The Affordable Care Act: Medicaid Expansion & Healthcare Exchanges

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Summary Points

- The Affordable Care Act requires that almost all individuals have health insurance by 2014 or face a fine – this was upheld by the Supreme Court in 2012.
- However, the Supreme Court ruling allows states to choose whether or not to expand their Medicaid programs to cover individuals at 138% of the FPL by 2014.
- States or the federal government will develop and implement health insurance exchanges in the states so that consumers can more easily compare health plans.
- Medicaid Cost-Sharing models will change under the new eligibility programs.
- If all 50 states implemented the Medicaid expansion, it would cover an additional 21.6 million of the 41.2 million currently uninsured adults (or 52%).
- The additional cost of implementing the Medicaid expansion is estimated to be only a 2.8 percent increase from what states would have spent between 2014 and 2022 without the health reform law. However, this number is significantly overstated, as CBO's calculations do not factor in the savings that state and local governments will realize in their health care spending for the uninsured
- Financial impact of the ACA is uncertain for a variety of reasons.

This document was produced to serve as a source of information for the American Academy of Family Physicians, its state chapters, AAFP members, and other interested parties. The contents should not be construed as a statement, official or otherwise, of AAFP policy or positions with respect to any subject(s) contained within.

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Preamble

This document was produced by the American Academy of Family Physicians (AAFP) as a source of information for AAFP state chapters, members, and other interested parties on the policy impact of the Medicaid expansion provisions included in the "Patient Protection and Affordable Care Act" (ACA) and as modified by the Supreme Court decision.

This report outlines the history of the Medicaid program, its funding mechanisms, and the opportunities provided through the ACA. The report also details the interactions between Medicaid programs and the health insurance exchanges that will begin in 2014. Finally, the document provides a series of data tables that demonstrate the impact of proposed policies on the uninsured, state budgets, and the overall health care system.

The content of the report should not be construed as an official statement on a state's decision to participate, or not participate, in the Medicaid expansion as allowed for under current law. The AAFP supports policies that seek to ensure health care coverage for all and we will continue to advance laws, regulations, and policies that are consistent with this goal.

The AAFP hopes that you find this report beneficial to your advocacy efforts.

Frequent Abbreviations Used in this Paper

AAFP = American Academy of Family Physicians
ACA = Affordable Care Act
CBO = Congressional Budget Office
DSH = Disproportionate Share Hospital Payments
FMAP = Federal Medical Assistance Percentage
FPL = Federal Poverty Level
GME = Graduate Medical Education
PPACA = Patient Protection and Affordable Care Act
SPA = State Plan Amendments
SSI = Supplemental Security Income
TANF = Temporary Assistance for Needy Families
UI = Uninsured

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What is Medicaid?

A large component of mandatory federal spending, Medicaid is an entitlement program that was enacted in 1965 through the Social Security Amendments of 1965 (P.L. 89-97). Medicaid finances the delivery of a variety of health care services to designated needy populations along with the Medicare and the Children's Health Insurance Program (CHIP). The program is jointly funded by federal and state governments and features an open-ended spending model with total outlays dependent on the generosity of state Medicaid programs.[1] Though classified as an entitlement program in the federal budget, states have the option to participate in the program. If they choose to participate in the program, which all 50 states do, they must adhere to federal rules in order to receive reimbursements to offset a percentage of their Medicaid costs.[2] According to the June 28, 2012 Supreme Court decision (*National Federation of Independent Business v. Sebelius*) regarding the constitutionality of the Patient Protection and Affordable Care Act (PPACA or ACA), participation in the Medicaid Expansion program, is optional.[3]

Eligibility Requirements for Medicaid

To be eligible for Medicaid, participants must meet certain requirements, some of which the states determine. People with disabilities are eligible for Medicaid in all 50 states. In select states, those with disabilities qualify automatically if they receive Supplemental Security Income (SSI) benefits.[4] Financial requirements such as applicants' income and their resources or assets, as well as where they fall within one of the 50 distinct eligible population groups as defined in Title XIX of the Social Security Act, also entitle participants to Medicaid coverage. Some states also have programs that allow the disabled with incomes above regular Medicaid limits to enroll in the program. In addition, disabled children can qualify for Medicaid either under family-based income or the disability-related rules.

States are required to apply rules used by the Temporary Assistance for Needy Families (TANF) program or the federal SSI program when determining eligibility for Medicaid based on income. TANF is a block grant program for states that aims to move unemployed recipients into the working population. Enacted as welfare reform legislation in 1996, TANF replaced old welfare programs known as Aid to Families with Dependent Children, Job Opportunities and Basic Skills Training, and Emergency Assistance.[5]

In 2014, some states will expand their Medicaid program eligibility under provisions in the ACA. Expansion of the Medicaid program enables states to cover those under age 65, including the disabled, with incomes below 133 percent of the federal poverty level (FPL), which is about $14,856 for a single individual or $29,700 for a family of four.[6]

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[1] (Herz, 2010)
[2] (Herz, 2010)
[3] Please see the following pages of this brief for an explanation of the Medicaid Expansion (See: Title II – Role of Public Programs, Subtitle A – Improved Access to Medicaid – Sec. 2001. Medicaid Coverage for the Lowest Income Populations, which begins on page 179 of the law).
[4] (U.S. Department of Health and Human Services, 2012)
[5] (U.S. Department of Health and Human Services, 2012)
[6] (Affordable Care Act and Reconciliation Act, 2010)

How Is Medicaid Financed?

