Consider Savings as Well as Costs

State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019

Timely Analysis of Immediate Health Policy Issues

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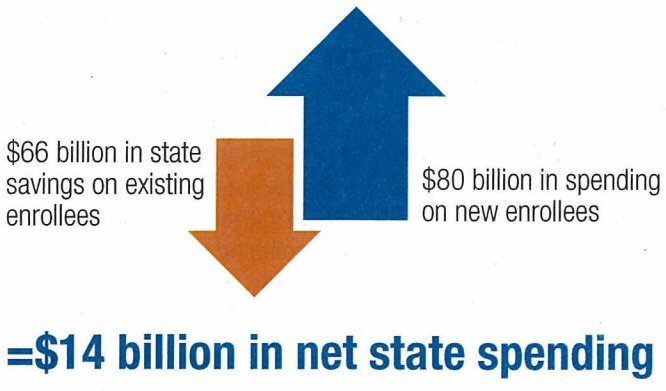
Summary

National health reform will result in additional spending by both federal and state governments as more Americans gain access to affordable health care, typically because of publicly funded subsidies. But there will also be important sources of savings for state and local governments. In this paper, we use the Health Insurance Policy Simulation Model (HIPSM) to produce a consistent set of estimates for important spending and savings items. In addition to national estimates, we present state-level estimates for all increased costs included in the national estimates, as well as some of the savings. We find that:

- Total state savings would exceed states' new costs, as federal dollars substitute for projected state and local spending without the ACA, and as states eliminate current Medicaid eligibility for adults who qualify for federal subsidies in the exchange. Overall, the federal government would spend $704 billion to $743 billion more under health reform than without it. The states, on the other hand, would spend $92 to $129 billion less under the ACA than without it over the same time period, between 2014 and 2019 (Figure 2).
- If states leave current Medicaid eligibility unchanged, the Medicaid expansion would lead to $526 billion in additional federal and $14 billion in additional state spending from 2014 to 2019. These figures, both of which are included in the above totals, are made up of two components. State spending on additional enrollees, both among those who qualify today and those who are newly eligible, will rise by $80 billion. However, these costs are offset by $66 billion in new federal spending on existing enrollees under the Affordable Care Act (ACA), as such enrollees move into eligibility categories that qualify for higher levels of federal support (Figure 1). The federal government would also spend $345 billion on premium and cost-sharing subsidies in the new health benefit exchanges.
- There would be considerable state and regional variation in these costs and savings, reflecting differences in factors such as current Medicaid eligibility rules and the characteristics of the pre-reform uninsured.
- Elimination of Medicaid eligibility for certain adults with incomes above 138 percent of the Federal Poverty Level (FPL) will be one source of state savings included in the above totals. Between 2014 and 2019, states will save $69 billion, while the federal government saves $89 billion. Part of this maintenance of effort savings will come from discontinued eligibility through Section 1115 waivers and Social Security Act Section 1931, accounting for $11.6 billion and $10.3 billion in federal and collective state savings, respectively. A portion of these federal savings will be offset by federal spending on premium and cost-sharing subsidies, as these low-income adults are likely to move into the exchange when they lose Medicaid eligibility.
- By significantly reducing the uninsured population, the ACA will roughly halve spending on uncompensated care. If states and the federal government reduce their total spending on uncompensated care by 12.5 percent to 25 percent, the federal government will save between $39 billion and $78 billion while states collectively save $26 billion to $52 billion, which is included in the above estimates.
- States will also reduce spending on individuals with mental illness. Currently, state and local governments use general fund dollars to pay for a large portion of state mental health costs. The ACA will extend Medicaid to many low-income people with mental illness who previously were uninsured, increasing state mental

Figure 1. The Effect of the Medicaid Expansion on State Budgets



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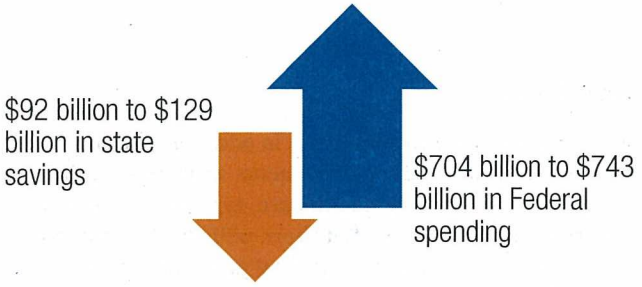
health programs' federal funding. Using 25 to 50 percent of these federal dollars to substitute for state and local spending, states could collectively save between $11 billion and $22 billion dollars from 2014-2019, which is part of our totals.

- From 2020 onwards, federal match rates for new Medicaid eligibles would be 90 percent, lower than during the period from 2014 to 2019. States would thus spend more on new Medicaid enrollees than previously. States would nevertheless achieve net savings under the ACA because savings would continue to exceed increased costs. Net annual state savings would be $12 billion to $19 billion for the year 2020, with similar amounts in later years.

Because of limitations in state-level data, we could not translate all of the above savings into state-specific numbers. Accordingly, our state estimates show a less favorable fiscal picture for states and localities than is indicated by our national estimates, which themselves probably undercount net state fiscal gains under the ACA.

Figure 2. The Effect of the ACA on Federal and State Budgets



Introduction

Many observers have tried to estimate the fiscal effects of the Patient Protection and Affordable Care Act (ACA) on states.[1] Various estimates have focused on the state Medicaid costs that will result from increased enrollment.[2] Some have noted the cost effects of various possible state policy choices, such as a state decision to retain increased Medicaid payment rates for certain primary care providers after additional federal funding for that increase ends in 2015.[3] Relatively few have sought to compare both the costs and savings that states could realize under the ACA. Most studies in the latter category have found that, as a whole, states are likely to come out ahead.[4]

This paper adds to the prior literature by combining national and state-specific estimates of both costs and fiscal gains for states, coupled with analysis of fiscal effects for the federal government. Our national estimates differ from those in prior Urban Institute publications for several reasons: we use 2011 data, rather than 2010 data, to develop baseline estimates; our Medicaid cost projections include children as well as adults; and we provide national cost estimates of the savings from state elimination of eligibility categories for adults with incomes above 138 percent of the Federal Poverty Level (FPL) that go beyond coverage provided pursuant to 1115 waivers and Section 1931 of the Social Security Act.

Factors for which we estimate cost effects in each state include:

- Increased Medicaid enrollment among both currently eligible and newly eligible individuals;
- Eliminating or reducing spending on optional Medicaid coverage for certain adults with modified adjusted gross income (MAGI)[5] above 138 percent of the FPL, who will qualify for federally subsidized coverage in the exchange;
- Reducing state and local spending on uncompensated care because of federal Medicaid dollars, federally subsidized coverage in the exchange, and private sources of health coverage for the newly insured;
- Increasing the federal matching rate applicable to certain adults who are currently eligible for Medicaid in some states; and
- Providing federal subsidies for health plans in the exchange serving state residents who do not qualify for Medicaid.

Two additional effects are included in our national, but not our state estimates:

- Because of significant interstate differences involving the structure of mental health and substance abuse services, we produce only national estimates of aggregate state and federal cost effects when state spending on mental health services is replaced by federal Medicaid dollars.
- Our state-specific cost estimates of eliminating Medicaid eligibility for adults above 138 percent of the FPL are limited to two categories of Medicaid eligibility: waivers under Section 1115 of the Social Security Act; and families' eligibility under Section 1931 of the Social Security Act. National survey data are sufficient to estimate cost effects from cutting back other Medicaid eligibility for adults above 138 percent FPL, but they do not suffice to develop reliable state-specific estimates.

As a result, our state-specific estimates do not reflect the full measure of savings that states will experience under the ACA, based on the factors quantified in this paper. Other state fiscal effects are entirely outside the scope of both our national and state-specific analysis, including:

- State savings on the Children's Health Insurance Program (CHIP) after 2015, when federal matching rates could increase by 23 percentage points or

state spending obligations could end entirely, depending on what Congress does about the program;

- State savings from increasing the applicable Federal Medical Assistance Percentage (FMAP) for certain adults with incomes under 138 percent FPL (including the medically needy and some recipients of home- and community-based services) by reclassifying such adults as "newly eligible;"
- Potential state Medicaid savings from the more efficient and coordinated management of care furnished to seniors and people with disabilities who are dually eligible for both Medicare and Medicaid;
- Potential state and local cost savings on Medicaid and public employee coverage resulting from delivery system and payment reforms;
- Effects on Medicaid administrative costs for states, which might fall because of more data-driven and less labor-intensive eligibility determination,[6] or might rise because of the increased volume of applications;
- Increased state revenue from taxes on insurance premiums, which will rise with the number of insured;
- Modest increases in income and sales tax receipts, resulting from increased wages paid by the small minority of employers that reduce their compensation of workers through health insurance offers;[7]
- Lower premiums for public employee coverage resulting from reduced cost-shifting that follows from less uncompensated care—an effect emphasized by some (but not all) analysts;[8] and
- Increased state and local public employee health costs resulting from more acceptance of coverage offers caused by the ACA's individual mandate.

