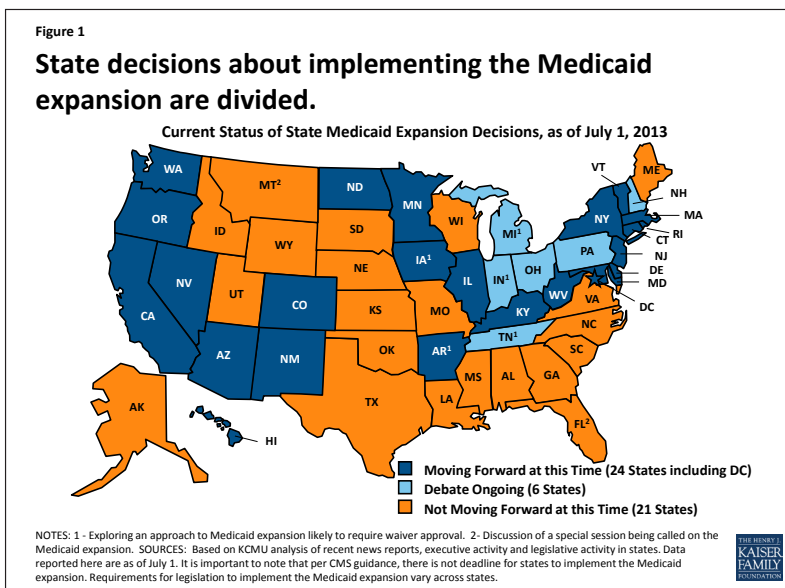


# Analyzing the Impact of State Medicaid Expansion Decisions

July 2013

One of the major vehicles in the Affordable Care Act (ACA) to increase health insurance coverage is an expansion of Medicaid to adults with incomes at or below 138% of the federal poverty level (FPL). While the expansion was intended to be implemented in all states, as a result of the Supreme Court decision on the ACA, it is now effectively a state choice. States are divided about implementing the Medicaid expansion. As of July 2013, 24 states are moving forward with the expansion, 21 states are not planning to move forward, and there is ongoing debate in 6 states.<sup>1</sup> (Figure 1) The following brief highlights 5 key ways that state decisions will shape the outcome of the Medicaid expansion.



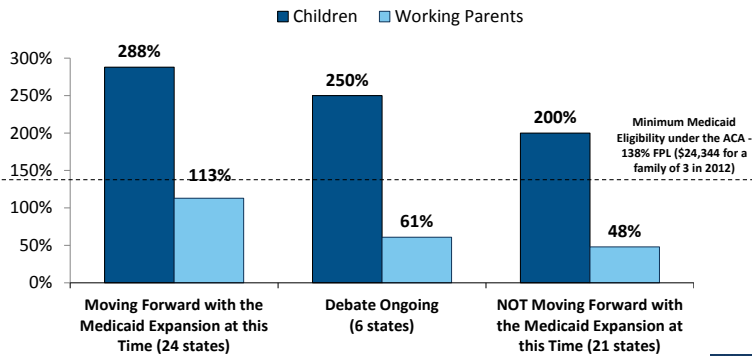
**1. Current Medicaid eligibility levels for adults vary widely across the country and without the Medicaid expansion there will be large gaps in coverage for millions.**

*States that are not moving forward with the expansion currently have more limited Medicaid eligibility standards than states moving forward.* Currently, all states have Medicaid and CHIP eligibility levels for children that exceed federal core requirements. States not currently moving forward with the expansion have a lower median Medicaid eligibility level for parents (48% FPL) compared to states that are moving forward (113% FPL). (Figure 2) Furthermore, half of the states not moving forward have eligibility levels for parents that are below half the poverty level. (Figure 3) None of the states in the group that are not moving forward with the expansion currently provide Medicaid-comparable coverage to adults without dependent children.<sup>2</sup> (Figure 4)

Figure 2

**Current Medicaid eligibility levels are lower in states NOT moving forward with the Medicaid expansion at this time.**

Median Medicaid/CHIP Eligibility Limit, January 2013:



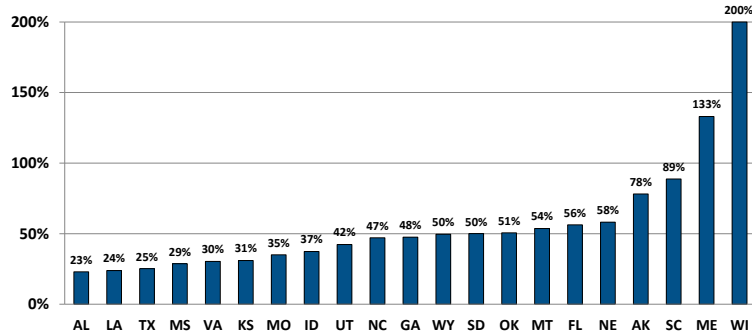
SOURCE: Status of Medicaid expansion decisions based on KCMU analysis of recent news reports as well as executive and legislative activity in states as of July 1, 2013. Eligibility data based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, January 2013.



Figure 3

**Half of states NOT moving forward with the Medicaid expansion at this time limit parent eligibility to below half the poverty level.**

Medicaid Income Eligibility Limits for Working Parents in States NOT Moving Forward with the Medicaid Expansion at this Time:

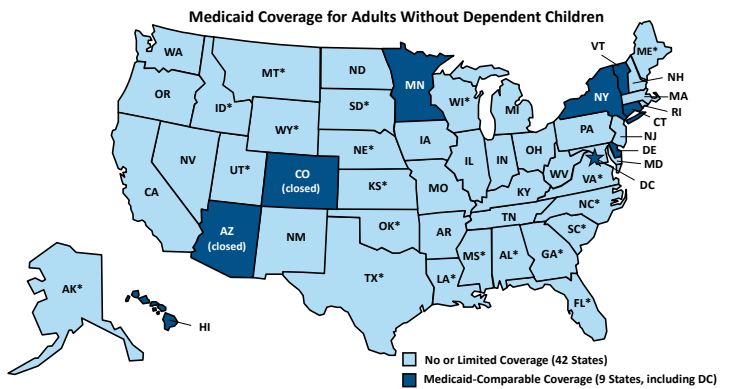


SOURCE: Status of Medicaid expansion decisions based on KCMU analysis of recent news reports as well as executive and legislative activity in states as of July 1, 2013. Eligibility data based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, January 2013.



Figure 4

**None of the states NOT moving forward at this time currently provide Medicaid-comparable coverage for childless adults.**



NOTE: Map identifies the broadest scope of coverage in the state.  
 SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.



***In the states not moving forward with the Medicaid expansion, there will be large gaps in coverage and millions will not have access to affordable coverage options.*** In states not moving forward with the expansion, nearly all childless adults will remain ineligible for Medicaid as well as parents with incomes above current eligibility levels. Individuals with incomes below poverty are not eligible to receive subsidies to purchase coverage in the new marketplaces. Therefore, there will be large gaps in coverage for adults (both parents and childless adults). (Figure 5)

**2. State decisions about the Medicaid expansion will have significant implications for health care for the uninsured.**

***A large body of research shows that Medicaid increases access to care and protects low-income people against high out-of-pocket medical costs.*** Children and adults enrolled in Medicaid have much better access to care than the uninsured. On key measures of access to preventive and primary care, Medicaid enrollees fare as well as the privately insured. Medicaid's limits on cost-sharing help to ensure that cost is not a barrier to obtaining care, and Medicaid beneficiaries are far less likely to face heavy financial burdens for health care than low-income people with private health insurance. (Figure 6)<sup>3</sup>

The Oregon Health Insurance Experiment, which used a rigorous experimental design and solid analytic methods, adds to the weight of the existing evidence that Medicaid improves access to needed care and provides essential financial protection for low-income people. The study found that, after one year, the adults who gained Medicaid were far more likely to have a regular place of care and a regular doctor than those who did not gain coverage, as well as significant increases in outpatient visits, preventive care, use of prescription drugs, and hospital admissions. Medicaid also improved self-reported health. New findings at two years confirm statistically significant improvements in access, utilization, and self-reported health (especially mental health), and show that Medicaid virtually eliminated catastrophic out-of-pocket (OOP) medical spending for the adults who gained coverage.<sup>4,5,6</sup>