Medicaid is jointly financed by states and the federal government at different rates depending on the state. States pay for the program initially and are later reimbursed by the federal government for the "federal share" of the state's Medicaid costs. There is no limit or cap to the total amount of federal funds a state may obtain. Annual costs of the Medicaid program and federal reimbursement amounts for each state depend on various factors including eligibility rules, beneficiary participation, the scope of offered benefits, provider reimbursement rates, and other supplemental payments.[7]

The Federal Medical Assistance Percentages (FMAP) formula determines the federal reimbursement for each state. FMAP is calculated to determine the state-specific share for Medicaid program benefit costs. The formula produces higher federal shares for states with per- capita personal income levels lower than the national average. Conversely, states with per-capita individual income levels higher than the national average receive a lower percentage of federal reimbursement funds as a result of the FMAP formula. The formula, set into law by the Social Security Act (Section 1905(b)), requires the Secretary of Health and Human Services to calculate and publish the updated FMAP rates each year. The FMAP always works out to reimburse states up to at least 50 percent of program costs, while some states can receive as much as 83 percent, the statutory maximum. Mississippi received the highest FMAP reimbursement at 74.18 percent for the year 2012 (see attached tables and charts for current FMAP rates for all 50 states).

It is important to note that FMAP rates are strictly used to reimburse states for health care services, not administrative expenditures. Each state receives a separate federal match, generally at 50 percent, though some exceptions apply, for Medicaid administrative functions. Some higher-matched functions, such as those with a 75 percent federal match, include reimbursement for survey and certification of nursing facilities, operation of approved Medicaid fraud control unit, and operation of approved Medicaid management information systems. Though these functions appear to be quite large, generally these administrative costs represent only about 5 percent of total Medicaid spending per year.[8]

Medicaid Cost-Sharing Models

Traditionally, Medicaid enabled states require certain beneficiaries to share in the cost of Medicaid services. However, the law places limits on the amount of cost sharing states can levy, which beneficiary groups can be required to share costs, and the services for which cost sharing can be charged.[9] Service-based cost sharing rules differ from participation-related cost sharing in several ways. Service-based cost sharing mainly requires beneficiaries to pay a co-payment to providers at the time of care delivery. Participation-related cost sharing requires beneficiaries to pay premiums, usually on a monthly basis, whether or not they sought care that month. In addition, beneficiary cost sharing can also be levied under rules stipulated in the Deficit Reduction Act, (DRA), in that states can impose premiums and cost sharing through Medicaid state plan amendments instead of through waiver authority, though subject to specific prohibitions. Both waivers and state plan amendments (SPA) are legal authorities by which states can change their Medicaid programs. Waivers and SPAs

[7] (Herz, 2010)
[8] (Herz, 2010)
[9] (Herz, 2010)

have different requirements and approval processes because they allow states to do different things. States submit SPA applications to CMS for the propose of making changes to their Medicaid program administration. SPA applications must comply with all federal Medicaid requirements and there is no cost or budget requirement associated with submitting.[10] By contrast, states can apply for waivers as a formal request to have certain federal Medicaid requirements waived. State waiver applications must directly relate to specific statutes within federal Medicaid regulations. Most waivers must be cost effective or cost-neutral to pass CMS budget requirements.[11]

Provider Reimbursement under Medicaid

Federal statute allows states to institute their own payment rates, but stipulates that these rates must be ample enough to encourage an adequate amount of providers to accept Medicaid patients. Further, statute requires that covered benefits available to the general population must equate to what is available to Medicaid beneficiaries in the same geographic area. Due to new ACA regulations, for CY2013 and CY2014 the federal government mandates that Medicaid payment rates for primary care physicians providing preventive health services be raised to at least the same rates paid to Medicare providers for the same services. To reduce the initial burden of this regulation, the federal government will cover the difference between Medicare payment rates and the existing Medicaid payment rates as of July 1, 2009 for those two years only (CY2013 and CY2014).[12]

Federal regulations place restrictions on how states can apply cost-sharing models used in providing reimbursement to providers who care for Medicaid patients. States cannot increase payments to providers to compensate for charges that the provider has waived, or those that go uncollected such as deductibles, co-insurance, co-payments, or comparable charges. The Medicare reasonable cost reimbursement principles stipulate the only exception to this clause, the state does reimburse providers for lost revenue. This includes state-paid reimbursements to hospitals for uncompensated care, otherwise called disproportionate share hospital (DSH) payments. Typically, DSH payments are distributed to hospitals that treat great numbers of low-income individuals and Medicaid patients. Under the ACA, DSH payments will be slowly phased out to zero as the number of uninsured individuals requiring uncompensated care becomes less as a result of the broader health insurance coverage. It is important to note - states that choose not to expand their Medicaid programs still lose DSH payments.

Additionally, when states choose to contract with select managed care organizations that do not participate in the state's Medicaid cost-sharing requirements, the state is required to independently determine payments to these organizations as though regular cost-sharing rates were actually collected.

ACA Medicaid Expansion

In June 2012, the Supreme Court levied its much anticipated ruling on the Affordable Care Act. The Court ruled the individual mandate, attendant health insurance reforms, consumer protections, and the new program that provides health insurance tax credits and subsidies to the needy population

[10] (Families USA, 2012)
[11] (Families USA, 2012)
[12] (Herz, 2010)

constitutional. However, the justices ruled that the law's requirement that each state expand its Medicaid program or lose all federal Medicaid reimbursements was coercive and therefore unconstitutional. The unconstitutional provisions designated funds to be distributed to each state in order to assist in expanding its Medicaid program to cover nonelderly adults with incomes below 138 percent of the federal poverty level. Before the ACA, few states covered nondisabled patients up to this income level, and even fewer states covered nondisabled adults without dependent children in Medicaid.[13] Under the provisions, if a state refused to expand its program, the federal government would withhold all current Medicaid program funds from that state. The Supreme Court ruling allows each state the option to refuse to expand its Medicaid program, and the federal government may not withhold current Medicaid funding from that state if it decides not to expand.