On balance, the factors we could not include in our national estimates are

Table 1: ACA's State Budget Effects, Included in and Excluded from this Paper

		National Estimates	State-Specific Estimates	Not Included in Paper
Favorable Effects on State and Local Budgets	Ending Medicaid for adults > 138 percent of FPL covered by §§1115 and 1931	X	X	
	Reduced spending on uncompensated care	X	X	
	Higher FMAP for some adults under §§1115 and 1931	X	X	
	Ending Medicaid for adults > 138 percent of FPL covered outside §§1115 and 1931	X		
	Replacing state spending on mental health services with federal Medicaid dollars	X		
	Reduced state spending on CHIP after FY 2015			X
	Increasing FMAP for adults' current Medicaid coverage outside §§1115 and 1931			X
	Potential savings on dual eligibles			X
	Potential savings on public employee coverage from reduced cost-shifting			X
	Increased premium tax revenue			X
	Potential Medicaid and public employee savings from delivery system reform			X
	Increased income and sales tax revenue			X
Uncertain Net Effects	Medicaid administrative costs			X
Unfavorable Effects	State costs of increased Medicaid enrollment of currently eligible populations	X	X	
	State costs for newly eligible adults, 2017-2019	X	X	
	State costs for newly eligible adults in 2020 and later years, when federal match reaches its low point of 90 percent	X		
	Higher public employee costs, more ESI offers accepted			X

likely to provide further net fiscal gains to states and localities.[9]

Table 1 shows how this report addresses all of these potential state budget effects.

Results

In this paper, we estimate the state and federal shares of Medicaid and CHIP spending on acute care for the nonelderly, both with and without the ACA, for the years 2014 to 2019. We separately estimate effects for 2020, when the percentage of Medicaid costs paid by the federal government will reach its final level. We also estimate federal spending on subsidies in the exchange.

Under the ACA, there would be higher Medicaid enrollment and thus additional spending. For those previously ineligible for Medicaid, the federal government would pay the large majority of their costs—100 percent from 2014-2016, decreasing to 90 percent after 2019. Less obviously, there would be additional federal spending—and thus state savings—on certain current Medicaid enrollees in states that have extended income-based eligibility to adults close to or exceeding 133 percent of the FPL, since states will be able to reclassify such enrollees as "newly eligible" adults who qualify for enhanced federal funding levels, as we explain later in more detail. Also, states would no longer be required to maintain eligibility and current spending levels for many adults with incomes above 138 percent of the FPL after 2014. These would qualify for subsidized coverage in the new health benefit exchanges, subsidies that would be federally funded. For medically needy adults with incomes above that level, states could shift costs to the federal government without eliminating Medicaid eligibility. Such adults would obtain comprehensive coverage in the exchange, so they would generally take much longer to meet applicable "spend-down" requirements.

Also, the increase in insurance coverage under the ACA would substantially reduce the amount spent on uncompensated care. This would lead to significant savings for both federal and state governments. Finally, a certain amount of spending on mental health services currently funded by state general fund dollars would be paid by Medicaid, typically through coverage of newly eligible adults. Thus, a significant portion would be funded by the federal government, allowing federal funds to substitute for current state spending.

Table 2 summarizes our estimates for 2014-2019 nationally. If eligibility for adults remained unchanged, the Medicaid expansion would result in additional federal spending of $460 billion and additional state spending of $80 billion. However, federal matching rates increase for certain populations of adults in limited benefits programs and prior expansion states, explained in more detail later in the paper, leading to an additional $66 billion of federal spending and state savings of the same amount. Additionally, if states were to rescind eligibility for certain adults above 138 percent of the FPL or otherwise shift their costs to federally subsidized coverage in the exchange, there would be savings of $89 billion at the federal and $69 billion at the state level.[10] The federal government would spend $345 billion in premium and cost-sharing subsidies in the exchanges. With gains in insurance coverage, payments for uncompensated care would decline by $39 billion to $78 billion for the federal government and $26 billion to $52 billion for state and local governments. An additional effect of ACA's Medicaid expansion is that federal Medicaid dollars would substitute for $11 billion to $22 billion on mental health care that would otherwise be paid by state general funds. Both of these ranges reflect assumptions about the extent to which states and localities can substitute federal dollars for current spending, as explained later. In total, the federal government would spend $704 billion to $743 billion more

Table 2: Effect of ACA on State and Federal Total Spending, 2014 - 2019

Billions $	Difference in Federal Spending		Difference in State Spending	
	Low	High	Low	High
Medicaid expansion[1]	460	460	80	80
Increased federal Medicaid match for currently eligible adults	66	66	-66	-66
Eliminating Medicaid eligibility for adults >138% FPL[2]	-89	-89	-69	-69
Premium and cost-sharing subsidies in the exchanges	345	345	0	0
Uncompensated care savings	-78	-39	-52	-26
Mental health savings[3]	0	0	-22	-11
Total difference in spending	704	743	-129	-92

Source: Urban Institute analysis, HIPSM 2014-2019.
[1]Spending on acute care for the nonelderly
[2]Federal savings in Medicaid spending partially offset by additonal federal spending on subsidies included in the fourth row. Adults include (a) those eligible for coverage under 1115 waivers and Social Security Act Section 1931 and (b) 50% of others above 138% FPL who report Medicaid enrollment
[3]Federal mental health expenditures are included in the Medicaid expansion row.

under the ACA than without it, but states would pay $92 billion to $129 billion less under the ACA. In the following, we consider each of these costs and savings in more detail and, whenever possible given the limitations of available data, provide state-by-state estimates. We also estimate patterns of spending and savings for 2020 and afterwards, when federal match rates would remain constant at lower levels than will apply in 2014-2019.

Medicaid and CHIP Spending

In Table 3, we estimate the total spending on acute care for the non-elderly in each state, separating the federal and state shares. The numbers presented are totals from 2014 to 2019. In the "No Reform" scenario, eligibility rules are unchanged from current law. Enrollment and spending in Medicaid and CHIP would change over time in response to economic and demographic changes, and the federal matching rate would remain unchanged.

The "Reform" scenario simulates the Medicaid expansion under the ACA and the effect on Medicaid/CHIP enrollment of other provisions of the law, such as the individual mandate. No changes are made to pre-ACA Medicaid eligibility. The scenario thus includes the effects of increased enrollment among children and adults who qualify for Medicaid or CHIP under current law. Those made eligible for Medicaid under the expansion—those previously ineligible, but whose income is below 138 percent of the FPL—would have 100 percent of their costs covered by the federal government from 2014 to 2016. This rate would be scaled back gradually to 90 percent in 2020 and following years.

Overall, the federal government would spend $460 billion and the state $80 billion under the ACA. It is important to note, however, that there would be substantial additional federal spending—and thus state savings—on existing enrollees. Under the ACA, "newly eligible" adults for whom greatly enhanced federal funding is available include those who, under current law, qualify for less than full Medicaid benefits.[11] Some states currently offer Medicaid with reduced benefits to some low-income adults through Section 1115 waivers; state spending on those adults could fall because of their reclassification as "newly eligible." Further, seven states that, before ACA, already extended full Medicaid coverage to both parents and childless adults up to at least 100 percent FPL are identified here as "prior expansion" states. The ACA increases the federal match rate for childless adults who would have been classified as "newly eligible" in these states, starting in 2014 at halfway between the state's normal rate and 100 percent, gradually rising to 93 percent in 2019 and 90 percent in 2020 and later years.[12] Table 3 by itself should not be used as an estimate of the cost of the Medicaid expansion; the savings in Table 4 should be included as well. The $80 billion in additional state costs would thus be offset by $66 billion in in state savings, even if states do not reduce Medicaid eligibility.

To illustrate differences in Medicaid spending patterns, compare New York and Texas. In New York, the federal government would spend $10.3 billion more on new enrollees from 2014 to 2019 under the ACA, while the state would spend an additional $9.8 billion, assuming that current eligibility categories were neither cut back nor received increased federal matching funds. However, New York qualifies as a prior expansion state. Parents up to 150 percent of the FPL and adult nonparents up to 100 percent of the FPL are currently eligible for full Medicaid benefits. Thus, many current enrollees with incomes below 138 percent of the FPL would have the federal government pay a larger share of their costs than under current law. In total, this would substitute $20.4 billion in federal dollars for current-law state costs. Thus New York's state and local spending on Medicaid declines by a net amount of $10.6 billion, notwithstanding (a) increased enrollment of parents and children who qualify for Medicaid under current law, for whom the state must pay its standard share of Medicaid costs and (b) the state's responsibility to begin paying a small portion of the cost of newly eligible adults, beginning in 2017.

In Texas, the federal government would spend $49.4 billion more and the state would spend $5.3 billion more, assuming that current eligibility categories are neither reduced nor benefit from increased federal funding levels. In Texas, adult parents are eligible today only up to 26 percent of the FPL, and there is no income-based eligibility pathway for adult nonparents. As a result, Texas is not a prior expansion state benefiting from additional federal spending on existing enrollees. Further, it does not extend limited benefits to otherwise ineligible low-income adults through 1115 waivers. As a result, Table 4 does not show any increase in federal funding for existing Medicaid eligibles. However, both New York and Texas will benefit from increased funding for other "limited benefit" eligibility categories that we did not model, because of limitations in available data, including coverage of women diagnosed with breast and cervical cancer, certain disabled recipients of home- and community-based services or nursing home care, participants in the state's family planning waiver (and potentially pregnant women, depending on how HHS interprets the ACA).

