

The Financial Benefit to Hospitals from State Expansion of Medicaid

Timely Analysis of Immediate Health Policy Issues

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Summary

States across the country are debating whether to expand Medicaid eligibility to cover adults with incomes up to 138 percent of the federal poverty level (FPL). Originally mandated by the Patient Protection and Affordable Care Act (ACA), this expansion was essentially transformed into a state option by the U.S. Supreme Court decision last June.

Hospitals have emerged as key participants in the debate. Many argue that Medicaid expansion is essential to protect them from the effect of the ACA's cuts to hospital reimbursement—above all, those involving payments to so-called “Disproportionate Share Hospitals” (DSH). Some disagree, contending that hospitals will not gain from Medicaid expansion, since it undermines more generously reimbursed private coverage.

In this paper, we begin by reviewing Congressional Budget Office (CBO) estimates of the revenue sources used to pay for the ACA's coverage expansion. According to CBO, the ACA will cut DSH funding by \$56 billion during 2013-2022. However, the legislation will also reduce Medicare fee-for-service hospital payments by \$260 billion—more than four times the amount of DSH cuts. By the end of the decade, the latter step alone is expected to lower hospitals' Medicare reimbursement, relative to private levels, by 10.4 percent.

We also use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate both hospitals' increased Medicaid revenue and private revenue reductions resulting from expansion. Altogether, Medicaid expansion would provide hospitals with an additional \$293.9 billion from 2013 to 2022, representing 22.8 percent of what they would have received from Medicaid without the ACA. On the other hand, expansion could cost hospitals \$113.6 billion in private payments, since

expansion would shift some patients into Medicaid from subsidized private coverage in health insurance exchanges and from private employer plans.

Put simply, a Medicaid expansion increases the number of patients for whom hospitals are paid, but some patients shift from private to more poorly reimbursed public coverage. The net result of these two factors greatly favors hospitals. *Altogether, for each dollar in private revenue that a Medicaid expansion eliminates, hospitals' Medicaid revenue rises by \$2.59.*

Even with a Medicaid expansion, hospitals will continue to provide uncompensated care, 46 percent of which, according to this study, will go to patients with incomes at or below 138 percent of FPL. Medicaid expansion could let the ACA's new provision for hospital-based presumptive eligibility cover a sizable portion of these remaining uncompensated care costs.

The ACA's implicit bargain was that, in exchange for major reductions, not just to DSH payments, but also to basic Medicare fee-for-service reimbursement, hospitals would receive increased revenue when formerly uninsured patients obtain health coverage. This was expected to result primarily from two factors: expanded Medicaid eligibility and new subsidies that help low- and moderate-income households buy coverage through health insurance exchanges.

States cannot change what hospitals must pay toward the ACA's coverage expansion. However, state decisions will greatly influence hospitals' offsetting economic gains. Whether the ACA creates net economic pain or gain for hospitals will depend significantly on whether states add Medicaid expansion to the remainder of the federal legislation.

Introduction

The ACA treated hospitals like many other parts of the health care system. Hospitals helped finance new subsidies to cover the low- and moderate-income uninsured. In return, the ACA's coverage expansion offered revenue for newly insured patients.

On June 28, 2012, the Supreme Court issued a landmark decision, *National Federation of Independent Business v. Sebelius*,¹ which placed the future of this tacit bargain squarely in the hands of state-level leaders. Each state must now choose whether to implement the

ACA's expansion of Medicaid eligibility to 138 percent of FPL.

Hospitals across the country have weighed in on this issue. Many have emphasized the need for Medicaid expansion to offset the



financial damage done by the ACA's cuts to Disproportionate Share Hospital (DSH) payments,² while others have also noted the role played by broader Medicare reductions to fee-for-service payments.³ Still others have argued that offsetting losses to private coverage could completely offset any financial gains from Medicaid expansion.⁴

To help hospitals assess their stake in the ACA's Medicaid expansion, we begin by itemizing the financial contributions hospitals will make to support the ACA's coverage expansion. We then analyze the Medicaid expansion's potential impact on the number of uninsured and on hospital financing, nationally and in each state. This analysis incorporates earlier work done by Holahan and colleagues for the Kaiser Commission on Medicaid and the Uninsured,⁵ but we also conduct additional analyses using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM),⁶ using methods described in the methodological appendix.