If a state does choose to expand its Medicaid program under the ACA, the federal government will fully fund Medicaid coverage for newly eligible individuals (individuals who were not eligible for coverage before the ACA, but under new eligibility rules are now covered under the expansion) through 2016. In 2017, the federal government's Medicaid funding rate for the newly eligible beneficiaries drops to 95 percent, and then finally to 90 percent in 2020 and beyond.

With full implementation of the Medicaid expansion under the ACA in all of the states, the Congressional Budget Office (CBO) has estimated that enrollment increases in Medicaid would amount to about half of the total coverage increases projected under the new law.[14] CBO also estimates that expanding the program will add insignificant costs to what states would have spent on Medicaid without the implementation of health reform, which provides insurance coverage to 17 million additional low-income adults and children.[15] The additional cost of implementing the Medicare expansion is estimated to be only a 2.8 percent increase from what states would have spent between 2014 and 2022 without the health reform law.[16] However, this number is significantly overstated, as CBO's calculations do not factor in the savings that state and local governments will realize in their health care spending for the uninsured.[17] The Urban Institute estimates that the overall state savings in these areas will total between $26 and $52 billion from 2014 through 2019, while The Lewin Group's estimate number comes out to around $101 billion in savings from uncompensated care.[18]

"Critics argue that state budgets will be hit hard by the costs of extending Medicaid to people who are already eligible for the program but unenrolled under current state rules, but will enroll as a result of health reform. States will receive the standard federal Medicaid matching rate for covering these individuals (57 percent, on average), which is well below the 93 percent average federal match noted above for people whom the Affordable Care Act makes newly eligible for Medicaid. But the CBO, Urban Institute, and Lewin Group estimates all account for the cost to states of covering the already eligible individuals who will enroll. CBO's 93 percent average federal share of the Medicaid expansion's costs and the estimate that state Medicaid costs will rise just 2.8 percent on average — and the even lower Urban Institute and Lewin estimates of state costs — reflect this cost."[19]

[13] (Urban Institute Health Policy Center, 2012)
[14] (Urban Institute Health Policy Center, 2012)
[15] (Angeles, 2012)
[16] (Angeles, 2012)
[17] (Angeles, 2012)
[18] (Angeles, 2012)
[19] (Angeles, 2012)

Whether or not a state chooses to accept the Medicaid expansion, the federal government will stop reimbursing hospitals for disproportionate share hospital (DSH) payments and states for other high costs of uncompensated care that usually fall on local governments when the uninsured or poor use hospital services but are unable to pay for them.[20] The loss of these payments serves as an appealing incentive for states to expand their Medicaid programs, because expanding coverage would in turn, lower the cost of uncompensated care because most residents who would have been uninsured under the old Medicaid eligibility criteria, will now qualify for benefits and will be required to enroll.

To further encourage states to accept the Medicaid expansion funds, and therefore reduce the burden of uncompensated care, economists report that states that chose to expand would experience budget gains. "States that reject the ACA coverage expansion would turn down significant amounts of federal money, thus forgoing employment increases in the health sector and other industries."[21]

Those states that choose not to implement the Medicaid expansion will be faced with a costly coverage issue. Some people, who would be eligible for tax credits and subsidies under the expansion, will instead be required to pay higher cost-sharing rates to obtain the mandated insurance. Further, these federal tax credits and subsidies would not be available for most people with incomes below FPL. Consequently, the uninsured living above poverty could receive help in purchasing insurance, but those living below the poverty line would not.[22]

In other words, as the Center for Budget and Policy Priorities notes:

> *In states forgoing the Medicaid expansion, therefore, working people with incomes above the Medicaid eligibility limit but below the poverty line would have neither Medicaid nor subsidized exchange coverage. Due to the low wages they earn, many working-poor parents would have incomes too high to qualify for Medicaid but too low to qualify for subsidies to buy coverage in the exchanges. Many would likely remain uninsured and go without needed care. According to the Urban Institute, there are 11.5 million uninsured people nationwide with incomes below the poverty line who would be newly eligible for Medicaid under the expansion. They would be at risk of remaining uninsured if their states do not move forward and expand Medicaid.*[23]

The requirement that all individuals obtain health insurance will increase Medicaid enrollment for individuals who are currently eligible but not enrolled, whether or not a state decides to expand Medicaid. Thus, the state's Medicaid spending will increase irrespective of the decision to expand. A state refusing to expand its program leaves a tremendous gap in coverage for some of the poorest Americans. (For more detailed state-by-state statistics on this coverage gap, please see the attached tables.)

Health Insurance Exchanges & Health Insurance Premium Program

Under the ACA, each state must establish and implement a "health insurance exchange." These exchanges will function like government agencies or non-profit organizations in order to create a

[20] (Urban Institute Health Policy Center, 2012)
[21] (Urban Institute Health Policy Center, 2012)
[22] (Urban Institute Health Policy Center, 2012)
[23] (Angeles, 2012)

more organized, transparent, and competitive market for individuals to buy health insurance. Exchanges will offer information to consumers to help them pick a plan that best suits their needs. The exchange will also levy a certification process for insurance company plans to make sure they meet certain requirements to participate in the exchange market.[24]

In addition to expanding Medicaid to those with incomes below 138 percent of the poverty level, the ACA also provides new insurance premium subsidies for people living between 100 percent to 400 percent of the FPL (which is about $88,000 for a family of four).[25] This premium assistance program will help families obtain health coverage to comply with the individual mandate of the ACA.

