and Figure 2).

Under current law, nonexpansion states will spend \$62.2 billion on Medicaid and CHIP acute care for the nonelderly in 2019. If these 19 states expanded Medicaid eligibility, state spending on Medicaid would rise by \$2.6 billion, or 4.2 percent. Depending on enrollment, the increase in state spending could range from \$2.3 billion to \$3.0 billion, or from

3.7 percent to 4.8 percent. The expected 4.2 percent increase in state Medicaid costs is small, despite the projected 34.3 percent increase in Medicaid enrollment, because the federal government would pay 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. Evidence from the expansion states for which comprehensive analyses are available indicates that Medicaid expansion had a net positive budgetary impact.

In Wisconsin, state spending on Medicaid and CHIP would decline after Medicaid expansion (4.0 percent under expected take-up) because the federal government would pay a higher share of the costs

Figure 2. Difference in Federal and State Medicaid Spending with Full Medicaid Expansion, 2019 (\$ billions)



Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Higher take-up = 2017 take-up rate across all current expansion states. Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate. Lower take-up = lower enrollment because of greater effect of the loss of the mandate and/or state waivers.

Table 6. State Spending on Medicaid and CHIP in Nonexpansion States, 2019 (\$ millions)

State	Current Law (ACA)	Full Implementation of Medicaid Expansion		
		Expected Take-Up		
		Spending	Difference	Percent Difference
Alabama	1,683	1,780	97	5.7%
Florida	9,577	9,763	187	2.0%
Georgia	3,927	4,172	246	6.3%
Idaho	569	608	39	6.9%
Kansas	1,050	1,108	58	5.5%
Maine	859	884	25	3.0%
Mississippi	1,441	1,535	93	6.5%
Missouri	3,998	4,099	101	2.5%
Nebraska	768	804	36	4.7%
North Carolina	5,673	5,785	112	2.0%
Oklahoma	1,921	2,038	117	6.1%
South Carolina	1,631	1,742	111	6.8%
South Dakota	490	512	22	4.5%
Tennessee	3,776	3,967	191	5.0%
Texas	16,707	17,692	984	5.9%
Utah	975	1,042	67	6.9%
Virginia	4,207	4,401	193	4.6%
Wisconsin	2,666	2,559	-107	-4.0%
Wyoming	304	319	15	4.9%
Total	62,222	64,808	2,586	4.2%

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: Expected take-up = HIPSM-simulated take-up across current expansion states in 2019 without the individual mandate.

of some existing Medicaid enrollees. Wisconsin is currently receiving the standard 58.77 percent federal matching rate for nondisabled adults with incomes up to 100 percent of FPL.¹² If the state expanded Medicaid, the federal government would pay 90 percent of the costs of adult nonparents in this group, in addition to paying 58.77 percent of the costs of adult parents. The state's savings on nondisabled, nonparent adults more than outweighs the additional costs of new enrollees.

Potential reductions in uncompensated care spending (Table 7). Uncompensated care has declined in Medicaid expansion states.^{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. 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 any new Medicaid expansions, uncompensated care for uninsured people in nonexpansion states would total \$35.5 billion in 2019. We estimate that the federal government will fund \$14.2 billion of this total, state and local

governments \$8.9 billion, and health care providers \$12.4 billion.¹⁵

If all the nonexpansion states expanded Medicaid, the demand for uncompensated care in these 19 states would decline by \$8.0 billion under expected take-up (estimates range from \$7.8 billion to \$8.4 billion). The federal government would potentially save \$3.2 billion, state and local governments \$2.0 billion, and providers \$2.8 billion. This is only one of several state cost offsets for Medicaid expansion.

Discussion

If all 19 nonexpansion states fully implemented the Medicaid expansion, 4.5 million more people would be enrolled in health coverage in 2019, reducing the nonelderly uninsured rate in those states from 16.9 percent to 12.6 percent, and reducing the national uninsured rate from 12.5 percent to 10.5 percent. With full expansion, 6.6 million uninsured people nationwide would be eligible for but not enrolled in Medicaid, and 6.1 million uninsured people would be eligible for marketplace premium tax credits, leaving room for additional outreach and enrollment activities to lower the uninsurance rate further.

The resulting increase in Medicaid enrollment would increase federal spending on health care financial assistance by an estimated \$34.4 billion. This increase in spending on health

care could have positive impacts on the economies of the affected states, particularly in states running at less than full employment. For example, a recent study in Montana found that Medicaid expansion led to an additional \$350 to \$400 million circulating in the state's economy each year, supporting 5,000 jobs and \$280 million in personal income.¹⁶

If all the nonexpansion states expanded Medicaid, these states' spending on Medicaid would increase by \$2.6 billion—but that does not account for the full budgetary impact. Medicaid expansion could yield savings in other areas:

- \$2.0 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 categories¹⁷
- 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 recent study covering all expansion states found that as of 2015, "there were no significant increases in

Table 7. Uncompensated Care in Nonexpansion States by Payer, 2019 (\$ 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	14,200	11,100	-3,100	11,000	-3,200	10,800	-3,400
State/local government	8,900	6,900	-2,000	6,900	-2,000	6,800	-2,100
Health care providers	12,400	9,700	-2,700	9,600	-2,800	9,500	-2,900
Total	35,500	27,700	-7,800	27,500	-8,000	27,100	-8,400

Source: Urban Institute analysis using HIPSIM 2018. Reform simulated in 2019.