Many of our analyses compare what would happen, under the ACA, if (a) all states expand Medicaid and (b) no states do so. This lets policy-makers see the state-by-state impact of adding Medicaid expansion to the rest of the ACA. In some cases, constraints in available data limit us to showing effects by region, without state-specific estimates. We conclude that, as a whole, hospitals would benefit financially from Medicaid expansion. That said, the specific ramifications of expansion will vary by state and by hospital.

Most of our estimates show results for the entire 2013–2022 period. However, to give readers a concrete sense of the one-year magnitude of cost and coverage effects in the relatively near future, we also attach appendix tables that show estimated results for 2016.

Hospitals help fund the ACA

The ACA committed roughly \$1.5 trillion during 2012–2022 to cover millions of low- and moderate-income uninsured, according to the CBO.⁷ The law expanded Medicaid to all poor and near-poor residents. It also provided subsidies in health insurance

exchanges (HIXes) for consumers with incomes too high for Medicaid but too low to afford health insurance without an employer's help. CBO nevertheless found that the legislation, as a whole, would reduce the federal budget deficit because of the law's offsetting financing mechanisms, some of which focused directly on hospitals.

CBO projects that, over the next ten years (2013–2022), the ACA will:

- reduce Medicaid DSH funding by \$22 billion;⁸
- lower Medicare DSH funding by \$34 billion;⁹ and
- reduce by \$260 billion future increases to Medicare fee-for-service hospital payments¹⁰—a decline more than four times the size of the ACA's Medicaid and Medicare DSH cuts combined.

The Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) estimates that the latter reduction, by itself, will cause 15 percent of all American hospitals to become unprofitable by 2019; by 2030, it will drive a total of 25 percent into the red.¹¹ Medicare payments will fall from 67 percent of private levels in 2009 to 60 percent by 2020,¹² a 10.4 percent relative decline. By 2030, Medicare hospital payments will average slightly more than 55 percent of private amounts, according to CMS actuaries. These forecasts have been criticized as overstating the likely effects of the ACA's Medicare reductions by failing to take into account that hospitals can respond to lower revenues by improving productivity and lowering costs.

Whether or not the Actuary's concerns prove fully warranted, the ACA's funding mechanisms will significantly reduce hospital reimbursement in each state. By far the largest of these cuts, the elimination of \$260 billion in slated Medicare increases to hospital fee-for-service reimbursement, is completely unaffected by whether a state expands Medicaid. The second-largest of these cuts, to Medicare DSH payments, is likewise unchanged by whether or not a state adopts the Medicaid expansion. Rather, it applies equally throughout the

country, based on the total national decline in the number of uninsured.¹³ A hospital with more uncompensated care can claim additional Medicare DSH reimbursement, but the total amount of such payments will be significantly reduced, regardless of what happens in a particular state.

The smallest of these cuts, to Medicaid DSH payments, will be affected, to some degree, by the number of uninsured within a state.¹⁴ A state that fails to expand Medicaid and so has numerous uninsured may experience a reduction in its Medicaid DSH cuts. This effect should not be exaggerated, however. Medicaid DSH funding is likely to be cut in all states, even those most favored by whatever formula is ultimately adopted by CMS. Moreover, based on the ACA's statutory terms, a state's DSH amount will be influenced by factors other than the number of uninsured, including whether the state limits DSH funding to hospitals with large numbers of uninsured and significant uncompensated care; whether the state was a "high-DSH state" before the ACA; and whether the state used DSH funds to meet budget neutrality requirements for waivers under Section 1115 of the Social Security Act. CMS has not yet explained how each state's DSH cuts will be calculated, but it is already clear that, whether or not a state expands Medicaid, its hospitals will receive fewer Medicaid DSH dollars than before the ACA.

Many hospitals are intensely focused on the ACA's reforms to the health care delivery system and payment methodologies—and for good reason. Bundled payments, accountable care organizations, patient-centered medical homes, penalties for rehospitalization and hospital-acquired conditions, value-based Medicare payments, and many other changes are being implemented in the near-term. But fundamental to the ACA's financing were major reductions to hospital payments, primarily involving Medicare, but also affecting Medicaid. These cuts were premised on an offsetting increase in revenue for the newly insured, but whether such revenues fully materialize now depends on state policy choices, as explored below.