Beginning in 2014, all state exchanges must be operational for individuals and small business (defined as businesses with up to 100 employees, though states have the option to expand the exchange to include bigger businesses) to buy insurance on their own. If a state does not set up an exchange, per the ACA, the federal government will step in and run the exchange in the state. The federal government also will offer technical and financial assistance in helping states establish exchanges.[26]

This insurance market reform will improve access to health insurance not only for those who receive the premium assistance, but for all health insurance consumers as the provision establishes a health insurance marketplace in each state. According to the Center for Budget and Policy Priorities, "the expansion of health-care coverage will help protect residents against preventable illnesses and should result in a healthier workforce."[27] Studies have shown that access to care and insurance coverage are directly correlated to a healthier workforce, and lower morbidity.[28],[29]

In addition to expanding Medicaid and the implementation of health insurance exchanges, provisions in the ACA[30] authorize redistribution of unused Medicare-funded Graduate Medical Education (GME) residency slots by allowing schools to count training done in outpatient settings.[31] Though these GME residency spaces are funded by Medicare, being able to have residents see patients in clinics, which will be more heavily utilized once the individual mandate takes effect in 2014, allows the workforce to expand slightly. Many of the patients utilizing outpatient clinics will be new Medicaid recipients, and will be seen by primary care residents. However, Medicaid-funded GME residency slots are determined differently by each state's budget and can be cut in some states.

The establishment of insurance exchanges and the expansion of Medicaid are meant to work together along with the other provisions in the ACA to improve coverage and access to health care for all. Improved coverage and access lead to better population health, which also leads to cost savings for states as well as the federal government.

[24] (Kaiser Family Foundation, 2012)
[25] (The Lewin Group, 2010)
[26] (Kaiser Family Foundation, 2012)
[27] (Angeles, 2012)
[28] (Sommers, Baicker, & Epstein, 2012)
[29] (Finkelstein, 2012)
[30] (Affordable Care Act and Reconciliation Act, 2010)
[31] (American Medical Association, 2011)

Explanation of Data Tables

The following data tables are meant to address the impact of the Medicaid Expansion in each of the 50 states. Though data compiled in these tables demonstrates the financial impact of implementing the Medicaid expansion, they also show that it is worth the cost. As a direct result of the expansion, the number of Medicaid enrollees will increase by 14.9 million in 2014 and by 25.9 million in 2020.[32] However, the data presented in the following pages are unable to illustrate the entire financial impact of expanding Medicaid.

Survey data and economic projection models cannot capture the entire financial reality of the Medicaid expansion and insurance exchanges for a variety of reasons. For example, data do not account for individuals with fluctuating incomes and changing family composition. The eligibility for Medicaid and insurance subsidies is so sensitive that taking an extra shift, cutting working hours, or having a baby could change a recipient's eligibility level. It is estimated that within six months of the implementation of the Medicaid expansion and insurance exchange subsidies (2014), 35 percent of adults with family incomes below 200 percent of FPL will experience a shift (also known as 'churn') between Medicaid and the insurance exchanges.[33] Within a year of implementation, it is estimated that 50 percent or 28 million people will experience the same shift.[34]

As some researchers argue, to minimize the effect of patient churn between programs, it would behoove the government to adopt strategies such as instituting minimum guaranteed eligibility periods or adopt "dual certification" for some plans that serve both Medicaid and exchange eligibles.[35]

Other unpredictable aspects that heavily affect the financial burden for state implementation include economic improvement or downturn, and loss or addition of jobs. Further, data are unable to predict or capture information on possible lack of provider participation in Medicaid and the effect of reduced DSH payments.

Researchers also point out that another large issue with the Medicaid expansion and the individual mandate includes what has become known as the "woodwork effect." This represents the population of currently eligible, but uninsured individuals, who will be required to obtain insurance or face a penalty.[36]

While the federal government will cover 100 percent at first, then eventually 90 percent, of the newly eligible Medicaid population, the "woodwork" population will not be covered by the expansion funds; thus, the states must pay for these individuals under the current FMAP cost-sharing rates.[37]

Finally, data limitations and financial burden forecasts of the expansion also fail to factor in cost savings from expanded access to care. As previously cited in this report, state-expanded Medicaid programs to cover low-income adults was significantly associated with reduced mortality, improved self-reported health, and extended access to care.[38] Increased access to care, leads to healthier

[32] (Office of the Actuary, Centers for Medicare & Medicaid Services, 2012)
[33] (Sommers & Rosenbaum, How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges, 2011)
[34] (Sommers & Rosenbaum, How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges, 2011)
[35] (Sommers & Rosenbaum, How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges, 2011)
[36] (Sommers & Epstein, Why States Are So Miffed about Medicaid — Economics, Politics, and the "Woodwork Effect", 2011)
[37] (Sommers & Epstein, Why States Are So Miffed about Medicaid — Economics, Politics, and the "Woodwork Effect", 2011)
[38] (Sommers, Baicker, & Epstein, 2012)

populations, which leads to less expensive care, which, in turn, should lead to a significant reduction in health care costs.

