

Exhibit 34

medicaid
and the uninsured

**Medicaid Coverage and Spending in Health Reform:
National and State-by-State Results for Adults at or Below 133% FPL**

Prepared by:

John Holahan and Irene Headen
Urban Institute

May 2010

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) expands Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL) which will extend coverage to large numbers of the nation's uninsured population, especially adults. However, the ultimate reach of the program will depend heavily on both federal and state actions to implement the new law. The Congressional Budget Office (CBO) has provided national estimates of the impacts of health reform, but does not provide state-by-state estimates. We know that the impact of health reform will vary across states based on coverage levels in states today. This analysis provides national and state-by-state estimates of the increases in coverage and the associated costs compared to a baseline scenario without the Medicaid expansions in health reform. Nationally and across states, this analysis shows that:

- ***Medicaid expansions will significantly increase coverage and reduce the number of uninsured***
- ***The federal government will pay a very high share of new Medicaid costs in all states***
- ***Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted***

Today there is a great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership and priorities. These variations make it impossible to know how each state individually will respond to the new health reform law. There are a range of implementation scenarios that will impact the number of people who participate or sign up for coverage and these participation rates are directly related to the estimates of coverage and cost for health reform. Since it is impossible to predict the behavior of each state, this analysis examines two participation rate scenarios that are applied uniformly across states; however, we recognize that some states may implement reform to achieve coverage levels above expectations and others may be slower to implement reform or face implementation barriers that result in lower coverage levels. The two modeled scenarios are:

1. ***Standard Participation Scenario.*** This scenario attempts to approximate participation rates used by the CBO to estimate the national impact of the Medicaid expansion and then examines the results by state. These results assume moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible. This scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups.
2. ***Enhanced Outreach Scenario.*** This scenario examines the impact and reach of Medicaid assuming a more aggressive outreach and enrollment campaign by federal and state governments as well as key stakeholders including community based organizations and providers that would promote more robust participation among those newly eligible (75 percent participation among the newly eligible that are currently uninsured and lower participation across other coverage groups) and higher participation among those currently eligible for coverage than in the standard scenario.

Even in a scenario with higher participation, we did not assume that there will be full or 100 percent participation. We did not model a participation rate lower than the standard, but this scenario might result in coverage levels that are not a substantial improvement over what would have occurred in the absence of reform (or baseline levels).

This analysis estimates the impact of the coverage provisions for adults in health reform between 2014 and 2019 but does not account for other Medicaid changes in the law. For a more detailed description of the methods used in the analysis for this brief and a description of how the changes in the Medicaid match rates are applied to different populations, see the full text of the report and boxes 1 and 2 at the end of the executive summary.

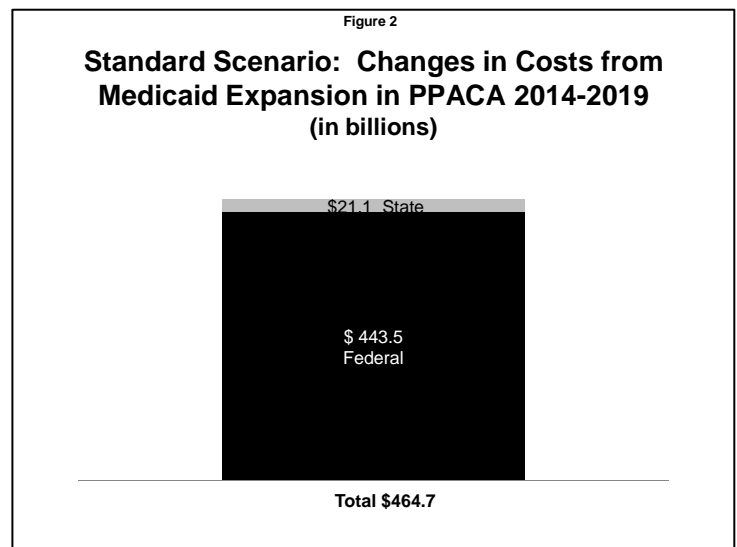
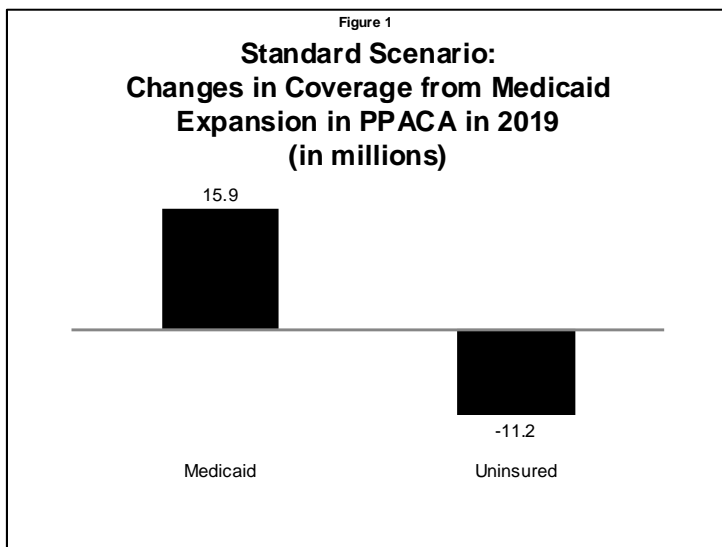
Standard Participation Scenario

This scenario assumes that states will implement health reform and achieve levels of participation similar to current enrollment in Medicaid among those made newly eligible for coverage; however, this scenario assumes little additional participation among those currently eligible. These results attempt to approximate participation rates used by the CBO.

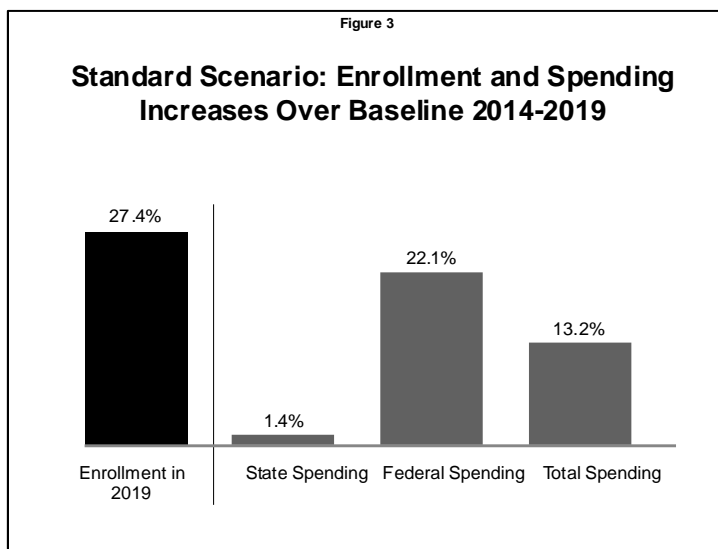
National Results

Medicaid expansions will significantly increase coverage and reduce the number of uninsured. Medicaid enrollment is projected to increase by 15.9 million by 2019. This new coverage would result in a reduction of uninsured adults under 133 percent of poverty of 11.2 million, a 45 percent reduction in 2019 (Figure 1). States with more limited coverage and higher uninsured rates pre-reform (like Texas) will see larger decreases in the uninsured compared to states with broader coverage and fewer uninsured pre-reform (like Massachusetts).

The federal government will pay a very high share of new Medicaid costs in all states. In this scenario, federal spending would increase by \$443.5 billion and state spending would increase by \$21.1 billion between 2014-2019 (Figure 2). Thus about 95 percent of all new spending would be by the federal government. Spending in 2014 is expected to be relatively small, particularly for states because enrollment is being phased-in and the federal matching rate for new eligibles is 100 percent. Overall and state spending increases by 2019 as coverage is phased in to full implementation levels and federal matching rates for new eligibles fall to 93 percent from 100 percent.



Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted (baseline). Nationally, enrollment is expected to increase by 27.4 percent compared to baseline. This increase in enrollment far exceeds increases in state spending relative to baseline of 1.4 percent. Due to the large increase in federal matching rates, the federal increases in Medicaid spending compared to baseline are expected to be 22.1 percent with overall spending increases of 13.2 percent. (Figure 3) The federal matching rates pre-reform and pre-ARRA average 57.1 percent. The federal matching rate after reform is the combination of current matching rates on current eligibles, expansion state match rate for certain childless adults, and the higher federal matching rates on new eligibles. The aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 61.6 percent; however, states that have had large increases in the number of new eligibles will see the greatest increases in matching rates.



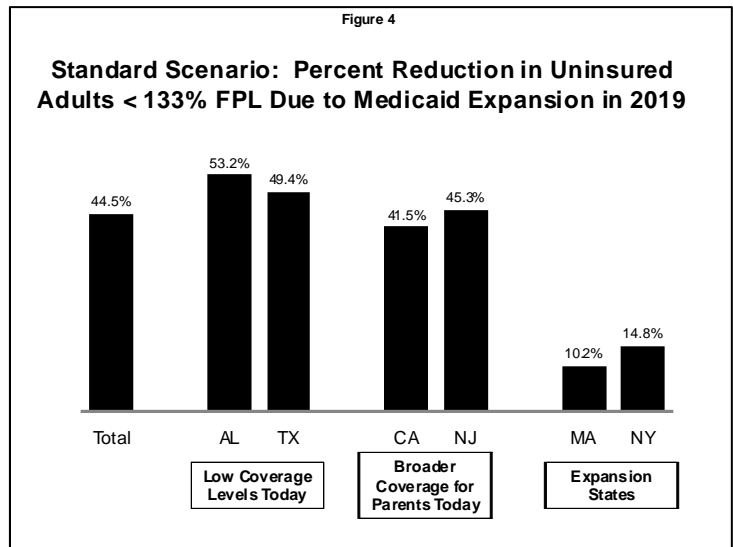
State-by-State Results

The impact of the Medicaid expansions under health reform will vary across states based on current levels of coverage and current match rates for states. The next section reviews the variation in the impact of costs and coverage across states. For state-by-state results of the standard scenario see Table 1. For purposes of this discussion we group the results into the experience in three types of states. For each group we will use the results from two states as illustrative of the experience for other states in that group:

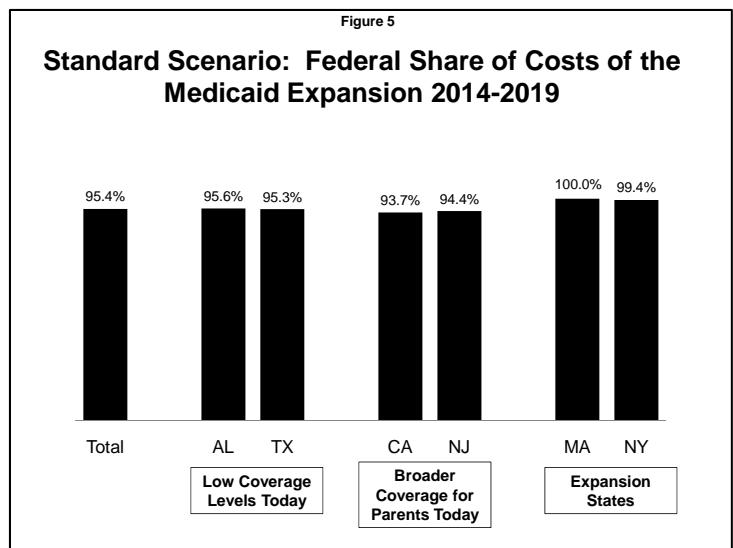
- States with low Medicaid eligibility for adults today (Alabama and Texas)
- States that have broader coverage today for parents but have no Medicaid coverage for childless adults (California and New Jersey), and
- Expansion states that cover both parents and childless adults in Medicaid today (Massachusetts and New York).¹

¹ For this analysis we assume that there are seven “expansion states” which include: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

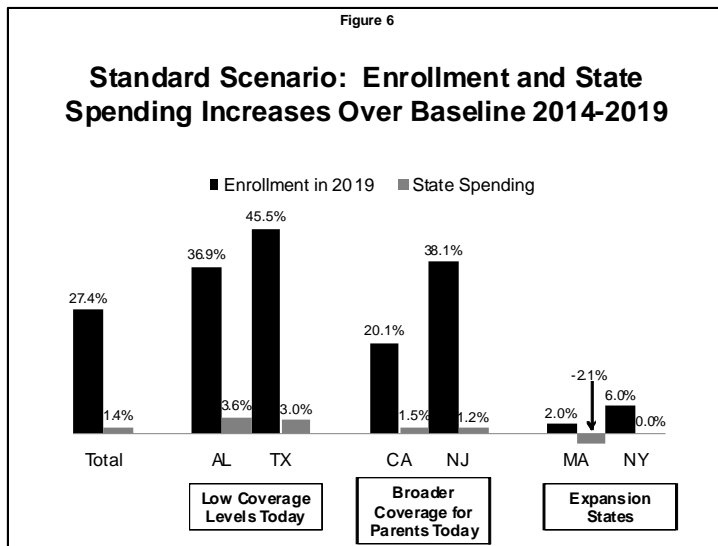
The Medicaid expansion will result in large reductions in the uninsured across states, but especially in states that have higher levels of uninsured today. Overall, the Medicaid expansion is expected to result in a decrease in the number of uninsured of 11.2 million people, or 45 percent of the uninsured adults below 133 percent of poverty. States with low coverage levels and higher uninsured rates today will see larger reductions (Alabama 53.2 percent and Texas 49.4). States with broader coverage levels for parents today, no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 41.5 percent and New Jersey 45.3 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 10.2 percent reduction and New York 14.8 percent). (Figure 4) Overall, Texas and California could each see a reduction in the uninsured of about 1.4 million compared to baseline in 2019.