Notes: Higher take-up = 2017 take-up rate across all current expansion states. Expected take-up = HIPSIM-simulated take-up across current expansion states in 2019 without the individual mandate. Lower take-up = lower enrollment because of greater effect of the loss of the mandate and/or state waivers.

spending from state funds as a result of the expansion.”¹⁸ 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,¹⁹ Alaska,²⁰ California,¹⁹ Colorado,²¹ the District of Columbia,¹⁹ Kentucky,²² Maryland,¹⁹ Michigan,¹⁹ New Jersey,²³ New Mexico,²⁴ Oregon,¹⁹ Pennsylvania,¹⁹ Washington State,²⁵ and West Virginia.¹⁹ 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.²⁶

Several states are seeking changes to their Medicaid programs such as work requirements and lifetime benefit limits.²⁷ 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.

The research shows that, compared with nonexpansion states, Medicaid

expansion states have seen larger declines in the number of uninsured people, lower uncompensated care, economic benefits from additional health care spending, and net gains to state budgets. There is also evidence that state cost increases resulting from higher caseloads are outweighed by state savings and revenue growth caused by expansion in most states with available data. 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 19 nonexpansion states would see similar benefits if they expanded Medicaid eligibility.

NOTES

- 1 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 Supreme Court’s decision in *National Federation of Independent Business v. Sebelius* (2012) effectively made the ACA’s Medicaid expansion voluntary for states. 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.
- 2 For more on how recent administrative actions would affect health coverage, see: Blumberg LJ, Buettgens M, Wang R. Updated: the potential impact of short-term limited duration policies on insurance coverage, premiums, and federal spending. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending>.
- 3 Buettgens M, Kenney GM. What if more states expanded Medicaid in 2017? Changes in eligibility, enrollment, and the uninsured. Washington: Urban Institute; 2017. <https://www.urban.org/research/publication/what-if-more-states-expanded-medicaid-2017-changes-eligibility-enrollment-and-uninsured>.
- 4 Dorn S, Buettgens M. The cost of not expanding Medicaid: an updated analysis. Washington: Urban Institute; 2017. <https://www.urban.org/research/publication/cost-not-expanding-medicaid-updated-analysis>.
- 5 Garfield R, Damico A. The coverage gap: uninsured poor adults in states that do not expand Medicaid. Menlo Park, CA: Kaiser Family Foundation; 2017. <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.
- 6 Blumberg LJ, Buettgens M, Wang R. Updated: the potential impact of short-term limited duration policies on insurance coverage, premiums, and federal spending. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending>.
- 7 Specifically, Kaiser’s estimates are based on the Current Population Survey. The data underlying HIPSIM are based on the American Community Survey, and HIPSIM simulation results replicate the latest available estimates of the uninsured population from the National Health Interview Survey.
- 8 For details on how HIPSIM simulates the ACA’s individual mandate, see: Blumberg LJ, Buettgens M, Wang R. Updated: the potential impact of short-term limited duration policies on insurance coverage, premiums, and federal spending. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending>.
- 9 Centers for Medicare & Medicaid Services. Medicaid & CHIP: June 2015 monthly applications, eligibility determinations and enrollment report. Baltimore: Centers for Medicare & Medicaid Services; 2015. <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2015-enrollment-report.pdf>.
- 10 Centers for Medicare & Medicaid Services. Re: express lane eligibility option. Baltimore: Centers for Medicare & Medicaid Services; 2010. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho10003.pdf>.
- 11 Kaiser Family Foundation. Where are states today? Medicaid and CHIP eligibility levels for children, pregnant women, and adults. Menlo Park, CA: Kaiser Family Foundation. <https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>.
- 12 Federal financial participation in state assistance expenditures; federal matching shares for Medicaid, the Children’s Health Insurance Program, and aid to needy aged, blind, or disabled persons for October 1, 2017 through September 30, 2018. *Fed Regist.* 2016;81(220):80078–80080.
- 13 Dranove D, Garthwaite C, Ody C. The impact of the ACA’s Medicaid expansion on hospitals’ uncompensated care burden and the potential effects of repeal. New York: Commonwealth Fund; 2017. <http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medicaid-expansion-hospital-uncompensated-care>.
- 14 Antonisse L, Garfield R, Rudowitz R, Artiga S. The effects of Medicaid expansion under the ACA: updated findings from a literature review. Menlo Park, CA: Kaiser Family Foundation; 2018. <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/>. See also the state-specific analyses cited in the Discussion section.
- 15 These proportions are based on analysis of uncompensated care in 2013: Coughlin TA, Holahan J, Caswell K, McGrath M. *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*. Menlo Park, CA: Kaiser Family Foundation; 2014. <https://www.urban.org/research/publication/uncompensated-care-uninsured-2013>.
- 16 Ward B, Bridge B. The economic impact of Medicaid expansion in Montana. Missoula: University of Montana, Bureau of Business and Economic Research. <http://governor.mt.gov/Portals/16/Ward%20Presentation%20to%20MT%20HELP%20Oversight%20Cmte%20March%202018.pdf>.