These examples show the importance of pre-ACA Medicaid eligibility rules in determining the fiscal effects of the legislation on particular states. Other important factors include the number and income distribution of uninsured in a state. Currently, about 17 percent of the nonelderly in New York are uninsured, and 44 percent of these are below 138 percent of the FPL. In Texas, 30 percent of the nonelderly are uninsured. Nearly half of these are below 138 percent of the FPL. There would thus be considerably more newly eligible Medicaid enrollees in Texas than New York, resulting in a much larger infusion of federal Medicaid dollars into Texas—$49 billion, as shown by Table 3, compared to $31 billion for New York, as shown by Tables 3 and 4 combined.

Table 3: Total State and Federal Medicaid Spending (Assuming Current State Financial Responsibilities Continue)[1], 2014 - 2019 Totals

Does Not Include State Savings On Existing Enrollees Shown In Table 4.

Millions $	No Reform		Reform		Difference	
	Federal Spending	State Spending	Federal Spending	State Spending	Federal Spending	State Spending
New England:	**70,603**	**63,347**	**78,384**	**67,475**	**7,781**	**4,127**
Connecticut	10,653	10,554	12,174	12,028	1,520	1,474
Maine	11,147	6,143	12,706	6,885	1,558	742
Massachusetts	34,323	34,152	35,766	35,513	1,443	1,362
New Hampshire	3,611	3,602	5,285	3,826	1,675	224
Rhode Island	6,754	6,088	8,151	6,309	1,397	221
Vermont	4,116	2,808	4,304	2,914	188	106
Middle Atlantic:	**236,667**	**221,346**	**275,855**	**242,211**	**39,189**	**20,865**
Delaware	3,230	3,222	3,750	3,718	519	496
District of Columbia	4,628	1,983	5,339	2,036	711	53
Maryland	11,531	11,531	18,121	12,284	6,590	753
New Jersey	24,653	24,524	35,374	26,207	10,721	1,683
New York	121,851	121,239	132,180	131,020	10,329	9,781
Pennsylvania	70,774	58,846	81,092	66,946	10,318	8,100
East North Central:	**255,607**	**177,984**	**321,216**	**192,598**	**65,609**	**14,615**
Illinois	55,118	54,185	71,317	56,860	16,199	2,675
Indiana	52,011	28,924	60,464	33,435	8,453	4,511
Michigan	56,754	37,172	68,953	38,742	12,199	1,570
Ohio	67,430	41,084	91,273	43,569	23,843	2,485
Wisconsin	24,293	16,619	29,209	19,992	4,916	3,373
West North Central:	**103,835**	**71,172**	**131,440**	**76,329**	**27,606**	**5,157**
Iowa	13,765	8,228	14,432	8,643	668	415
Kansas	12,596	8,283	15,864	8,580	3,269	297
Minnesota	20,966	20,966	24,201	22,012	3,235	1,046
Missouri	41,680	24,276	56,987	27,136	15,307	2,860
Nebraska	7,046	4,788	9,148	5,098	2,102	310
North Dakota	1,817	1,060	3,053	1,177	1,235	117
South Dakota	5,966	3,571	7,755	3,683	1,790	112
South Atlantic:	**194,958**	**128,110**	**311,715**	**137,273**	**116,757**	**9,163**
Florida	62,884	50,634	109,659	55,354	46,776	4,720
Georgia	34,631	18,902	55,851	20,449	21,220	1,547
North Carolina	46,585	25,511	69,433	26,608	22,848	1,096
South Carolina	17,987	7,675	27,700	8,235	9,713	560
Virginia	21,550	21,379	31,374	22,303	9,824	925
West Virginia	11,321	4,008	17,697	4,323	6,376	315
East South Central:	**137,441**	**62,513**	**182,596**	**65,052**	**45,155**	**2,539**
Alabama	26,721	12,552	37,352	13,153	10,631	601
Kentucky	43,605	18,541	54,725	19,088	11,120	547
Mississippi	24,037	7,656	31,609	8,020	7,572	364
Tennessee	43,078	23,765	58,910	24,792	15,832	1,027
West South Central:	**153,894**	**90,577**	**228,223**	**97,557**	**74,329**	**6,980**
Arkansas	15,030	5,613	21,810	5,989	6,781	377
Louisiana	19,781	7,958	32,175	8,797	12,394	839
Oklahoma	24,324	12,586	30,095	13,073	5,771	487
Texas	94,760	64,420	144,143	69,697	49,383	5,277
Mountain:	**81,558**	**48,268**	**107,067**	**53,258**	**25,509**	**4,990**
Arizona	33,298	17,354	37,037	18,807	3,740	1,453
Colorado	11,769	11,749	19,800	12,438	8,031	689
Idaho	6,715	2,905	8,818	3,054	2,102	148
Montana	3,486	1,630	4,736	1,729	1,250	99
Nevada	5,242	5,231	8,863	5,552	3,620	320
New Mexico	11,566	4,752	14,262	5,774	2,696	1,023
Utah	8,209	3,376	11,292	4,557	3,083	1,181
Wyoming	1,272	1,270	2,260	1,347	988	77
Pacific:	**185,320**	**178,762**	**243,789**	**190,142**	**58,469**	**11,380**
Alaska	1,496	1,464	2,460	1,572	964	108
California	148,487	147,955	196,451	154,157	47,965	6,202
Hawaii	3,892	3,171	4,660	3,747	768	576
Oregon	11,291	6,776	16,315	9,551	5,024	2,775
Washington	20,154	19,396	23,903	21,116	3,749	1,719
Total	**1,419,883**	**1,042,078**	**1,880,287**	**1,121,895**	**460,404**	**79,816**

Source: Urban Institute analysis, HIPSM 2014-2019.

[1]Spending on acute care for the nonelderly. Assumes all current eligibility categories continue, without any enhanced federal funding.

Table 4: New Federal Medicaid Spending and State Savings on Existing Enrollees[1], 2014 - 2019 Totals

Millions $	Reform		
	Limited Benefits	Prior Expansion	Total
New England:	**3,059**	**7,346**	**10,405**
Connecticut	3,059	0	3,059
Maine	0	981	981
Massachusetts	0	5,790	5,790
New Hampshire	0	0	0
Rhode Island	0	0	0
Vermont	0	575	575
Middle Atlantic:	**10,016**	**21,534**	**31,551**
Delaware	0	1,181	1,181
District of Columbia	0	0	0
Maryland	0	0	0
New Jersey	0	0	0
New York	0	20,354	20,354
Pennsylvania	10,016	0	10,016
East North Central:	**10,394**	**0**	**10,394**
Illinois	0	0	0
Indiana	5,179	0	5,179
Michigan	0	0	0
Ohio	0	0	0
Wisconsin	5,215	0	5,215
West North Central:	**2,017**	**0**	**2,017**
Iowa	1,758	0	1,758
Kansas	0	0	0
Minnesota	259	0	259
Missouri	0	0	0
Nebraska	0	0	0
North Dakota	0	0	0
South Dakota	0	0	0
South Atlantic:	**0**	**0**	**0**
Florida	0	0	0
Georgia	0	0	0
North Carolina	0	0	0
South Carolina	0	0	0
Virginia	0	0	0
West Virginia	0	0	0
East South Central:	**0**	**0**	**0**
Alabama	0	0	0
Kentucky	0	0	0
Mississippi	0	0	0
Tennessee	0	0	0
West South Central:	**0**	**0**	**0**
Arkansas	0	0	0
Louisiana	0	0	0
Oklahoma	0	0	0
Texas	0	0	0
Mountain:	**2,352**	**4,843**	**7,195**
Arizona	0	4,843	4,843
Colorado	0	0	0
Idaho	0	0	0
Montana	0	0	0
Nevada	0	0	0
New Mexico	1,761	0	1,761
Utah	591	0	591
Wyoming	0	0	0
Pacific:	**3,812**	**715**	**4,527**
Alaska	0	0	0
California	0	0	0
Hawaii	0	715	715
Oregon	3,030	0	3,030
Washington	782	0	782
Total	**31,651**	**34,437**	**66,088**

Source: Urban Institute analysis, HIPSM 2014-2019.
[1]Spending on acute care for the nonelderly

Notes: Before ACA, "limited benefit" states provided less than full Medicaid benefits to some adults through 1115 waivers; and "prior expansion" states covered parents and childless adults up to at least 100 percent FPL. These states will experience increased federal matching rates for some of these adults. This table underestimates state savings by failing to account for (a) income disregards in some states; (b) premium support programs; and (c) limited benefits provided to adults outside 1115 waivers, including through medically needy eligibility.

In Table 5, we estimate the savings from eliminating Medicaid eligibility for certain adults over 138 percent of the FPL or otherwise shifting some of their costs to federally subsidized coverage in the exchange. For each state, we show the savings we can identify based on terminating eligibility now provided to adults above 138 percent of the FPL through Section 1115 waivers or Section 1931, as noted earlier. There are other categories of eligibility for which a state could revoke eligibility above 138 percent of the FPL, such as coverage of pregnant women and special eligibility categories for adults with tuberculosis, breast cancer or cervical cancer. Also, as noted above, a significant proportion of medically needy costs for such adults will shift to the exchange as they gain comprehensive coverage and face much greater difficulty incurring the costs needed to trigger the start of Medicaid payments. However, state-specific survey data are insufficient, given our existing eligibility models, to estimate state-specific effects for these eligibility categories, so we do not include those effects in Table 5, even though some of those effects are included in our national estimates shown in Table 2.