Table 1: The Medicaid Expansion Is an Important Lever for Decreasing the Uninsured Population, 2022 (Thousands)

	Reduction in the Uninsured ¹					
	No ACA	ACA with No States Expanding Medicaid		ACA with All States Expanding Medicaid ²		Incremental Impact of Medicaid Expansion
	Total Uninsured	N	%	N	%	N
US TOTAL	53,277	15,092	28.3%	25,347	47.6%	10,255
Regional Totals³						
New England	1,101	261	23.7%	435	39.5%	174
Middle Atlantic	6,696	1,900	28.4%	2,781	41.5%	881
East North Central	6,307	1,833	29.1%	3,308	52.4%	1,475
West North Central	2,388	615	25.7%	1,135	47.5%	520
South Atlantic	10,059	2,926	29.1%	5,170	51.4%	2,244
East South Central	3,033	937	30.9%	1,768	58.3%	830
West South Central	9,453	3,218	34.0%	5,000	52.9%	1,781
Mountain	4,397	1,289	29.3%	1,892	43.0%	603
Pacific	9,843	2,112	21.5%	3,859	39.2%	1,747
State Totals						
Alabama	711	217	30.5%	457	64.3%	240
Alaska	137	45	32.6%	72	52.4%	27
Arizona	1,420	386	27.2%	438	30.9%	52
Arkansas	574	183	31.8%	329	57.3%	146
California	8,061	1,731	21.5%	3,154	39.1%	1,424
Colorado	868	244	28.1%	402	46.3%	158
Connecticut	405	95	23.3%	181	44.6%	86
Delaware	120	40	33.7%	47	39.5%	7
District of Columbia	70	5	7.8%	25	35.8%	20
Florida	4,181	1,247	29.8%	2,116	50.6%	869
Georgia	2,107	592	28.1%	1,082	51.3%	489
Hawaii	115	17	14.8%	57	49.9%	40
Idaho	251	69	27.5%	125	49.9%	56
Illinois	1,860	489	26.3%	898	48.3%	408
Indiana	867	218	25.2%	487	56.2%	269
Iowa	299	54	18.1%	74	24.8%	20
Kansas	383	80	20.9%	182	47.6%	102
Kentucky	740	227	30.7%	408	55.2%	181
Louisiana	877	256	29.1%	527	60.1%	272
Maine	146	45	30.8%	74	50.6%	29
Maryland	780	189	24.2%	327	42.0%	138
Massachusetts	224	38	16.9%	40	17.8%	2
Michigan	1,372	415	30.2%	632	46.1%	218
Minnesota	467	135	28.8%	177	38.0%	43
Mississippi	562	158	28.1%	327	58.2%	169
Missouri	805	235	29.2%	494	61.3%	259
Montana	184	60	32.4%	98	53.6%	39
Nebraska	238	65	27.1%	113	47.6%	49
Nevada	586	155	26.4%	263	44.8%	108
New Hampshire	138	38	27.9%	65	47.0%	26
New Jersey	1,415	357	25.3%	590	41.7%	233
New Mexico	556	182	32.7%	280	50.4%	98
New York	2,954	915	31.0%	1,086	36.8%	171
North Carolina	1,651	408	24.7%	795	48.1%	387
North Dakota	80	14	17.5%	35	44.5%	22
Ohio	1,627	534	32.8%	991	60.9%	457
Oklahoma	647	226	34.9%	352	54.4%	126
Oregon	690	163	23.6%	353	51.2%	190
Pennsylvania	1,357	393	28.9%	705	52.0%	313
Rhode Island	126	28	21.8%	54	43.1%	27
South Carolina	775	237	30.6%	440	56.7%	203
South Dakota	116	32	27.7%	58	50.5%	26
Tennessee	1,020	335	32.9%	575	56.4%	240
Texas	7,355	2,554	34.7%	3,792	51.6%	1,237
Utah	442	163	36.9%	239	54.0%	76
Vermont	61	18	28.8%	22	35.1%	4
Virginia	1,071	339	31.7%	554	51.7%	215
Washington	840	157	18.7%	223	26.5%	66
West Virginia	273	102	37.5%	184	67.4%	82
Wisconsin	581	177	30.5%	300	51.7%	123
Wyoming	89	30	33.8%	46	51.8%	16

Source: Holahan et al, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," November 2012, Kaiser Commission for Medicaid and the Uninsured

¹ Note that uninsurance depends not only on new Medicaid enrollment, but also other coverage transitions such as movement into the exchanges or ESI takeup.

² Estimates include enrollment changes that would have occurred under the ACA without the Medicaid expansion.

³ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Medicaid Expansion would Greatly Affect Health Coverage and Hospital Revenues

By reducing the number of uninsured, Medicaid expansion would reduce hospital

uncompensated care. While it would modestly reduce private payments, expansion would raise hospitals' Medicaid revenues by a much larger amount. Expansion would also allow much uncompensated care for the remaining uninsured to be covered through Medicaid's new hospital-based presumptive eligibility. This section analyzes these effects.