- 17 We incorporated these beneficiaries into our estimates to the extent that they could be identified. Some eligibility groups, such as the medically needy, are difficult to identify using survey data.
- 18 Sommers BD, Gruber J. Federal funding insulated state budgets from increased spending related to Medicaid expansion. *Health Aff.* 2017;36(5):938–944. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1666>.
- 19 Bachrach D, Boozang P, Herring A, Reyneri DG. States expanding Medicaid see significant budget savings and revenue gains. Princeton, NJ: Robert Wood Johnson Foundation; 2016. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.
- 20 Evans A, Folkemer J, Menges J, Mouna A, Pantaleo N, Ricci E, Singh P. *Assessment of Medicaid Expansion and Reform: Initial Analysis*. Arlington, VA: Menges Group; 2016. http://www.akleg.gov/basis/get_documents.asp?session=29&docid=29735.
- 21 Brown C, Fisher SB, Resnick P. *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015–16 through FY 2034–35*. Denver: Colorado Health Foundation; 2016. <https://www.coloradohealth.org/reports/assessing-economic-and-budgetary-impact-medicare-expansion-colorado-fy-2015-16-through-fy>.
- 22 Deloitte Development LLC. *Commonwealth of Kentucky Medicaid Expansion Report, 2014*. Oakland, CA: Deloitte Development LLC; 2015. http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.
- 23 This analysis found net reductions in state spending because of expansion; it did not consider revenue effects. New Jersey Department of Human Services. Discussion points, FY 2016–2017. Trenton: New Jersey Department of Human Services; 2016. http://www.njleg.state.nj.us/legislativepub/budget_2017/DHS_response.pdf.
- 24 Reynis LA. *Economic and Fiscal Impacts of Medicaid Expansion in New Mexico*. Albuquerque: University of New Mexico, Bureau of Business and Economic Research; 2016. http://bber.unm.edu/media/publications/Medicaid_Expansion_Final2116R.pdf.
- 25 Dorn S, Francis N, Rudowitz R, Snyder L. The effects of the Medicaid expansion on state budgets: an early look in select states. Menlo Park, CA: Kaiser Family Foundation; 2015. <http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicare-expansion-on-state-budgets-an-early-look-in-select-states>.
- 26 New Mexico’s analysis projects net state budget gains until state fiscal year 2020–2021, when a small net adverse budget impact is anticipated. Reynis notes that his revenue estimates are conservative. In Alaska, net state budget losses are forecast starting in federal fiscal year 2017. Alaska does not have sales or individual income taxes, so the analysis by Evans and colleagues concluded that state general revenue would not be affected by expansion-generated economic activity. Every other state collects sales taxes, individual income taxes, or both, so these fiscal conditions in Alaska do not apply to nonexpansion states. Lee C, Pome E, Beleavev M, Pyon D, Park M. *State Government Tax Collections Summary Report: 2014, Economy-Wide Statistics Brief: Public Sector*. Washington: US Census Bureau; 2015. <https://www2.census.gov/govs/statetax/G14-STC-Final.pdf>. Even Alaska collects corporate income tax, but Evans and colleagues did not estimate the impact of expansion on such tax revenues.
- 27 As of March 2018, work requirement waivers had been approved for Arkansas, Kentucky, and Indiana; see: Luby T. Thousands of Arkansas Medicaid recipients must start working in June. *CNN Money*. March 5, 2018. <http://money.cnn.com/2018/03/05/news/economy/arkansas-medicare-work-requirements/index.html>. No waivers for lifetime benefit limits have been approved, but Maine, Arizona, Utah, Wisconsin, and Kansas have applied for them; see: Weixel N. Trump officials face decision on lifetime limits for Medicaid. *The Hill*. February 13, 2018. <http://thehill.com/policy/healthcare/373544-trump-officials-face-decision-on-lifetime-limits-for-medicare>.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute. The author is grateful for comments and suggestions from Genevieve Kenney, Linda Blumberg, and John Holahan, and for copyediting by Vicky Gan.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute’s Health Policy Center, its staff, and its recent research, visit <http://www.urban.org/policy-centers/health-policy-center>.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.