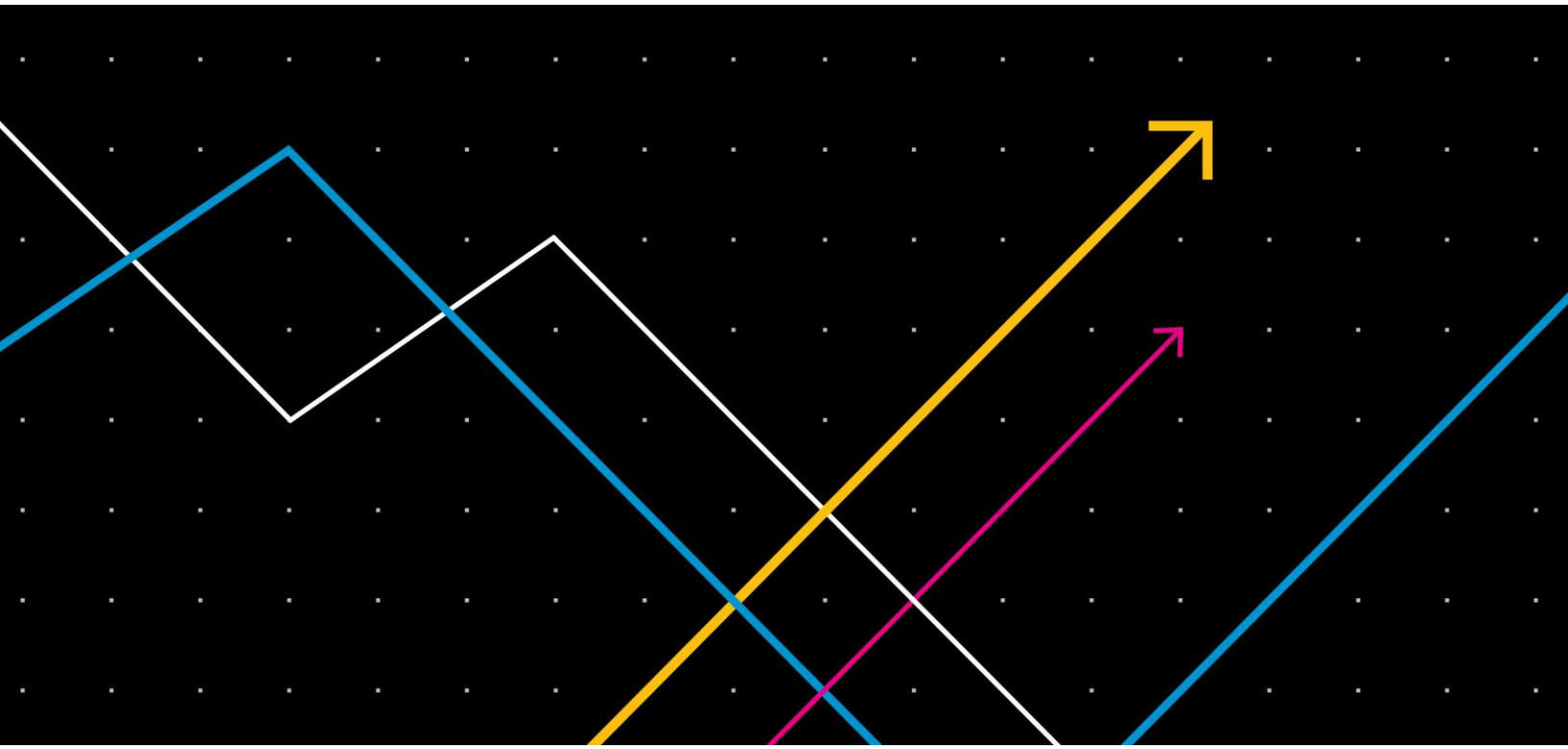

RESEARCH REPORT

2.3 Million People Would Gain Health Coverage in 2024 if 10 States Were to Expand Medicaid Eligibility

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URBAN INSTITUTE

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Errata

This report was corrected on October 24, 2023. Page vi of the executive summary was amended to state that a 2022 voter referendum approved Medicaid expansion in South Dakota, not South Carolina.

Executive Summary

Under the Affordable Care Act, states have the option to expand Medicaid eligibility to nonelderly people with incomes up to 138 percent of the federal poverty level. As of the time of writing, only 10 states had not agreed to do so: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. A 2022 voter referendum approved Medicaid expansion in South Dakota, which took effect in July 2023. In March 2023, the governor of North Carolina signed Medicaid expansion into law.[1] This brief examines coverage in 2024, hence, we consider North Carolina and South Dakota as Medicaid expansion states. Governors, legislators, and other stakeholders in many of the nonexpansion states are actively debating Medicaid expansion.

We estimated the effect on health coverage and costs if these 10 nonexpansion states were to fully implement a Medicaid expansion in 2024 and all else stayed the same. We find the following:

- Medicaid enrollment would increase by 5 million people if all 10 remaining states were to expand eligibility, an increase of nearly 32 percent.
- 2.3 million fewer people in current nonexpansion states would be uninsured, a reduction of 25 percent.
- An additional 2.3 million people with incomes up to 138 percent of the federal poverty level will switch from the Marketplaces to Medicaid coverage, which will have lower cost sharing without deductibles.
- Groups with the highest gains in coverage because of Medicaid expansion include non-Hispanic Blacks, young adults, and women, particularly women of reproductive age.
- Federal spending on Medicaid and the Marketplaces in these states would increase by about $24 billion, a 17.5 percent increase. This would be partially offset by $731 million in federal government savings on uncompensated care.
- State spending on Medicaid in those states would increase by $1.5 billion, or 3 percent. This would be partially offset by $457 million in state and local government savings on uncompensated care.

- The remaining state spending would be fully or largely offset by savings in other areas and potential new revenue. Several comprehensive analyses of current expansion states have found that Medicaid expansion had a net positive impact on many state budgets.
- In addition, for the first two years after a new Medicaid expansion, the federal government would pay a higher share of the costs of currently eligible Medicaid enrollees.

President Biden's budget for fiscal year 2024 would provide federally funded, "Medicaid-like" coverage to individuals not eligible for assistance because their state did not expand Medicaid.[2] If the federal government were to provide Medicaid-like coverage through the Marketplaces to all of those who would gain Medicaid eligibility under expansion, we assume that the reduction in the number of uninsured would be the same as under Medicaid expansion.[3] The difference would be that it would be federally funded and those gaining eligibility would enroll in the Marketplaces. We estimate that the federal government would spend nearly $8 billion more in 2024 under the president's proposal than if all states were to expand Medicaid, while states would spend $918 million less.

There is growing evidence that increased health coverage, whether Medicaid or "Medicaid-like," lowers mortality and increases the financial security of low-income families (Goldie, Lurie, and McCubbin 2019; Miller Jonson, and Wherry 2021; Caswell and Waidman 2017). It can also decrease the number of unwanted pregnancies and increase access to effective contraception (Grindlay and Grossman 2016; Johnston and McMorrow 2020), which is particularly important after the Supreme Court's decision that revoked the constitutional right to abortion in 2022. Medicaid expansion also improves hospital finances and can boost state economies (Blavin 2017; Dranove, Garthwaite, and Ody 2017). Many states have found that savings and new revenue outweigh any new spending because of Medicaid expansion.

2.3 Million People Would Gain Health Coverage in 2024 if 10 States Were to Expand Medicaid Eligibility

Under the Affordable Care Act (ACA), states have the option to expand Medicaid eligibility to nonelderly people with incomes up to 138 percent of the federal poverty level (FPL).[4] States that have not expanded Medicaid have notably higher uninsured rates than expansion states (Kelsey-Starkey, Bunch, and Lindstrom 2023). At the time of writing, only 10 states have not done so: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. In March 2023, the governor of North Carolina signed Medicaid expansion into law, and it is expected to take effect upon the signing into law of the financial year 2023–24 Appropriations Act.[5] However, this had not been passed at the time of writing.[6] Beginning in July 2023, Medicaid expansion took effect in South Dakota.[7] This report examines coverage in 2024, hence, we consider North Carolina and South Dakota as Medicaid expansion states.