The actual federal share of the costs of the Medicaid expansion varies based on state coverage levels today, but it is always very high. States with low coverage levels today will see the vast majority of the costs of new enrollment financed by the federal government over the 2014 to 2019 period because most of their increased enrollment is from individuals made eligible by health reform who qualify for the high newly eligible match rate (for Alabama, 96 percent and Texas, 95 percent). States with broader coverage of parents today have the majority of costs financed by the federal government, but at slightly lower levels because they experience a higher participation of those currently eligible whose coverage is reimbursed at the states' regular match rates (California, 94 percent and New Jersey 94 percent). For expansion states, the level of federal financing varies with the proportion of current eligibles to newly eligible or those eligible for the expansion match rate. Massachusetts, a state with no new eligibles, will actually achieve some savings because the benefit of the expansion match rate for current and new coverage of childless adults outweighs any new state costs related to increases in participation for parents at the regular Medicaid match rate. States with state funded coverage programs for adults benefit because these adults will be considered newly eligible for Medicaid and qualify for the newly eligible match rate. Generally, states will benefit from a large influx of federal dollars and new coverage is likely to reduce the need for state payments for uncompensated care. (Figure 5)



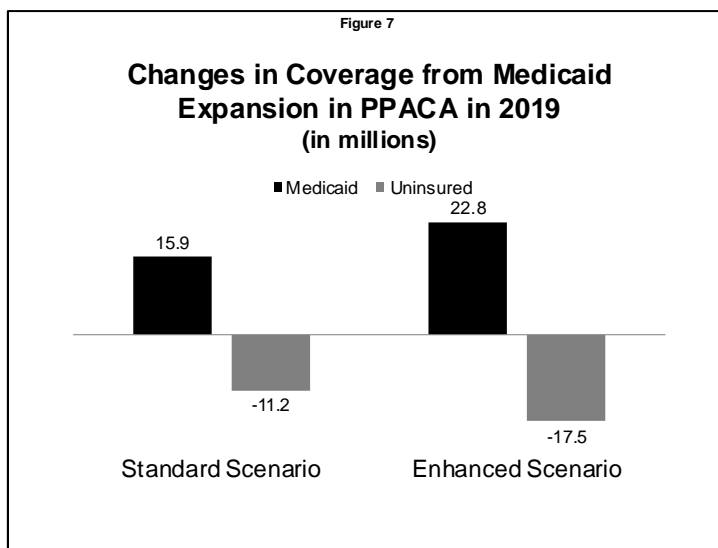
Compared to projected enrollment without health reform, increases in new enrollment and coverage will far exceed new state costs, but these increases vary based on current levels of coverage across states. States with more modest coverage today are expected to see large increases in enrollment compared to projections without health reform. Increases in enrollment will be lower in states that have already covered a large share of these populations. Increases in enrollment far exceed increases in state spending relative to baseline estimates and this differential is biggest in states with low coverage today. For example, Texas could see an increase in enrollment of 46 percent but an increase in state spending of about 3 percent. Federal spending in Texas is expected to increase by 39 percent compared to baseline. States with low coverage today are expected to see large increases in federal spending relative to baseline both because of the very favorable matching rate on new eligibles and because these states also have a high regular Medicaid match rate for current eligibles. Increases in coverage and spending will be lower in states that have already covered a large share of these populations. (Figure 6)



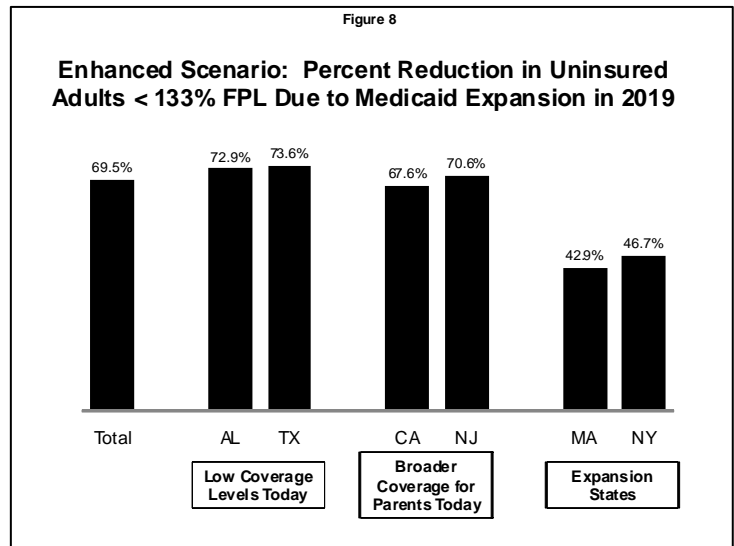
Enhanced Outreach Scenario

This scenario examines the impact on Medicaid and the uninsured assuming a more aggressive outreach and enrollment campaign at both the federal and state levels that would promote more robust participation in Medicaid and further reduce the number of uninsured in this low-income population compared to the standard scenario. The enhanced scenario also assumes that individuals respond favorably to the new mandate for coverage. Even though the large majority of those eligible for Medicaid will be exempt from the penalties for failure to comply with the mandate, a new culture of coverage along with outreach efforts are likely to yield more participation. These factors would increase participation of both those made newly eligible for coverage under health reform and eligible for coverage prior to changes in reform.

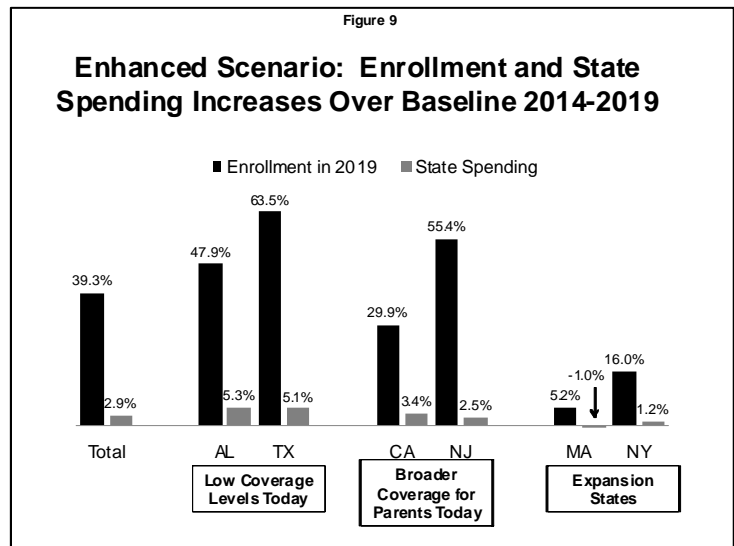
Under the enhanced outreach scenario applied uniformly across states, Medicaid enrollment could increase by 22.8 million by 2019 resulting in a 17.5 million reduction in uninsured adults under 133 percent of poverty (a 70 percent reduction). (Figure 7)



Compared to the standard scenario, states will see larger reductions in the uninsured. Similar to the standard scenario, states with low coverage levels today will see larger reductions (Alabama 73 percent and Texas 74 percent). States with broader coverage levels for parents but no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 68 percent and New Jersey 71 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 43 percent reduction and New York 47 percent). (Figure 8) In this scenario, California could see a reduction in the uninsured of 2.3 million and Texas could see a 2.1 million reduction compared to baseline projections in 2019. See Table 2 for the state-by-state results of the enhanced participation scenario.



Under these higher participation assumptions, new spending for Medicaid would continue to be mostly federal (92.5 percent) over the 2014 to 2019 period. State spending could increase by \$43 billion while federal spending could increase by \$532 billion. The share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs. Relative to baseline spending, Medicaid enrollment could increase by 39 percent, significantly higher than state spending increases of 2.9 percent. Federal spending nationally in this scenario could be about 27 percent higher than baseline projections. (Figure 9) . In this scenario, the aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 62.1 percent; however, states with large increases in the number of new eligibles will see the greatest increases in matching rates.



Limited Outreach Scenario

Right now, states are still in the midst of a major economic downturn facing historic declines in revenues and increased demand for public programs. The impact of the downturn varies across states and the economic recovery will vary across states as well. Heading into health reform, some states will move quickly to promote coverage with efforts that may begin in 2010, while others may move more slowly. Some are challenging and opposing health reform through amendments to their state statutes and constitutions, ballot initiatives and court challenges. Continuing an approach to Medicaid that dates back to its enactment in 1965, health reform revises the standards with which states that choose to participate in the program must comply. Because

Medicaid is voluntary, states may choose to not to participate and thereby forego the federal Medicaid funding to which participating states are entitled. States that elect not to implement these new requirements in effect would be making the choice not to participate.

The outcome of state actions will affect the extent to which implementation of health reform reaches its fullest potential. If states fall short of implementation expectations, fewer individuals will be covered and more individuals will remain uninsured. Under this scenario, states would also forgo large sums of federal funding tied to the coverage of those made newly eligible under reform. Even though states would have higher numbers of uninsured in this scenario, they will also face a reduction in the federal dollars to support uncompensated care since the new law calls for reductions in disproportionate share hospital payments (DSH) of \$14 billion over the 2014 to 2019 period.

Conclusion

The changes to the Medicaid program under the Patient Protection and Affordability Care Act (PPACA) significantly expand Medicaid coverage for adults. There will be large increases in coverage and federal funding in exchange for a small increase in state spending. States with low coverage levels and high uninsured rates will see the largest increases in coverage and federal funding. Higher levels of coverage will allow states to reduce payments they make to support uncompensated care costs.

The impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond, so this analysis looked at a range of participation assumptions that are applied uniformly across states, but in reality this will vary. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and see greater reductions in the number of uninsured.

Box 1: Methods Summary

The Model Database. We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data for 2006 and 2007). It is generally accepted that the CPS has an undercount of the Medicaid population. We adjust for the undercount with a partial adjustment to state administrative data. We then generate a 2009 dataset by growing the population to 2009. We account for the impact of unemployment on coverage which has the effect of reducing employer coverage, increasing Medicaid enrollment, and increasing the number of uninsured. We also benchmark to 2009 CPS total population estimates by state and estimate population growth to 2019 using growth rates based on Census population projections.

Eligibility Simulation. To estimate the impact of health reform on states, we use a model developed at the Urban Institute's Health Policy Center (Health Insurance Policy Simulation Model or HIPSM). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS to simulate the eligibility determination process. The model identifies eligibility for Section 1115 waiver programs which is critical for determining match rates for coverage in seven states: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

Participation Rates. Once we have identified individuals who are newly eligible for Medicaid, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to participate at relatively higher rates post-reform because they currently lack coverage but not all new participation will come from the ranks of the uninsured. Participation rates are also likely to increase for those who are currently eligible but not participating in Medicaid. Under the standard scenario, we use a set of participation rates that attempt to approximate those used by CBO (57% participation from the uninsured and lower rates for other coverage groups). The actual participation rates assumed in the CBO estimates are not publicly available. We also look at the impact of a scenario with aggressive broader outreach and enrollment efforts and stronger response to the individual mandate (even though the Medicaid population is largely exempt from these requirements). In this scenario we assume 75% participation of the uninsured and lower rates for other coverage groups.

Baseline Coverage	Standard Scenario	Enhanced Scenario
Current Eligibles		
ESI	3%	5%
Non-group	7%	10%
Uninsured	10%	40%
New Eligibles		
ESI	25%	25%
Non-group	54%	60%
Uninsured	57%	75%

Cost per Person. We make estimates on the costs per enrollee using data from HIPSM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. Estimates from MEPS are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Cost per enrollee is then grown to 2019 using growth rates taken from the CBO March 2009 baseline.

The Baseline. We use estimates of state and federal Medicaid spending in the baseline, i.e. what would have happened without reform if current law continued, to assess the impact of reform. Baseline enrollment and national spending totals for the years 2009-2019 were calculated using published CBO estimates from March 2009 to grow data from the 2007 Medicaid Statistical Information Statistics (MSIS) and CMS Form-64 Medicaid Financial Report (CMS-64). Using published Federal Medical Assistance Percentages (FMAP) from the Department of Health and Human Services, we calculated the federal and state share of spending for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total spending amounts in 2009. This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year, without the adjustments made by the American Recovery and Reinvestment Act (ARRA).

Other Assumptions. These estimates do not account for: increased participation for states with current Medicaid coverage levels above 133% FPL because after 2014 states are unlikely to continue to cover these individuals on Medicaid; costs associated with the increase in physician payment rates for primary care; the effects of reform for children; or the fiscal implications of the reductions of disproportionate share hospital payments. Finally, the analysis also does not account for any changes in Medicaid between 2010 and 2014. States are permitted to extend coverage to childless adults and receive their regular federal medical assistance percentages (FMAP) until 2014.

Box 2: Medicaid Match Rates for Coverage in Health Reform Summary

The health reform law establishes a new, minimum standard for Medicaid coverage that is uniform across the country and fills the biggest gaps in coverage for low-income people. Specifically, the PPACA requires states by January 1, 2014, to extend Medicaid eligibility to all groups of people under age 65 with income up to 133 percent of the FPL who are not otherwise eligible for Medicaid.² For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents to 133 percent of the federal poverty line. The law specifies different match rates for individuals eligible for coverage as of December 1, 2009; those made newly eligible for coverage under health reform and for certain expansion states.

- Regular Medicaid Matching Rate:** The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 76 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for “already-eligible” individuals (people who qualify for Medicaid under the rules in effect on December 1, 2009).
- Newly-Eligible Matching Rate:** The newly-eligible matching rate assures that the federal government finances much of the cost of the Medicaid expansion to 133 percent of the FPL included in the health reform legislation. It is set at 100 percent in FY2014 through FY2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Beginning in 2014, it is available for non-elderly adults with income up to 133 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009.
- “Expansion” States Matching Rate:** The transition-matching rate is designed to provide some additional federal help to “expansion” states (states that expanded coverage for adults to at least 100 percent of the FPL prior to enactment of health reform). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults. This analysis assumes that there are seven states that fall into this category: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont.

Enhanced Matching Rates for Parents and Childless Adults, 2014 and Beyond

Year	Newly-Eligible Parents & Childless Adults (up to 133% FPL)	Medicaid-Eligible Childless Adults in “Expansion” States Only		
		Transition Percentage used to Calculate Enhanced Match	Example: State with 50% Original FMAP <i>Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]</i>	Example: State with 60% Original FMAP <i>Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]</i>
2014	100%	50%	75%	80%
2015	100%	60%	80%	84%
2016	100%	70%	85%	88%
2017	95%	80%	86%	88%
2018	94%	90%	89.6%	90.6%
2019	93%	100%	93%	93%
2020 on	90%	100%	90%	90%

²To promote coordination, the gross income standard that will be used for the premium tax credits available in the Exchanges also will apply to most existing Medicaid eligibility groups. A standard five percent of income disregard will be built into the gross income test for Medicaid to compensate for the loss of other, existing Medicaid disregards. In addition, states will no longer be able to impose asset tests on most Medicaid populations.