Texas, for example, does not have any eligibility for adults above 138 percent of the FPL under 1115 waivers or Section 1931. Thus, we show no savings in the state-specific estimates, even though Texas may be able to realize savings by moving to the exchange certain Medicaid-enrolled adults over 138 percent FPL who cannot be identified based on information available in the Current Population Survey (CPS), such as pregnant women, women diagnosed with breast and cervical cancer, etc.

In California, the state extends eligibility to some adults with MAGI over 138 percent of the FPL in eligibility categories for which we can produce state-specific estimates. By moving these adults over 138 percent FPL into the exchange, California would take them off Medicaid, allowing $2.2 billion in savings for both the state and federal

Table 5: Federal and State Spending Effects From Eliminating Medicaid Eligibility >138% FPL Under 1115 Waivers and Section 1931, 2014 - 2019 Totals

Millions $	Reform	
	Federal Spending	State Spending
New England:	**-1,762**	**-1,611**
Connecticut	-176	-176
Maine	-72	-40
Massachusetts	-1,089	-1,089
New Hampshire	0	0
Rhode Island	-75	-67
Vermont	-349	-238
Middle Atlantic:	**-1,639**	**-1,571**
Delaware	-2	-2
District of Columbia	-117	-50
Maryland	-157	-157
New Jersey	-1,276	-1,276
New York	-80	-80
Pennsylvania	-7	-6
East North Central:	**-2,438**	**-1,985**
Illinois	-1,045	-1,032
Indiana[1]	0	0
Michigan	0	0
Ohio	0	0
Wisconsin	-1,393	-953
West North Central:	**-1,525**	**-1,221**
Iowa	-754	-450
Kansas	0	0
Minnesota	-771	-771
Missouri	0	0
Nebraska	0	0
North Dakota	0	0
South Dakota	0	0
South Atlantic:	**-4**	**-2**
Florida	0	0
Georgia	0	0
North Carolina	-4	-2
South Carolina	0	0
Virginia	0	0
West Virginia	0	0
East South Central:	**0**	**0**
Alabama	0	0
Kentucky	0	0
Mississippi	0	0
Tennessee	0	0
West South Central:	**0**	**0**
Arkansas[2]	0	0
Louisiana	0	0
Oklahoma[2]	0	0
Texas	0	0
Mountain:	**-658**	**-374**
Arizona	-515	-268
Colorado	0	0
Idaho	0	0
Montana	0	0
Nevada	-80	-80
New Mexico	-55	-22
Utah	-9	-4
Wyoming	0	0
Pacific:	**-3,558**	**-3,503**
Alaska	0	0
California	-2,190	-2,190
Hawaii	-34	-28
Oregon[1]	0	0
Washington	-1,334	-1,284
Total	**-11,585**	**-10,267**

Source: Urban Institute analysis, HIPSM 2014-2019.
[1]State has potential savings but due to a small sample size, no such records exist in our data.
[2]State has premium assistance for adults that is not included as a limited benefits program in our model.

Note: This table does not list savings on state Medicaid costs in other eligibility categories above 138% FPL, some of which are included in Table 2.

governments within two eligibility groups alone—namely, those covered under 1931 and 1115 waivers. Because of California's 50 percent FMAP, the state and the federal government would share evenly in these savings. As with Texas, California could obtain additional savings through cutting back other optional Medicaid eligibility categories for which we could not produce state-specific estimates. In both states—as in all states—the federal government's Medicaid savings would be offset by increased federal spending on subsidies in the exchange. For those below 200 percent of the FPL who qualify for exchange subsidies, federal spending on subsidies would in general exceed federal Medicaid savings. That is so because (a) subsidies are funded entirely by the federal government in the exchange, without any state matching share; and (b) private insurance costs typically exceed Medicaid costs for serving comparable populations, primarily because of higher provider payments with private coverage.[13] Put differently, shifting costs from Medicaid to the exchange saves money for states but is likely to increase federal spending.

There are major open questions regarding the future of CHIP under the ACA. While federal match rates will increase after 2016 by 23 percentage points, the necessary federal funds were not allocated. There appear to be three possible scenarios for the future of the program: the law remains unchanged and federal funding for CHIP becomes exhausted; the higher match rates remain unchanged and federal funding is added for 2017 and later years; or the law is amended to continue current match rates while adding federal funding after 2016. The result of the first would likely be major declines in CHIP enrollment and the shifting of many of those children above 138 percent of the FPL into the exchanges. This would lead to a significant decrease in state spending, though the families affected would likely pay higher premiums and cost sharing. The second scenario would also see lower state spending because of higher federal

Table 6: Federal Spending on Exchange Subsidies, 2014 - 2019 Totals

Millions $	Reform		
	Premium Subsidies	Cost-Sharing Subsidies	Total
New England:	**7,839**	**1,202**	**9,041**
Connecticut	2,240	295	2,535
Maine	1,113	172	1,285
Massachusetts	2,417	444	2,860
New Hampshire	802	60	862
Rhode Island	830	132	962
Vermont	437	100	537
Middle Atlantic:	**37,698**	**4,680**	**42,377**
Delaware	482	50	532
District of Columbia	395	63	458
Maryland	3,338	506	3,844
New Jersey	6,285	782	7,068
New York	16,715	1,860	18,575
Pennsylvania	10,482	1,418	11,900
East North Central:	**37,297**	**4,890**	**42,187**
Illinois	9,916	1,440	11,356
Indiana	4,273	666	4,939
Michigan	7,925	919	8,844
Ohio	9,888	1,264	11,151
Wisconsin	5,295	601	5,896
West North Central:	**16,765**	**1,933**	**18,698**
Iowa	2,115	281	2,396
Kansas	2,501	182	2,683
Minnesota	3,736	599	4,335
Missouri	5,162	471	5,633
Nebraska	1,682	223	1,906
North Dakota	692	71	762
South Dakota	876	106	983
South Atlantic:	**43,615**	**5,376**	**48,991**
Florida	19,341	2,125	21,466
Georgia	7,273	695	7,968
North Carolina	7,416	1,356	8,771
South Carolina	3,284	378	3,662
Virginia	5,352	735	6,087
West Virginia	949	87	1,037
East South Central:	**14,713**	**1,751**	**16,465**
Alabama	2,663	344	3,007
Kentucky	3,461	273	3,734
Mississippi	2,642	312	2,954
Tennessee	5,948	823	6,770
West South Central:	**39,350**	**4,255**	**43,606**
Arkansas	2,921	315	3,236
Louisiana	3,300	271	3,571
Oklahoma	3,229	354	3,583
Texas	29,900	3,315	33,215
Mountain:	**22,356**	**1,844**	**24,200**
Arizona	5,586	488	6,074
Colorado	4,839	361	5,200
Idaho	1,717	157	1,875
Montana	1,205	86	1,291
Nevada	2,467	211	2,678
New Mexico	3,239	247	3,486
Utah	2,543	236	2,778
Wyoming	761	57	818
Pacific:	**52,445**	**5,482**	**57,927**
Alaska	527	119	645
California	41,995	4,247	46,242
Hawaii	562	128	690
Oregon	3,691	449	4,140
Washington	5,669	540	6,209
Total	**272,078**	**31,413**	**303,491**

Source: Urban Institute analysis, HIPSM 2014-2019.

matching rates. For this work, we simulated the third scenario. In other words, given the current uncertainty, we do not factor in either (a) any potential effects from the possible end of federal CHIP allotments, and the consequent expiration of state matching obligations, or (b) the provision of enhanced CHIP match rates.

Premium and Cost-Sharing Subsidies in the Exchanges

Under the ACA, subsidized coverage in the new health insurance exchanges will be available to those with incomes below 400 percent of the FPL who are not eligible for public coverage, such as Medicaid, and who do not have an affordable offer of ESI coverage. There are two types of subsidies. Premium subsidies reduce the premium that an enrollee would have to pay, and cost-sharing subsidies reduce the amount a family would pay for health care out-of-pocket. These subsidies are paid for entirely by the federal government. In Table 6, we show the spending on each, state by state.

To illustrate some causes of state-level variation in exchange spending, consider Minnesota and Utah. Despite their overall difference in population (estimated 4.5 million and 2.5 million, respectively, in 2011), these states have about the same number of nonelderly uninsured (estimated 460,000 and 430,000, respectively). However, 217,000 of these are between 138 and 400 percent of the FPL in Minnesota, while only 165,000 are in that range in Utah. It should come as no surprise, then, that $4.3 billion would be spent on subsidies in Minnesota from 2014 to 2019, but only $2.8 billion in Utah.

There would be $39 billion in additional federal spending on exchange subsidies under the higher savings listed in Table 2 based on reductions in Medicaid eligibility that go beyond 1115 waivers and Section 1931. Federal and private spending would substitute for the Medicaid spending of those adults above 133 percent of the FPL losing eligibility. This is not included in either Table 5, as indicated above, or in Table 6.