Another recent study provides additional evidence that Medicaid provides access to health care services comparable to that of employer-sponsored insurance (ESI), and at significantly lower costs. If low-income adult Medicaid beneficiaries were instead covered by ESI, their OOP spending for health care services would be three times higher; total spending for their care would be over 25% higher.<sup>7</sup>

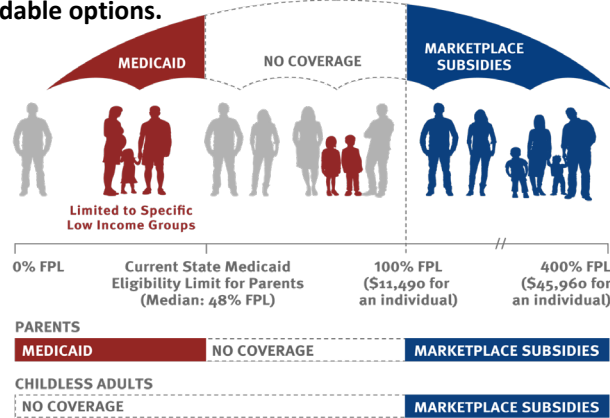
***Studies show that Medicaid coverage contributes to improvements in health outcomes.*** The IOM's authoritative report on the consequences of being uninsured found that health insurance coverage is associated with better health outcomes. People with insurance are more likely to have a regular source of care and greater and more appropriate use of health services, factors that improve the likelihood of disease screening and early detection, management of chronic illnesses, and effective treatment of acute conditions.<sup>8</sup>

**3. State decisions about the Medicaid expansion have significant consequences for the uninsured that disproportionately affect the South and people of color.**

***Decisions to implement the Medicaid expansion in states with large uninsured populations have a disproportionate effect.*** Nearly half (46%) of the 25.4 million non-elderly uninsured with incomes at or below 138% FPL (\$15,856 for an individual annually in 2013) live in the 21 states that are not moving forward with the Medicaid expansion at this time. (Figure 7) Texas, Florida and Georgia account for over half of the non-elderly uninsured population with incomes at or below 138% FPL in the states not moving forward with

Figure 5

**In states that do not expand Medicaid, there will be large gaps in coverage, leaving millions of low-income adults with no affordable options.**



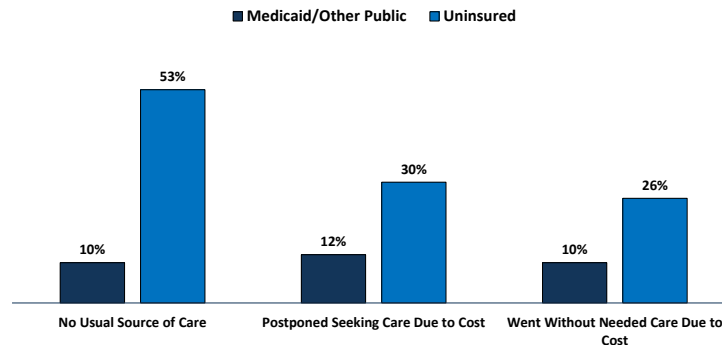
NOTE: Applies to states that do not expand Medicaid. The current median state Medicaid eligibility limit for parents is 48% FPL in the 21 states that are not moving forward with the Medicaid expansion at this time.