Table 1: Standard Participation Scenario

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
Northeast											
Connecticut	114,083	75,864	48.0%	\$263	\$4,686	\$4,949	94.7%	20.1%	1.2%	21.0%	11.1%
Maine	43,468	27,877	47.4%	-\$118	\$1,857	\$1,738	100%*	11.8%	-1.5%	12.9%	7.7%
Massachusetts**	29,921	10,401	10.2%	-\$1,274	\$2,137	\$864	100%*	2.0%	-2.1%	3.5%	0.7%
New Hampshire	55,918	34,625	48.7%	\$63	\$1,204	\$1,267	95.0%	38.8%	1.1%	21.3%	11.2%
New Jersey	390,490	292,489	45.3%	\$533	\$9,030	\$9,563	94.4%	38.1%	1.2%	20.9%	11.1%
New York	305,945	223,175	14.8%	\$50	\$8,049	\$8,099	99.4%	6.0%	0.0%	3.3%	1.7%
Pennsylvania	482,366	282,014	41.4%	\$1,054	\$17,086	\$18,140	94.2%	21.7%	1.4%	17.7%	10.5%
Rhode Island	41,185	29,147	50.6%	\$70	\$1,559	\$1,629	95.7%	20.0%	0.7%	14.6%	8.1%
Vermont	4,484	3,214	10.2%	-\$26	\$112	\$86	100%*	2.8%	-0.6%	1.9%	0.9%
Midwest											
Illinois	631,024	429,258	42.5%	\$1,202	\$19,259	\$20,461	94.1%	25.8%	1.6%	25.9%	13.8%
Indiana	297,737	215,803	44.2%	\$478	\$8,535	\$9,013	94.7%	29.4%	2.5%	22.9%	16.1%
Iowa	114,691	74,498	44.1%	\$147	\$2,800	\$2,947	95.0%	25.3%	1.4%	15.7%	10.3%
Kansas	143,445	89,265	50.9%	\$166	\$3,477	\$3,643	95.4%	42.0%	1.7%	24.0%	14.8%
Michigan	589,965	430,744	50.6%	\$686	\$14,252	\$14,938	95.4%	30.2%	2.0%	21.5%	14.8%
Minnesota	251,783	132,511	44.2%	\$421	\$7,836	\$8,257	94.9%	32.9%	1.2%	22.0%	11.6%
Missouri	307,872	207,678	45.5%	\$431	\$8,395	\$8,826	95.1%	29.8%	1.7%	19.5%	13.0%
Nebraska	83,898	50,364	53.9%	\$106	\$2,345	\$2,451	95.7%	36.2%	1.5%	23.5%	14.4%
North Dakota	28,864	17,198	45.1%	\$32	\$595	\$627	94.9%	44.0%	1.4%	16.9%	10.8%
Ohio	667,376	462,024	50.0%	\$830	\$17,130	\$17,960	95.4%	31.9%	1.6%	19.2%	12.8%
South Dakota	31,317	18,594	51.9%	\$32	\$717	\$748	95.8%	25.9%	1.1%	16.4%	10.5%
Wisconsin	205,987	127,862	50.6%	\$205	\$4,252	\$4,457	95.4%	20.8%	0.9%	12.7%	8.0%
South											
Alabama	351,567	244,804	53.2%	\$470	\$10,305	\$10,776	95.6%	36.9%	3.6%	35.9%	25.7%
Arkansas	200,690	154,836	47.6%	\$455	\$9,401	\$9,856	95.4%	27.9%	4.7%	38.9%	29.1%
Delaware	12,081	7,916	15.9%	\$3	\$387	\$390	99.2%	6.7%	0.1%	6.2%	3.3%
District of Columbia	28,900	15,308	49.1%	\$42	\$902	\$944	95.6%	16.1%	0.9%	8.3%	6.1%
Florida	951,622	683,477	44.4%	\$1,233	\$20,050	\$21,283	94.2%	34.7%	1.9%	24.3%	14.3%
Georgia	646,557	479,138	49.4%	\$714	\$14,551	\$15,265	95.3%	40.4%	2.7%	28.9%	19.8%
Kentucky	329,000	250,704	57.1%	\$515	\$11,878	\$12,393	95.8%	37.3%	3.5%	32.2%	24.0%
Louisiana	366,318	277,746	50.7%	\$337	\$7,273	\$7,610	95.6%	32.4%	1.7%	21.6%	14.4%
Maryland	245,996	174,484	46.2%	\$533	\$9,112	\$9,645	94.5%	32.4%	1.7%	29.6%	15.6%
Mississippi	320,748	256,920	54.9%	\$429	\$9,865	\$10,294	95.8%	41.2%	4.8%	37.0%	28.9%
North Carolina	633,485	429,272	46.6%	\$1,029	\$20,712	\$21,741	95.3%	38.2%	2.6%	29.0%	19.7%
Oklahoma	357,150	261,157	53.1%	\$549	\$12,179	\$12,728	95.7%	51.2%	4.0%	48.2%	32.7%
South Carolina	344,109	247,478	56.4%	\$470	\$10,919	\$11,389	95.9%	38.4%	3.6%	36.0%	26.3%
Tennessee	330,932	245,691	43.3%	\$716	\$11,072	\$11,788	93.9%	20.9%	2.5%	20.4%	14.3%
Texas	1,798,314	1,379,713	49.4%	\$2,619	\$52,537	\$55,156	95.3%	45.5%	3.0%	38.9%	24.7%
Virginia	372,470	245,840	50.6%	\$498	\$9,629	\$10,127	95.1%	41.8%	1.8%	35.1%	18.4%
West Virginia	121,635	95,675	56.7%	\$164	\$3,781	\$3,945	95.9%	29.5%	2.4%	20.4%	15.6%
West											
Alaska	42,794	33,106	48.4%	\$117	\$2,046	\$2,163	94.6%	38.5%	2.1%	36.9%	19.5%
Arizona	105,428	81,095	13.6%	\$56	\$2,091	\$2,147	97.4%	7.7%	0.2%	4.2%	2.9%
California	2,008,796	1,406,101	41.5%	\$2,982	\$44,694	\$47,676	93.7%	20.1%	1.5%	23.0%	12.3%
Colorado	245,730	166,471	50.0%	\$286	\$5,917	\$6,203	95.4%	47.7%	1.8%	37.1%	19.4%
Hawaii	84,130	42,381	50.0%	-\$28	\$2,999	\$2,971	100%*	38.0%	-0.5%	46.8%	24.0%
Idaho	85,883	59,078	53.9%	\$101	\$2,402	\$2,502	96.0%	39.4%	2.5%	27.1%	19.4%
Montana	57,356	37,978	49.6%	\$100	\$2,178	\$2,278	95.6%	54.5%	3.7%	40.0%	27.9%
Nevada	136,563	100,813	47.0%	\$188	\$3,445	\$3,633	94.8%	61.7%	2.9%	49.8%	27.1%
New Mexico	145,024	111,279	52.6%	\$194	\$4,510	\$4,704	95.9%	28.3%	2.1%	21.3%	15.5%
Oregon	294,600	211,542	56.7%	\$438	\$10,302	\$10,739	95.9%	60.6%	3.6%	50.6%	33.1%
Utah	138,918	78,284	52.5%	\$174	\$4,129	\$4,304	96.0%	56.1%	3.7%	35.3%	26.2%
Washington	295,662	189,463	52.2%	\$380	\$8,271	\$8,651	95.6%	25.2%	1.2%	26.0%	13.6%
Wyoming	29,899	19,099	53.0%	\$32	\$683	\$715	95.6%	40.0%	1.2%	26.8%	14.0%
Total	15,904,173	11,221,455	44.5%	\$21,148	\$443,530	\$464,678	95.4%	27.4%	1.4%	22.1%	13.2%

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

Table 2: Enhanced Outreach Scenario

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
	Northeast										
Connecticut	154,664	113,876	72.1%	\$440	\$5,048	\$5,488	92.0%	27.3%	2.0%	22.6%	12.3%
Maine	59,502	41,858	71.1%	-\$65	\$2,105	\$2,040	100%*	16.2%	-0.8%	14.7%	9.1%
Massachusetts**	75,569	43,508	42.9%	-\$628	\$2,783	\$2,155	100%*	5.2%	-1.0%	4.5%	1.8%
New Hampshire	76,744	52,146	73.4%	\$117	\$1,470	\$1,586	92.6%	53.3%	2.1%	26.0%	14.0%
New Jersey	567,852	455,627	70.6%	\$1,078	\$11,129	\$12,207	91.2%	55.4%	2.5%	25.7%	14.1%
New York	820,623	706,575	46.7%	\$2,859	\$17,170	\$20,030	85.7%	16.0%	1.2%	7.1%	4.1%
Pennsylvania	682,880	458,200	67.2%	\$2,041	\$19,489	\$21,530	90.5%	30.8%	2.7%	20.2%	12.4%
Rhode Island	53,841	40,850	70.9%	\$100	\$1,768	\$1,868	94.6%	26.2%	1.1%	16.5%	9.2%
Vermont	15,509	13,443	42.9%	\$8	\$283	\$291	97.4%	9.7%	0.2%	4.9%	2.9%
Midwest											
Illinois	911,830	694,012	68.8%	\$2,468	\$22,109	\$24,577	90.0%	37.2%	3.3%	29.7%	16.6%
Indiana	427,311	337,987	69.1%	\$899	\$10,112	\$11,010	91.8%	42.2%	4.8%	27.1%	19.6%
Iowa	163,264	117,621	69.6%	\$257	\$3,298	\$3,555	92.8%	36.1%	2.4%	18.4%	12.4%
Kansas	192,006	131,528	75.1%	\$260	\$4,033	\$4,293	93.9%	56.2%	2.6%	27.8%	17.5%
Michigan	812,818	635,231	74.6%	\$1,096	\$16,944	\$18,040	93.9%	41.6%	3.2%	25.6%	17.9%
Minnesota	348,684	211,781	70.7%	\$745	\$9,116	\$9,861	92.4%	45.6%	2.1%	25.6%	13.9%
Missouri	437,735	324,276	71.0%	\$773	\$10,228	\$11,001	93.0%	42.4%	3.1%	23.8%	16.2%
Nebraska	110,820	71,053	76.0%	\$155	\$2,732	\$2,886	94.6%	47.8%	2.2%	27.4%	16.9%
North Dakota	40,017	26,457	69.4%	\$57	\$709	\$766	92.5%	61.0%	2.5%	20.2%	13.2%
Ohio	901,023	670,992	72.6%	\$1,335	\$19,578	\$20,913	93.6%	43.1%	2.6%	22.0%	14.9%
South Dakota	41,847	27,160	75.8%	\$46	\$844	\$890	94.9%	34.6%	1.6%	19.3%	12.5%
Wisconsin	277,116	188,043	74.3%	\$314	\$4,912	\$5,226	94.0%	28.0%	1.4%	14.7%	9.4%
South											
Alabama	455,952	335,547	72.9%	\$693	\$11,404	\$12,097	94.3%	47.9%	5.3%	39.7%	28.9%
Arkansas	286,347	234,695	72.1%	\$761	\$11,523	\$12,284	93.8%	39.9%	7.9%	47.7%	36.3%
Delaware	28,839	23,317	46.9%	\$90	\$686	\$776	88.4%	15.9%	1.6%	11.0%	6.6%
District of Columbia	38,763	22,891	73.4%	\$62	\$1,068	\$1,129	94.5%	21.5%	1.3%	9.9%	7.3%
Florida	1,376,753	1,073,391	69.7%	\$2,537	\$24,260	\$26,797	90.5%	50.2%	3.8%	29.4%	18.0%
Georgia	907,203	721,558	74.4%	\$1,233	\$17,916	\$19,149	93.6%	56.7%	4.6%	35.6%	24.9%
Kentucky	423,757	337,987	77.0%	\$695	\$13,220	\$13,915	95.0%	48.1%	4.7%	35.8%	26.9%
Louisiana	507,952	409,869	74.8%	\$536	\$8,937	\$9,472	94.3%	44.9%	2.8%	26.5%	17.9%
Maryland	348,140	267,555	70.8%	\$1,060	\$10,881	\$11,941	91.1%	45.9%	3.4%	35.3%	19.4%
Mississippi	419,571	350,091	74.8%	\$581	\$10,959	\$11,539	95.0%	53.9%	6.4%	41.1%	32.4%
North Carolina	887,560	661,292	71.8%	\$1,791	\$24,720	\$26,511	93.2%	53.5%	4.6%	34.6%	24.0%
Oklahoma	470,358	367,541	74.8%	\$789	\$13,436	\$14,225	94.5%	67.4%	5.8%	53.2%	36.6%
South Carolina	443,020	334,296	76.2%	\$615	\$12,109	\$12,724	95.2%	49.4%	4.7%	39.9%	29.4%
Tennessee	474,240	372,894	65.7%	\$1,523	\$13,128	\$14,651	89.6%	29.9%	5.4%	24.2%	17.8%
Texas	2,513,355	2,055,888	73.6%	\$4,514	\$62,056	\$66,570	93.2%	63.5%	5.1%	45.9%	29.8%
Virginia	504,466	365,514	75.2%	\$863	\$11,129	\$11,992	92.8%	56.7%	3.1%	40.5%	21.8%
West Virginia	156,582	129,185	76.5%	\$217	\$4,182	\$4,399	95.1%	37.9%	3.2%	22.6%	17.4%
West											
Alaska	59,914	49,061	71.7%	\$219	\$2,379	\$2,598	91.6%	53.9%	3.9%	42.9%	23.4%
Arizona	305,634	273,008	45.6%	\$739	\$4,861	\$5,600	86.8%	22.4%	2.9%	9.9%	7.5%
California	2,986,362	2,291,221	67.6%	\$6,544	\$54,936	\$61,481	89.4%	29.9%	3.4%	28.3%	15.8%
Colorado	337,706	249,208	74.8%	\$470	\$6,925	\$7,395	93.6%	65.6%	2.9%	43.4%	23.2%
Hawaii	110,203	64,167	75.7%	\$30	\$3,414	\$3,444	99.1%	49.7%	0.5%	53.3%	27.8%
Idaho	115,730	85,523	78.1%	\$133	\$2,896	\$3,028	95.6%	53.1%	3.3%	32.7%	23.5%
Montana	78,840	56,889	74.3%	\$155	\$2,558	\$2,713	94.3%	75.0%	5.7%	47.0%	33.3%
Nevada	196,168	156,025	72.7%	\$338	\$4,100	\$4,438	92.4%	88.6%	5.2%	59.3%	33.1%
New Mexico	201,855	163,105	77.1%	\$278	\$5,608	\$5,885	95.3%	39.4%	3.0%	26.5%	19.4%
Oregon	386,845	292,651	78.4%	\$555	\$11,723	\$12,279	95.5%	79.6%	4.6%	57.6%	37.9%
Utah	180,478	113,872	76.3%	\$227	\$4,695	\$4,921	95.4%	72.8%	4.8%	40.2%	30.0%
Washington	395,577	276,096	76.1%	\$567	\$9,573	\$10,139	94.4%	33.6%	1.8%	30.1%	15.9%
Wyoming	40,041	27,488	76.2%	\$49	\$818	\$867	94.3%	53.6%	1.9%	32.0%	17.0%
Total	22,809,862	17,524,046	69.5%	\$43,218	\$531,958	\$575,176	92.5%	39.3%	2.9%	26.5%	16.4%

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

Introduction

This paper examines the impacts of the Patient Protection and Affordable Care Act (PPACA) on state and federal Medicaid coverage and associated costs. The PPACA will expand Medicaid coverage to large numbers of the nation's uninsured population. Currently, Medicaid provides fairly broad coverage of children, but there is less extensive coverage of parents and coverage of non-disabled childless adults is generally prohibited unless a state has a waiver. The law would expand Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL). As has been true in the past, undocumented immigrants are not eligible for Medicaid.

There is a great deal of variation today across states in terms of Medicaid coverage, uninsured rate and fiscal capacity so it is no surprise that the Medicaid expansion in health reform will affect states differently. While the new coverage requirements do not take effect until 2014, several states have raised concerns about the fiscal implications of expanded eligibility for Medicaid particularly because states are currently dealing with the severe economic downturn and the resulting sharp decline in their revenues. This analysis shows that while there will be significant increases in coverage and new federal revenues, there will be only small increases in how much more money states will be expected to spend on Medicaid from their own funds.

Federal Matching Rates Under PPACA

Under the PPACA, the federal government will finance the vast majority of spending for those made newly eligible for Medicaid. The PPACA will provide states, for all new eligibles, with 100 percent federal funding in 2014-2016, 95 percent federal financing in 2017, 94 percent federal financing in 2018, 93 percent federal financing in 2019 and 90 percent federal financing for 2020 and subsequent years.

However, some states, prior to passage of the PPACA had already made childless adults eligible for Medicaid up to 100 percent FPL at lower federal matching rates than those described above under the new law. Policymakers did not want those states that had gone further than others to be financially worse off under the PPACA. Consequently, the new law phases in an increase in the federal match rates so that by 2019, federal matching rates for childless adults who have been eligible for Medicaid through Section 1115 waivers will equal the rate for newly eligible populations at 93 percent

As Medicaid eligibility expands under the PPACA, new efforts are made at the state and federal level for program outreach, enrollment procedures are simplified, and the requirement to obtain coverage shifts perceptions of individual responsibility, we also anticipate significant increases in the enrollment of uninsured individuals currently eligible for Medicaid. With the exception of the childless adults in the waiver states described above, the federal government will pay current matching rates for any new enrollees who are eligible under pre-PPACA Medicaid rules. Under PPACA, states are now required to maintain eligibility standards in place on March 23, 2010. The different matching rates are shown in Table 1.

In general, one could think of states as falling into one of three categories:

- States who will have very large numbers of new eligibles starting in 2014 like Alabama and Texas. These tend to be states in the south and some in the west that have low levels of current eligibility and coverage. Most of their new enrollees will be newly eligible under PPACA and they will receive the high federal matching rates for them.

- States that have already covered large numbers of adults, mostly parents, through their Medicaid programs, using poverty related provisions of Medicaid law (these states do not cover childless adults through waiver programs). These include many states such as California and New Jersey. Because of higher participation rates among current eligibles, a smaller share of their new enrollees under PPACA will be from those made newly eligible.
- States that currently cover parents and childless adults in Medicaid today like Massachusetts and New York, or “expansion states”.
 - Massachusetts and Vermont that already cover childless adults with incomes above 133 percent of the FPL through Section 1115 waiver programs. These states will have no new eligibles; they will, however, receive the higher “waiver” matching rates on those currently eligible childless adults, including prior and new enrollees.
 - States that have extended coverage through Section 1115 waiver programs to childless adults but did not do so for those all the way up to 133 percent of the FPL. These states, Arizona, Hawaii, Delaware, Maine, and New York will receive the waiver matching rate for the childless adults that are currently eligible under these rules. Because PPACA expands eligibility for those up to 133 percent of the FPL, these states will receive the law’s higher matching rates for their new eligibles.