Uncompensated Care

As Buettgens and colleagues showed in earlier research, the number of uninsured would be cut roughly in half under the ACA.[14] Spending on uncompensated care for the uninsured would decrease by more than half (Table 7). Hadley and colleagues estimated that about 45 percent of uncompensated care is paid for by the federal government, 30 percent by state and local governments, and the remaining 25 percent from private sources such as health care providers.[15] States and localities pay hospitals and sometimes other providers through disproportionate share hospital payments, other grants and contracts from states or localities, direct operation of public hospitals, "general assistance-type" health coverage, grants and delegation of taxing authority from states to localities, funding for medical schools, etc. Given the complexities of how uncompensated care is funded, the ACA's reduction in payments to disproportionate share hospitals,[16] and the political difficulties of reducing provider payments at the same rate as the decrease in need for uncompensated care, it is not realistic to assume that the decrease in the amount of uncompensated care consumed would result in a corresponding amount of savings. We compute a moderate range for actual savings: between 25 and 50 cents for every dollar in reduced uncompensated care spending, or between 12.5 and 25 percent of current spending on uncompensated care. We apply this to both the federal and the state/local government shares. Accordingly, we anticipate that state and local government will capture in savings just 7.5 to 15.0 percent of the total reduction in uncompensated care costs experienced in each state.[17]

In Texas, for example, state and local governments' share of uncompensated care costs for 2014-2019, based on nationally applicable percentages, would be $21.3 billion without reform and $9.6 billion under the ACA, as the amount of uncompensated care in Texas would decline by 55 percent. Our estimated savings would be from one quarter to one half of the difference, i.e., from $2.9 billion to $5.8 billion over the entire six-year period. The federal share of such costs in Texas would be $31.9 billion without reform and $14.4 billion under the ACA. The corresponding range of federal savings we estimate would thus be $4.4 billion to $8.7 billion. Federal savings on uncompensated care are offset by federal subsidies in the exchange as well as federal Medicaid costs, including for newly eligible adults. That is because the main factor responsible for decreased uncompensated care is increased coverage through Medicaid and subsidies in the exchange.

State Savings on Mental Health Care

In FY 2008, state mental health agencies spent an estimated $36.8 billion. Of this amount, 45.4 percent, or $16.7 billion, represented state and local costs outside Medicaid.[18] Medicaid paid for 46 percent of state mental health services, or $16.9 billion. Other funds were provided by Medicare, federal block grants and additional sources.

The ACA's expansion of Medicaid coverage to reach adults with incomes up to 138 percent of FPL will have a major impact on these state-administered systems of care. Among the adults served by state mental health agencies, 79 percent are either unemployed or outside the labor force. Nevertheless, 43 percent of consumers served by these agencies have no Medicaid coverage.[19]

When the ACA is fully implemented, Medicaid coverage is expected to increase from 12.4 to 23.3 percent of individuals with mental illness or substance abuse disorders, and Medicaid's mental health spending is projected to rise by 49.7 percent.[20] If the latter increase had applied to state mental health agencies in FY 2008, their Medicaid revenue would have grown by $8.4 billion. Trended forward based on per capita changes in state and local health spending projected by the CMS Office of the Actuary,[21] the increased Medicaid revenue would total $82.7 billion for 2014-2019. Of this amount, $79.4 billion would represent new federal dollars, based on the average federal matching percentage projected for newly eligible adults.[22]

Notwithstanding past patterns through which state policymakers have strategically used increased Medicaid dollars to reduce state budgetary commitments to mental health care,[32] one should not overstate the extent to which Medicaid dollars can substitute for other resources. Many people served by state mental health agencies will continue to be uninsured. Some will have a connection to the criminal justice system that precludes eligibility for assistance, for example, and others may suffer from cognitive or other impairments that complicate Medicaid enrollment. Further, some important services are not easily reimbursable through Medicaid. Examples include care provided by Institutions for Mental Disease, which Medicaid traditionally excludes, and certain types of substance abuse treatment and residential support. And some of these new Medicaid dollars may be used to address unmet needs among the mentally ill, which are likely to grow in the wake of today's state budget shortfalls and the resulting cuts to state-funded mental health services.

Taking these factors into account, if we assume that between a quarter and half of increased Medicaid reimbursement will substitute for state and local spending, state and local savings in this area would range from $13 billion to $26 billion over the six years from 2014 to 2020 (total from Table 2 and Table 9). Because of major interstate differences in program structure and interplay with ACA coverage effects, we did not develop state-specific estimates of these savings.

Offsetting Costs with Savings, 2014-2019

In Table 8, we put together all of the cost and savings items for which we produced state-level estimates. For our national estimates (Tables 2 and 10), we included two additional savings items for which we did not provide state-level estimates: a higher level of

Table 7: State and Federal Spending on Uncompensated Care, 2014 - 2019 Totals

	No Reform			Reform			Low Savings[2]		High Savings[3]	
	Federal Share	State Share	Total[1]	Federal Share	State Share	Total[1]	Federal Share	State Share	Federal Share	State Share
New England:	**9,172**	**6,115**	**20,383**	**4,942**	**3,295**	**10,982**	**-1,058**	**-705**	**-2,115**	**-1,410**
Connecticut	3,388	2,259	7,529	2,033	1,356	4,519	-339	-226	-677	-452
Maine	1,599	1,066	3,553	916	611	2,037	-171	-114	-341	-228
Massachusetts	1,609	1,073	3,576	1,008	672	2,240	-150	-100	-301	-200
New Hampshire	1,079	720	2,399	353	235	784	-182	-121	-363	-242
Rhode Island	1,033	689	2,297	381	254	848	-163	-109	-326	-217
Vermont	463	309	1,029	250	167	555	-53	-36	-107	-71
Middle Atlantic:	**38,803**	**25,868**	**86,228**	**19,685**	**13,124**	**43,746**	**-4,779**	**-3,186**	**-9,559**	**-6,372**
Delaware	1,192	795	2,649	336	224	746	-214	-143	-428	-285
District of Columbia	261	174	581	94	63	209	-42	-28	-84	-56
Maryland	3,202	2,135	7,116	1,473	982	3,273	-432	-288	-865	-576
New Jersey	5,923	3,949	13,162	2,881	1,920	6,401	-761	-507	-1,521	-1,014
New York	17,577	11,718	39,061	9,185	6,124	20,412	-2,098	-1,399	-4,196	-2,797
Pennsylvania	10,647	7,098	23,659	5,716	3,811	12,703	-1,233	-822	-2,465	-1,643
East North Central:	**38,931**	**25,954**	**86,512**	**16,991**	**11,327**	**37,757**	**-5,485**	**-3,657**	**-10,970**	**-7,313**
Illinois	11,980	7,986	26,621	6,669	4,446	14,819	-1,328	-885	-2,655	-1,770
Indiana	5,574	3,716	12,387	2,476	1,650	5,501	-775	-516	-1,549	-1,033
Michigan	7,424	4,949	16,498	3,594	2,396	7,986	-958	-638	-1,915	-1,277
Ohio	9,763	6,509	21,696	2,823	1,882	6,274	-1,735	-1,157	-3,470	-2,313
Wisconsin	4,190	2,793	9,311	1,430	953	3,177	-690	-460	-1,380	-920
West North Central:	**13,089**	**8,726**	**29,086**	**4,429**	**2,953**	**9,843**	**-2,165**	**-1,443**	**-4,330**	**-2,886**
Iowa	766	511	1,702	352	235	783	-103	-69	-207	-138
Kansas	2,223	1,482	4,939	896	597	1,990	-332	-221	-663	-442
Minnesota	2,587	1,725	5,749	906	604	2,013	-420	-280	-841	-560
Missouri	4,360	2,906	9,688	1,054	703	2,342	-826	-551	-1,653	-1,102
Nebraska	1,604	1,069	3,564	628	419	1,396	-244	-163	-488	-325
North Dakota	662	441	1,470	287	191	638	-94	-62	-187	-125
South Dakota	888	592	1,974	307	204	681	-145	-97	-291	-194
South Atlantic:	**54,442**	**36,295**	**120,982**	**20,645**	**13,763**	**45,878**	**-8,449**	**-5,633**	**-16,898**	**-11,266**
Florida	19,331	12,887	42,958	5,457	3,638	12,126	-3,469	-2,312	-6,937	-4,625
Georgia	9,821	6,547	21,824	4,476	2,984	9,948	-1,336	-891	-2,672	-1,781
North Carolina	12,996	8,664	28,879	6,920	4,614	15,378	-1,519	-1,013	-3,038	-2,025
South Carolina	4,740	3,160	10,533	1,026	684	2,281	-928	-619	-1,857	-1,238
Virginia	5,634	3,756	12,520	2,421	1,614	5,381	-803	-535	-1,606	-1,071
West Virginia	1,921	1,280	4,268	344	229	764	-394	-263	-788	-526
East South Central:	**20,021**	**13,347**	**44,490**	**6,607**	**4,404**	**14,681**	**-3,353**	**-2,236**	**-6,707**	**-4,471**
Alabama	4,469	2,979	9,931	1,882	1,255	4,183	-647	-431	-1,293	-862
Kentucky	5,147	3,431	11,437	1,022	681	2,271	-1,031	-687	-2,062	-1,375
Mississippi	3,586	2,390	7,968	1,800	1,200	4,001	-446	-298	-893	-595
Tennessee	6,819	4,546	15,154	1,902	1,268	4,227	-1,229	-820	-2,459	-1,639
West South Central:	**41,998**	**27,998**	**93,328**	**16,910**	**11,273**	**37,577**	**-6,272**	**-4,181**	**-12,544**	**-8,363**
Arkansas	3,135	2,090	6,967	919	613	2,043	-554	-369	-1,108	-739
Louisiana	3,441	2,294	7,646	627	418	1,393	-703	-469	-1,407	-938
Oklahoma	3,537	2,358	7,859	974	650	2,165	-641	-427	-1,281	-854
Texas	31,885	21,256	70,855	14,389	9,593	31,976	-4,374	-2,916	-8,748	-5,832
Mountain:	**19,314**	**12,876**	**42,920**	**9,398**	**6,265**	**20,884**	**-2,479**	**-1,653**	**-4,958**	**-3,305**
Arizona	4,498	2,999	9,997	2,713	1,808	6,028	-446	-298	-893	-595
Colorado	4,773	3,182	10,606	2,610	1,740	5,799	-541	-361	-1,082	-721
Idaho	1,249	833	2,776	668	446	1,485	-145	-97	-290	-194
Montana	682	455	1,516	340	227	757	-85	-57	-171	-114
Nevada	3,526	2,350	7,835	1,474	982	3,274	-513	-342	-1,026	-684
New Mexico	1,763	1,175	3,917	730	487	1,623	-258	-172	-516	-344
Utah	2,363	1,575	5,250	712	475	1,583	-413	-275	-825	-550
Wyoming	460	307	1,023	151	101	335	-77	-52	-155	-103
Pacific:	**43,820**	**29,213**	**97,377**	**23,273**	**15,515**	**51,717**	**-5,137**	**-3,425**	**-10,274**	**-6,849**
Alaska	538	359	1,196	194	129	430	-86	-57	-172	-115
California	34,024	22,683	75,610	18,107	12,071	40,238	-3,979	-2,653	-7,959	-5,306
Hawaii	916	610	2,035	774	516	1,721	-35	-24	-71	-47
Oregon	3,278	2,186	7,285	1,056	704	2,346	-556	-370	-1,111	-741
Washington	5,063	3,375	11,251	3,142	2,095	6,982	-480	-320	-960	-640
Total	**279,588**	**186,392**	**621,307**	**122,879**	**81,920**	**273,065**	**-39,177**	**-26,118**	**-78,354**	**-52,236**