Expanding Medicaid eligibility and establishing health insurance exchanges aligns with the AAFP's principles of seeking to ensure health care coverage for all by increasing access to care and enabling physicians to provide cost-efficient, quality care. As many family physicians treat Medicaid recipients and low-income patients on a daily basis, the AAFP is generally supportive of the provisions in the ACA that expand the Medicaid program and establish insurance exchanges.

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Tables

Table 1 & 1a: Increase in Number of Uninsured & Uncompensated Care Costs with No Health Reform under Alternative Assumptions, 2009-2019
This table shows the number of uninsured persons (breaking out the percentage of these persons who are not elderly) and the cost (in billions of dollars) that it took to care for these people in 2009 and then estimates how much it will cost in 2014 and 2019. Estimates take into consideration best, intermediate and worst case scenarios. The tables also show the increase in cost in percentages (Table 1a).

Table 2: Sources of Funding of Uncompensated Care Spending (in billions of 2008 Dollars)
This table explains the breakdown between Medicare, Medicaid, State & Local funds, Direct Care Programs, Physicians, and Private funds in funding for all uncompensated health care services in both percentages and billions of dollars.

Table 3: Estimated Changes in Spending on Uncompensated Care under Health Reform
This table shows estimates from the House of Representatives and the Senate on the changes in spending on uncompensated health care under the Affordable Care Act in billions of dollars and millions of people in 2009, 2014, and 2019.

Table 4: 2011 – 2012 Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages
This table lists the Federal Medical Assistance Percentages (FMAP), and the Enhanced Federal Medical Assistance Percentages (eFMAP) for each state. The FMAP is used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. Under Medicaid, Section 1905(b) in the Social Security Act calls for the Secretary of Health and Human Services to calculate and publish the FMAP rates each year. The eFMAP is for the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating eFMAP.

Table 5: State Medicaid Eligibility
This table details each state's population and the breakdown of where that population receives its health insurance in both millions of people and percentages of the total population.

Table 6: State Health Insurance Exchange Eligibility
This table breaks state uninsured populations into 5 separate poverty levels in order to assist in estimates on how many of the uninsured in each state would be eligible for Medicaid or subsidies to buy health insurance through state exchanges.

Table 7: Medicaid Expansion to 133% of Federal Poverty Level: Estimated Increase in Enrollment & Spending Relative to Baseline by 2019
This table shows the estimated increase in enrollment and spending for each state relative to the baseline if that state were to take the Medicaid expansion.

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Table Appendix

Table 1 & Table 1a: Increase in Number of Uninsured & Uncompensated Care Costs with No Health Reform under Alternative Assumptions, 2009-2019[39]

TABLE 1

	2009			2014			2019		
	N (millions)	%nonelderly	$ billions	N (millions)	%nonelderly	$ billions	N (millions)	%nonelderly	$ billions
Worst Case	49.1	18.40%	$62.10	57.7	20.90%	$92.30	65.7	23.20%	$141.40
Intermediate Case	49.1	18.40%	$62.10	56.2	20.40%	$87.00	62.2	21.90%	$123.10
Best Case	49.1	18.40%	$62.10	53.1	19.30%	$106.60	57	20.10%	$106.60

TABLE 1a

% Change	2009 – 2014	2014 – 2019	2009 – 2019
Worst Case	48.70%	53.20%	127.80%
Intermediate Case	40.10%	41.50%	98.30%
Best Case	30.40%	31.60%	71.70%

Table 2: Sources of Funding of Uncompensated Care Spending (in billions of 2008 Dollars)[40]

Source	$	%
Medicare	$7.20	12.50%
Medicaid	$10.90	19%
State & Local	$10.60	18.50%
Direct Care Programs	$14.60	24.40%
Physicians	$7.80	13.60%
Private	$6.30	11%
TOTAL	**$57.40**	**100%**

Table 3: Estimated Changes in Spending on Uncompensated Care under Health Reform[41]

	Number of uninsured (millions)	Cost per uninsured person	Spending on uncompensated care (billions)
SENATE			
2009	49.1	$1,264	$62.10
2014	34	$1,588	$54
2019	23	$2,026	$46.60
HOUSE			
2009	49.1	$1,264	$62.10
2014	23	$1,588	$36.50
2019	18	$2,026	$36.50

39, 40, 41 Urban Institute - The Cost of Uncompensated Care with and without Health Reform - March 2010
http://www.urban.org/UploadedPDF/412045_cost_of_uncompensated.pdf

Table 4: 2011 – 2012 Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages[42]

STATE	Federal Medical Assistance Percentages	Enhanced Federal Medical Assistance Percentages
Alabama	68.62	78.03
Alaska	50.00	65.00
AmericanSamoa*	50.00	65.00
Arizona	67.30	77.11
Arkansas	70.71	79.50
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	54.17	67.92
District of Columbia**	70.00	79.00
Florida	56.04	69.23
Georgia	66.16	76.31
Guam*	50.00	65.00
Hawaii	50.48	65.34
Idaho	70.23	79.16
Illinois	50.00	65.00
Indiana	66.96	76.87
Iowa	60.71	72.50
Kansas	56.91	69.84
Kentucky	71.18	79.83
Louisiana	61.09	72.76
Maine	63.27	74.29
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	66.14	76.30
Minnesota	50.00	65.00
Mississippi	74.18	81.93
Missouri	63.45	74.42
Montana	66.11	76.28
Nebraska	56.64	69.65
Nevada	56.20	69.34
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	69.36	78.55
New York	50.00	65.00
North Carolina	65.28	75.70
North Dakota	55.40	68.78
Northern Mariana Islands*	50.00	65.00
Ohio	64.15	74.91
Oklahoma	63.88	74.72
Oregon	62.91	74.04
Pennsylvania	55.07	68.55
Puerto Rico*	50.00	65.00
Rhode Island	52.12	66.48
South Carolina	70.24	79.17
South Dakota	59.13	71.39
Tennessee	66.36	76.45
Texas	58.22	70.75
Utah	70.99	79.69
Vermont	57.58	70.31
Virgin Islands*	50.00	65.00
Virginia	50.00	65.00
Washington	50.00	65.00
West Virginia	72.62	80.83
Wisconsin	60.53	72.37
Wyoming	50.00	65.00