A major determinant of the financial impact on states of the Medicaid reforms in the PPACA will be the numbers of eligible people in each of the eligibility categories (current eligibles, new eligibles, parents, childless adults) who actually enroll in the program, i.e. the group specific participation rates. The Congressional Budget Office (CBO) seems to have assumed relatively modest participation rates in Medicaid, primarily because the law imposes no financial penalties for the lowest income people who do not obtain health insurance coverage, and this would include much if not all of those eligible for Medicaid (CBO, 2009). However, there are likely to be strong outreach efforts on the part of state and

federal governments, community based organizations as well as on the part of health care providers. Moreover, there will be some new generalized societal pressure to obtain insurance coverage since most people will be required to do so. For example, the insurance coverage rate for low-income people in Massachusetts is very high, even though this population is not penalized for being uninsured. While we do not expect all states to achieve the coverage rates observed in Massachusetts, participation could be higher than assumed by CBO. Thus we present results that approximate CBO participation rate assumptions as well as a set of assumptions with somewhat higher participation rates.

The key results below can be summarized as follows. Medicaid enrollment will clearly increase under health reform, by about 16.0 million and possibly more. The federal government will pay a very high share of new Medicaid spending under reform in all states. States with very low coverage rates today are perhaps the greatest beneficiaries because most of their new enrollment is from new eligibles for whom there is the extremely high federal matching rate. States with broader current coverage today, particularly of parents, have somewhat lower share of new spending borne by the federal government but the federal share still approximates 90 percent. The seven states with Section 1115 waiver programs that have provided extensive coverage to non-parents benefit from the phase-in of the higher expansion rate as well as the higher match on any new eligibles. States with state-funded programs that cover adults benefit from the fact that these adults are all considered new Medicaid eligibles. Other states that do not have state funded programs but make substantial contributions to uncompensated care can thus reduce the spending and will benefit from a large influx of federal dollars. While most states will experience some increase in spending, this is quite small relative to the federal matching payments and low relative to the costs of uncompensated care that they would bear if they were no health reform.

We do not address a number of topics that would affect state revenues. We did not assume changes in state Medicaid eligibility levels above 133% FPL (after 2014), although the availability of federal subsidies for the purchase of coverage through the new health insurance exchanges mean that states are likely to stop covering these somewhat higher income people through Medicaid. This change will affect a sizable share of the medically needy population and will provide significant savings to states that have, in the past, extended coverage in this way. These individuals will then obtain subsidized coverage through the new insurance exchanges. If states do continue to cover those with incomes above 133 percent FPL, there could be higher participation because of reform – we do not account for this either.

Second, we did not include estimates of increased costs resulting from higher physician payment rates under Medicaid. The effects of these rate increases will be fully borne by the federal government in 2013 and 2014, but not thereafter.

Third, we did not examine the eligibility provisions that affect children, but these provisions generally seem to benefit states financially. Under the new law, states are required to maintain coverage levels for children in Medicaid and CHIP through 2019 and funding for CHIP is extended from 2013 through 2015. If CHIP is reauthorized by 2015, the new law provides states with a 23 percentage point increase in the CHIP match rate (up to 100 percent) and if CHIP is not reauthorized, we assume that these children (i.e., those above 133% FPL) would likely be enrolled in exchanges with all subsidies financed by the federal government.

Fourth, we did not examine the fiscal implications of the reductions of disproportionate share hospital payments. Most states will be affected by these provisions, but the payment reductions will be small in comparison to estimates of the spending changes presented in this paper.

Finally, we did not examine any changes in Medicaid between 2010 and 2014. States are permitted to extend coverage to childless adults and receive their regular federal medical assistance percentages (FMAP) until 2014. States with state funded programs for childless adults may well take advantage of the opportunity to enroll these populations in Medicaid and will achieve significant savings by doing so.

Methods

The Model Database. We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data from 2006 and 2007). Two years of data are used to increase sample size, but estimates can still be imprecise, particularly in smaller states.¹ As described below, we attached eligibility indicators to identify those eligible for Medicaid under PPACA rules. The CPS has excellent income information and allows us to identify, with a fair degree of accuracy, those who would become eligible under the law's Medicaid eligibility expansion to individuals with incomes up to 133 percent of the FPL. The CPS also provides information on health insurance coverage (or lack of coverage) during the past year. However, it is generally accepted that the CPS undercounts the number of people enrolled in Medicaid, as evidenced by a substantial discrepancy between state Medicaid administrative data and CPS estimates (cites). We make a partial adjustment of the CPS data to state administrative data totals (see Dubay, Holahan, and Cook, 2007, for a complete description of this adjustment). We then reweight the total population to hit 2009 population estimates. We account for the impact of unemployment on coverage using estimates made by Holahan and Garrett (2009). This analysis estimated the impact of unemployment on changes in employer and public coverage and the uninsured. Assuming a nine percent unemployment rate, we used these results to reduce employer coverage, increase Medicaid enrollment, and increase the number of uninsured. We also benchmark to 2009 CPS total population estimates by state in addition to taking into account coverage and income distributions in the reweighting process. We estimate population growth to 2019 using growth rates based on Census population projections.

Eligibility Simulation. To estimate the impact of health reform on states, we need to simulate current eligibility. Once we identify whether individuals are currently eligible, we can then estimate the impact of expanding coverage to 133 percent of the FPL.² Individuals eligible for Medicaid, the Children's Health

Insurance Program (CHIP), and state-only financed programs are identified using a detailed Medicaid and CHIP eligibility model developed at the Urban Institute's Health Policy Center (Dubay and Cook, 2009). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS, simulating the eligibility determination process. The model also accounts for the pathways by which individuals can gain eligibility. Most important for our purposes, it identifies eligibility for Section 1115 waiver programs. Because Section 1115 waiver eligibles are treated differently under reform in seven states, it is important to identify those who are eligible for and currently enrolled through 1115 waiver programs. The states that we identified as meeting section 1115 program benchmark standards include Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

Family-level characteristics used in determining eligibility, such as income, are based on the health insurance unit (HIU). The model takes into account childcare expenses, work expenses, and earnings disregards in determining eligibility in the baseline. However, because the CPS does not collect information on monthly income, it is not possible to determine how eligibility status changes as a result of income fluctuations throughout the year. For non-citizens, the eligibility simulation also takes into account length of residency in the United States in states where this is a factor in eligibility. To account for the possibility that some foreign born individuals are unauthorized immigrants and therefore not eligible for public health insurance coverage, the model imputes legal immigrant status. Legal immigrant status is imputed based on a model that identified immigration status on the March 2004 CPS and then was used to predict immigration status on the March 2007 and 2008 CPS file used here. Estimates derived from the model are consistent with those produced using the March 2008 CPS (Passel and Cohen, 2009).

Participation Rates. Once we have identified individuals who are newly eligible for Medicaid under PPACA rules, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to participate at relatively high rates post-reform, but not all new participation will come from the ranks of the uninsured. Some who now have employer-sponsored or non-group coverage will see Medicaid as a preferred alternative, due to low or no premiums, better benefits, and lower or no cost sharing. Some are likely to drop private coverage and take up Medicaid once eligible. Participation rates are also likely to increase for those who are currently eligible but not participating in Medicaid, regardless of whether they currently have employer-sponsored coverage, non-group coverage, or are uninsured, due to expanded outreach and simplified enrollment processes expected under the PPACA. Thus we make assumptions about increased take-up rates among those populations as well.

In our first scenario, we make Medicaid participation assumptions that approximate those used by CBO. We adjust take-up rates so that our expenditure estimates are in line with CBO's estimates. This includes lower take-up rates for the early years of the reform plan when CBO assumes lower expenditures due to a phasing up of new Medicaid enrollment. In the early years, CBO assumes little increase in enrollment of those eligible for Medicaid under pre-PPACA rules.

In the second scenario, we assume that the take-up rates will be higher than under the CBO-consistent assumptions. The justification for higher participation rate assumptions are that individuals will respond to the presence of the new legal requirement to have coverage even though this population is largely exempt from any financial penalties for non-compliance, expectations of strong outreach efforts on the part of advocacy organizations, and the incentives providers will face to enroll beneficiaries, particularly in the light of reductions of disproportionate share hospital payments. These factors will primarily affect take-up by the uninsured and the assumptions made are consistent with the participation rates embedded in the Urban Institute's Health Insurance Policy Simulation Model

(HIPSM). The assumptions are calibrated to reflect evidence on take-up rates in public programs as well as the literature on the crowding out of private coverage under public program expansions. The two alternative sets of take-up rates are presented in Table 2 (without the phase-in adjustment).

Cost per Person. We use estimates of the costs per enrollee from HIPSM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. HIPSM estimates are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Costs per enrollee are then inflated to 2019 using growth rates from the CBO March 2009 baseline.

The Baseline. In order to assess the impacts of reform, we must first construct estimates of state and federal spending in the absence of PPACA, i.e., baseline spending. Baseline enrollment and national spending totals for the years 2009-2019 were calculated by applying CBO's predicted Medicaid enrollment and spending growth rates from the March 2009 baseline to data on enrollment and spending from the 2007 Medicaid Statistical Information Statistics (MSIS). We adjust MSIS spending data to spending on Medicaid benefits reported by the CMS-64, since the CMS-64 data is considered to be a more accurate data source due to its use in the calculation of federal matching payments for the states. The "adjusted" MSIS then provides 2007 estimates of enrollment and spending for children, adults, disabled and aged for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total

spending amounts in 2009 (Federal Register, 2007). This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year (Federal Register, 2008 & 2009), without the adjustments made by the American Recovery and Reinvestment Act (ARRA).

National Results

Impact on Coverage. Table 3 presents the 2019 national coverage impacts of the Medicaid provisions in PPACA under the two alternative participation rate assumptions. Under the lower participation rate assumptions (keyed to CBO assumptions), 15.9 million low-income individuals will be added to Medicaid under PPACA. Of these, 15.0 million are those who will be newly eligible under PPACA rules; 94.1 percent of new enrollees would be those who become eligible after the PPACA Medicaid expansion. In addition, 200,000 will be individuals already eligible for Medicaid through Section 1115 waiver programs who would newly enroll because of reform. Another 0.8 million are those adults (primarily parents) who are currently eligible for Medicaid and who would take up coverage under reform. The table also shows that there are 400,000 childless adults already enrolled in Section 1115 waiver programs who would receive enhanced matching payments.

Under the higher participation rate assumption, significantly more of today's uninsured population who are currently eligible but not enrolled in Medicaid would enter the program, including "waiver" populations (i.e., childless adults currently eligible through 1115 waivers). In total, 2.8 million people who are currently eligible but not covered by Medicaid would enroll under the higher assumptions, in addition to 19.4 million made newly eligible for the program. Total new enrollment under this scenario would be 22.8 million, 85.0 percent of which would be newly eligible people.

Table 3 also shows that Medicaid enrollment would increase by 27.4 percent relative to the baseline under the lower participation rate assumption and by 39.3 percent under the higher participation rate assumption. Further, Table 3 also shows that the Medicaid coverage under the lower participation rate

assumption would reduce the number of uninsured by 11.2 million; 4.7 million new enrollees would have had other coverage in the absence of PPACA. Under the higher participation rate assumption, the Medicaid expansion would reduce the number of uninsured by about 17.5 million.

Overall Impact on Cost. In aggregate, across the years 2014-2019, state spending will increase by \$21.1 billion under the lower participation rate assumption and federal spending will increase by \$443.5 billion. Thus about 95 percent of all new spending will be paid for by the federal government.

Under the higher participation rate assumption, state spending will increase by \$43.2 billion while federal spending will increase by \$532.0 billion. The share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs (Table 1).

The second panel of Table 4 shows that new spending in 2014 will be relatively small, particularly for states. Spending will be low in 2014 because enrollment is being phased-in and the federal matching rate for new eligibles is 100 percent. By 2019, new spending on Medicaid will be about \$105 billion under the lower participation rate assumptions or \$132 billion under the higher. The federal government will bear a slightly lower share of overall spending than in 2014. By 2019, enrollment is fully phased-in and the federal matching rates on new eligibles will be reduced to 93 percent (90 percent in 2020 and thereafter). Thus, overall spending is higher and the federal share is slightly lower. The share of spending borne by the federal government after 2019 will be slightly below the levels seen in 2019.

The third panel shows the six year estimates divided into new spending on current and new eligibles. Spending on current eligibles includes the waiver populations in Section 1115 waiver program states for whom there is an enhanced match under PPACA. Spending on new enrollees who are

currently eligible accounts for about one fifth of state spending under the lower participation assumption, because states pay a much higher share of the costs attributable to current eligibles than they do for those newly eligible. In contrast, spending by the federal government is predominantly for new eligibles because of the very high matching rates for this group.

Under the higher participation rate assumption, state spending on current eligibles exceeds that for new eligibles. This is because we assume higher participation rates for those who are currently eligible but not enrolled in this scenario. Again, states spend relatively little on new eligibles. Federal spending under this participation rate assumption is higher than under the lower participation assumption for both current and new eligibles. It is higher for current eligibles because more people are assumed to be covered. Federal spending is higher under this scenario for new eligibles because there would be more new enrollees and the federal government bears most of the costs associated with them.

The fourth panel shows new state and federal spending relative to the baseline, that is, spending that would have occurred without the PPACA Medicaid expansion. Under the lower participation rate assumption, state spending will increase by 1.4 percent while federal spending would increase by 22.1 percent under the new law. Again, the differential occurs because of the very high matching rate on new eligibles as well as the phase in of higher matching rates on prior state waiver populations.

Under the higher participation rate assumption, the number of new enrollees will be much greater, but there would still only be an increase in state spending of about 2.9 percent relative to the baseline. In contrast, the federal government will increase spending on Medicaid by 26.5 percent relative to the baseline. Overall (including state and federal spending), the Medicaid expansion envisioned in health reform will increase Medicaid spending by 13.2 percent under the lower participation rate assumption, and 16.4 percent under the higher. The percentage increases in spending relative to the baseline are lower than the percentage increases in enrollment (relative to the baseline) because the new enrollees are considerably less expensive than the individuals currently being covered.

Results by State: Lower Participation Rates

Increases in State and Federal Spending. This section highlights results for individual states. Tables 5-8 provide results of the simulations using the lower participation rate assumptions. Table 5 shows that states with Section 1115 waiver programs -- Maine, Massachusetts, New York, Vermont, Delaware, Arizona, and Hawaii -- will have a very high share of PPACA Medicaid spending borne by the federal government. This occurs because the federal matching rate will increase each year for "waiver" states, as described earlier, until it reaches the same rate as is provided for new eligibles under the law. For the states that have already covered all or most childless adults with incomes below 133 percent FPL and are paying as much as 50 percent of the cost for these enrollees, the enhanced match provides substantial fiscal relief.

Hawaii, Maine, Massachusetts, and Vermont actually save money while states such as Arizona and Delaware will have relatively low new spending. Hawaii, Maine, Massachusetts, and Vermont benefit because the higher federal matching dollars that they will get for their waiver enrollees will exceed the additional state dollars that will be spent on increased enrollment among other previously eligible people. The other waiver states such as Arizona and Delaware also will benefit from the enhanced match. They have some new enrollees for whom they will receive very high federal matching rates. However, unlike Massachusetts and Vermont, spending by Arizona and Delaware on new enrollment among previous eligibles will not exceed their gains from the higher match on their waiver enrollees, although Hawaii just about breaks even.