Source: Urban Institute analysis, HIPSM 2014-2019.

[1]Federal and State spending on uncompensated care do not add to the total, which also takes into account private spending.

[2]Savings if the federal and state governments, respectively, reduce spending by 25 percent of the decline in their share of uncompensated care.

[3]Savings if the federal and state governments, respectively, reduce spending by 50 percent of the decline in their share of uncompensated care.

Table 8: Differences in Total State and Federal Spending, ACA vs. No Reform, 2014 - 2019

Does not include savings on mental health costs and certain medicaid eligibility cutbacks over 138% fpl included in national results.

	Difference in Federal Spending		Difference in State Spending	
	Low Savings	High Savings	Low Savings	High Savings
New England:	**24,408**	**23,350**	**-8,593**	**-9,298**
Connecticut	6,600	6,261	-1,987	-2,213
Maine	3,581	3,411	-393	-506
Massachusetts	8,854	8,703	-5,617	-5,717
New Hampshire	2,355	2,173	102	-19
Rhode Island	2,121	1,958	44	-64
Vermont	897	844	-743	-779
Middle Atlantic:	**106,698**	**101,919**	**-15,443**	**-18,629**
Delaware	2,016	1,802	-829	-972
District of Columbia	1,010	969	-25	-53
Maryland	9,844	9,412	308	19
New Jersey	15,752	14,991	-100	-607
New York	47,080	44,982	-12,051	-13,450
Pennsylvania	30,995	29,763	-2,744	-3,566
East North Central:	**110,267**	**104,782**	**-1,421**	**-5,077**
Illinois	25,182	23,854	758	-127
Indiana	17,796	17,022	-1,184	-1,701
Michigan	20,085	19,128	931	293
Ohio	33,260	31,525	1,329	172
Wisconsin	13,944	13,254	-3,254	-3,714
West North Central:	**44,630**	**42,465**	**475**	**-968**
Iowa	3,964	3,861	-1,863	-1,932
Kansas	5,620	5,288	76	-145
Minnesota	6,637	6,217	-264	-545
Missouri	20,113	19,287	2,309	1,758
Nebraska	3,764	3,520	148	-15
North Dakota	1,904	1,810	55	-8
South Dakota	2,627	2,481	15	-82
South Atlantic:	**157,295**	**148,845**	**3,528**	**-2,105**
Florida	64,773	61,305	2,408	95
Georgia	27,852	26,516	656	-235
North Carolina	30,096	28,577	81	-931
South Carolina	12,447	11,519	-59	-678
Virginia	15,108	14,305	389	-146
West Virginia	7,018	6,624	53	-210
East South Central:	**58,267**	**54,913**	**303**	**-1,932**
Alabama	12,991	12,345	170	-261
Kentucky	13,822	12,791	-140	-828
Mississippi	10,080	9,634	66	-231
Tennessee	21,373	20,144	208	-612
West South Central:	**111,662**	**105,390**	**2,799**	**-1,382**
Arkansas	9,463	8,909	7	-362
Louisiana	15,261	14,558	370	-99
Oklahoma	8,714	8,073	60	-367
Texas	78,224	73,851	2,362	-554
Mountain:	**53,767**	**51,288**	**-4,232**	**-5,885**
Arizona	13,695	13,248	-3,956	-4,253
Colorado	12,690	12,149	328	-32
Idaho	3,832	3,687	51	-45
Montana	2,455	2,370	42	-15
Nevada	5,706	5,193	-101	-443
New Mexico	7,630	7,372	-933	-1,105
Utah	6,031	5,619	311	36
Wyoming	1,728	1,651	25	-27
Pacific:	**112,227**	**107,091**	**-74**	**-3,499**
Alaska	1,524	1,437	50	-7
California	88,037	84,058	1,359	-1,294
Hawaii	2,103	2,068	-190	-213
Oregon	11,638	11,082	-626	-996
Washington	8,926	8,446	-667	-988
Total	**779,221**	**740,044**	**-22,657**	**-48,775**

Source: Urban Institute analysis, HIPSM 2014-2019.

Medicaid maintenance-of-effort savings for adults and savings on state mental health spending, as explained earlier. Other fiscal effects, most of which are favorable to states, are in neither our federal nor state estimates, as explained in the introduction. Considering only the factors for which state-specific estimates are provided, federal spending would increase by a total of $740 billion to $779 billion and state spending would decrease by $23 billion to $49 billion. We see considerable variations in state spending under the high and low savings scenarios. States such as New York, Connecticut, Iowa, and Arizona would see significant savings under both scenarios. States such as California, Arkansas, Rhode Island, and North Carolina would see increased costs in the low scenario and reduced costs under the high scenarios, with the magnitude of savings under the high scenario being greater than or roughly equal in magnitude to the additional costs under the low scenario. States such as Texas, New Hampshire, and Colorado would see additional costs under the low scenario greater in magnitude that the savings under the high scenario. Finally, states such as Michigan, Utah, and Missouri would see additional spending under both scenarios.

For illustration, consider one state in each of these groups (Table 9). New York would save substantially on Medicaid expansion costs alone. This is because it is a prior expansion state, as explained earlier. The state would see some Maintenance of Effort (MOE) savings under our state-specific savings assumptions, and would see significant savings on uncompensated care spending. California and Texas would both see increased spending on Medicaid of $5-6 billion from 2014 to 2019 and uncompensated care savings of the same magnitude. California would also have savings from reducing Medicaid eligibility for adults because its existing eligibility rules are more generous than in Texas. Net spending for both states would range from modestly negative to modestly positive. Michigan would spend $1.6 billion more

Table 9: Effect of ACA on Various Types of State Spending, 2014 - 2019

Does not include savings on mental health costs and certain medicaid eligibility cutbacks over 138% FPL included in national results.

Billions $	New York		California		Texas		Michigan	
Medicaid expansion[1]	9.8		6.2		5.3		1.6	
Enhanced Matching and Limited Benefits Programs	-20.4		0.0		0.0		0.0	
Relaxing Medicaid MOE for adults	-0.1		-2.2		0.0		0.0	
Uncompensated care savings	-2.8	-1.4	-5.3	-2.7	-5.8	-2.9	-1.3	-0.6
Total difference in spending	**-13.5**	**-12.1**	**-1.3**	**1.4**	**-0.6**	**2.4**	**0.3**	**0.9**

Source: Urban Institute analysis, HIPSM 2014-2019.
Note: Does not include the high MOE savings scenario or savings on mental health spending.
[1]Spending on acute care for the nonelderly

on Medicaid, while uncompensated care savings would partially offset this expenditure by $0.6 billion to $1.3 billion. Therefore, net spending effects in Michigan are positive in both scenarios. Michigan currently enrolls a relatively small number of adults in Medicaid through income-based eligibility—similar to Texas—but has a much lower uninsured rate among adults than Texas. Thus, uncompensated care savings are significantly smaller in Michigan.