Figure 6

**Medicaid helps to address many barriers to care faced by those who are uninsured.**

**Access to Care for Adults by Health Insurance Status, 2011**

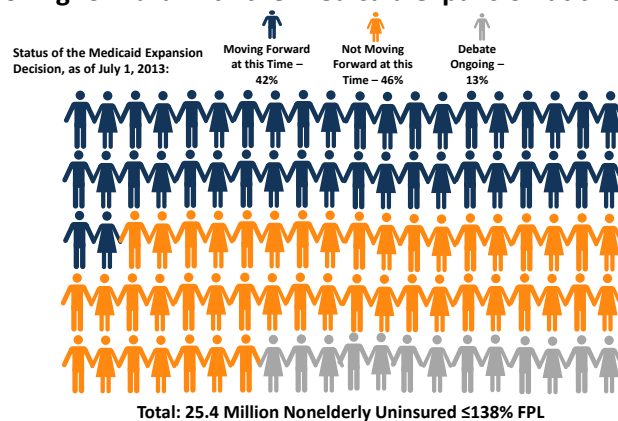


NOTES: In past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).  
SOURCE: KCMU analysis of 2011 NHIS data.



Figure 7

**Nearly half of uninsured <138% FPL reside in states not moving forward with the Medicaid expansion at this time.**



SOURCE: KCMU/ Urban Institute analysis of 2012 ASEC Supplement to the CPS.



the expansion and about 25% of this population across all states. States that are still debating the Medicaid expansion account for 13% of this population. Forty-two percent of the non-elderly uninsured potentially eligible for the Medicaid expansion live in states that are moving forward, and over one in three people in this group live in California. While a small portion of the non-elderly uninsured population at 138% FPL, mostly children and some adults currently eligible for Medicaid, will be able to obtain coverage even if a state does not choose to expand Medicaid, many of these individuals are adults who will remain uninsured.

***In the South, more than 8 in 10 uninsured individuals with incomes at or below 138% FPL live in states that are not moving forward with the expansion.*** Among the 17 states in the South, six (Arkansas, DC, Delaware, Kentucky, Maryland, and West Virginia) are currently moving forward with the expansion and debate is still on-going in Tennessee; the remaining 10 states in this region are not moving forward at this time. Over half (55%) of the uninsured at or below 138% FPL in the South live in 3 large states - Texas, Florida and Georgia – all of which are not moving forward with the expansion. The South is more heavily affected than other regions; the share of the uninsured with incomes at or below 138% FPL living in states that are not moving forward with the expansion is smaller in the Midwest (25%), the West (8%) and the Northeast (2%). The fact that California, which has a large uninsured population, is moving forward helps to keep the share relatively low in the West. (Figure 8)

***People of color will be disproportionately affected by state decisions to expand Medicaid.*** People of color make up the majority of uninsured individuals with incomes below the Medicaid expansion limit in both states moving forward and states not moving forward with the expansion. Nearly half (47%) of all uninsured people of color under the Medicaid expansion limit reside in states that not moving forward with the Medicaid expansion at this time. Nearly 6 in 10 uninsured Blacks with incomes below this level reside in states that are not moving forward with the Medicaid expansion at this time.<sup>9</sup> (Figure 9)

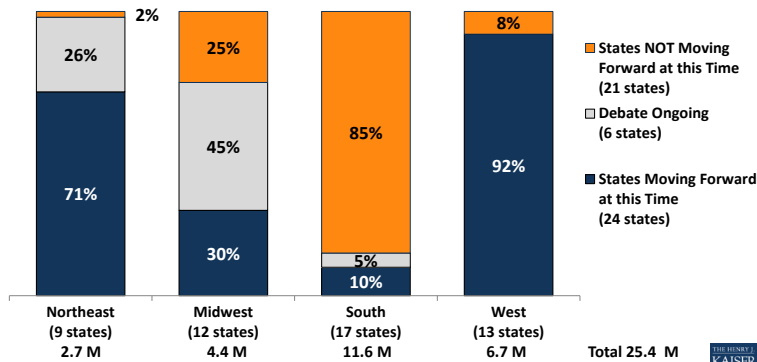
#### **4. Estimates show that there will be significant coverage and fiscal implications tied to state decisions about the Medicaid expansion.**