New York will have over 99 percent of its new costs paid by the federal government. New York already covers parents with incomes above 133 percent FPL and will receive its current match on these enrollees, including any new enrollment among current eligibles. New York will benefit from the higher PPACA match on childless adults that it is currently covering (individuals with incomes up to 100 FPL)

and will receive the very high federal match for the new eligibles under PPACA with incomes between 100 and 133 percent of poverty.

In general, states with high levels of current eligibility receive a high, but somewhat lower share of new spending coming from the federal government. For example, California has relatively more current eligibles and fewer new eligibles than the average state, although it does not have a waiver program (i.e., it does not cover childless adults via 1115 waiver today). Nonetheless, the federal government will still pay 93.7 percent of new Medicaid costs for Californians over the 2014-2019 period.

The federal government will pay for at least 95 percent of new Medicaid spending for most lower-income states throughout the country under the PPACA. For example, Alabama, Mississippi, Oklahoma, and South Carolina will receive federal payments covering about 96 percent of expenditures, and Texas 95 percent of their costs.

There is another set of states including Pennsylvania, Minnesota, Wisconsin, and Washington that cover childless adults in programs funded entirely by the states. These states will benefit greatly from the PPACA because these groups will be considered new eligibles. They will receive the new higher matching rate which will greatly reduce current state spending. Other states that support hospitals and clinics providing large amounts of uncompensated care will also benefit from having much of their uninsured populations covered by insurance and heavily subsidized by the federal government.

Increases in Spending by Current and New Eligibles. Table 6 provides the same information, divided by current eligibles and new eligibles. The results show federal spending by states on current eligibles is very high in the Section 1115 waiver states. Spending on current eligibles includes the “waiver population” (childless adults for which there will be a higher match) as well as new participation among other currently eligible adults. Table 6 shows that all of the new spending in Massachusetts and Vermont is on the current eligibles; these states save money under PPACA because of the higher

matching rate for the waiver population. A high share of new spending in New York will be on current eligibles; they will receive their current match on currently eligible parents and the higher match on childless adults. Thus, New York bears a higher share of new spending than states without as much prior eligibility. In contrast, in most other states, particularly in the south and west, the majority of the new spending is on new eligibles for whom they will receive an extremely high federal match rate.

Increases in Enrollment Relative to Baseline; Impact on the Uninsured. Table 7 shows the impact of the PPACA Medicaid eligibility expansion on the uninsured population in 2019. Overall, the number of uninsured adults with incomes below 133 percent FPL will fall by 44.5 percent. In some states with broader eligibility and coverage, there are relatively few new eligibles. Since there are low take-up rates among current eligibles, there is less of an effect on the uninsured. This is the case, for example, in Arizona, Delaware, Massachusetts, New York, and Vermont.

Table 7 also shows increased enrollment relative to the baseline, that is, the number of individuals the state is already covering. The increase relative to the baseline will be lower in states with broad coverage and higher in states with more restrictive eligibility requirements regardless of the impact of the expansion. The results in Table 7 show that Massachusetts would have an increase in enrollment of 2.0 percent, Vermont 2.8 percent, New York 6.0 percent and Arizona 7.7 percent. These states have covered large numbers of childless adults through Section 1115 waiver programs and therefore would experience relatively little new enrollment. On the other hand, states with low levels of coverage prior to the PPACA would experience relatively high levels of new enrollment. For example, Alabama would increase enrollment by 36.9 percent, Oklahoma by 51.2 percent, Texas by 45.5 percent, and Nevada by 61.7 percent.

Increases in Spending Relative to Baseline; Federal and State. Table 8 shows state by state baseline spending in addition to the new Medicaid spending that will occur under PPACA. Overall, state spending will increase by 1.4 percent while federal spending will increase by 22.1 percent; overall Medicaid spending would increase by 13.2 percent. Thus new state spending is not large compared to the underlying baseline. This is particularly striking because of the increased enrollment of 27.4 percent. This is because the new enrollees are considerably less expensive than those already covered under Medicaid, as well as the very high federal matching payments.

The increases in spending under PPACA will be lower in states that have already covered a large share of these populations either through waivers or other programs. Hawaii, Maine, Massachusetts and Vermont will actually spend less relative to the baseline than they are spending today on Medicaid (Vermont also receives an additional 2.2 percent increase in their matching rate for baseline spending on parents which we have not accounted for). Again, this is because of the increased matching on waiver populations. Other waiver states will see very small increases in state spending relative to the baseline. The increases in spending relative to the baseline will also be lower for states with more long-term care coverage, which increases baseline expenditures. New York will spend very little compared to current levels because of the high match on their waiver population and on new enrollees, but also because of its large expenditure baseline that includes higher than average long-term care spending. California's own spending will increase by only 1.5 percent relative to the baseline, despite an overall increase of 12.3 percent.

States with more modest coverage today -- Alabama, Arkansas, Mississippi, Oklahoma, South Carolina, and Texas -- will see very large overall (federal and state) increases in spending relative to the current Medicaid base. But even these states will see relatively small increases in their own spending, both because they are low-income states and thus have higher than average matching rates on their current eligibles, but also because of the very favorable matching rate on new eligibles. Alabama will

have spending from state funds increased by 3.6 percent, Arkansas by 4.7 percent, Mississippi by 4.8 percent, Oklahoma by 4.0 percent, South Carolina by 3.6 percent, and Texas by 3.0 percent. Thus, despite rather substantial increases in overall spending on Medicaid in these states, only a relatively small share of the cost will be borne by the states themselves.

Table 8 also shows the change in effective federal matching rates. The federal matching rates pre-reform and pre-ARRA average 57.1 percent. The effective federal matching rate after reform is the combination of current matching rates on current eligibles, expanded matching rates on childless adults or Section 1115 waiver programs, and the higher federal matching rates on new PPACA eligibles. States that will experience large increases in the number of new eligibles will see the greatest increases in effective matching rates. For example, the FMAP in Texas will increase from 60.6 percent to 67.4 percent, in Oklahoma from 64.9 percent to 72.5 percent. In contrast, states that have greater current coverage, particularly of parents, will see relatively small increases in their effective federal matching rate. For example, the federal matching rate in New York will increase from 50.0 to 50.8 percent and Vermont from 58.7 to 59.3 percent.

Results by State: Higher Participation Rates

Increases in Federal and State Spending. Tables 9 through 12 show results from the higher participation rate scenario. In this scenario, there are higher participation rates among both current and new eligibles. But compared to the first scenario, a larger share of the increase in Medicaid spending under PPACA will be attributable to higher take-up among current eligibles. For these people, states will receive their current matching rates. Thus, the share of new spending borne by the federal government is somewhat lower under this scenario than under the other, but we still find that, in virtually all states, over 90 percent of new spending under reform will be paid for with federal dollars (Table 9).

Maine and Massachusetts continue to save money even in the higher participation rate scenario. Vermont no longer will save under this scenario because the new spending on current eligibles will exceed their savings from the higher match on waiver eligibles. New York has a very large share of current eligibles because of its coverage of parents with incomes above 133 percent FPL as well as its coverage of childless adults. The share borne by the federal government, however, falls relative to the scenario assuming lower participation rates because of the higher enrollment of current eligibles in this scenario. The share of spending borne by the federal government in low coverage states remains at or above 90 percent even under the higher participation rate scenario.

Increases in Spending by Current and New Eligibles. Table 10 provides information on spending for current eligibles and new eligibles. Nationally, 87.2 percent of new spending will be for new eligibles, but there are some important exceptions. All new spending in Vermont and Massachusetts will be for current eligibles. Since currently covered waiver populations receive an enhanced match under PPACA, new state spending will be very low. In general, the share of new spending on new eligibles will be lower than the average in states with more current coverage, e.g. California and New York, because of the assumption of higher take-up rates among current eligibles. This has a bigger effect in those states with more current eligibles than in states with fewer. Again, the results show that over 90 percent of overall spending in most states in the south and west is on new eligibles.

Increases in Enrollment Relative to Baseline; Impact on the Uninsured. Table 11 shows that under the higher participation rate scenario, Medicaid will cover 22.8 million additional Americans. Of these, 17.5 million would have been uninsured in the absence of PPACA. The number of uninsured adults with incomes less than 133 percent FPL would decline by 69.5 percent. The impact on the uninsured will be

greater in states with low current levels of coverage. This tends to occur because these states tend to have low rates of employer-sponsored insurance and higher uninsured rates to begin with.

Further, Table 11 shows the new enrollment as a percent of number of people projected to be enrolled in Medicaid in the baseline. This figure represents a 39.3 percent increase nationally. New enrollment is considerably lower in waiver states; 5.2 percent in Massachusetts, 9.7 percent in Vermont, 16.0 percent in New York, and 22.4 percent in Arizona. In contrast, states with lower coverage in the baseline experience much greater increases in enrollment. For example, in Alabama enrollment increases by 47.9 percent, in Oklahoma by 67.4 percent, in Texas by 63.5 percent, and in Nevada by 88.6 percent.

Increases in Spending Relative to Baseline; Federal and State. Table 12 shows new state by state levels of Medicaid spending under reform, in addition to state by state baseline levels of spending. Again, as discussed in the previous section, new state spending relative to the baseline will be relatively small. Even with the higher participation rate assumptions, new state spending will amount to a 2.9 percent increase over baseline spending. Federal spending will increase by 26.5 percent relative to the baseline and overall Medicaid spending will increase by 16.4 percent.

The largest increases in state spending will be in states with less coverage to begin with. These are the same states that will have the largest increases in federal spending relative to the baseline. States that have had more generous coverage will see less of an increase in state spending as well as less of an increase in federal spending. Some of the increases in state spending relative to the baseline are affected by long-term care expenditures. Thus states in the northeast and Midwest with significant long-term care spending will see less of an increase in new spending relative to the total Medicaid baseline, all else being equal.

Massachusetts will save money under PPACA, even with the higher participation rate assumptions. Total Medicaid spending in Massachusetts will increase by only 1.8 percent, simply because there are fewer new people to be covered. Vermont and New York are in somewhat the same position. Even with the higher participation rates assumptions, state spending in New York and Vermont will increase little relative to the baseline, 1.2 percent and 0.2 percent respectively. Federal expenditures in New York and Vermont will increase by 7.1 and 4.9 percent, respectively.

Many states in the south and the west will see increases in federal spending of over 30 percent relative to the baseline. In general, these states have relatively low long-term care spending and the coverage expansion to individuals with incomes up to 133 percent of the FPL represents a sharp increase in coverage. Despite the large overall increases in total Medicaid spending, the increase in state spending relative to the baseline is still low, i.e. 5.3 percent Alabama, 2.8 percent in Louisiana, 4.7 percent in South Carolina, 5.1 percent in Texas, 3.0 percent in New Mexico, and 2.9 percent in Arizona.

Table 12 also shows increases in effective federal matching rates under the higher participation rate assumptions. The results are similar to those shown in Table 9, but because there is more new coverage under this scenario, the average new federal matching rate increase is slightly higher here, rising from 57.1 percent to 62.1 percent. Again, states that had substantial coverage of parents prior to reform will see relatively small increases in the average federal matching rate because these groups will continue to receive the current matching rate for these populations. Thus, New York's effective matching rate will increase from 50.0 to 51.4 percent and Vermont's from 58.7 to 59.8 percent. In contrast, the average matching rate in Texas will increase from 60.6 to 68.1 percent. In Oklahoma, the federal matching rate will effectively increase from 64.9 percent to 72.8 percent. In all of the states with substantial increases in new eligibles, we see that the average matching rate will increase by at least five percentage points under PPACA.

Conclusion

The changes to the Medicaid program under the Patient Protection and Affordability Care Act (PPACA) will expand coverage by an estimated 15.9 to 22.8 million low-income individuals under the participation rate scenarios modeled in this paper. We have shown in this paper that most of the cost of the new expansion will be borne by the federal government. States will have relatively small increases in state spending, but these will be swamped by the new federal dollars that they will receive because of the reform. This is particularly true in the states that have low coverage today and will experience the largest increases in individuals newly eligible for the program. States that already have extensive coverage, particularly of parents, will benefit to a somewhat lesser degree, but will still have the overwhelming share of new spending borne by the federal government. States that have used Section 1115 waiver programs to cover childless adults will benefit from provisions that will provide them with higher federal matching rates over time. All states will also benefit from the fact that they no longer will either need to provide state funded insurance or finance uncompensated care for as large a population as they do today. New state spending relative to states' own baselines, what they would have spent in the absence of reform, is relatively small; there will be large increases in coverage in exchange for small net increases in state spending. By contrast, the increases in federal spending relative to the baseline will be quite large.

Of course, the impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond, so this analysis looked at a range of participation assumptions that are applied uniformly across states, but in reality this will vary. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and see greater reductions in the number of uninsured.

Note

¹ The American Community Survey (ACS) has much larger samples and will offer an opportunity to make these estimates more precise in the future. There is also measurement error, not surprisingly, in the simulation of eligibility because the complexity in measuring income disregards both individuals and families, thus making the ability to discriminate between old and new eligibles difficult.

² In this analysis we increase Medicaid coverage to individuals with incomes up to 133 percent FPL using a gross income measure. The law would have states begin to use the modified adjusted gross income (MAGI). We conclude that the MAGI is close to gross income for those who might be Medicaid eligible. The MAGI contains both subtractions and additions to adjusted gross income (AGI). These largely affect the individual retirement account (IRA) conversions and rollovers which are deducted from AGI and IRA deductions, student loan interest deductions, tuition deductions, foreign income and housing deductions which are added back into AGI. Health savings accounts deductions are also included in MAGI. We conclude that these are not likely to affect the numbers of people eligible for Medicaid. In this analysis, we used a gross income measure of 133 percent FPL. The law allows another five percent for disregards. We estimate that this would add \$8.8 billion under the lower participation rate assumption and \$9.6 billion under the higher participation rate assumption to total Medicaid spending.

References

Congressional Budget Office (CBO). "Spending and Enrollment Detail for CBO's March 2009 Baseline: Medicaid." Washington, DC: CBO, March 2009.

Dubay, L. and A. Cook. "How Will the Uninsured Be Affected by Health Reform?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2009.

Dubay, L., J. Holahan and A. Cook. "The Uninsured and the Affordability of Health Insurance Coverage." *Health Affairs* 26(1): Q22-W30, 2007.

Federal Register. "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2008 Through September 30, 2009." Washington, DC: U.S. Government Printing Office, Vol. 72, No. 228, November 28, 2007.

Federal Register. "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2009 Through September 30, 2010." Washington, DC: U.S. Government Printing Office, Vol. 73, No. 229, November 26, 2008.

Federal Register. "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, 2010 through September 30, 2011." Washington, DC: U.S. Government Printing Office, Vol. 74, No. 227, November 27, 2009.

Holahan J., B. Garrett, I. Headen and A. Lucas. "Health Reform: The Cost of Failure." Washington, DC: The Urban Institute, May 21, 2009.

Passel, J. and D. Cohen. "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center, April 2009.

**Table 1
Federal Matching Rate Schedule**

	2014	2015	2016	2017	2018	2019
Current Eligibles	CMR	CMR	CMR	CMR	CMR	CMR
Waiver Population**	50%	60%	70%	80%	90%	100%
New Eligibles	100%	100%	100%	95%	94%	93%

*CMR= the current federal matching rate as of 2009

**Waiver population matching rates represent the percent of the difference between the Newly Eligibles Matching Rate (NER) and the Current Matching Rate (CMR) that will be applied in addition to the Current Matching Rate for this population. For example, the federal matching rate in 2014 for the waiver population would equal the following: $CMR + .5(NER-CMR)$.