Wisconsin is unique among nonexpansion states in that they extended eligibility to adults up to 100 percent of FPL in 2014 without accepting the ACA's Medicaid expansion. Except for Wisconsin, among adults in nonexpansion states, only parents at very low incomes can be eligible for Medicaid with full benefits.[8] The highest parent eligibility thresholds among these states are in Tennessee and South Carolina, 82 percent and 67 percent of FPL, respectively. The remaining nine states have thresholds at 50 percent of FPL or below, with the lowest being Texas and Alabama, at 16 percent and 18 percent of FPL, respectively.[9]

People with incomes below 100 percent of FPL are also ineligible for Marketplace premium tax credits (PTCs).[10] Thus, in nonexpansion states, many uninsured adults with incomes below 100 percent of FPL are caught in a coverage gap, qualifying for neither Medicaid nor premium tax credits to purchase Marketplace coverage. They generally have no affordable health insurance options. Additionally, people with incomes between 100 and 138 percent of FPL may be ineligible for tax credits if they have an affordable offer of other coverage. Medicaid has no such requirement for eligibility, so they would gain eligibility for assistance if their state were to expand Medicaid.

This report updates a series of reports using the Urban Institute's Health Insurance Policy Simulation Model to estimate the recent impact of Medicaid expansion (Buettgens and Ramchandani

2022; Buettgens 2021; Simpson 2020). We estimate new Medicaid enrollment if all nonexpansion states were to expand eligibility, along with the resulting decline in the number of uninsured people. We show how this would affect different age, gender, and racial/ethnic groups. We also consider the costs of Medicaid expansion. We assume that states have fully resumed normal Medicaid eligibility processing after the continuous coverage requirement expired in April 2023 (Buettgens and Green 2022).

If all 10 remaining states were to expand eligibility, we find that Medicaid enrollment would increase by 5 million people, and 2.3 million fewer people in current nonexpansion states would be uninsured, a reduction of 25 percent. Groups with the highest gains in coverage because of Medicaid expansion include non-Hispanic Blacks, young adults, and women, particularly women of reproductive age. The federal government would pay 90 percent of the costs of newly eligible Medicaid enrollees. Although states would have to pay the remaining 10 percent, Medicaid expansion gives states opportunities to reduce current spending and increase revenue. Several comprehensive analyses of current expansion states have found that Medicaid expansion had a net positive impact on many state budgets. In addition, for the first two years after a new Medicaid expansion, the federal government would pay a higher share of the costs of currently eligible Medicaid enrollees. This new federal spending would outweigh any additional state spending.

President Biden's budget for fiscal year 2024 provides Medicaid-like coverage to individuals in nonexpansion states.[11] The budget does not provide details of the proposal, so we assume that the intention is to provide comparable, federally funded Marketplace coverage for all who would gain eligibility if their state were to expand Medicaid. Hence, the difference in the number of uninsured people would be essentially the same under Medicaid expansion and the president's budget proposal. It is important to note that similar congressional proposals we simulated in 2022 were more limited in scope (Holahan et al. 2021). Under the president's proposal, nearly all of the new enrollment would be in the Marketplaces, though some dependents of people newly enrolling in the Marketplace who are currently eligible for Medicaid or Children's Health Insurance Program (CHIP) would newly enroll. Government costs would be notably different between the two policies. We estimate that the federal government would spend nearly $8 billion more in 2024 under the president's budget proposal than if all states were to expand Medicaid, while states would spend $918 million less.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

Methods

We produced our estimates using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

We updated the model using state-level Marketplace enrollment from the 2023 Marketplace Open Enrollment Period report released by the Centers for Medicare & Medicaid Services.[12] By comparing those enrollment estimates with estimated Marketplace enrollment before the enhanced PTCs, we measured how the demand for Marketplace coverage increased in each state because of enhancing PTCs. We found substantial variation across states that has important implications for our results.

Using our recently updated estimates of Medicaid enrollment in 2022 and 2023, we estimated the increase in Marketplace coverage because of losses of Medicaid enrollment after the states have resumed normal Medicaid processing after the continuous coverage requirement ends in April 2023

(Buettgens and Green 2022). We describe the details of our methodology in separate reports (Buettgens and Banthin 2020; 2022).

In this brief, we simulate Medicaid enrollment in 2024 had the remaining 10 states expanded eligibility that year. Based on pre-COVID-19 pandemic Medicaid enrollment data from 2019, released by the US Department of Health and Human Services, enrollment experiences in previous Medicaid expansions varied across states.[13] Using these enrollment data and HIPSM simulation, we estimate slightly more than 72 percent of uninsured people and 13 percent of people with employer-sponsored insurance who gained eligibility under Medicaid expansion had enrolled in the program by 2019.[14] We assume the Medicaid take-up rate for new expansion states is the average rate among current expansion states. However, take-up may vary depending on state decisions we cannot predict, such as outreach and assistance efforts. Also, states could combine Medicaid expansion with Medicaid waivers that introduce other changes in the program. Our estimates further assume that the states have fully resumed normal Medicaid enrollment processing after April 2023 (Buettgens and Banthin 2022).

In this report, we also simulate the Medicaid-like coverage proposal under the president's budget for fiscal year 2024. We assume the population gaining eligibility for Medicaid-like coverage and Medicaid expansion is the same. In an earlier report, we examined similar policies expanding eligibility for Marketplace PTCs in nonexpansion states (Holahan et al. 2021).

Results

Changes in Health Coverage in Nonexpansion States

We estimate that if the 10 remaining nonexpansion states were to expand Medicaid in 2024, Medicaid enrollment would increase by 5 million people, or 31.8 percent (table 1). There would be 2.3 million fewer uninsured people in nonexpansion states, a decline of 25 percent. About 2.3 million current Marketplace enrollees with incomes below 138 percent of FPL would become eligible for Medicaid and receive coverage with lower cost sharing. About 536,000 low-income working families would transition from employer-sponsored health insurance to Medicaid, receiving coverage that is generally without premiums and with lower cost sharing. Finally, 133,000 people currently enrolled in unregulated health coverage that does not comply with ACA standards would gain comprehensive Medicaid coverage.

TABLE 1

Health Insurance Coverage Distribution of the Nonelderly in Nonexpansion States, 2024 (thousands of people)

Current law (cov_OEP23sARPAESI_2024) compared with Medicaid expansion (cov_OEP23ExpMRB3_2024) and the president's proposal (cov_OEP23GapFillD_2024) in 2024

	Current law		Medicaid expansion, ARPA PTCs		Change from current law	Percent difference from current law	President's proposal		Change from Medicaid expansion	Percent difference from Medicaid expansion
Insured (MEC)	67,563	86.9%	69,959	90.0%	2,396	3.5%	69,959	90.0%	0	0.0%
Employer	39,736	51.1%	39,200	50.4%	-536	-1.3%	39,200	50.4%	0	0.0%
Private nongroup	9,160	11.8%	7,069	9.1%	-2,091	-22.8%	11,917	15.3%	4,847	68.6%
Marketplace with PTC	7,531	9.7%	5,193	6.7%	-2,338	-31.0%	10,681	13.7%	5,488	105.7%
Full-pay Marketplace	263	0.3%	230	0.3%	-33	-12.5%	93	0.1%	-137	-59.5%
Other nongroup	1,366	1.8%	1,647	2.1%	280	20.5%	1,143	1.5%	-504	-30.6%
Medicaid/CHIP	15,772	20.3%	20,795	26.8%	5,023	31.8%	15,947	20.5%	-4,847	-23.3%
Disabled	2,567	3.3%	2,598	3.3%	31	1.2%	2,598	3.3%	0	0.0%
Medicaid expansion	0	0.0%	6,144	7.9%	6,144	100.0%	0	0.0%	-6,144	-100.0%
Traditional nondisabled adult	3,274	4.2%	2,047	2.6%	-1,227	-37.5%	3,344	4.3%	1,297	63.3%
Nondisabled Medicaid/CHIP child	9,931	12.8%	10,006	12.9%	75	0.8%	10,006	12.9%	0	0.0%
Other public	2,895	3.7%	2,895	3.7%	0	0.0%	2,895	3.7%	0	0.0%
Uninsured (no MEC)	10,165	13.1%	7,769	10.0%	-2,396	-23.6%	7,769	10.0%	0	0.0%
Uninsured	9,055	11.6%	6,792	8.7%	-2,263	-25.0%	6,792	8.7%	0	0.0%
Noncompliant nongroup	1,110	1.4%	977	1.3%	-133	-12.0%	977	1.3%	0	0.0%
Total	**77,729**	**100.0%**	**77,729**	**100.0%**	**0**	**0.0%**	**77,729**	**100.0%**	**0**	**0.0%**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program. Results simulated for 2024. Total is total in nonexpansion states. The President's budget for fiscal year 2024 would provide federally funded, Medicaid-like coverage to individuals not eligible for assistance because their state did not expand Medicaid.