42 Federal Register / Vol. 75, No 217 / Wednesday, November 10, 2010 / Notices / 69082

Table 5: State Medicaid Eligibility[43]

State	Population	Uninsured	%	Employer #	%	Individual #	%	Medicaid #	%	Medicare #	%	Other Public #	%
Alabama	4,660,300	744,100	16	2,293,317	49	151,547	3	712,560	15	698,959	15	59,844	1
Alaska	676,700	121,800	18	357,158	53	19,526	3	92,495	14	49,104	7	36,555	5
Arizona	6,593,200	1,258,600	19	2,884,043	44	335,823	5	1,268,486	19	775,001	12	71,225	1
Arkansas	2,861,400	540,300	19	1,212,502	42	113,840	4	491,754	17	449,058	16	53,925	2
California	36,899,700	7,162,700	19	16,653,354	45	2,219,707	6	6,935,398	19	3,622,707	10	305,830	1
Colorado	4,979,600	688,700	14	2,691,346	54	375,826	8	599,870	12	498,102	10	125,732	3
Connecticut	3,485,100	385,600	11	2,073,743	60	157,102	5	389,664	11	463,261	13	NSD	NSD
Delaware	877,600	107,100	12	464,667	53	33,037	4	136,308	16	128,533	15	7,950	1
District of Columbia	601,500	74,700	12	292,976	49	32,471	5	138,326	23	60,505	10	NSD	NSD
Florida	18,413,600	3,924,800	21	7,796,662	42	888,285	5	2,466,555	13	2,975,507	16	361,819	2
Georgia	9,671,400	1,942,600	20	4,755,286	49	479,146	5	1,330,272	14	914,876	9	249,304	3
Hawaii	1,228,900	94,500	8	685,927	56	48,274	4	194,362	16	174,711	14	31,081	3
Idaho	1,526,900	262,400	17	733,322	48	126,531	8	203,608	13	182,792	12	18,254	1
Illinois	12,814,300	1,863,800	15	6,643,979	52	604,785	5	2,077,803	16	1,539,986	12	83,885	1
Indiana	6,348,800	864,400	14	3,312,146	52	194,974	3	1,036,801	16	862,799	14	77,655	1
Iowa	2,973,300	345,000	12	1,659,259	56	183,406	6	402,761	14	356,833	12	26,011	1
Kansas	2,731,300	351,000	13	1,461,645	54	153,619	6	324,761	12	376,388	14	63,882	2
Kentucky	4,279,400	659,900	15	2,065,127	48	147,752	3	783,888	18	570,061	13	52,675	1
Louisiana	4,432,600	765,800	17	2,026,874	46	209,494	5	827,234	19	559,132	13	NSD	NSD
Maine	1,288,300	125,600	10	610,881	47	53,525	4	287,482	22	184,149	14	26,651	2
Maryland	5,681,500	749,700	13	3,363,614	59	269,378	5	603,305	11	635,783	11	59,708	1
Massachusetts	6,613,100	327,900	5	3,776,537	57	286,714	4	1,345,192	20	858,502	13	NSD	NSD
Michigan	9,785,300	1,272,600	13	5,112,516	52	442,902	5	1,550,408	16	1,368,419	14	NSD	NSD
Minnesota	5,189,400	463,100	9	2,965,091	57	287,378	6	748,538	14	671,756	13	53,542	1
Mississippi	2,877,500	555,300	19	1,148,124	40	132,786	5	618,437	21	378,592	13	44,221	2
Missouri	5,967,100	853,300	14	3,041,597	51	346,813	6	860,937	14	820,093	14	NSD	NSD
Montana	968,300	161,500	17	422,870	44	84,396	9	127,974	13	152,145	16	19,426	2
Nebraska	1,777,300	217,100	12	968,490	54	132,564	7	196,351	11	229,560	13	33,326	2
Nevada	2,628,900	552,400	21	1,341,913	51	132,039	5	259,594	10	297,954	11	45,020	2
New Hampshire	1,306,600	131,500	10	812,620	62	71,794	5	93,478	7	187,377	14	9,838	1
New Jersey	8,667,900	1,297,000	15	4,947,895	57	331,190	4	1,016,100	12	1,067,529	12	NSD	NSD
New Mexico	1,987,100	424,400	21	780,982	39	68,005	3	422,529	21	246,891	12	44,304	2
New York	19,221,100	2,797,100	15	9,195,874	48	764,113	4	4,065,143	21	2,332,296	12	66,635	0
North Carolina	9,229,900	1,620,300	18	4,356,610	47	391,798	4	1,443,815	16	1,199,522	13	217,816	2
North Dakota	630,400	74,100	12	341,547	54	66,022	#	57,261	9	82,660	13	8,768	1
Ohio	11,392,400	1,565,900	14	6,027,987	53	536,625	5	1,603,380	14	1,574,740	14	83,780	1
Oklahoma	3,634,500	638,500	18	1,707,237	47	133,484	4	569,790	16	505,435	14	80,050	2
Oregon	3,802,600	637,900	17	1,865,619	49	236,677	6	495,729	13	532,760	14	NSD	NSD
Pennsylvania	12,422,200	1,361,700	11	6,678,593	54	581,683	5	1,852,086	15	1,893,282	15	54,827	0
Rhode Island	1,037,500	121,800	12	544,239	52	39,735	4	180,170	17	141,647	14	9,930	1
South Carolina	4,507,800	843,600	19	2,102,349	47	188,093	4	618,833	14	674,061	15	80,874	2
South Dakota	799,900	104,800	13	403,245	50	60,493	8	103,322	13	110,508	14	17,561	2
Tennessee	6,243,900	933,700	15	2,924,891	47	311,416	5	1,054,851	17	873,008	14	146,058	2
Texas	24,840,100	6,234,900	25	11,059,096	45	926,555	4	3,966,983	16	2,313,572	9	339,021	1
Utah	2,804,800	390,100	14	1,700,677	61	151,473	5	263,511	9	281,324	10	NSD	NSD
Vermont	619,200	58,700	9	311,277	50	23,762	4	141,565	23	78,334	13	NSD	NSD
Virginia	7,700,400	1,039,300	13	4,339,961	56	395,994	5	731,474	9	904,549	12	289,047	4
Washington	6,664,000	887,400	13	3,423,653	51	371,920	6	1,023,926	15	789,593	12	167,561	3
West Virgnia	1,802,200	245,800	14	858,197	48	29,638	2	318,561	18	324,238	18	25,770	1
Wisconsin	5,584,700	511,500	9	3,090,694	55	297,411	5	832,646	15	822,484	15	NSD	NSD
Wyoming	535,800	88,000	16	281,322	53	32,638	6	61,882	12	61,649	12	10,322	2