***Millions of individuals will remain uninsured due to state decisions not to implement the Medicaid expansion.*** Based on an analysis prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, the number of uninsured could be reduced by a total of 24.7 million in 2016. Part of this reduction (14.7 million) is tied to other provisions in the ACA including new requirements that most individuals must have coverage, the no-wrong-door interface for marketplace and Medicaid/CHIP coverage, eligibility simplification, new subsidies in the marketplace, and increased participation among those currently eligible for Medicaid. If all states implemented the Medicaid expansion, this would reduce the uninsured by an additional 10 million individuals. However, 4.9 million of these people reside in states that are not moving forward with the expansion and an additional 1.5 million reside in states that are still debating the expansion. (Figure 10) States not moving forward and those still debating the expansion would experience larger percentage reductions in the uninsured than the states that are moving forward. Those with incomes below poverty left uninsured will not have any affordable coverage options through Medicaid or the marketplaces.<sup>10</sup>

Figure 8

**In the South, over 8 in 10 uninsured individuals ≤138% FPL reside in states NOT moving forward with the Medicaid expansion at this time.**

Distribution of Nonelderly Uninsured ≤138% FPL by Geographic Region and Status of State Medicaid Expansion:



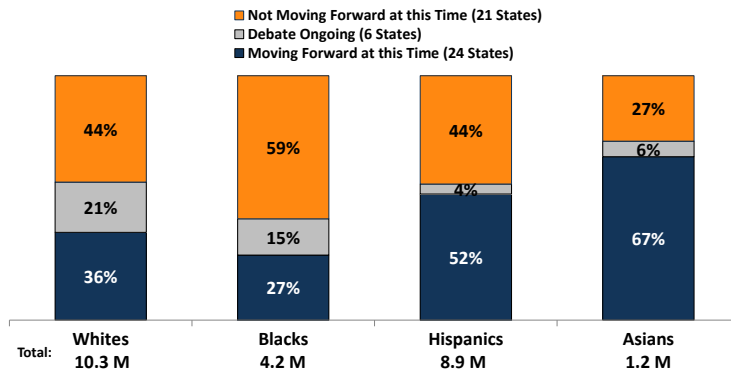
SOURCE: Uninsured data based on KCMU analysis of 2011 American Community Survey. Status of Medicaid expansion decisions based on KCMU analysis of recent news reports as well as executive and legislative activity in states as of July 1, 2013.



Figure 9

**The impact of current state Medicaid expansion decisions varies widely by race/ethnicity.**

Distribution of uninsured ≤138% FPL by race/ethnicity and status of state Medicaid expansion:



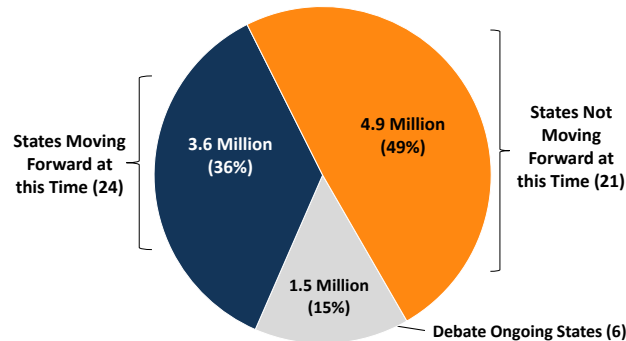
Note: Asians includes Asians and Pacific Islanders.  
SOURCE: Uninsured data based on KCMU analysis of 2011 American Community Survey. Status of Medicaid expansion decisions based on KCMU analysis of recent news reports as well as executive and legislative activity in states as of July 1, 2013.