Changes in Medicaid Enrollment

Medicaid enrollment in nonexpansion states would increase by 31.8 percent if these states expanded eligibility in 2024 (table 2). States that would see the largest increases in Medicaid enrollment under expansion include Wyoming (56.1 percent), Florida (36.7 percent), and Kansas (35.6 percent). The state with the lowest increase in enrollment would be Wisconsin (7.2 percent), which has already expanded eligibility to adults up to 100 percent of FPL.

These estimates assume that each state would have the same share of those gaining Medicaid eligibility choose to enroll, based on the average take-up rate observed across states that have already expanded Medicaid (see Methods on page 3). However, there is variation in take-up between existing expansion states. Enrollment could be higher than projected in states with more effective outreach and application assistance. Conversely, it could be lower than projected if states impose premiums for Medicaid or additional restrictions such as work requirements.

TABLE 2

Medicaid/CHIP Enrollment by Nonexpansion States, 2024 (thousands of people)

	Current Law		Medicaid Expansion, ARPA PTCs				President's Proposal			
State	Total	Share of nonelderly population	Total	Share of nonelderly population	Change from current law	Percent difference from current law	Total	Share of nonelderly population	Difference from Medicaid expansion	Percent difference from Medicaid expansion
Alabama	971	23.7%	1,297	31.6%	326	33.6%	975	23.8%	-322	-24.8%
Florida	3,497	20.0%	4,781	27.3%	1,284	36.7%	3,525	20.1%	-1,256	-26.3%
Georgia	2,023	21.0%	2,694	28.0%	671	33.2%	2,033	21.1%	-661	-24.5%
Kansas	376	14.9%	510	20.3%	134	35.6%	382	15.2%	-128	-25.1%
Mississippi	622	25.1%	818	32.9%	196	31.4%	630	25.4%	-187	-22.9%
South Carolina	966	22.6%	1,286	30.1%	321	33.2%	970	22.7%	-316	-24.6%
Tennessee	1,400	24.4%	1,716	29.9%	316	22.6%	1,404	24.4%	-312	-18.2%
Texas	4,870	18.6%	6,543	25.0%	1,673	34.4%	4,967	19.0%	-1,576	-24.1%
Wisconsin	996	20.6%	1,067	22.1%	72	7.2%	1,004	20.8%	-64	-6.0%
Wyoming	53	9.9%	82	15.5%	30	56.1%	57	10.8%	-25	-30.5%
Total	**15,772**	**20.3%**	**20,795**	**26.8%**	**5,023**	**31.8%**	**15,947**	**20.5%**	**-4,847**	**-23.3%**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit; CHIP = Children's Health Insurance Program. Total is total in nonexpansion states. The president's budget for fiscal year 2024 would provide federally funded, Medicaid-like coverage to individuals not eligible for assistance because their state did not expand Medicaid.

Changes in the Uninsured

Among the 10 nonexpansion states, all would have uninsured rates in 2024 under current law of around 10 percent or higher, except Wisconsin, which has extended eligibility to all adults up to 100 percent of FPL. If the 10 nonexpansion states expanded Medicaid eligibility in 2024, the number of uninsured people would decline by 25 percent (table 3). States with the largest reductions include Mississippi (39.4 percent), Alabama (37 percent), and South Carolina (32 percent). Wisconsin will have the smallest reduction of 8.1 percent because it has already expanded eligibility to adults up to 100 percent of FPL. After expanding Medicaid, only Texas and Wyoming would have an uninsured rate of higher than 10 percent.

Immigration status is a major barrier to Medicaid eligibility (Broder and Lessard 2023). Undocumented immigrants are ineligible for Medicaid. Lawfully present adult immigrants who are residents in the US for less than five years are not eligible for Medicaid; lawfully present immigrant children who are residents for less than five years are eligible for Medicaid and CHIP in some states. In Texas and a few other states, lawfully present immigrants are not eligible for Medicaid, regardless of length of residency. As a result, Texas, which has the highest uninsured rate in the country (14.2 percent), would see declines in the number of uninsured (21.6 percent) below the average for all nonexpansion states, though that still represents a substantial gain in health coverage.

TABLE 3

Uninsured by Nonexpansion States, 2024 (thousands of people)

	Current Law		Medicaid Expansion, ARPA PTCs				President's Proposal			
State	Total	As percent of state nonelderly population	Total	As percent of state nonelderly population	Change from current law	Percent change from the Current law	Total	As percent of state nonelderly population	Difference from Medicaid expansion	Percent change from Medicaid expansion
Alabama	394	9.6%	248	6.0%	-146	-37.0%	248	6.0%	0	0.0%
Florida	2,043	11.7%	1,529	8.7%	-514	-25.2%	1,529	8.7%	0	0.0%
Georgia	1,049	10.9%	756	7.8%	-293	-27.9%	756	7.8%	0	0.0%
Kansas	287	11.4%	197	7.9%	-90	-31.3%	197	7.9%	0	0.0%
Mississippi	253	10.2%	153	6.2%	-100	-39.4%	153	6.2%	0	0.0%
South Carolina	408	9.5%	277	6.5%	-131	-32.0%	277	6.5%	0	0.0%
Tennessee	558	9.7%	407	7.1%	-151	-27.0%	407	7.1%	0	0.0%
Texas	3,708	14.2%	2,906	11.1%	-802	-21.6%	2,906	11.1%	0	0.0%
Wisconsin	280	5.8%	258	5.3%	-23	-8.1%	258	5.3%	0	0.0%
Wyoming	75	14.1%	61	11.5%	-14	-18.3%	61	11.5%	0	0.0%
Total	**9,055**	**11.6%**	**6,792**	**8.7%**	**-2,263**	**-25.0%**	**6,792**	**8.7%**	**0**	**0.0%**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit.

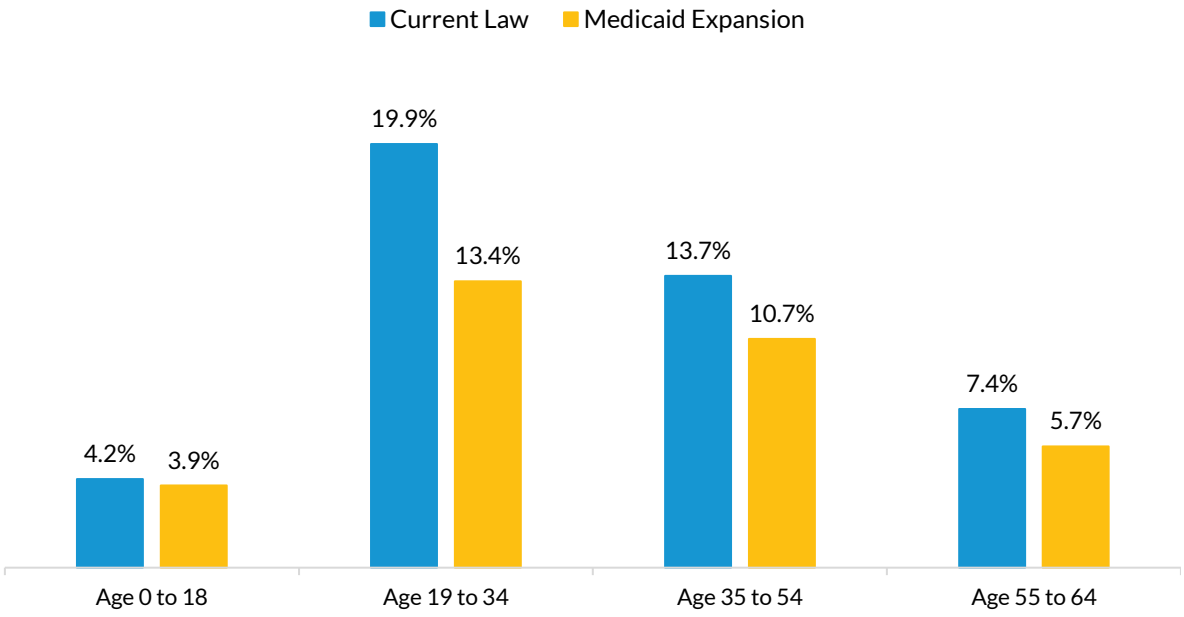
The Uninsured by Age Group

Young adults (aged 19 to 34) in nonexpansion states have the highest uninsured rates of any age group, 19.9 percent in 2024, without Medicaid expansion (figure 1 and table 4). They would also see the greatest decline in the number of uninsured under Medicaid expansion, 32.4 percent. Adults aged 35 to 54 have the next highest uninsured rate (13.7 percent) and would see a 21.7 percent reduction under Medicaid expansion. Adults aged 55 to 64 have a lower uninsured rate (7.4 percent) because they tend to have higher incomes and value health coverage more highly because of their higher health care needs. The number of uninsured adults in this age group would decline by 23.5 percent if the remaining states were to expand Medicaid.