NOTE: NSD = Not Sufficient Data

43 Kaiser Family Foundation statehealthfacts.org

Table 6: State Health Insurance Exchange Eligibility[44]

State	UI at 100% FPL	%	U 100% to 138% of FPL	%	UI 139% to 250% FPL	%	UI 251% to 399% FPL	%	UI 400% +	%
Alabama	352,079	48%	87,728	12%	177,792	24%	63,249	9%	NSD	NSD
Alaska	46,963	39%	12,466	10%	30,591	26%	19,528	16%	10,170	8%
Arizona	552,026	45%	178,016	15%	259,449	21%	145,720	12%	92,426	8%
Arkansas	198,351	38%	76,415	15%	150,403	29%	54,266	10%	46,876	9%
California	2,936,834	42%	926,349	13%	1,658,960	24%	872,327	12%	627,188	9%
Colorado	264,344	38%	82,044	12%	166,399	24%	91,273	13%	82,588	12%
Connecticut	124,193	33%	34,999	9%	95,410	25%	55,426	15%	67,901	18%
Delaware	35,763	34%	10,925	10%	28,694	27%	15,890	15%	13,309	13%
District of Columbia	33,215	46%	NSD	NSD	18,005	25%	9,580	13%	6,336	9%
Florida	1,509,107	39%	485,954	13%	914,191	24%	529,392	14%	420,214	11%
Georgia	865,206	45%	224,980	12%	435,565	23%	215,335	11%	181,889	9%
Hawaii	45,379	50%	NSD	NSD	18,998	21%	NSD	NSD	8,891	10%
Idaho	99,477	38%	34,122	13%	82,493	32%	29,670	11%	NSD	NSD
Illinois	779,803	42%	231,814	13%	437,577	24%	231,373	13%	158,248	9%
Indiana	348,930	41%	91,358	11%	207,582	24%	123,965	14%	83,755	10%
Iowa	118,151	35%	49,041	14%	93,828	27%	44,048	13%	36,146	11%
Kansas	134,863	39%	49,550	14%	90,434	26%	41,335	12%	33,860	10%
Kentucky	281,495	43%	98,302	15%	156,158	24%	78,585	12%	40,529	6%
Louisiana	339,983	45%	85,247	11%	180,405	24%	94,967	13%	58,380	8%
Maine	31,871	26%	15,869	13%	37,231	30%	23,808	19%	15,903	13%
Maryland	268,311	36%	88,960	12%	213,290	29%	99,608	14%	66,902	9%
Massachusetts	115,439	36%	NSD	NSD	72,319	23%	NSD	NSD	NSD	NSD
Michigan	555,100	44%	173,097	14%	266,410	21%	130,167	10%	132,087	11%
Minnesota	143,216	31%	46,292	10%	137,820	30%	84,431	18%	47,291	10%
Mississippi	267,006	48%	61,176	11%	122,075	22%	55,767	10%	44,633	8%
Missouri	363,690	43%	92,345	11%	222,928	26%	113,552	13%	60,047	7%
Montana	54,724	34%	15,406	10%	41,534	26%	27,498	17%	21,127	13%
Nebraska	65,055	30%	28,419	13%	65,036	30%	35,612	17%	20,680	10%
Nevada	216,927	40%	71,433	13%	137,279	25%	64,999	12%	54,168	10%
New Hampshire	33,461	26%	13,369	10%	36,315	28%	26,909	21%	20,717	16%
New Jersey	453,052	36%	129,059	10%	329,019	26%	189,905	15%	170,891	13%
New Mexico	185,147	44%	51,616	12%	82,227	20%	52,547	13%	45,471	11%
New York	970,694	36%	301,678	11%	702,719	26%	401,718	15%	352,563	13%
North Carolina	698,289	44%	215,679	13%	419,155	26%	148,328	9%	122,603	8%
North Dakota	27,721	38%	7,034	10%	20,095	27%	12,433	17%	NSD	NSD
Ohio	652,006	42%	195,685	13%	415,694	27%	176,342	11%	110,749	7%
Oklahoma	235,849	37%	73,004	11%	176,462	28%	98,349	15%	52,500	8%
Oregon	249,268	39%	96,622	15%	178,519	28%	71,251	11%	37,405	6%
Pennsylvania	483,779	36%	169,090	13%	364,853	27%	191,548	14%	134,515	10%
Rhode Island	48,357	41%	11,749	10%	29,119	24%	14,118	12%	15,731	13%
South Carolina	361,218	43%	96,394	12%	212,895	25%	99,243	12%	68,377	8%
South Dakota	41,488	40%	13,169	13%	25,513	24%	13,887	13%	10,458	10%
Tennessee	401,657	43%	145,819	16%	235,614	25%	94,308	10%	NSD	NSD
Texas	2,464,519	40%	849,498	14%	1,589,986	26%	751,478	12%	477,885	8%
Utah	132,883	34%	52,779	14%	103,479	27%	56,630	15%	42,498	11%
Vermont	15,647	27%	NSD	NSD	15,842	27%	10,740	19%	10,571	18%
Virginia	356,335	35%	115,282	11%	302,060	29%	144,072	14%	112,226	11%
Washington	299,570	34%	110,928	13%	245,435	28%	135,894	15%	88,364	10%
West Virginia	101,099	42%	34,311	14%	43,958	18%	38,021	16%	24,997	10%
Wisconsin	164,236	33%	53,119	11%	146,922	29%	83,441	17%	56,076	11%
Wyoming	26,054	30%	7,909	9%	27,432	31%	13,417	15%	12,652	14%