Note that there are sources of state savings for which we have national estimates but not state-specific estimates. Accordingly, the state-specific numbers shown in Tables 8 and 9 do not equal the national totals shown in Table 2 and likely underestimate each state's potential fiscal gains under the ACA. To take the example of mental health services:

- During fiscal year 2009, Texas spent $1.1 billion in General Fund revenues on such care.[24] And for Michigan, $410 million in combined General Fund and local dollars were spent by the state's mental health agency in 2008.[25] If 40 percent of these amounts were shifted to federal Medicaid dollars during the average year from 2014 through 2019, the resulting savings would exceed each state's "worst case" scenario of $2.4 billion and $900 million, respectively, in increased net spending.
- Even with proposed budget cuts, California's Department of Mental Health was projected to spend $1.47 billion in General Fund dollars in FY 2010-2011.[26] Shifting just one-sixth of this cost to the federal government during each year from 2014 through 2019 would fully offset the state's six-year net spending rise of $1.4 billion under the worst-case scenario shown in Tables 8 and 9.

2020 and Beyond

Our estimates so far have focused on 2014-2019, the first six years of the Medicaid expansion and health benefit exchanges under the ACA. During this period, federal Medicaid match rates for the newly eligible decline from 100 percent to 93 percent. Match rates for certain adults in "prior expansion" states rise up to 93 percent. Beginning in 2020, all of these match rates are set at 90 percent and do not change in subsequent years. Thus, total state spending on Medicaid from 2014 to 2019 will be lower than from 2020 onwards. Table 10 presents results for 2020 in the same format as Table 2. States would still spend less under the ACA than without it, notwithstanding the slight reduction in the proportion of Medicaid costs paid by the federal government. The pattern

Table 10: Net Effects of ACA on Total State and Federal Spending, 2020

Billions $	Difference in Federal Spending		Difference in State Spending	
	Low	High	Low	High
Medicaid expansion[1]	105	105	23	23
Increased federal Medicaid match for currently eligible adults	14	14	-14	-14
Eliminating Medicaid eligibility for adults >138% FPL[2]	-18	-18	-14	-14
Premium and cost-sharing subsidies in the exchanges	68	68	0	0
Uncompensated care savings	-15	-8	-10	-5
Mental Health Savings[3]	0	0	-4	-2
Total difference in spending	**155**	**163**	**-19**	**-12**

Source: Urban Institute analysis, HIPSM 2020.
[1]Spending on acute care for the nonelderly
[2]Federal savings in Medicaid spending partially offset by additonal federal spending on subsidies included in the fourth row. Adults include (a) those eligible for coverage under 1115 waivers and Social Security Act Section 1931 and (b) 50% of others above 138% FPL who report Medicaid enrollment.
[3]Federal mental health expenditures are included in the Medicaid expansion row.

for subsequent years will be similar to 2020, but with some differences driven by economic and demographic changes over time.

Methods

To estimate the effects of health reform and the individual mandate, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[27] HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance and insurance market reforms.The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage and health insurance coverage resulting from specific reforms.[28]

For each year from 2014 to 2020, we used HIPSM to simulate the costs and coverage of health care both with the ACA implemented and without the ACA. Population changes over this period are based on Census projections. The following assumptions were made about economic conditions and the growth of underlying health care costs. We assume a decrease in the unemployment rate such that full employment is reached by 2015 and that unemployment rates continue in the subsequent years. Health care cost growth is assumed to be 4 percent annually for public and 5 percent for private spending. Our estimates thus do not assume an aggressive "bending of the cost curve." If that is achieved, our cost estimates would, of course, be lower.

To simulate state-level results, we made the following enhancements to the model not reflected in earlier documentation:

- Two years of CPS data (survey years 2010 and 2009) were pooled together to increase state sample size. Results for large states are based on a larger number of surveyed households than results for small states, and thus have greater accuracy. Note that the CPS oversamples small states, so the number of observations is not necessarily proportional to state size.
- Medical expenditures were adjusted to reflect state-level differences in health care pricing and utilization as measured in the National Health Expenditure Accounts.[29]
- Private health insurance premiums reflect both the state-level differences in expenditures from the previous item and state-specific differences in the risk pools of enrollees for a given type of insurance.
- The ACA was inspired in its general form by the comprehensive health reforms enacted in Massachusetts. The HIPSM results for Massachusetts without the ACA take into account some important provisions of that state's health reform law such as the individual mandate and exchange (the Connector), though we did not comprehensively model it.

We calibrate the behavior of our model so that a standard expansion of Medicaid and CHIP achieves take-up rates consistent with the empirical literature.[30] These baseline take-up rates for the uninsured are between 60 and 70 percent, depending on person type and income group. The ACA contains important provisions that would increase take-up. States are required to establish a Web site capable of determining eligibility for Medicaid and automatically enrolling eligibles. Hospitals would be able to make presumptive eligibility determinations. There would be other new requirements for simplifying enrollment and renewal of Medicaid and CHIP. Take-up rates vary based on individual characteristics, but the model achieves an average take-up rate of about 73 percent for the uninsured who are newly eligible. This rate is higher than the baseline rate due to outreach and enrollment simplification provisions in the ACA,[31] as well as a modest indirect effect of the individual mandate as observed in health reform in Massachusetts; low-income consumers unaffected by that state's mandate nevertheless were prompted to enroll when they paid careful attention to communications from state agencies regarding health coverage, unaware of the limits of the individual requirement to obtain coverage.[32] Our Medicaid take-up analysis is consistent with the enhanced outreach scenario in Holahan and Headen.[33] Had we instead used the lower take-up rates that are implied by the Congressional Budget Office's estimates of ACA's cost,[34] our projected state cost increases for Medicaid enrollment would have been reduced, and net state fiscal effects would have appeared more favorable.

To model federal and state Medicaid expenditure, we simulate several federal match rate scenarios as specified in the ACA. For the first three years of reform, 2014-2016, the federal government will pay 100 percent of the costs of new Medicaid eligibles (Table 11). Beginning in 2017, the federal match rate decreases to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019. The 90 percent federal match rate for new eligibles in 2020 is carried forward into subsequent years.

For the majority of current eligibles, the federal government will pay a percentage of costs according to state-specific FMAP. The FMAP formula was developed in 1965 to give more support to states with lower per capita incomes and falls between 50 percent and 76 percent, with the upper bound varying slightly by year. However, there are several pathways through which current eligibles will receive higher match rates, shown in Table 11.

Firstly, states that have expanded their Medicaid programs to include all adults with incomes up to 100 percent FPL will receive a higher match rate for some of this population under reform. Seven states currently use Medicaid to cover adults through at least 100 percent of the FPL: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York and Vermont. These states will see a phased-in increase of the federal match rate for their childless adult population according to the following formula:

Federal Match Rate = State FMAP + ((New Eligible Match Rate – State FMAP) * Transition Percentage)

The transition percentage increases from 50 percent to 100 percent between

Table 11: Federal Match Rates for New Medicaid Eligibles and Current Eligibles with Enhanced Matching

	New Eligibles and Currently Eligible Adults in Limited Benefits States	Current Eligibles in Expansion States			
		Transition Percentage	Enhanced Match Rates		
2014	100%	50%	75%	to	83%
2015	100%	60%	80%	to	86%
2016	100%	70%	85%	to	90%
2017	95%	80%	86%	to	89%
2018	94%	90%	90%	to	91%
2019	93%	100%	93%		
2020 on	90%	100%	90%		

2014 and 2020 since the childless adults in these seven states receive the New Eligible Match Rate by 2019. In the intermediate years, the Transition Percentage increases from 50 percent such that states with lower FMAPs receive more support.

Secondly, states that have enacted limited Medicaid benefits programs for adults will receive the New Eligible Match Rate for these adults, provided their incomes are under 138 percent of the FPL. There are 10 states that have either extended limited Medicaid benefits to adults eligible through section 1115, or have taken advantage of the ACA's option to cover childless adults before 2014: Connecticut, Indiana, Iowa, Minnesota, New Mexico, Oregon, Pennsylvania, Utah, Washington and Wisconsin.[35] The ACA considers childless adults in these states as new eligibles in 2014 and thereafter.[36]

Conclusion

More than half of the substantial increase in insurance coverage under the ACA would come from increased enrollment in Medicaid.[37] The large majority of new Medicaid enrollees would have been ineligible in the past, so the federal government will pay a substantially higher share of their costs than for those eligible under pre-ACA rules. This federal share of costs for newly eligible adults declines from 100 percent in 2014-2016, to 90 percent in 2020 and subsequent years, so additional enrollment in later years would mean additional state spending. However, the ACA also contains many provisions that substitute federal spending for state spending on such things as uncompensated care and mental health services, leading to savings for states that would significantly exceed additional state spending on new Medicaid enrollees.

There will be significant variation in state spending and savings. The most important factors include:

- The number of people, particularly low-income adults, currently without insurance;
- The overall income distribution in a state;
- The current presence or absence of income-based Medicaid eligibility thresholds for adults, particularly nonparents, close to or exceeding 138 percent of the FPL; and
- State implementation decisions, such as Medicaid maintenance-of-effort, the Basic Health Program option, and decisions about provider payment levels. The present national analysis assumes a uniform implementation.

Even under the limited savings categories for which we provide state-level estimates, only five states would have ranges of net spending entirely above zero. Our estimates understate the savings that states would achieve. An accurate picture of net state spending under the ACA and if the law were repealed must take into account all of the types of savings we described earlier, including those requiring state-specific analysis too detailed for this paper covering all states and D.C.

End Notes

1 For an overall analysis that explains key reasons for disparate estimates, see Randall R. Bovbjerg, Barbara A. Ormond, and Vicki Chen, "State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, February 2011, http://www.kff.org/healthreform/upload/8149.pdf.