Medicaid and CHIP eligibility thresholds for children are already well above 138 percent of FPL, so they would not gain eligibility under the ACA's Medicaid expansion. However, the number of uninsured children would still fall by 7.3 percent under Medicaid expansion. As more parents become eligible and are enrolled, their already-eligible children are more likely to be enrolled as well.

FIGURE 1

Uninsured by Age Group



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Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

TABLE 4

Uninsured Women and Men, by Race and Age (thousands of people)

	Current Law			Medicaid Expansion, ARPA PTCs				
	Number of uninsured	Percent of total	Uninsured rate	Number of uninsured	Percent of total	Uninsured rate	Change from current law	Percent difference from current law
Age								
Age 0 to 18	929	10.3%	4.2%	861	12.7%	3.9%	-68	-7.3%
Age 19 to 34	3,917	43.3%	19.9%	2,649	39.0%	13.4%	-1,268	-32.4%
Age 35 to 54	3,412	37.7%	13.7%	2,673	39.4%	10.7%	-739	-21.7%
Age 55 to 64	797	8.8%	7.4%	609	9.0%	5.7%	-187	-23.5%
Total	**9,055**	**100.0%**	**11.6%**	**6,792**	**100.0%**	**8.7%**	**-2,263**	**-25.0%**
Race								
White, non-Hispanic	3,205	35.4%	7.5%	2,268	33.4%	5.3%	-936	-29.2%
Hispanic	4,023	44.4%	23.6%	3,371	49.6%	19.7%	-653	-16.2%
Black, non-Hispanic	1,329	14.7%	9.9%	755	11.1%	5.6%	-574	-43.2%
Other	498	5.5%	11.2%	399	5.9%	9.0%	-100	-20.0%
Total	**9,055**	**100.0%**	**11.6%**	**6,792**	**100.0%**	**8.7%**	**-2,263**	**-25.0%**
Gender								
Men	4,975	54.9%	12.9%	3,783	55.7%	9.8%	-1,192	-24.0%
Women	4,080	45.1%	10.4%	3,010	44.3%	7.7%	-1,071	-26.2%
Total	**9,055**	**100.0%**	**11.6%**	**6,792**	**100.0%**	**8.7%**	**-2,263**	**-25.0%**
Women								
White, non-Hispanic	1,425	34.9%	6.6%	986	32.8%	4.6%	-438	-30.8%
Hispanic	1,797	44.0%	21.4%	1,476	49.0%	17.6%	-321	-17.9%
Black, non-Hispanic	627	15.4%	8.8%	361	12.0%	5.1%	-266	-42.4%
Other	232	5.7%	10.1%	187	6.2%	8.2%	-45	-19.5%
Total	**4,080**	**100.0%**	**10.4%**	**3,010**	**100.0%**	**7.7%**	**-1,071**	**-26.2%**

	Current Law			Medicaid Expansion, ARPA PTCs				
	Number of uninsured	Percent of total	Uninsured rate	Number of uninsured	Percent of total	Uninsured rate	Change from current law	Percent difference from current law
Women of reproductive ages (19–44)								
White, non-Hispanic	777	31.3%	9.2%	472	27.6%	5.6%	-305	-39.3%
Hispanic	1,175	47.3%	32.0%	944	55.2%	25.7%	-231	-19.6%
Black, non-Hispanic	389	15.7%	12.7%	190	11.1%	6.2%	-200	-51.3%
Other	141	5.7%	14.1%	106	6.2%	10.7%	-34	-24.4%
Total	**2,482**	**100.0%**	**15.3%**	**1,712**	**100.0%**	**10.6%**	**-770**	**-31.0%**
Women of older ages (45–64)								
White, non-Hispanic	515	44.5%	6.6%	389	43.9%	5.0%	-125	-24.4%
Hispanic	390	33.8%	22.0%	320	36.1%	18.0%	-70	-18.0%
Black, non-Hispanic	189	16.3%	9.5%	125	14.1%	6.3%	-64	-33.7%
Other	62	5.4%	11.9%	53	6.0%	10.2%	-9	-14.3%
Total	**1,156**	**100.0%**	**9.6%**	**888**	**100.0%**	**7.4%**	**-268**	**-23.2%**
Men of younger ages (19–44)								
White, non-Hispanic	1,074	32.4%	12.7%	711	29.3%	8.4%	-363	-33.8%
Hispanic	1,588	47.9%	40.4%	1,344	55.4%	34.2%	-244	-15.4%
Black, non-Hispanic	485	14.6%	19.0%	239	9.9%	9.3%	-246	-50.7%
Other	170	5.1%	18.5%	130	5.4%	14.1%	-40	-23.6%
Total	**3,318**	**100.0%**	**20.9%**	**2,424**	**100.0%**	**15.3%**	**-894**	**-26.9%**
Men of older ages (45–64)								
White, non-Hispanic	554	47.4%	7.4%	428	47.2%	5.7%	-126	-22.8%
Hispanic	387	33.1%	22.7%	322	35.5%	18.8%	-66	-16.9%
Black, non-Hispanic	167	14.3%	10.4%	108	11.9%	6.7%	-59	-35.3%
Other	61	5.2%	13.4%	50	5.5%	10.9%	-11	-18.7%
Total	**1,170**	**100.0%**	**10.4%**	**907**	**100.0%**	**8.1%**	**-262**	**-22.4%**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit. Results simulated for 2024. Total is total in nonexpansion states. The president's budget for fiscal year 2024 would provide federally funded, Medicaid-like coverage to individuals not eligible for assistance because their state did not expand Medicaid.

The Uninsured by Race/Ethnicity

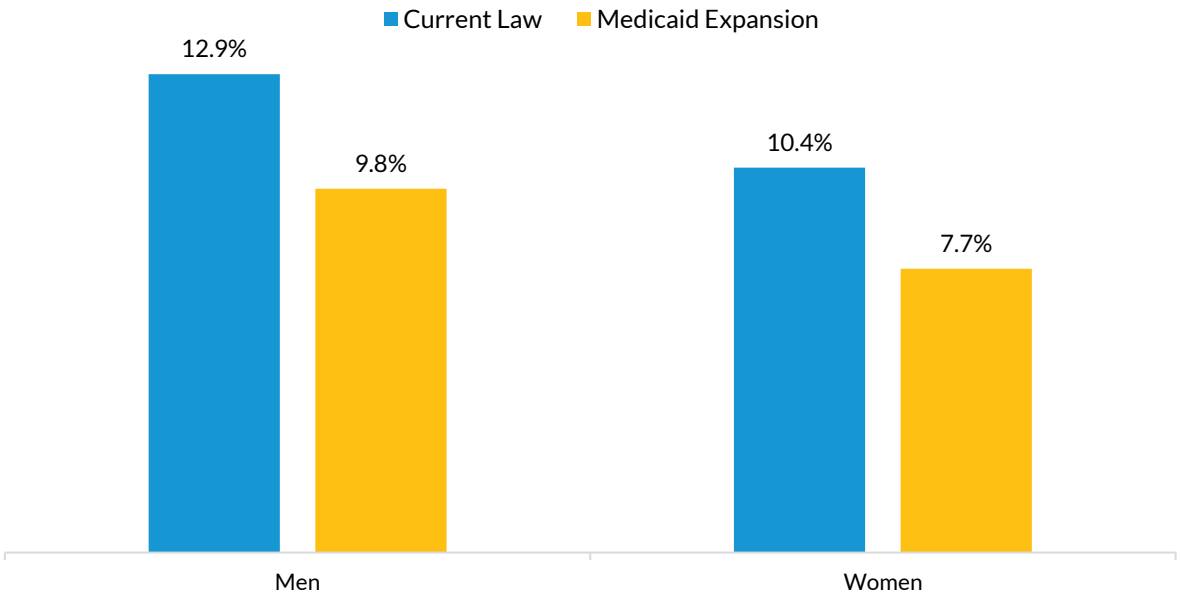
If the remaining 10 states were to expand Medicaid eligibility, the number of uninsured non-Hispanic Blacks would fall by 43.2 percent (table 4 and figure 2). Uninsurance among non-Hispanic whites would fall by 29.2 percent. We estimate that the uninsured rate for non-Hispanic whites and non-Hispanic Blacks would be close in the 10 nonexpansion states under Medicaid expansion, at about 5 percent. Thus, Medicaid expansion would eliminate a longstanding inequality in health coverage in these states.