Figure 10

**State decisions on the Medicaid expansion will have implications for reductions in the uninsured.**

Reduction in the Uninsured Due to Medicaid Expansion by the Status of State Medicaid Expansion:



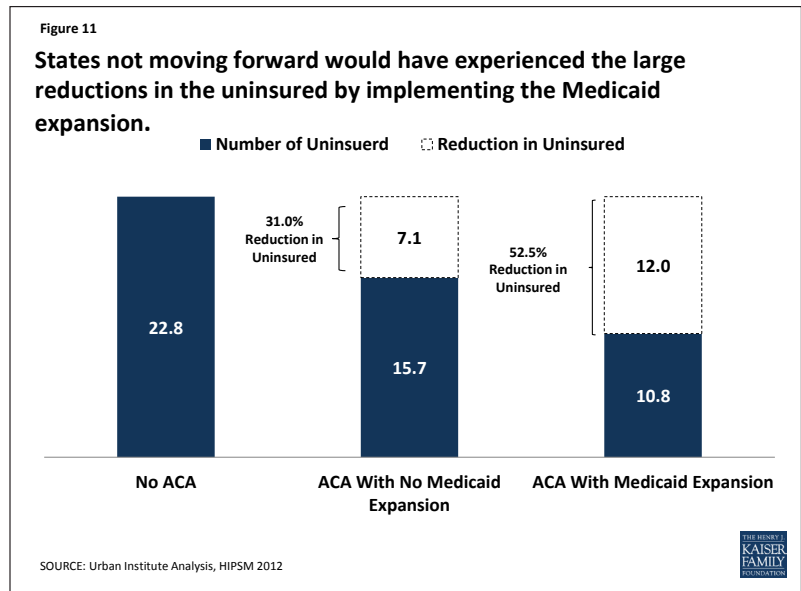
Incremental Reduction in the Uninsured Due to Medicaid Expansion in 2016: 10 Million

SOURCE: Urban Institute Analysis, HPSM 2012



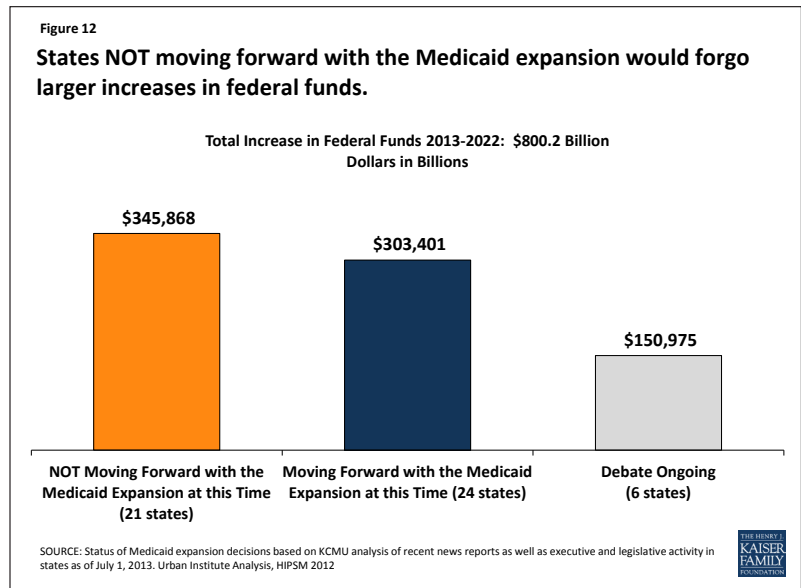
**States not moving forward would have experienced greater percentage reduction in the uninsured compared to states moving forward.**

For states that are not moving forward, estimates show a 7.1 million decrease in the uninsured without the Medicaid expansion (due to other ACA provisions) but a 12 million reduction if these states were to implement the Medicaid expansion — an additional 4.9 million. If they implemented the Medicaid expansion, these states could see a 52.5% reduction in their total uninsured population (compared to a 40.9% reduction expected in the states that are planning to move forward). (Figure 11)