**Table 2
Participation Rates by Simulation Scenario**

	Baseline Insurance Coverage	Participation Assumption I	Participation Assumption II
Current Eligibles			
	ESI	3%	5%
	Nongroup	7%	10%
	Uninsured	10%	40%
Waiver Population			
	ESI	3%	5%
	Nongroup	7%	10%
	Uninsured	10%	40%
New Eligibles			
	ESI	25%	25%
	Nongroup	54%	60%
	Uninsured	57%	75%

Table 3
National Totals
Coverage Impacts from Medicaid Expansion in PPACA in 2019

Increases in Enrollment, By Population (in millions)						
	New Eligibles	Current Eligibles	from Waiver Eligibles	Total New Enrollment	% New Eligibles	Waiver Enrollees
Participation Assumption I	15.0	0.8	0.2	15.9	94.1%	0.4
Participation Assumption II	19.4	2.8	0.6	22.8	85.0%	0.4

Increase in Medicaid Enrollment Relative to the Baseline			
	Baseline Enrollment	New Medicaid Enrollees	% Change in Enrollment
Participation Assumption I	58.0	15.9	27.4%
Participation Assumption II	58.0	22.8	39.3%

Impact on Medicaid Enrollment and the Uninsured (in millions)			
	Medicaid New Enrollees	Uninsured	% Decrease in Uninsured Adults under
Participation Assumption I	15.9	11.2	44.5%
Participation Assumption II	25.2	17.5	69.5%

Table 4
National Totals
Expenditure Impacts from Medicaid Expansion in PPACA, 2014-2019

	State and Federal Spending, 2019 (in billions)			2014-
	State Spending	Federal Spending	Total	% Federal Spending
Participation Rates Assumption I	\$21.1	\$443.5	\$464.7	95.4%
Assumption II	\$43.2	\$532.0	\$575.2	92.5%

	State and Federal Spending by Year (in billions)							
	2014				2019			
	State Spending	Federal Spending	Total	% Federal	State Spending	Federal Spending	Total	% Federal Spending
Participation Rates Assumption I	\$0.1	\$28.7	\$28.9	99.5%	\$7.8	\$97.0	\$104.8	92.5%
Assumption II	\$1.4	\$33.6	\$35.0	96.0%	\$13.3	\$118.6	\$132.0	89.9%

	State and Federal Spending For Current and New Eligibles, 2014-2019								
	State			Federal			Total		
	Current Eligibles	New Eligibles	Total	Current Eligibles	New Eligibles	Total	Current Eligibles	New Eligibles	Total
Participation Rates Assumption I	\$4.1	\$17.1	\$21.1	\$16.4	\$427.2	\$443.5	\$20.5	\$444.2	\$464.7
Assumption II	\$23.8	\$19.4	\$43.2	\$49.6	\$482.4	\$532.0	\$73.4	\$501.8	\$575.2

	Increases in Spending Over Baseline, 2014-2019 (in billions)					
	State		Federal		Total	
	Baseline	New	Baseline	New	Baseline	New
Participation Rates Assumption I	\$1,504.0	\$21.1 (1.4%)	\$2,005.5	\$443.5 (22.1%)	\$3,509.5	\$464.7 (13.2%)
Assumption II	\$1,504.0	\$43.2 (2.9%)	\$2,005.5	\$532.0 (26.5%)	\$3,509.5	\$575.2 (16.4%)

Table 5

**Medicaid Expansion to 133%: Additional Spending by States in Reform
Lower Participation Rate Assumption
(in millions)**

		2014-2019			
		Total State Spending	Total Federal Spending	Total Spending	% Federal Spending
Northeast					
	Connecticut	\$263	\$4,686	\$4,949	94.7%
	Maine	-\$118	\$1,857	\$1,738	100%*
	Massachusetts	-\$1,274	\$2,137	\$864	100%*
	New Hampshire	\$63	\$1,204	\$1,267	95.0%
	New Jersey	\$533	\$9,030	\$9,563	94.4%
	New York	\$50	\$8,049	\$8,099	99.4%
	Pennsylvania	\$1,054	\$17,086	\$18,140	94.2%
	Rhode Island	\$70	\$1,559	\$1,629	95.7%
	Vermont	-\$26	\$112	\$86	100%*
Midwest					
	Illinois	\$1,202	\$19,259	\$20,461	94.1%
	Indiana	\$478	\$8,535	\$9,013	94.7%
	Iowa	\$147	\$2,800	\$2,947	95.0%
	Kansas	\$166	\$3,477	\$3,643	95.4%
	Michigan	\$686	\$14,252	\$14,938	95.4%
	Minnesota	\$421	\$7,836	\$8,257	94.9%
	Missouri	\$431	\$8,395	\$8,826	95.1%
	Nebraska	\$106	\$2,345	\$2,451	95.7%
	North Dakota	\$32	\$595	\$627	94.9%
	Ohio	\$830	\$17,130	\$17,960	95.4%
	South Dakota	\$32	\$717	\$748	95.8%
	Wisconsin	\$205	\$4,252	\$4,457	95.4%
South					
	Alabama	\$470	\$10,305	\$10,776	95.6%
	Arkansas	\$455	\$9,401	\$9,856	95.4%
	Delaware	\$3	\$387	\$390	99.2%
	District of Columbia	\$42	\$902	\$944	95.6%
	Florida	\$1,233	\$20,050	\$21,283	94.2%
	Georgia	\$714	\$14,551	\$15,265	95.3%
	Kentucky	\$515	\$11,878	\$12,393	95.8%
	Louisiana	\$337	\$7,273	\$7,610	95.6%
	Maryland	\$533	\$9,112	\$9,645	94.5%
	Mississippi	\$429	\$9,865	\$10,294	95.8%
	North Carolina	\$1,029	\$20,712	\$21,741	95.3%
	Oklahoma	\$549	\$12,179	\$12,728	95.7%
	South Carolina	\$470	\$10,919	\$11,389	95.9%
	Tennessee	\$716	\$11,072	\$11,788	93.9%
	Texas	\$2,619	\$52,537	\$55,156	95.3%
	Virginia	\$498	\$9,629	\$10,127	95.1%
	West Virginia	\$164	\$3,781	\$3,945	95.9%
West					
	Alaska	\$117	\$2,046	\$2,163	94.6%
	Arizona	\$56	\$2,091	\$2,147	97.4%
	California	\$2,982	\$44,694	\$47,676	93.7%
	Colorado	\$286	\$5,917	\$6,203	95.4%
	Hawaii	-\$28	\$2,999	\$2,971	100%*
	Idaho	\$101	\$2,402	\$2,502	96.0%
	Montana	\$100	\$2,178	\$2,278	95.6%
	Nevada	\$188	\$3,445	\$3,633	94.8%
	New Mexico	\$194	\$4,510	\$4,704	95.9%
	Oregon	\$438	\$10,302	\$10,739	95.9%
	Utah	\$174	\$4,129	\$4,304	96.0%
	Washington	\$380	\$8,271	\$8,651	95.6%
	Wyoming	\$32	\$683	\$715	95.6%
Total		\$21,148	\$443,530	\$464,678	95.4%

*Federal Government essentially picks up all of net new spending while the state actually saves money due to the federal government spending more on currently enrolled 1115 waiver non-parents

Table 6
Medicaid Expansion to 133%: Additional Spending by States in Reform by Eligibility Type
Lower Participation Rate Assumption
(in millions)

	Current Eligibles*			2014-2019			% New Eligible Spending
	State Spending	Federal Spending	Total Spending	State Spending	Federal Spending	Total Spending	
Northeast							
Connecticut	\$79	\$79	\$158	\$184	\$4,607	\$4,791	96.8%
Maine	-\$183	\$233	\$49	\$65	\$1,624	\$1,689	97.2%
Massachusetts	-\$1,274	\$2,137	\$864	\$0	\$0	\$0	0.0%
New Hampshire	\$16	\$16	\$32	\$47	\$1,188	\$1,235	97.5%
New Jersey	\$180	\$180	\$360	\$353	\$8,850	\$9,203	96.2%
New York	-\$94	\$4,426	\$4,332	\$145	\$3,623	\$3,767	46.5%
Pennsylvania	\$390	\$468	\$858	\$664	\$16,619	\$17,282	95.3%
Rhode Island	\$9	\$9	\$18	\$62	\$1,549	\$1,611	98.9%
Vermont	-\$26	\$112	\$86	\$0	\$0	\$0	0.0%
Midwest							
Illinois	\$452	\$458	\$909	\$751	\$18,801	\$19,552	95.6%
Indiana	\$148	\$266	\$413	\$330	\$8,270	\$8,600	95.4%
Iowa	\$38	\$63	\$101	\$109	\$2,737	\$2,846	96.6%
Kansas	\$29	\$44	\$73	\$137	\$3,433	\$3,570	98.0%
Michigan	\$124	\$188	\$312	\$562	\$14,064	\$14,626	97.9%
Minnesota	\$113	\$113	\$225	\$308	\$7,723	\$8,031	97.3%
Missouri	\$103	\$177	\$281	\$328	\$8,217	\$8,545	96.8%
Nebraska	\$13	\$20	\$33	\$93	\$2,325	\$2,418	98.7%
North Dakota	\$9	\$15	\$23	\$23	\$580	\$604	96.3%
Ohio	\$157	\$257	\$414	\$674	\$16,873	\$17,546	97.7%
South Dakota	\$3	\$5	\$9	\$28	\$711	\$740	98.9%
Wisconsin	\$38	\$55	\$92	\$168	\$4,197	\$4,365	97.9%
South							
Alabama	\$64	\$137	\$201	\$406	\$10,169	\$10,575	98.1%
Arkansas	\$90	\$240	\$329	\$366	\$9,161	\$9,527	96.7%
Delaware	-\$6	\$157	\$151	\$9	\$229	\$238	61.2%
District of Columbia	\$6	\$15	\$21	\$35	\$887	\$922	97.7%
Florida	\$455	\$565	\$1,019	\$778	\$19,486	\$20,264	95.2%
Georgia	\$144	\$261	\$404	\$571	\$14,290	\$14,861	97.4%
Kentucky	\$45	\$106	\$151	\$470	\$11,772	\$12,242	98.8%
Louisiana	\$51	\$128	\$179	\$285	\$7,145	\$7,430	97.6%
Maryland	\$176	\$176	\$353	\$357	\$8,936	\$9,293	96.3%
Mississippi	\$40	\$127	\$167	\$389	\$9,739	\$10,128	98.4%
North Carolina	\$217	\$397	\$614	\$811	\$20,316	\$21,127	97.2%
Oklahoma	\$68	\$132	\$200	\$481	\$12,047	\$12,528	98.4%
South Carolina	\$37	\$87	\$124	\$433	\$10,832	\$11,265	98.9%
Tennessee	\$295	\$531	\$826	\$421	\$10,541	\$10,962	93.0%
Texas	\$554	\$812	\$1,366	\$2,065	\$51,724	\$53,790	97.5%
Virginia	\$119	\$119	\$238	\$380	\$9,510	\$9,890	97.7%
West Virginia	\$14	\$40	\$54	\$149	\$3,741	\$3,890	98.6%
West							
Alaska	\$37	\$38	\$74	\$80	\$2,008	\$2,088	96.6%
Arizona	\$22	\$1,225	\$1,247	\$35	\$866	\$900	41.9%
California	\$1,247	\$1,247	\$2,494	\$1,735	\$43,447	\$45,182	94.8%
Colorado	\$52	\$52	\$103	\$234	\$5,866	\$6,100	98.3%
Hawaii	-\$141	\$189	\$48	\$112	\$2,810	\$2,923	98.4%
Idaho	\$5	\$13	\$18	\$95	\$2,389	\$2,484	99.3%
Montana	\$14	\$30	\$44	\$86	\$2,148	\$2,234	98.1%
Nevada	\$52	\$52	\$104	\$135	\$3,393	\$3,529	97.1%
New Mexico	\$16	\$38	\$53	\$179	\$4,472	\$4,650	98.9%
Oregon	\$28	\$47	\$75	\$409	\$10,255	\$10,665	99.3%
Utah	\$10	\$25	\$35	\$164	\$4,105	\$4,269	99.2%
Washington	\$52	\$54	\$106	\$328	\$8,217	\$8,545	98.8%
Wyoming	\$5	\$5	\$9	\$27	\$679	\$706	98.7%
Total	\$4,092	\$16,362	\$20,454	\$17,056	\$427,169	\$444,224	95.6%

*Includes newly enrolled 1115 waiver eligible population

Table 7
Medicaid Expansion to 133% of FPL

**Impact of Reform on Uninsured Populations; Increase in Enrollment Relative to Baseline
Lower Participation Rate Assumption**

2019					
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	Baseline Medicaid Enrollment	% Change in Enrollment
Northeast					
Connecticut	114,083	75,864	48.0%	567,331	20.1%
Maine	43,468	27,877	47.4%	367,836	11.8%
Massachusetts**	29,921	10,401	10.2%	1,464,896	2.0%
New Hampshire	55,918	34,625	48.7%	144,072	38.8%
New Jersey	390,490	292,489	45.3%	1,025,757	38.1%
New York	305,945	223,175	14.8%	5,136,867	6.0%
Pennsylvania	482,366	282,014	41.4%	2,219,363	21.7%
Rhode Island	41,185	29,147	50.6%	205,565	20.0%
Vermont	4,484	3,214	10.2%	159,835	2.8%
Midwest					
Illinois	631,024	429,258	42.5%	2,449,446	25.8%
Indiana	297,737	215,803	44.2%	1,013,278	29.4%
Iowa	114,691	74,498	44.1%	452,614	25.3%
Kansas	143,445	89,265	50.9%	341,840	42.0%
Michigan	589,965	430,744	50.6%	1,952,376	30.2%
Minnesota	251,783	132,511	44.2%	764,717	32.9%
Missouri	307,872	207,678	45.5%	1,031,437	29.8%
Nebraska	83,898	50,364	53.9%	231,612	36.2%
North Dakota	28,864	17,198	45.1%	65,637	44.0%
Ohio	667,376	462,024	50.0%	2,088,824	31.9%
South Dakota	31,317	18,594	51.9%	121,115	25.9%
Wisconsin	205,987	127,862	50.6%	988,055	20.8%
South					
Alabama	351,567	244,804	53.2%	952,205	36.9%
Arkansas	200,690	154,836	47.6%	718,305	27.9%
Delaware	12,081	7,916	15.9%	181,158	6.7%
District of Columbia	28,900	15,308	49.1%	179,890	16.1%
Florida	951,622	683,477	44.4%	2,741,705	34.7%
Georgia	646,557	479,138	49.4%	1,598,648	40.4%
Kentucky	329,000	250,704	57.1%	880,957	37.3%
Louisiana	366,318	277,746	50.7%	1,130,318	32.4%
Maryland	245,996	174,484	46.2%	758,215	32.4%
Mississippi	320,748	256,920	54.9%	778,772	41.2%
North Carolina	633,485	429,272	46.6%	1,658,226	38.2%
Oklahoma	357,150	261,157	53.1%	697,357	51.2%
South Carolina	344,109	247,478	56.4%	896,326	38.4%
Tennessee	330,932	245,691	43.3%	1,584,178	20.9%
Texas	1,798,314	1,379,713	49.4%	3,955,352	45.5%
Virginia	372,470	245,840	50.6%	890,205	41.8%
West Virginia	121,635	95,675	56.7%	412,987	29.5%
West					
Alaska	42,794	33,106	48.4%	111,144	38.5%
Arizona	105,428	81,095	13.6%	1,364,237	7.7%
California	2,008,796	1,406,101	41.5%	9,985,807	20.1%
Colorado	245,730	166,471	50.0%	514,871	47.7%
Hawaii	84,130	42,381	50.0%	221,574	38.0%
Idaho	85,883	59,078	53.9%	217,961	39.4%
Montana	57,356	37,978	49.6%	105,156	54.5%
Nevada	136,563	100,813	47.0%	221,412	61.7%
New Mexico	145,024	111,279	52.6%	512,199	28.3%
Oregon	294,600	211,542	56.7%	485,926	60.6%
Utah	138,918	78,284	52.5%	247,841	56.1%
Washington	295,662	189,463	52.2%	1,175,565	25.2%
Wyoming	29,899	19,099	53.0%	74,760	40.0%
Total	15,904,173	11,221,455	44.5%	58,045,730	27.4%