Hispanics would see substantial, though smaller, declines in the number of uninsured people (16.2 percent). This is largely because of the restrictions on Medicaid eligibility for immigrants that we discussed above (Broder and Lessard 2023). Hispanics would still have the highest uninsured rate of any racial or ethnic group, 23.6 percent without Medicaid expansion, or 19.7 percent with expansion.

The number of uninsured people of other racial and ethnic groups—Asians/Pacific Islanders, American Indians, and those reporting multiple racial groups—would see a 20 percent reduction in uninsurance if the remaining states were to expand Medicaid.

FIGURE 2

Uninsured by Gender



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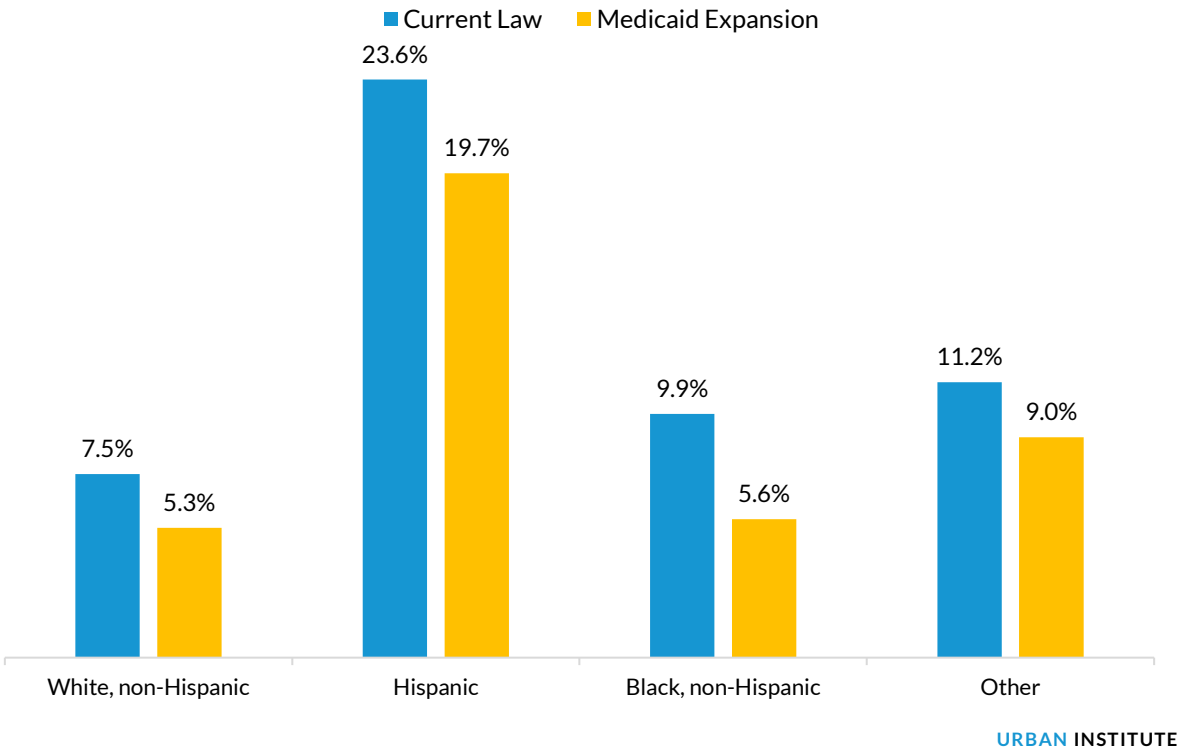
Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

The Uninsured by Gender

If the remaining 10 states were to expand Medicaid, we estimate that there would be 1 million fewer uninsured women and about 1.2 million fewer uninsured men (table 4 and figure 3). However, there are currently fewer uninsured women than men in these states, so the number of uninsured women would decline by 26.2 percent under Medicaid expansion, compared with 24 percent for men (table 4 and figure 2). The lower uninsured rate among women in nonexpansion states is partly because more than half of adult Marketplace enrollees are women. Without expansion, Medicaid is not generally available to adult men or women except to parents at very low incomes and low-income pregnant women during the term of pregnancy.[15]

FIGURE 3

Uninsured by Race



Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

The Intersection of Race, Age, and Gender

The result noted above that younger adults currently have the highest uninsurance rates and would see the greatest reductions in uninsurance because of Medicaid expansion holds when women and men are considered separately. Women of reproductive age (19 to 44) would see a 31 percent reduction in

uninsurance, compared with a 23.2 percent reduction for women aged 45 to 64. By comparison, men aged 19 to 44 would see a 26.9 percent reduction in uninsurance, compared with a 22.4 percent reduction for men aged 45 to 64.

For all ages and genders, non-Hispanic Blacks would see the highest reductions in uninsurance, with non-Hispanic whites seeing lower reductions and Hispanics seeing the lowest reductions of any racial and ethnic group. In particular, non-Hispanic Black women of reproductive age would see a 51.3 percent reduction in uninsurance, the largest decrease of any group we considered. Non-Hispanic white women of reproductive age would see a 39.3 percent reduction, Hispanic women of reproductive age would see a 19.6 percent reduction, and other women of reproductive age would see a 24.4 percent reduction.

Changes in Health Coverage under the President's Budget Proposal

We assume that the president's budget proposal will provide comparable Marketplace PTC coverage to those who would gain eligibility under Medicaid expansion. With this assumption, we would see the same changes in uninsurance by age, race/ethnicity, and gender under both policies. The difference would be in the type of coverage new enrollees would have: 4.8 million people would be enrolled in the Marketplaces under the president's proposal rather than Medicaid. There would still be an increase in Medicaid and CHIP enrollment under the president's proposal. As people newly enroll in the Marketplaces, their family members will be screened for Medicaid and CHIP eligibility, and more would enroll.

Changes in Federal Costs

The federal government would pay 90 percent of the costs of Medicaid enrollees who newly become eligible under expansion. This would apply to most new Medicaid enrollees, but there would also be an increase in enrollment among those who were already eligible, particularly among children. As more parents enroll in coverage, more of their eligible children will also be enrolled in Medicaid and CHIP. For eligible enrollees before expansion, the federal government pays the state's standard federal medical assistance percentage, which is much lower than 90 percent.[16]

As a result, if the remaining 10 states expanded Medicaid eligibility, the federal government would spend $24.3 billion more on health care in those states in 2024, a 17.5 percent increase (table 5). States with the largest increases would be Kansas (29.1 percent), Alabama (22.3 percent), and Texas (21.4 percent). As we have seen, Wisconsin would have the smallest enrollment increases, so the increase in federal spending would also be small (6 percent). Wyoming would have a smaller increase (2.5 percent)

because there was a large increase in Marketplace enrollment in the 2023 open enrollment period. As a result, many current enrollees would transfer to Medicaid. Nongroup premiums are relatively high in the state, so the federal government saves money on this population, partially offsetting the costs of new enrollment among the uninsured.

Along with benefiting those gaining better access to health care, this additional federal spending can lead to improved hospital finances, new jobs, and more state revenue. See the Discussion section on page 20 for more information and citations.