**States that do not move forward with the expansion will forgo billions in federal funds.**

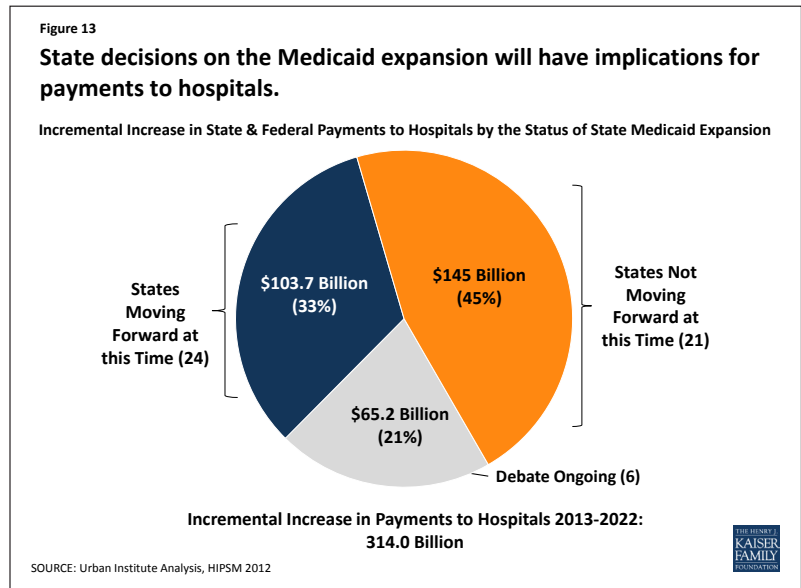
By not moving forward, states will be forgoing billions in federal dollars. The 21 states that are not expanding Medicaid would forgo \$35 billion in federal funds in 2016 and \$345.9 billion over the 2013-2022 period, while the 6 states still currently debating the expansion would forgo \$15.2 billion in 2016 and \$151 billion over the 2013-2022 period. These states would have experienced larger percentage increases in federal funds relative to the states moving forward with the expansion. States not moving forward with the expansion are more likely to see modest increases in state spending over the 2013-2022 period; however, increases in federal funds would greatly exceed increases in state costs. In addition, costs could be offset by reduced spending for uncompensated care, state specific savings and increases in economic activity.<sup>11</sup> (Figure 12)



5. **State decisions about the Medicaid expansion will also have implications for uncompensated care costs and provider revenues, as well as broader fiscal and economic effects.**

**Increased coverage will reduce state spending for uncompensated care costs.** An estimated 30 percent of uncompensated care expenditures are paid for by state and local governments. States could save an estimated one-third of this by reducing payments to hospitals and clinics that provide charity care to the uninsured due to increased coverage. Estimated national savings of \$18.3 billion over the ten year period in reduced uncompensated care spending would add to the savings or mitigate relatively small state increases in costs.

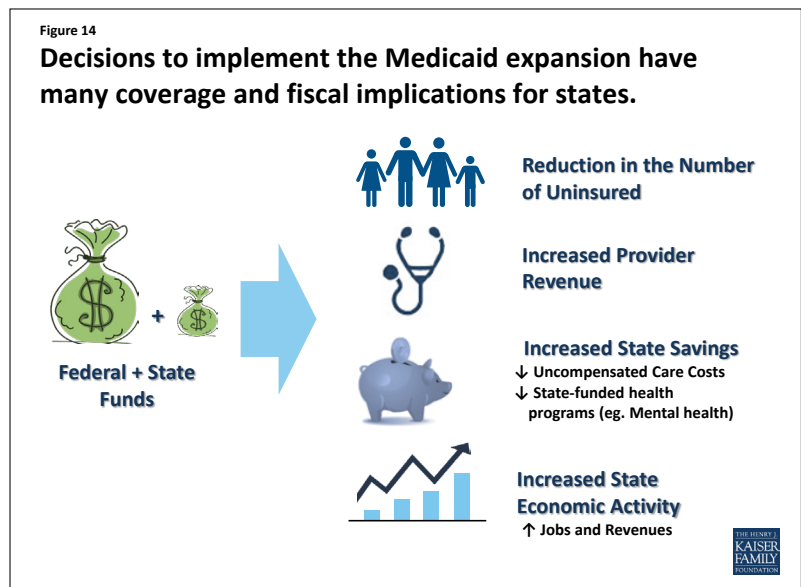
**The Medicaid expansion could increase revenues to hospitals, offsetting hospital reimbursement reductions that were also included in the ACA.** If all states implemented the Medicaid expansion, hospitals could see \$300 billion over the 2013-2022 period – a 23% increase in Medicaid reimbursement for hospitals. In states that do not implement the Medicaid expansion, hospitals will miss out on an estimated \$145 billion over the 2013-2022 period in Medicaid payments tied to coverage, but will still face cutbacks in Medicare and Medicaid disproportionate share hospital payments as well as lower Medicare payment rates that take effect independent of whether or not a state adopts the Medicaid expansion.<sup>12</sup> (Figure 13)