*Includes newly enrolled 1115 waiver eligible population

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Table 8
Medicaid Expansion to 133% of FPL
Change in Total Spending (in millions)
Lower Participation Rate Assumption

	Total Spending 2014-2019						Percent Change in Spending			Federal Matching Rates		
	Baseline Spending			New Spending in Reform			State	Federal	Total	Baseline	Effective Post Reform	
	State Spending	Federal Spending	Total	State Spending	Federal Spending	Total						
Northeast												
Connecticut	\$22,336	\$22,336	\$44,672	\$263	\$4,686	\$4,949	1.2%	21.0%	11.1%	50.0%	54.5%	
Maine	\$8,147	\$14,358	\$22,504	-\$118	\$1,857	\$1,738	-1.5%	12.9%	7.7%	63.8%	66.9%	
Massachusetts	\$61,268	\$61,268	\$122,535	-\$1,274	\$2,137	\$864	-2.1%	3.5%	0.7%	50.0%	51.4%	
New Hampshire	\$5,656	\$5,656	\$11,312	\$63	\$1,204	\$1,267	1.1%	21.3%	11.2%	50.0%	54.5%	
New Jersey	\$43,267	\$43,267	\$86,534	\$533	\$9,030	\$9,563	1.2%	20.9%	11.1%	50.0%	54.4%	
New York	\$243,371	\$243,371	\$486,743	\$50	\$8,049	\$8,099	0.0%	3.3%	1.7%	50.0%	50.8%	
Pennsylvania	\$76,746	\$96,261	\$173,008	\$1,054	\$17,086	\$18,140	1.4%	17.7%	10.5%	55.6%	59.3%	
Rhode Island	\$9,504	\$10,704	\$20,208	\$70	\$1,559	\$1,629	0.7%	14.6%	8.1%	53.0%	56.2%	
Vermont	\$4,079	\$5,800	\$9,880	-\$26	\$112	\$86	-0.6%	1.9%	0.9%	58.7%	59.3%	
Midwest												
Illinois	\$73,760	\$74,352	\$148,112	\$1,202	\$19,259	\$20,461	1.6%	25.9%	13.8%	50.2%	55.5%	
Indiana	\$18,784	\$37,322	\$56,106	\$478	\$8,535	\$9,013	2.5%	22.9%	16.1%	66.5%	70.4%	
Iowa	\$10,672	\$17,886	\$28,558	\$147	\$2,800	\$2,947	1.4%	15.7%	10.3%	62.6%	65.7%	
Kansas	\$10,055	\$14,500	\$24,555	\$166	\$3,477	\$3,643	1.7%	24.0%	14.8%	59.1%	63.8%	
Michigan	\$34,465	\$66,281	\$100,746	\$686	\$14,252	\$14,938	2.0%	21.5%	14.8%	65.8%	69.6%	
Minnesota	\$35,561	\$35,561	\$71,123	\$421	\$7,836	\$8,257	1.2%	22.0%	11.6%	50.0%	54.7%	
Missouri	\$24,932	\$42,985	\$67,917	\$431	\$8,395	\$8,826	1.7%	19.5%	13.0%	63.3%	66.9%	
Nebraska	\$7,082	\$9,958	\$17,040	\$106	\$2,345	\$2,451	1.5%	23.5%	14.4%	58.4%	63.1%	
North Dakota	\$2,307	\$3,512	\$5,819	\$32	\$595	\$627	1.4%	16.9%	10.8%	60.4%	63.7%	
Ohio	\$50,823	\$89,146	\$139,969	\$830	\$17,130	\$17,960	1.6%	19.2%	12.8%	63.7%	67.3%	
South Dakota	\$2,762	\$4,366	\$7,129	\$32	\$717	\$748	1.1%	16.4%	10.5%	61.3%	64.5%	
Wisconsin	\$22,115	\$33,395	\$55,509	\$205	\$4,252	\$4,457	0.9%	12.7%	8.0%	60.2%	62.8%	
South												
Alabama	\$13,177	\$28,708	\$41,885	\$470	\$10,305	\$10,776	3.6%	35.9%	25.7%	68.5%	74.1%	
Arkansas	\$9,686	\$24,146	\$33,832	\$455	\$9,401	\$9,856	4.7%	38.9%	29.1%	71.4%	76.8%	
Delaware	\$5,488	\$6,226	\$11,713	\$3	\$387	\$390	0.1%	6.2%	3.3%	53.2%	54.6%	
District of Columbia	\$4,641	\$10,830	\$15,471	\$42	\$902	\$944	0.9%	8.3%	6.1%	70.0%	71.5%	
Florida	\$66,330	\$82,559	\$148,889	\$1,233	\$20,050	\$21,283	1.9%	24.3%	14.3%	55.5%	60.3%	
Georgia	\$26,677	\$50,268	\$76,945	\$714	\$14,551	\$15,265	2.7%	28.9%	19.8%	65.3%	70.3%	
Kentucky	\$14,733	\$36,944	\$51,677	\$515	\$11,878	\$12,393	3.5%	32.2%	24.0%	71.5%	76.2%	
Louisiana	\$19,267	\$33,679	\$52,946	\$337	\$7,273	\$7,610	1.7%	21.6%	14.4%	63.6%	67.6%	
Maryland	\$30,832	\$30,832	\$61,663	\$533	\$9,112	\$9,645	1.7%	29.6%	15.6%	50.0%	56.0%	
Mississippi	\$9,006	\$26,632	\$35,638	\$429	\$9,865	\$10,294	4.8%	37.0%	28.9%	74.7%	79.5%	
North Carolina	\$38,951	\$71,423	\$110,374	\$1,029	\$20,712	\$21,741	2.6%	29.0%	19.7%	64.7%	69.7%	
Oklahoma	\$13,640	\$25,264	\$38,903	\$549	\$12,179	\$12,728	4.0%	48.2%	32.7%	64.9%	72.5%	
South Carolina	\$12,984	\$30,353	\$43,336	\$470	\$10,919	\$11,389	3.6%	36.0%	26.3%	70.0%	75.4%	
Tennessee	\$28,115	\$54,214	\$82,329	\$716	\$11,072	\$11,788	2.5%	20.4%	14.3%	65.9%	69.4%	
Texas	\$88,000	\$135,124	\$223,124	\$2,619	\$52,537	\$55,156	3.0%	38.9%	24.7%	60.6%	67.4%	
Virginia	\$27,464	\$27,464	\$54,928	\$498	\$9,629	\$10,127	1.8%	35.1%	18.4%	50.0%	57.0%	
West Virginia	\$6,761	\$18,504	\$25,265	\$164	\$3,781	\$3,945	2.4%	20.4%	15.6%	73.2%	76.3%	
West												
Alaska	\$5,551	\$5,551	\$11,102	\$117	\$2,046	\$2,163	2.1%	36.9%	19.5%	50.0%	57.3%	
Arizona	\$25,571	\$49,308	\$74,879	\$56	\$2,091	\$2,147	0.2%	4.2%	2.9%	65.9%	66.7%	
California	\$194,004	\$194,004	\$388,007	\$2,982	\$44,694	\$47,676	1.5%	23.0%	12.3%	50.0%	54.8%	
Colorado	\$15,957	\$15,957	\$31,914	\$286	\$5,917	\$6,203	1.8%	37.1%	19.4%	50.0%	57.4%	
Hawaii	\$5,966	\$6,409	\$12,374	-\$28	\$2,999	\$2,971	-0.5%	46.8%	24.0%	51.8%	61.3%	
Idaho	\$4,009	\$8,860	\$12,869	\$101	\$2,402	\$2,502	2.5%	27.1%	19.4%	68.9%	73.3%	
Montana	\$2,706	\$5,447	\$8,153	\$100	\$2,178	\$2,278	3.7%	40.0%	27.9%	66.8%	73.1%	
Nevada	\$6,483	\$6,914	\$13,397	\$188	\$3,445	\$3,633	2.9%	49.8%	27.1%	51.6%	60.8%	
New Mexico	\$9,149	\$21,125	\$30,274	\$194	\$4,510	\$4,704	2.1%	21.3%	15.5%	69.8%	73.3%	
Oregon	\$12,038	\$20,366	\$32,404	\$438	\$10,302	\$10,739	3.6%	50.6%	33.1%	62.9%	71.1%	
Utah	\$4,742	\$11,683	\$16,425	\$174	\$4,129	\$4,304	3.7%	35.3%	26.2%	71.1%	76.3%	
Washington	\$31,830	\$31,830	\$63,661	\$380	\$8,271	\$8,651	1.2%	26.0%	13.6%	50.0%	55.5%	
Wyoming	\$2,553	\$2,553	\$5,107	\$32	\$683	\$715	1.2%	26.8%	14.0%	50.0%	55.6%	
Total	\$1,504,003	\$2,005,461	\$3,509,464	\$21,148	\$443,530	\$464,678	1.4%	22.1%	13.2%	57.1%	61.6%	

Table 9

**Medicaid Expansion to 133%: Additional Spending by States in Reform
Higher Participation Rate Assumption
(in millions)**

2014-2019				
	Total State Spending	Total Federal Spending	Total Spending	% Federal Spending
Northeast				
Connecticut	\$440	\$5,048	\$5,488	92.0%
Maine	-\$65	\$2,105	\$2,040	100%*
Massachusetts	-\$628	\$2,783	\$2,155	100%*
New Hampshire	\$117	\$1,470	\$1,586	92.6%
New Jersey	\$1,078	\$11,129	\$12,207	91.2%
New York	\$2,859	\$17,170	\$20,030	85.7%
Pennsylvania	\$2,041	\$19,489	\$21,530	90.5%
Rhode Island	\$100	\$1,768	\$1,868	94.6%
Vermont	\$8	\$283	\$291	97.4%
Midwest				
Illinois	\$2,468	\$22,109	\$24,577	90.0%
Indiana	\$899	\$10,112	\$11,010	91.8%
Iowa	\$257	\$3,298	\$3,555	92.8%
Kansas	\$260	\$4,033	\$4,293	93.9%
Michigan	\$1,096	\$16,944	\$18,040	93.9%
Minnesota	\$745	\$9,116	\$9,861	92.4%
Missouri	\$773	\$10,228	\$11,001	93.0%
Nebraska	\$155	\$2,732	\$2,886	94.6%
North Dakota	\$57	\$709	\$766	92.5%
Ohio	\$1,335	\$19,578	\$20,913	93.6%
South Dakota	\$46	\$844	\$890	94.9%
Wisconsin	\$314	\$4,912	\$5,226	94.0%
South				
Alabama	\$693	\$11,404	\$12,097	94.3%
Arkansas	\$761	\$11,523	\$12,284	93.8%
Delaware	\$90	\$686	\$776	88.4%
District of Columbia	\$62	\$1,068	\$1,129	94.5%
Florida	\$2,537	\$24,260	\$26,797	90.5%
Georgia	\$1,233	\$17,916	\$19,149	93.6%
Kentucky	\$695	\$13,220	\$13,915	95.0%
Louisiana	\$536	\$8,937	\$9,472	94.3%
Maryland	\$1,060	\$10,881	\$11,941	91.1%
Mississippi	\$581	\$10,959	\$11,539	95.0%
North Carolina	\$1,791	\$24,720	\$26,511	93.2%
Oklahoma	\$789	\$13,436	\$14,225	94.5%
South Carolina	\$615	\$12,109	\$12,724	95.2%
Tennessee	\$1,523	\$13,128	\$14,651	89.6%
Texas	\$4,514	\$62,056	\$66,570	93.2%
Virginia	\$863	\$11,129	\$11,992	92.8%
West Virginia	\$217	\$4,182	\$4,399	95.1%
West				
Alaska	\$219	\$2,379	\$2,598	91.6%
Arizona	\$739	\$4,861	\$5,600	86.8%
California	\$6,544	\$54,936	\$61,481	89.4%
Colorado	\$470	\$6,925	\$7,395	93.6%
Hawaii	\$30	\$3,414	\$3,444	99.1%
Idaho	\$133	\$2,896	\$3,028	95.6%
Montana	\$155	\$2,558	\$2,713	94.3%
Nevada	\$338	\$4,100	\$4,438	92.4%
New Mexico	\$278	\$5,608	\$5,885	95.3%
Oregon	\$555	\$11,723	\$12,279	95.5%
Utah	\$227	\$4,695	\$4,921	95.4%
Washington	\$567	\$9,573	\$10,139	94.4%
Wyoming	\$49	\$818	\$867	94.3%
Total	\$43,218	\$531,958	\$575,176	92.5%

*Federal Government essentially picks up all of net new spending while the state actually saves money due to the federal government spending more on currently enrolled 1115 waiver non-parents

Table 10
Medicaid Expansion to 133%: Additional Spending by States in Reform by Eligibility Type
Higher Participation Rate Assumption
(in millions)