Under the American Rescue Plan (ARP), states that newly expand Medicaid will receive a 5-percentage point increase in their federal medical assistance percentage for two years. In other words, the federal government will pay more for nonexpansion Medicaid enrollees. This temporary addition to federal spending is not included in our estimates because we wanted to give an accurate picture of long-term spending under Medicaid expansion.

TABLE 5

Federal Spending on Medicaid, CHIP, and Marketplace Tax Credits in Nonexpansion States, 2024 (millions of dollars)

	Current Law	Medicaid Expansion, ARPA PTCs			President's Proposal		
State	Total federal spending on Medicaid, CHIP, and Marketplace subsidies	Total federal spending on Medicaid, CHIP, and Marketplace subsidies	Change in federal spending from current law	Percent change from current law	Total federal spending on Medicaid, CHIP, and Marketplace subsidies	Change in federal spending from Medicaid expansion	Percent change from Medicaid expansion
Alabama	7,078	8,655	1,577	22.3%	9,886	1,231	14.2%
Florida	35,221	39,453	4,231	12.0%	42,635	3,182	8.1%
Georgia	15,307	18,348	3,041	19.9%	19,576	1,227	6.7%
Kansas	2,643	3,413	769	29.1%	3,648	235	6.9%
Mississippi	6,082	7,304	1,222	20.1%	7,633	329	4.5%
South Carolina	7,798	9,366	1,568	20.1%	9,944	578	6.2%
Tennessee	10,969	12,466	1,498	13.7%	12,887	420	3.4%
Texas	46,527	56,498	9,971	21.4%	57,029	531	0.9%
Wisconsin	6,331	6,713	382	6.0%	6,683	-29	-0.4%
Wyoming	822	842	20	2.5%	1,105	263	31.2%
Total	**138,778**	**163,058**	**24,280**	**17.5%**	**171,025**	**7,967**	**4.9%**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit; CHIP = Children's Health Insurance Program. Results simulated for 2024. Total is total in nonexpansion states. The president's budget for fiscal year 2024 would provide federally funded, Medicaid-like coverage to individuals not eligible for assistance because their state did not expand Medicaid.

Changes in State Costs

If the remaining 10 states expanded Medicaid eligibility, states would spend $1.5 billion more on new Medicaid enrollees, a 3 percent increase (table 6). States with the largest increases in spending include Mississippi (8.9 percent), Alabama (8.5 percent), and Wyoming (7.4 percent).

Wisconsin's spending will decrease by 8.3 percent with Medicaid expansion because they are currently covering adults up to 100 percent of FPL, with the federal government covering only 60.1 percent of the cost. If they were to expand Medicaid, the federal government would cover 90 percent of the cost of the same enrollees. In other words, by not accepting the ACA's Medicaid expansion, Wisconsin is spending more to cover fewer people. Tennessee's spending will decrease slightly by 0.1 percent because the state has one of the highest parent eligibility thresholds among nonexpansion states at 82 percent of FPL.

Table 6 does not represent the net impact of Medicaid expansion on state budgets. Medicaid expansion brings many opportunities for state savings and additional state revenue. We estimate state savings on uncompensated care in the next section and discuss the impact on state budgets more fully below. Most expansion states that have conducted comprehensive analyses have concluded that Medicaid expansion reduced total state spending.

These estimates also do not include the two-year increase in federal funding after a new Medicaid expansion under the ARP, as described above. During that time, new federal funding would outweigh state spending on Medicaid expansion enrollees.

TABLE 6

Total State Spending on Medicaid, CHIP, and Marketplace Tax Credits in Nonexpansion States, 2024 (millions of dollars)

	Current Law	Medicaid Expansion, ARPA PTCs			President's Proposal		
State	Total	Total	Change from current law	Percent change from current law	Total	Change from Medicaid expansion	Percent change from Medicaid expansion
Alabama	1,850	2,006	157	8.5%	1,858	-149	-7.4%
Florida	10,539	10,709	170	1.6%	10,630	-79	-0.7%
Georgia	4,947	5,220	274	5.5%	4,970	-250	-4.8%
Kansas	1,206	1,238	31	2.6%	1,222	-16	-1.3%
Mississippi	1,398	1,522	124	8.9%	1,420	-102	-6.7%
South Carolina	2,036	2,185	149	7.3%	2,048	-138	-6.3%
Tennessee	4,371	4,366	-5	-0.1%	4,385	19	0.4%
Texas	19,567	20,387	819	4.2%	19,907	-480	-2.4%
Wisconsin	3,162	2,901	-261	-8.3%	3,185	284	9.8%
Wyoming	333	358	25	7.4%	349	-8	-2.3%
Total	**49,409**	**50,892**	**1,482**	**3.0%**	**49,973**	**-918**	**-1.8%**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit; CHIP = Children's Health Insurance Program. Results simulated for 2024. Total is total in nonexpansion states. The president's budget for fiscal year 2024 would provide federally funded, Medicaid-like coverage to individuals not eligible for assistance because their state did not expand Medicaid.

Changes in Uncompensated Care

When the number of uninsured people declines, the demand for uncompensated care consumed by the uninsured will also decline. However, because of the complexities of how uncompensated care is financed, a reduction in demand will not necessarily result in comparable government savings. For the federal government, we estimate that half of the change in demand would be realized as savings in Medicare disproportionate share hospital payments. That results in $731 million in federal government savings for 2024 (table 7), which partially offsets the $24.3 billion in new federal Medicare spending (table 5).

Financing by state and local governments is more complicated. We assume that half of the change in demand will be realized as savings. That results in $457 million in savings that would partially offset the $1.5 billion in state Medicaid spending (table 6). We did not estimate these savings by state; there would likely be considerable variation.

TABLE 7

Uncompensated Care Spending in Nonexpansion States by Payer, 2024 (millions of dollars)

	Current Law	Medicaid Expansion, ARPA PTCs		President's Proposal	
	Spending	Spending	Change from current law	Spending	Difference from Medicaid expansion
Federal government	8,895	8,164	-731	8,109	-55
State/local government	5,559	5,103	-457	5,068	-34
Health care providers	6,619	5,330	-1,289	5,234	-97
Total	**21,074**	**18,597**	**-2,477**	**18,411**	**-186**

Source: The Urban Institute. Health Insurance Policy Simulation Model, 2023.
Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit. Results simulated for 2024. The President's budget for fiscal year 2024 would provide federally funded, Medicaid-like coverage to individuals not eligible for assistance because their state did not expand Medicaid.

Changes in Federal and State Costs under the President's Budget Proposal

Under the President's proposal of Medicaid-like coverage, more people will enroll in federally funded Marketplace PTCs rather than Medicaid, which is funded by federal and state governments. As a result, the federal government will spend about $8 billion more (table 5) and the state government will save $918 million (table 6) compared with Medicaid expansion in 2024. Besides being entirely funded by the federal government, covering the expansion population through the Marketplaces would also be more expensive because nongroup coverage generally pays health care providers at higher rates than Medicaid.

Spending in Wisconsin would follow a different pattern because they expanded Medicaid eligibility to 100 percent of FPL without accepting the ACA's Medicaid expansion, with the federal government paying a much higher share of the costs of those made newly eligible. As a result, federal spending in Wisconsin would be lower and state spending higher under the president's proposal.

Discussion

Over a decade after the Supreme Court made Medicaid expansion a state option under the ACA, it remains one of the most important health policy questions for states that have not already expanded

eligibility. Most recently, the North Carolina governor signed Medicaid expansion into law, and South Dakota implemented Medicaid expansion in July 2023.

While state policy debates on Medicaid expansion are ongoing, the president's budget for fiscal year 2024 proposed a federal alternative, providing "Medicaid-like" coverage to individuals in nonexpansion states. However, the budget does not outline the details of the provision. In past years, some in Congress have proposed similar federal policies to offer health coverage to those not eligible for assistance because their states have not expanded Medicaid. The most recent proposal was in the Build Back Better Act considered in 2021, which ultimately was not passed by Congress (Holahan et al. 2021).