NOTE: NSD = Not Sufficient Data

44 Kaiser Family Foundation statehealthfacts.org

Table 7: Medicaid Expansion to 133% of Federal Poverty Level: Estimated Increase in Enrollment & Spending Relative to Baseline by 2019[45]

	Enrollment in 2019	State Spending	Federal Spending	Total Spending
United States	27.40%	1.40%	22.10%	13.20%
Alabama	36.90%	3.60%	35.90%	25.70%
Alaska	38.50%	2.10%	36.90%	19.50%
Arizona	7.70%	0.20%	4.20%	2.90%
Arkansas	27.90%	4.70%	38.90%	29.10%
California	20.10%	1.50%	23.00%	12.30%
Colorado	47.70%	1.80%	37.10%	19.40%
Connecticut	20.10%	1.20%	21.00%	11.10%
Delaware	6.70%	0.10%	6.20%	3.30%
District of Columbia	16.10%	0.90%	8.30%	6.10%
Florida	34.70%	1.90%	24.30%	14.30%
Georgia	40.40%	2.70%	28.90%	19.80%
Hawaii	38.00%	-0.50%	46.80%	24.00%
Idaho	39.40%	2.50%	27.10%	19.40%
Illinois	25.80%	1.60%	25.90%	13.80%
Indiana	29.40%	2.50%	22.90%	16.10%
Iowa	25.30%	1.40%	15.70%	10.30%
Kansas	42.00%	1.70%	24.00%	14.80%
Kentucky	37.30%	3.50%	32.20%	24.00%
Louisiana	32.40%	1.70%	21.60%	14.40%
Maine	11.80%	-1.50%	12.90%	7.70%
Maryland	32.40%	1.70%	29.60%	15.60%
Massachusetts	2.00%	-2.10%	3.50%	0.70%
Michigan	30.20%	2.00%	21.50%	14.80%
Minnesota	32.90%	1.20%	22.00%	11.60%
Mississippi	41.20%	4.80%	37.00%	28.90%
Missouri	29.80%	1.70%	19.50%	13.00%
Montana	54.50%	3.70%	40.00%	27.90%
Nebraska	36.20%	1.50%	23.50%	14.40%
Nevada	61.70%	2.90%	49.80%	27.10%
New Hampshire	38.80%	1.10%	21.30%	11.20%
New Jersey	38.10%	1.20%	20.90%	11.10%
New Mexcio	28.30%	2.10%	21.30%	15.50%
New York	6.00%	0.00%	3.30%	1.70%
North Carolina	38.20%	2.60%	29.00%	19.70%
North Dakota	44.00%	1.40%	16.90%	10.80%
Ohio	31.90%	1.60%	19.20%	12.80%
Oklahoma	51.20%	4.00%	48.20%	32.70%
Oregon	60.60%	3.60%	50.60%	33.10%
Pennsylvania	21.70%	1.40%	17.70%	10.50%
Rhode Island	20.00%	0.70%	14.60%	8.10%
South Carolia	38.40%	3.60%	36.00%	26.30%
South Dakota	25.90%	1.10%	16.40%	10.50%
Tennessee	20.90%	2.50%	20.40%	14.30%
Texas	45.50%	3.00%	38.90%	24.70%
Utah	56.10%	3.70%	35.30%	26.20%
Vermont	2.80%	-0.60%	1.90%	0.90%
Virginia	41.80%	1.80%	35.10%	18.40%
Washington	25.20%	1.20%	26.00%	13.60%
West Virginia	29.50%	2.40%	20.40%	15.60%
Wisconsin	20.80%	0.90%	12.70%	8.00%
Wyoming	40.00%	1.20%	26.80%	14.00%

45 Kaiser Family Foundation statehealthfacts.org – http://www.statehealthfacts.org/comparereport.jsp?rep=68