	2014-2019							Total % New Eligible Spending
	Current Eligibles*			New Eligibles				
	State Spending	Federal Spending	Total Spending	State Spending	Federal Spending	Total Spending		
Northeast								
Connecticut	\$247	\$247	\$494	\$193	\$4,802	\$4,995	91.0%	
Maine	-\$137	\$317	\$180	\$72	\$1,788	\$1,860	91.2%	
Massachusetts	-\$628	\$2,783	\$2,155	\$0	\$0	\$0	0.0%	
New Hampshire	\$60	\$60	\$120	\$57	\$1,410	\$1,467	92.4%	
New Jersey	\$656	\$656	\$1,313	\$422	\$10,473	\$10,895	89.2%	
New York	\$2,679	\$12,679	\$15,358	\$181	\$4,491	\$4,672	23.3%	
Pennsylvania	\$1,320	\$1,583	\$2,903	\$721	\$17,906	\$18,627	86.5%	
Rhode Island	\$30	\$34	\$64	\$70	\$1,734	\$1,804	96.6%	
Vermont	\$8	\$283	\$291	\$0	\$0	\$0	0.0%	
Midwest								
Illinois	\$1,645	\$1,666	\$3,311	\$823	\$20,442	\$21,265	86.5%	
Indiana	\$530	\$953	\$1,483	\$369	\$9,159	\$9,528	86.5%	
Iowa	\$133	\$223	\$357	\$124	\$3,074	\$3,198	90.0%	
Kansas	\$104	\$156	\$260	\$156	\$3,877	\$4,033	93.9%	
Michigan	\$441	\$669	\$1,110	\$655	\$16,275	\$16,930	93.8%	
Minnesota	\$393	\$393	\$787	\$351	\$8,723	\$9,074	92.0%	
Missouri	\$388	\$667	\$1,055	\$385	\$9,561	\$9,946	90.4%	
Nebraska	\$48	\$70	\$118	\$107	\$2,661	\$2,768	95.9%	
North Dakota	\$31	\$53	\$84	\$26	\$656	\$683	89.1%	
Ohio	\$585	\$961	\$1,546	\$749	\$18,617	\$19,367	92.6%	
South Dakota	\$12	\$21	\$33	\$33	\$823	\$857	96.3%	
Wisconsin	\$123	\$181	\$304	\$190	\$4,731	\$4,922	94.2%	
South								
Alabama	\$256	\$543	\$798	\$437	\$10,861	\$11,299	93.4%	
Arkansas	\$333	\$891	\$1,224	\$428	\$10,632	\$11,060	90.0%	
Delaware	\$80	\$436	\$516	\$10	\$250	\$260	33.5%	
District of Columbia	\$21	\$48	\$69	\$41	\$1,020	\$1,061	93.9%	
Florida	\$1,643	\$2,040	\$3,683	\$895	\$22,219	\$23,114	86.3%	
Georgia	\$552	\$1,002	\$1,553	\$681	\$16,914	\$17,595	91.9%	
Kentucky	\$180	\$423	\$603	\$515	\$12,797	\$13,312	95.7%	
Louisiana	\$195	\$486	\$681	\$340	\$8,451	\$8,791	92.8%	
Maryland	\$648	\$648	\$1,296	\$412	\$10,233	\$10,645	89.1%	
Mississippi	\$160	\$501	\$661	\$421	\$10,457	\$10,878	94.3%	
North Carolina	\$859	\$1,567	\$2,426	\$932	\$23,153	\$24,085	90.9%	
Oklahoma	\$269	\$520	\$789	\$520	\$12,916	\$13,436	94.5%	
South Carolina	\$141	\$330	\$472	\$474	\$11,778	\$12,253	96.3%	
Tennessee	\$1,072	\$1,930	\$3,002	\$451	\$11,199	\$11,649	79.5%	
Texas	\$2,142	\$3,139	\$5,280	\$2,372	\$58,918	\$61,290	92.1%	
Virginia	\$432	\$432	\$864	\$431	\$10,697	\$11,128	92.8%	
West Virginia	\$55	\$155	\$210	\$162	\$4,027	\$4,189	95.2%	
West								
Alaska	\$128	\$131	\$260	\$91	\$2,248	\$2,339	90.0%	
Arizona	\$697	\$3,820	\$4,517	\$42	\$1,041	\$1,082	19.3%	
California	\$4,515	\$4,515	\$9,029	\$2,030	\$50,422	\$52,452	85.3%	
Colorado	\$199	\$199	\$398	\$271	\$6,726	\$6,997	94.6%	
Hawaii	-\$97	\$242	\$145	\$128	\$3,171	\$3,299	95.8%	
Idaho	\$18	\$42	\$60	\$115	\$2,854	\$2,969	98.0%	
Montana	\$57	\$121	\$178	\$98	\$2,437	\$2,536	93.5%	
Nevada	\$180	\$180	\$361	\$158	\$3,919	\$4,077	91.9%	
New Mexico	\$58	\$140	\$198	\$220	\$5,468	\$5,688	96.6%	
Oregon	\$89	\$149	\$238	\$466	\$11,575	\$12,041	98.1%	
Utah	\$42	\$101	\$143	\$185	\$4,593	\$4,778	97.1%	
Washington	\$189	\$197	\$386	\$377	\$9,376	\$9,753	96.2%	
Wyoming	\$17	\$17	\$34	\$32	\$801	\$834	96.1%	
Total	\$23,799	\$49,599	\$73,398	\$19,419	\$482,359	\$501,777	87.2%	

*Includes newly enrolled 1115 waiver eligible population

Table 11
Medicaid Expansion to 133% of FPL
Impact of Reform on Uninsured Populations; Increase in Enrollment Relative to Baseline
Higher Participation Rate Assumption

2019					
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	Baseline Medicaid Enrollment	% Change in Enrollment
Northeast					
Connecticut	154,664	113,876	72.1%	567,331	27.3%
Maine	59,502	41,858	71.1%	367,836	16.2%
Massachusetts**	75,569	43,508	42.9%	1,464,896	5.2%
New Hampshire	76,744	52,146	73.4%	144,072	53.3%
New Jersey	567,852	455,627	70.6%	1,025,757	55.4%
New York	820,623	706,575	46.7%	5,136,867	16.0%
Pennsylvania	682,880	458,200	67.2%	2,219,363	30.8%
Rhode Island	53,841	40,850	70.9%	205,565	26.2%
Vermont	15,509	13,443	42.9%	159,835	9.7%
Midwest					
Illinois	911,830	694,012	68.8%	2,449,446	37.2%
Indiana	427,311	337,987	69.1%	1,013,278	42.2%
Iowa	163,264	117,621	69.6%	452,614	36.1%
Kansas	192,006	131,528	75.1%	341,840	56.2%
Michigan	812,818	635,231	74.6%	1,952,376	41.6%
Minnesota	348,684	211,781	70.7%	764,717	45.6%
Missouri	437,735	324,276	71.0%	1,031,437	42.4%
Nebraska	110,820	71,053	76.0%	231,612	47.8%
North Dakota	40,017	26,457	69.4%	65,637	61.0%
Ohio	901,023	670,992	72.6%	2,088,824	43.1%
South Dakota	41,847	27,160	75.8%	121,115	34.6%
Wisconsin	277,116	188,043	74.3%	988,055	28.0%
South					
Alabama	455,952	335,547	72.9%	952,205	47.9%
Arkansas	286,347	234,695	72.1%	718,305	39.9%
Delaware	28,839	23,317	46.9%	181,158	15.9%
District of Columbia	38,763	22,891	73.4%	179,890	21.5%
Florida	1,376,753	1,073,391	69.7%	2,741,705	50.2%
Georgia	907,203	721,558	74.4%	1,598,648	56.7%
Kentucky	423,757	337,987	77.0%	880,957	48.1%
Louisiana	507,952	409,869	74.8%	1,130,318	44.9%
Maryland	348,140	267,555	70.8%	758,215	45.9%
Mississippi	419,571	350,091	74.8%	778,772	53.9%
North Carolina	887,560	661,292	71.8%	1,658,226	53.5%
Oklahoma	470,358	367,541	74.8%	697,357	67.4%
South Carolina	443,020	334,296	76.2%	896,326	49.4%
Tennessee	474,240	372,894	65.7%	1,584,178	29.9%
Texas	2,513,355	2,055,888	73.6%	3,955,352	63.5%
Virginia	504,466	365,514	75.2%	890,205	56.7%
West Virginia	156,582	129,185	76.5%	412,987	37.9%
West					
Alaska	59,914	49,061	71.7%	111,144	53.9%
Arizona	305,634	273,008	45.6%	1,364,237	22.4%
California	2,986,362	2,291,221	67.6%	9,985,807	29.9%
Colorado	337,706	249,208	74.8%	514,871	65.6%
Hawaii	110,203	64,167	75.7%	221,574	49.7%
Idaho	115,730	85,523	78.1%	217,961	53.1%
Montana	78,840	56,889	74.3%	105,156	75.0%
Nevada	196,168	156,025	72.7%	221,412	88.6%
New Mexico	201,855	163,105	77.1%	512,199	39.4%
Oregon	386,845	292,651	78.4%	485,926	79.6%
Utah	180,478	113,872	76.3%	247,841	72.8%
Washington	395,577	276,096	76.1%	1,175,565	33.6%
Wyoming	40,041	27,488	76.2%	74,760	53.6%
Total	22,809,862	17,524,046	69.5%	58,045,730	39.3%

*Includes newly enrolled 1115 waiver eligible population

**Massachusetts has a lower share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Table 12
Medicaid Expansion to 133% of FPL
Change in Total Spending, 2014-2019 (in millions)
Higher Participation Rates

	Total Spending 2014-2019						Percent Change in Spending			Federal Matching Rates	
	Baseline Spending			New Spending in Reform			State	Federal	Total	Baseline	Effective Post Reform
	State Spending	Federal Spending	Total	State Spending	Federal Spending	Total					
Northeast											
Connecticut	\$22,336	\$22,336	\$44,672	\$440	\$5,048	\$5,488	2.0%	22.6%	12.3%	50.0%	54.6%
Maine	\$8,147	\$14,358	\$22,504	-\$65	\$2,105	\$2,040	-0.8%	14.7%	9.1%	63.8%	67.1%
Massachusetts	\$61,268	\$61,268	\$122,535	-\$628	\$2,783	\$2,155	-1.0%	4.5%	1.8%	50.0%	51.4%
New Hampshire	\$5,656	\$5,656	\$11,312	\$117	\$1,470	\$1,586	2.1%	26.0%	14.0%	50.0%	55.2%
New Jersey	\$43,267	\$43,267	\$86,534	\$1,078	\$11,129	\$12,207	2.5%	25.7%	14.1%	50.0%	55.1%
New York	\$243,371	\$243,371	\$486,743	\$2,859	\$17,170	\$20,030	1.2%	7.1%	4.1%	50.0%	51.4%
Pennsylvania	\$76,746	\$96,261	\$173,008	\$2,041	\$19,489	\$21,530	2.7%	20.2%	12.4%	55.6%	59.5%
Rhode Island	\$9,504	\$10,704	\$20,208	\$100	\$1,768	\$1,868	1.1%	16.5%	9.2%	53.0%	56.5%
Vermont	\$4,079	\$5,800	\$9,880	\$8	\$283	\$291	0.2%	4.9%	2.9%	58.7%	59.8%
Midwest											
Illinois	\$73,760	\$74,352	\$148,112	\$2,468	\$22,109	\$24,577	3.3%	29.7%	16.6%	50.2%	55.9%
Indiana	\$18,784	\$37,322	\$56,106	\$899	\$10,112	\$11,010	4.8%	27.1%	19.6%	66.5%	70.7%
Iowa	\$10,672	\$17,886	\$28,558	\$257	\$3,298	\$3,555	2.4%	18.4%	12.4%	62.6%	66.0%
Kansas	\$10,055	\$14,500	\$24,555	\$260	\$4,033	\$4,293	2.6%	27.8%	17.5%	59.1%	64.2%
Michigan	\$34,465	\$66,281	\$100,746	\$1,096	\$16,944	\$18,040	3.2%	25.6%	17.9%	65.8%	70.1%
Minnesota	\$35,561	\$35,561	\$71,123	\$745	\$9,116	\$9,861	2.1%	25.6%	13.9%	50.0%	55.2%
Missouri	\$24,932	\$42,985	\$67,917	\$773	\$10,228	\$11,001	3.1%	23.8%	16.2%	63.3%	67.4%
Nebraska	\$7,082	\$9,958	\$17,040	\$155	\$2,732	\$2,886	2.2%	27.4%	16.9%	58.4%	63.7%
North Dakota	\$2,307	\$3,512	\$5,819	\$57	\$709	\$766	2.5%	20.2%	13.2%	60.4%	64.1%
Ohio	\$50,823	\$89,146	\$139,969	\$1,335	\$19,578	\$20,913	2.6%	22.0%	14.9%	63.7%	67.6%
South Dakota	\$2,762	\$4,366	\$7,129	\$46	\$844	\$890	1.6%	19.3%	12.5%	61.3%	65.0%
Wisconsin	\$22,115	\$33,395	\$55,509	\$314	\$4,912	\$5,226	1.4%	14.7%	9.4%	60.2%	63.1%
South											
Alabama	\$13,177	\$28,708	\$41,885	\$693	\$11,404	\$12,097	5.3%	39.7%	28.9%	68.5%	74.3%
Arkansas	\$9,686	\$24,146	\$33,832	\$761	\$11,523	\$12,284	7.9%	47.7%	36.3%	71.4%	77.3%
Delaware	\$5,488	\$6,226	\$11,713	\$90	\$686	\$776	1.6%	11.0%	6.6%	53.2%	55.3%
District of Columbia	\$4,641	\$10,830	\$15,471	\$62	\$1,068	\$1,129	1.3%	9.9%	7.3%	70.0%	71.7%
Florida	\$66,330	\$82,559	\$148,889	\$2,537	\$24,260	\$26,797	3.8%	29.4%	18.0%	55.5%	60.8%
Georgia	\$26,677	\$50,268	\$76,945	\$1,233	\$17,916	\$19,149	4.6%	35.6%	24.9%	65.3%	71.0%
Kentucky	\$14,733	\$36,944	\$51,677	\$695	\$13,220	\$13,915	4.7%	35.8%	26.9%	71.5%	76.5%
Louisiana	\$19,267	\$33,679	\$52,946	\$536	\$8,937	\$9,472	2.8%	26.5%	17.9%	63.6%	68.3%
Maryland	\$30,832	\$30,832	\$61,663	\$1,060	\$10,881	\$11,941	3.4%	35.3%	19.4%	50.0%	56.7%
Mississippi	\$9,006	\$26,632	\$35,638	\$581	\$10,959	\$11,539	6.4%	41.1%	32.4%	74.7%	79.7%
North Carolina	\$38,951	\$71,423	\$110,374	\$1,791	\$24,720	\$26,511	4.6%	34.6%	24.0%	64.7%	70.2%
Oklahoma	\$13,640	\$25,264	\$38,903	\$789	\$13,436	\$14,225	5.8%	53.2%	36.6%	64.9%	72.8%
South Carolina	\$12,984	\$30,353	\$43,336	\$615	\$12,109	\$12,724	4.7%	39.9%	29.4%	70.0%	75.7%
Tennessee	\$28,115	\$54,214	\$82,329	\$1,523	\$13,128	\$14,651	5.4%	24.2%	17.8%	65.9%	69.4%
Texas	\$88,000	\$135,124	\$223,124	\$4,514	\$62,056	\$66,570	5.1%	45.9%	29.8%	60.6%	68.1%
Virginia	\$27,464	\$27,464	\$54,928	\$863	\$11,129	\$11,992	3.1%	40.5%	21.8%	50.0%	57.7%
West Virginia	\$6,761	\$18,504	\$25,265	\$217	\$4,182	\$4,399	3.2%	22.6%	17.4%	73.2%	76.5%
West											
Alaska	\$5,551	\$5,551	\$11,102	\$219	\$2,379	\$2,598	3.9%	42.9%	23.4%	50.0%	57.9%
Arizona	\$25,571	\$49,308	\$74,879	\$739	\$4,861	\$5,600	2.9%	9.9%	7.5%	65.9%	67.3%
California	\$194,004	\$194,004	\$388,007	\$6,544	\$54,936	\$61,481	3.4%	28.3%	15.8%	50.0%	55.4%
Colorado	\$15,957	\$15,957	\$31,914	\$470	\$6,925	\$7,395	2.9%	43.4%	23.2%	50.0%	58.2%
Hawaii	\$5,966	\$6,409	\$12,374	\$30	\$3,414	\$3,444	0.5%	53.3%	27.8%	51.8%	62.1%
Idaho	\$4,009	\$8,860	\$12,869	\$133	\$2,896	\$3,028	3.3%	32.7%	23.5%	68.9%	73.9%
Montana	\$2,706	\$5,447	\$8,153	\$155	\$2,558	\$2,713	5.7%	47.0%	33.3%	66.8%	73.7%
Nevada	\$6,483	\$6,914	\$13,397	\$338	\$4,100	\$4,438	5.2%	59.3%	33.1%	51.6%	61.8%
New Mexico	\$9,149	\$21,125	\$30,274	\$278	\$5,608	\$5,885	3.0%	26.5%	19.4%	69.8%	73.9%
Oregon	\$12,038	\$20,366	\$32,404	\$555	\$11,723	\$12,279	4.6%	57.6%	37.9%	62.9%	71.8%
Utah	\$4,742	\$11,683	\$16,425	\$227	\$4,695	\$4,921	4.8%	40.2%	30.0%	71.1%	76.7%
Washington	\$31,830	\$31,830	\$63,661	\$567	\$9,573	\$10,139	1.8%	30.1%	15.9%	50.0%	56.1%
Wyoming	\$2,553	\$2,553	\$5,107	\$49	\$818	\$867	1.9%	32.0%	17.0%	50.0%	56.4%
Total	\$1,504,003	\$2,005,461	\$3,509,464	\$43,218	\$531,958	\$575,176	2.9%	26.5%	16.4%	57.1%	62.1%

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8076) is available on the Kaiser Family Foundation's website at www.kff.org.