Gains in and Benefits of Health Coverage

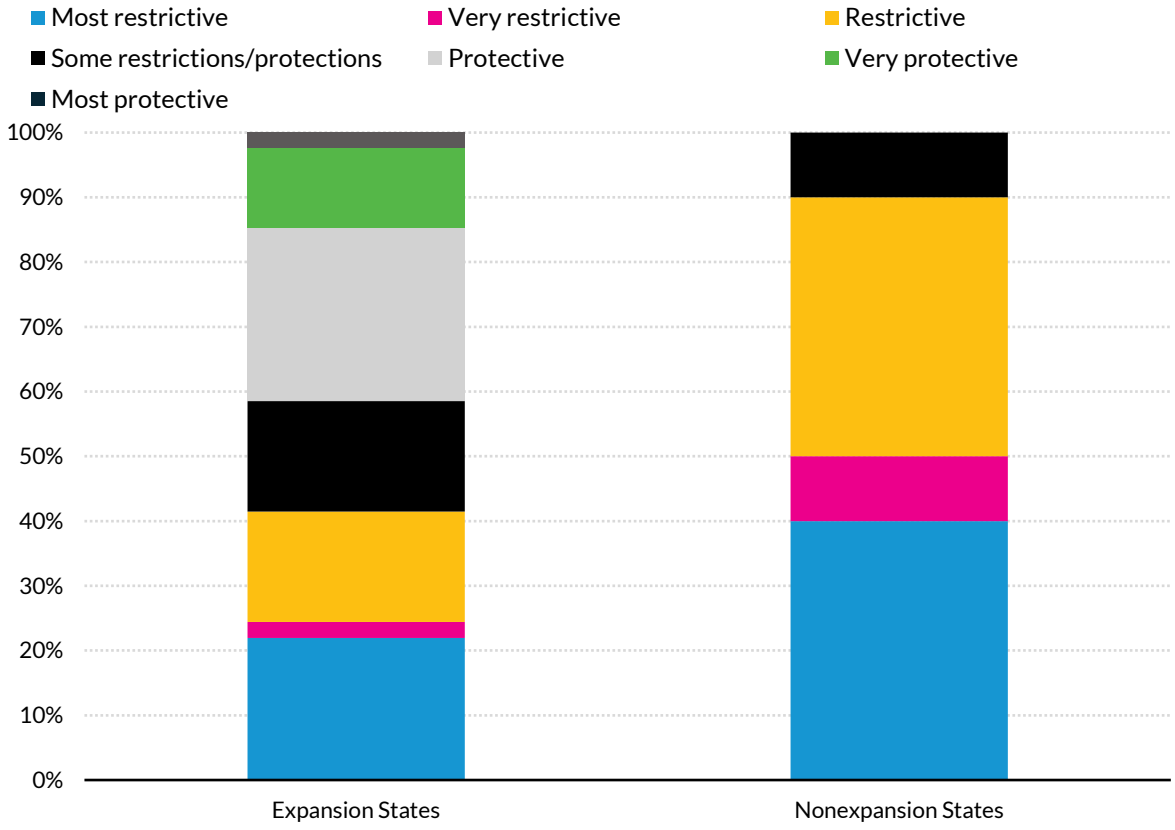
We estimate that 2.3 million fewer people would be uninsured if the remaining 10 states were to expand Medicaid eligibility. In addition, 133,000 people who currently have unregulated, non-ACA-compliant health coverage would be enrolled in Medicaid. Expansion would benefit many historically under-insured or vulnerable groups:

- Non-Hispanic Blacks would see the largest reductions in uninsurance of any racial or ethnic group (43.2 percent); Medicaid expansion would nearly equalize the uninsured rates of non-Hispanic Blacks and non-Hispanic whites in the 10 nonexpansion states (about 5 percent).
- Young adults (age 19 to 34) currently have the highest uninsurance rates of any age group (19.9 percent) and would also see the greatest reductions in uninsurance (32.4 percent).
- Women of reproductive age would see a larger reduction in uninsurance (31 percent) than either older women (23.2 percent) or men (22.4 percent). Health coverage in general and Medicaid expansion in particular are associated with a reduction in unwanted pregnancies and greater access to the most effective methods of contraception (See below). This is particularly relevant in the 2022 Supreme Court decision to eliminate the constitutional right to an abortion.[17] According to data from the Guttmacher Institute, nine of the 10 nonexpansion states are considered restrictive of abortion, while the remaining state has some restrictions and protections (figure 4).[18] By contrast, among the 40 states and the District of Columbia that have expanded Medicaid, only 17 are considered restrictive.
- Non-Hispanic Black women of reproductive age would see a 51.3 percent reduction in uninsurance, the largest change of any group we considered.

- Restrictions on Medicaid eligibility for immigrants, both legally present and undocumented, limit the potential gains in health coverage, particularly in states like Texas and Florida. Hispanics would see the smallest reductions in uninsurance of any racial or ethnic group (16.2 percent) and would continue to have the highest uninsured rate (19.7 percent).

FIGURE 4

State Abortion Access by Medicaid Expansion Status



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Source: The Guttmacher Institute, as of 5/17/2023.

Studies have found Medicaid expansion has many benefits beyond reducing the number of uninsured people:

- **Medicaid expansion saves lives.** At least two studies have found that health coverage under the ACA decreased mortality, and one found a statistically significant reduction in mortality in expansion states compared with nonexpansion states (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2021).

- **Expansion increases the financial security of those gaining health coverage.** Two studies found that Medicaid expansion improved financial security measures, such as credit scores, while reducing financial insecurity measures, such as medical debt collection balances (Caswell and Waidmann 2017; Hu et al. 2016).
- **Expansion can reduce unwanted pregnancies and increase access to effective contraception.** There is evidence that uninsured women are at higher risk than insured women of having an unwanted pregnancy because of their inability to access free or low-cost reproductive health services, including contraception (Grindlay and Grossman 2016). Kavanaugh and Pliskin (2020) found that access to health care was strongly associated with the use of nearly all methods of long-acting and short-acting contraception. Darney et al. (2020) found that Medicaid expansion is associated with increased access to the most effective methods of contraception. Johnston and McMorrow (2020) found that the ACA's expansion in health coverage significantly increased the use of contraception among Black women. This last result is particularly striking, given that we estimate that non-Hispanic Black women of reproductive age would see the highest reduction in uninsurance of any group we considered.
- **Expansion improves hospital finances.** Studies have shown this is achieved through lowered uncompensated care costs (Blavin 2017; Dranove, Garthwaite, and Ody 2017).
- **Expansion improves state economies.** A study in Montana found Medicaid expansion led to an additional $600 million circulating in the state's economy each year, supporting 5,900 to 7,500 jobs and $350 to $385 million in personal income (Ward and Bridge 2019).

Medicaid Expansion Has Often Resulted in Net Savings to State Budgets

If the remaining 10 states were to expand Medicaid eligibility, we estimate that federal spending would increase by $24.3 billion in 2024, or 17.5 percent. This would be partially offset by $731 million in savings on uncompensated care paid for by Medicare disproportionate share hospital payments. State spending on Medicaid would increase by $1.5 billion in 2024, or 3 percent. We estimate that state and local government spending on uncompensated care could decrease by $457 million in 2024, offsetting part of this increase.

However, this does not mean that Medicaid expansion would necessarily increase overall state spending. Though spending on Medicaid claims would increase because of higher caseloads, states could see substantial savings and new revenue. These offsets vary considerably by state but include the following:

- State and local governments save on uncompensated care.
- States receive higher federal matching rates for some beneficiaries who, without expansion, would have been covered through pre-ACA Medicaid eligibility categories. We include this to the extent that we can estimate it, though we may understate potential savings in some states.[19]
- As the federal government spends more on a state's health care, its economic activity increases, thereby increasing tax revenue.[20]
- State taxes on health care providers and health coverage premiums increase revenue.
- Demand decreases for non-Medicaid state-funded programs for low-income uninsured people (separate from uncompensated care).