2 See, e.g., Senate Finance Committee, Minority, and the House Energy and Commerce Committee, Majority, "Medicaid Expansion in the New Health Law: Costs to the States," 2011, http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf.

3 See, e.g., Florida Agency for Health Care Administration, "Overview of Federal Affordable Care Act," January 4, 2011, http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_to_SSEC_010411.pdf.

4 See, e.g., Stan Dorn and Matthew Buettgens, "Net Effects of the Affordable Care Act on State Budgets," prepared by the Urban Institute for First Focus, December 2010; The Lewin Group, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," Staff Working Paper #11, June 8, 2010; Council of Economic Advisers, "The Impact of Health Insurance Reform on State and Local Governments," September 2009; Maryland Health Care Reform Coordinating Council (HCRCC), "Final Report and Recommendations," January 1, 2011, http://dhmh.maryland.gov/healthreform/pdf/110110FINALREPORT.pdf; Andrew Allison, "Preliminary Estimates of the Impact of Federal Health Reform on State Spending in Kansas," Presentation to the Board of Directors, Kansas Health Policy Authority, May 18, 2010, http://www.khpa.ks.gov/ppaca/download/Impact%20of%20Federal%20Health%20Reform%20on%20Kansas%20-%20allison%20presentation.pdf.

5 MAGI bases income determination on federal income tax principles, which represents a considerable change from traditional Medicaid eligibility rules. January Angeles, *Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014,* prepared by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. June 2011, http://www.kff.org/healthreform/upload/8194.pdf.

6 For information about enhanced federal matching available to support state transitions to more data-driven eligibility methods envisioned under the ACA, see November 3, 2010, letter from Joel Ario and Cindy Mann to State Medicaid Directors, State Health Officials, and State Health Insurance Commissioners, Federal Support and Standards for Medicaid and Exchange Information Technology Systems.

7 Like most microsimulation models, HIPSM projects that a few employers that currently offer coverage will no longer do so under the ACA; and that some of these firms' gains will be shared with workers in the form of increased wages. However, the vast majority of employers that offer coverage today will continue doing so, according to HIPSM's estimates.

8 See, e.g., Council of Economic Advisers, op cit. Our Urban Institute colleagues have concluded that cost-shifting effects are modest, representing no more than 1.7 percent of private insurance costs. Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs," *Health Affairs,* September 2008, 27(5):w399-w415.

9 One other factor we did not address involved potential state savings from the application of Medicaid prescription drug rebates to managed care organizations. As originally interpreted by CMS, the ACA would have increased costs for some states by requiring them to make payments to the federal government reflecting pre-ACA rebates that exceeded minimum federal standards. CMS revised its interpretation to eliminate this requirement, leaving in place the ACA's potential savings from applying drug rebates to managed care plans. January Angeles, Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law, Center for Budget and Policy Priorities, October 21, 2010, http://www.cbpp.org/cms/index.cfm?fa=view&id=3310&emailView=1.

10 These estimates include savings for adults covered through 1115 waivers and Social Security Act Section 1931. They also include half of the costs for other adults with incomes above 138 percent FPL who report receiving Medicaid coverage and who are not known to be elderly or people with disabilities. We can identify many disabled adults in our underlying survey data, but not all. We divide into three groups the nonelderly adults who report receiving Medicaid, but whose incomes are above 138 percent of the FPL: (1) **The unambiguously disabled.** Those who we can identify as disabled retain Medicaid eligibility, under the ACA as modeled in our Tables. (2) **The clearly eligible.** We identify these individuals as having eligibility through waivers or Social Security Act §1931. In our full ACA simulation, we show the effects if states terminate their Medicaid eligibility, leaving most of these adults with subsidized coverage in the exchange. (3) **The remainder.** This third group consists mainly of the medically needy, pregnant women, enrollees in special programs (e.g., family planning, coverage for women with breast or cervical cancer, recipients of home- and community-based care) and disabled persons whom we could not definitively identify through their survey responses. Some of these eligibility groups are unlikely to be dropped by states, for legal or policy reasons. In addition, the difference between the national time-frame for reporting household circumstances under the CPS-ASEC and the shorter time frames often used to determine Medicaid eligibility introduces uncertainties into the survey results. Based on these factors, our national estimates assume that only half of this third group would lose eligibility, but we do not include these cost effects in our state-specific estimates. Some states may be able to go much further than the 50 percent reduction assumed in our national calculations.

11 Social Security Act Section 1905(y)(2), added by Affordable Care Act Section 2001(a)(3).

12 Social Security Act Section 1905(z), added by Affordable Care Act Section 10201(c).

13 Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" Inquiry, Winter 2003/2004; 40(4):323-342.

14 Matthew Buettgens, John Holahan, and Caitlin Carroll, "Health Reform across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," (Washington, DC: The Urban Institute, 2011).

15 Jack Hadley, John Holahan, Teresa A. Coughlin, Dawn M. Miller, "Covering the Uninsured in 2008: Current Costs, Sources Of Payment, And Incremental Costs," (Washington, DC: The Urban Institute, 2008) http://www.urban.org/url.cfm?ID=1001210.

16 Before the ACA, federal Medicaid DSH allotments were slated to rise from $9.9 billion in 2014 to $11 billion in 2019. The ACA reduced these payments by a small amount during the first few years the coverage expansion will be in full effect, with larger reductions in later years. Cuts are projected to equal $0.5 billion in 2014, $0.6 billion in 2015, $0.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019 and $4 billion in 2020. John Holahan and Stan Dorn, *What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the*

States? Prepared by the Urban Institute for the Robert Wood Johnson Foundation, June 2010. Medicare DSH payments are cut by much larger proportions, but they are refocused to address uncompensated care more than before the ACA. Greater New York Hospital Association, *Medicare Disproportionate Share Hospital Payments,* http://gnyha.org/10833/File.aspx.

[17] This percentage represents 25 to 50 percent of the 30 percent of uncompensated care that is paid by state and local governments nationally, according to Hadley and colleagues.

[18] This total includes General Fund expenditures (40 percent), other state expenditures outside Medicaid (3 percent), and local expenditures (2.4 percent). Ted Lutterman, *The Impact of the State Fiscal Crisis on State Mental Health Systems: Fall 2010 Update,* NASMHPD Research Institute, Inc (NRI), October 12, 2010. http://www.nri-inc.org/reports_pubs/2011ImpactOfStateFiscalCrisisOnMentalHealthSytems_Updated_12Feb11_NRI_Study.pdf.

[19] Theodore C. Lutterman, Bernadette E. Phelan, Ph.D., Azeb Berhane, Robert Shaw, and Verda Rana, Funding and Characteristics of State Mental Health Agencies, 2007, prepared by the National Association of State Mental Health Program Directors for the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, HHS Pub. No. (SMA) 09-4424, 2009. http://store.samhsa.gov/shin/content//SMA09-4424/SMA09-4424.pdf.

[20] Jeffrey A. Buck, *Medicaid Spending for Behavioral Health Treatment Services,* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, June 23, 2010, http://www.nationalgranteeconference.com/presentations/2010/J.%20Buck.pdf.

[21] CMS Office of the Actuary, *National Health Expenditure Projections 2009-2019 (September 2010),* Table 2.

[22] Authors' calculations, John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% Poverty" (Washington, DC: The Urban Institute, 2010), http://www.kff.org/healthreform/8076.cfm.

[23] Richard G. Frank and Sherry Glied, "Changes In Mental Health Financing Since 1971: Implications For Policymakers And Patients," *Health Affairs,* May/June 2006; 25(3): 601-613.

[24] Texas Comptroller of Public Accounts, *State Health Care Spending,* April 6, 2011.

[25] National Association of State Mental Health Program Directors Research Institute, Inc., *Revenues and Expenditures Reports from 2008,* "Table 24: SMHA-Controlled Mental Health Revenues, By Revenue Source and by State, FY 2008 (in millions)," http://www.nri-inc.org/projects/Profiles/RevExp2008/T24.pdf.

[26] California Legislative Analyst's Office, *The 2010-11 Budget: Health and Social Services Budget Primer,* March 24, 2010, http://www.lao.ca.gov/analysis/2010/health/hss_primer_0310.pdf.

[27] For more about HIPSM and a list of recent research using it, see http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), http://www.urban.org/url.cfm?ID=411905.

[28] HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

[29] National Health Expenditure Accounts, CMS Office of the Actuary. https://www.cms.gov/NationalHealthExpendData/.

[30] See, for example, Bowen Garrett, John Holahan, Allison Cook, Irene Headen, and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Urban Institute, 2009), http://www.kff.org/medicaid/upload/7901.pdf.

[31] See, e.g., ACA §1413.

[32] Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage,* prepared by the Urban Institute for the Robert Wood Johnson Foundation and the State Health Access Reform Evaluation, November 2009.

[33] Holahan and Headen, 2010.

[34] Holahan and Headen, 2010.

[35] We did not model states in which limited benefits are available only through premium assistance due to the difficulty of identifying premium assistance enrollees from survey data and the small enrollment in most such programs. These states include Arkansas, Idaho, Nevada, and Oklahoma.

[36] CMS, *State Medicaid Director Letter,* "New Option for Coverage of Individuals Under Medicaid," April 9, 2010, SMDL# 10-005, PPACA # 1.

[37] Buettgens, Holahan, and Carroll, 2010.

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