**States that implement the Medicaid expansion could also see savings or offsets and broader economic effects that vary by state and cannot be modeled using national data.**

Some offsets come from: transitioning current Medicaid coverage for specific groups (such as breast and cervical cancer targeted coverage) to “newly eligible” coverage, which has a higher federal match rate; transitioning current Medicaid coverage for individuals with incomes above 138% FPL to coverage in the exchange; and reduced state spending for programs that serve indigent populations (such as state-funded mental health or substance abuse programs).

States could also see revenue from broader economic effects of the Medicaid expansion, such as increased jobs, income and state tax revenues at the state level within the health care sector and beyond due to the multiplier effect of spending.<sup>13</sup> (Figure 14)





# Endnotes

- <sup>1</sup> Status of State Action on the Medicaid Expansion Decision, as of July 1, 2013. Kaiser Family Foundation. <http://www.kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> Accessed on July 12, 2013.
- <sup>2</sup> Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults. Kaiser Family Foundation, March 28, 2013. <http://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>
- <sup>3</sup> Medicaid: A Primer – Key Information on the Nation’s Health Coverage Program for Low-Income People. Kaiser Commission on Medicaid and the Uninsured. March 2013. <http://www.kff.org/medicaid/issue-brief/medicaid-a-primer/>
- <sup>4</sup> Amy Finkelstein, MIT and NBER; Sarah Taubman, NBER; Bill Wright, CORE; Mira Bernstein, NBER; Jonathan Gruber, MIT and NBER; Joseph P. Newhouse, Harvard and NBER; Heidi Allen, CORE; Katherine Baicker, Harvard and NBER; and the Oregon Health Study Group. The Oregon Health Insurance Experiment: Evidence from the First Year. NBER Working Paper No. 17190. Issued in July 2011. <http://www.nber.org/papers/w17190>.
- <sup>5</sup> Katherine Baicker, Ph.D., Sarah L. Taubman, Sc.D., Heidi L. Allen, Ph.D., Mira Bernstein, Ph.D., Jonathan H. Gruber, Ph.D., Joseph P. Newhouse, Ph.D., Eric C. Schneider, M.D., Bill J. Wright, Ph.D., Alan M. Zaslavsky, Ph.D., and Amy N. Finkelstein, Ph.D. for the Oregon Health Study Group. The Oregon Experiment — Effects of Medicaid on Clinical Outcomes. *N Engl J Med* 2013; 368:1713-1722. May 2, 2013. <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>
- <sup>6</sup> Poor People Have the Same Needs as Others. *New York Times*, May 7, 2013. <http://www.kff.org/medicaid/perspective/poor-people-have-the-same-needs-as-others/>
- <sup>7</sup> What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults. Kaiser Commission on Medicaid and the Uninsured. May 2013. <http://www.kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/>
- <sup>8</sup> *Care Without Coverage: Too Little, Too Late*. Institute of Medicine. National Academy Press. 2003.
- <sup>9</sup> Samantha Artiga and Jessica Stephens: The Impact of Current State Medicaid Expansion Decisions on Coverage by Race and Ethnicity. Kaiser Family Foundation. July, 2013. <http://www.kff.org/disparities-policy/issue-brief/the-impact-of-current-state-medicaid-expansion-decisions-on-coverage-by-race-and-ethnicity/>
- <sup>10</sup> John Holahan, Matthew Buettgens and Stan Dorn: The Cost of Not Expanding Medicaid. Kaiser Family Foundation. July 2013.
- <sup>11</sup> Ibid
- <sup>12</sup> Ibid
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