Most states with comprehensive analyses project net fiscal gains from expansion, even after states begin paying 10 percent of costs for Medicaid expansion enrollees. A study of all expansion states found "no significant increases in spending from state funds as a result of the expansion" by 2015 (Sommers and Gruber 2017). Comprehensive analyses of the budget impact of Medicaid expansion have concluded that, on balance, Medicaid expansion has yielded net gains to state budgets in the following states and the District of Columbia (Sommers and Gruber 2017): Alaska (Evans et al. 2016); Arkansas (Bachrach et al. 2016); California (Sommers and Gruber 2017); Colorado (Brown, Fisher, and Resnick 2016); Kentucky (Deloitte 2015); Louisiana (Louisiana Department of Health 2017); Maryland (Sommers and Gruber 2017); Michigan (Ayanian et al. 2017); New Jersey (NJ DHS 2016); New Mexico (Reynis 2012); Oregon (Sommers and Gruber 2017); Pennsylvania (Sommers and Gruber 2017); Virginia (VA DMAS 2018); Washington State (Dorn et al. 2015); and West Virginia (Sommers and Gruber 2017). Ten of these studies covered calendar year 2020 and beyond, when federal funding for Medicaid expansion will reach its final and lowest matching rate (90 percent). Eight of them found Medicaid expansion's impact on the state budget would be positive over that period. Two analyses projected eventual net budget losses, but these results may not be generalizable to other states.[21]

Under the ARP, the federal government will pay a higher share of the costs of nonexpansion Medicaid enrollees for the first years after a state newly expands Medicaid. During this time, the new federal funding would greatly outweigh any additional state spending on the Medicaid expansion population (Straw et al. 2021). This report shows the long-term impacts of Medicaid expansion, so we did not include this temporary funding in our estimates. It is also not included in any state analyses cited earlier in this section; many expansion states could save money by expanding Medicaid even without this provision.

A Federal Alternative to Medicaid Expansion Would Cost the Federal Government More

Under the president's proposed federal alternative to Medicaid expansion, those gaining eligibility for assistance would be enrolled in the Marketplaces rather than Medicaid. PTCs are funded entirely by the federal government, in contrast with Medicaid and CHIP, which are funded jointly by the state and federal governments. Also, nongroup health insurance generally reimburses health care providers at higher levels than Medicaid and CHIP. As a result, the federal government would spend nearly $8 billion more in 2024 than if all remaining states were to expand Medicaid. Conversely, states would spend $918 million less.

Connections with Other Current Health Policy Issues

In 2020, the Families First Coronavirus Relief Act prevented states from disenrolling people from Medicaid during the Department of Health and Human Services public health emergency unless they specifically ask to be disenrolled. As a result, Medicaid enrollment reached record levels (Buettgens and Green 2022). After the states have resumed normal processing in April 2023, states have up to 14 months to resume normal eligibility processing. This will likely result in more than 16 million enrollees losing Medicaid coverage. In our Medicaid expansion estimates, we assume that these large but temporary enrollment changes have already settled. They will not affect the eventual level of Medicaid enrollment if the remaining states were to expand eligibility.

Conclusion

Expanding Medicaid eligibility or implementing Medicaid-like coverage under the president's budget proposal in the remaining 10 nonexpansion states would reduce the number of uninsured people by 2.3 million in 2024. Having health coverage leads to reduced mortality and increased financial security. Young adults currently have the highest uninsured rate of any age group and would benefit the most from expansion. Women would see a larger increase in health coverage because of Medicaid expansion than men and women of reproductive age would see greater gains than older women. As far as racial and ethnic groups, non-Hispanic Blacks would see the largest increase in coverage, followed by non-Hispanic whites. Hispanics would see smaller, but still substantial, increases in health coverage due mainly to restrictions on Medicaid eligibility by immigration status.

In addition to all these benefits for those gaining coverage, Medicaid expansion improves hospital finances and creates jobs. Many expansion states have found that savings and new revenue because of Medicaid expansion outweigh the state's share of the cost of new Medicaid enrollees. The ARP added a further financial incentive for states newly expanding Medicaid by raising the share of the costs of currently eligible Medicaid enrollees paid for by the federal government for the first two years after expansion. Expanding Medicaid eligibility would thus provide substantial health and economic benefits at little or no cost to state governments.

Notes

[1] However, Medicaid expansion is dependent on the state's 2023–2024 budget being passed, which has not happened as of the time of writing; Jakob Emerson, "North Carolina Medicaid Expansion Unlikely in 2023," *Becker's Payer Issues* (blog), September 5, 2023, https://www.beckerspayer.com/policy-updates/north-carolina-medicaid-expansion-unlikely-in-2023.html.

[2] The White House, "FACT SHEET: The President's Budget for Fiscal Year 2024," The White House, March 9, 2023, https://www.whitehouse.gov/omb/briefing-room/2023/03/09/fact-sheet-the-presidents-budget-for-fiscal-year-2024/.

[3] Past legislative bills to fill the "coverage gap" have been more limited in scope and would cover fewer people. There are no details in the president's budget, so we follow the apparent intention of the proposal. See Holahan et al. 2021.

[4] The Supreme Court's decision in National Federation of Independent Business v. Sebelius (2012) effectively made the ACA's Medicaid expansion voluntary for states.

[5] "Governor Cooper Signs Medicaid Expansion into Law," North Carolina Office of the Governor, March 27, 2023, https://governor.nc.gov/news/press-releases/2023/03/27/governor-cooper-signs-medicaid-expansion-law.

[6] Emerson, "North Carolina Medicaid Expansion Unlikely in 2023."

[7] "Medicaid Expansion and Unwinding 2023," South Dakota Department of Social Services, accessed September 15, 2023.

[8] Some may be eligible for limited benefit programs. For example, low-income pregnant women can qualify for certain benefits during their term of pregnancy.

[9] "Medicaid Income Eligibility Limits for Parents, 2002-2023," KFF, accessed September 15, 2023, https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[10] Legal immigrants who are ineligible for Medicaid because they have been a resident in the US for less than five years are eligible even if their income is below 100 percent of FPL. There is also evidence that some nonimmigrants with lower incomes are enrolled in Marketplace coverage with tax credits—particularly with the enhanced tax credits under the American Rescue Plan Act—largely because income is particularly volatile for low-income workers, who are protected from having to repay tax credits if their annual income ends up below 100 percent of FPL (Buettgens and Banthin 2022).

[11] The White House, "FACT SHEET: The President's Budget for Fiscal Year 2024."

[12] "Marketplace 2023 Open Enrollment Period Report," Centers for Medicare & Medicaid Services, January 25, 2023, https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-final-national-snapshot.

[13] "Table 18: Medicaid and CHIP: June 2017 Monthly Applications and Eligibility Determinations Updated August 2017," Centers for Medicare & Medicaid Services, accessed September 15, 2023; Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data ," Centers for Medicare & Medicaid Services, accessed January 7, 2021, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

[14] Take-up rates during the Department of Health and Human Services public health emergency will be artificially high and not usable for this purpose.

[15] Data on plan selections at the end of the open enrollment period show that 54 percent or more of enrollees of all ages are female in all years since 2014, see "Affordable Care Act Indicators," KFF, accessed September 15, 2023, https://www.kff.org/state-category/affordable-care-act/2023-marketplace-open-enrollment-period/.

[16] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF, accessed September 15, 2023, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[17] Dobbs v. Jackson Women's Health Organization, 597 U. S. ___ (2022).

[18] "Interactive Map: US Abortion Policies and Access After Roe," Guttmacher Institute, accessed April 10, 2023, https://states.guttmacher.org/policies/.

[19] The largest such population is adults in Wisconsin with incomes up to 100 percent of FPL, who are not part of mandatory Medicaid categories, such as those with disabilities and parents with low incomes. We incorporate current beneficiaries who would receive the new eligible match rate into our estimates to the extent they could be identified. Some eligibility groups, such as the medically needy, are difficult to identify using survey data.

[20] Michael Chernew, "The Economics of Medicaid Expansion," *Health Affairs Forefront* (blog), March 21, 2016, https://www.healthaffairs.org/do/10.1377/hblog20160321.054035/full/.

[21] New Mexico's analysis projects net state budget gains until the state fiscal year 2020–21 when a small net adverse budget impact is anticipated. Reynis (2012) notes its revenue estimates are conservative. In Alaska, net state budget losses are forecasted to start in the federal fiscal year 2017. Alaska does not have sales taxes or individual income taxes, so Evans et al. (2016) concluded state general revenue would not be affected by expansion-generated economic activity. Every other state collects sales taxes, individual income taxes, or both, so Alaska's fiscal conditions do not apply to other nonexpansion states; see Lee et al. 2015. Lastly, even Alaska collects corporate income tax, but Evans et al. did not estimate the impact of expansion on such tax revenues.

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