Medicaid expansion would reduce the number of uninsured, thereby reducing hospital uncompensated care.

Whether or not a state expands Medicaid, the ACA will reduce the number of uninsured, thus lowering hospitals' burden of caring for patients who have no source of covering their hospital stays. New subsidies in HIXes, individual coverage requirements, incentives for employer-sponsored coverage, and streamlined enrollment methods will cause millions of previously uninsured Americans to receive coverage. If no state expands Medicaid, the ACA will lower the number of uninsured by 28 percent as of 2022. However, if all states expand Medicaid, the number of uninsured will decline by a much larger margin—48 percent (Table 1), thus causing a much more significant reduction in the amount of uncompensated care. Even as early as 2016, adding Medicaid expansion to the remainder of the ACA would cause the number of uninsured to fall by 43 percent, rather than 25 percent (Appendix Table A1).

Table 2: Hospitals' Private Revenues Decline Due to Decreased HIX Enrollment Between 100%-138% FPL if All States Expand Medicaid, 2013-2022 (Billions)

	Lost Hospital Revenue	
	\$	
US TOTAL	-92.2	
Regional Totals¹		
New England	-1.4	
Middle Atlantic	-6.4	
East North Central	-12.8	
West North Central	-3.9	
South Atlantic	-25.5	
East South Central	-6.4	
West South Central	-16.3	
Mountain	-6.9	
Pacific	-12.4	

Source: Urban Institute Analysis, HIPSMS 2012

Note: In allotting HIX premiums to hospital care, we used the projected distribution of private insurance payments, by service, from National Health Expenditure future estimates released by the CMS Office of the Actuary.

¹ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Table 3: Crowd-Out Under the Medicaid Expansion will Cause a Small Reduction in Hospitals' Private Insurance Revenues, 2013-2022 (Billions)

	Lost Private Hospital Revenue Due to Crowd-Out		
	Under the ACA with No States Expanding Medicaid	Under the ACA with All States Expanding Medicaid ¹	Incremental Impact of Medicaid Expansion
	\$		
US TOTAL	-7.2	-28.6	-21.4
Regional Totals²			
New England	-1.0	-1.4	-0.4
Middle Atlantic	-1.9	-4.2	-2.2
East North Central	-1.2	-4.4	-3.3
West North Central	-0.3	-1.9	-1.6
South Atlantic	-0.7	-5.1	-4.4
East South Central	-0.1	-1.9	-1.8
West South Central	-0.2	-2.6	-2.4
Mountain	-0.5	-1.9	-1.4
Pacific	-1.3	-5.2	-3.9

Source: Urban Institute Analysis, HIPSMS 2012

¹ Estimates include enrollment and expenditure changes that would have occurred under the ACA without the Medicaid expansion.

² The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Controlling for multiple factors, Hadley et al. showed that much more uncompensated care is incurred by the uninsured than the insured.¹⁵ For example, when Massachusetts' 2006 health reforms reduced the number of uninsured, uncompensated care payments declined by almost 40 percent in the first full year under the new law.¹⁶

Medicaid expansion would lower private insurance payments to hospitals.

Medicaid expansion would reduce hospitals' private revenue for two reasons. First, it would make citizens and qualified immigrants ineligible for subsidies in the HIX if they have incomes between 100 percent and 138 percent of FPL. (With an expansion, they would qualify for Medicaid and so lose eligibility for HIX subsidies.)¹⁷ If all states expand Medicaid, the resulting loss in hospital revenue from HIX plans will total \$92.2 billion from 2013 to 2022 (Table 2), including \$9.0 billion in 2016 (Appendix Table A2).

Second, "crowd-out" would reduce hospitals' private insurance revenue for patients outside the subsidized HIX. Past experience teaches that increased Medicaid

Table 4: The Medicaid Expansion will Lead to a Significant Increase in Medicaid Hospital Revenues, 2013-2022 (Billions)

	Total Medicaid Payments to Hospitals			Increase in Medicaid Hospital Revenues Under the ACA ¹			
	No ACA	ACA with No States Expanding Medicaid	ACA with All States Expanding Medicaid ²	Increase in Revenues with No States Expanding Medicaid		Incremental Impact of Medicaid Expansion on Revenues	
	\$	\$	\$	\$	%	\$	%
US TOTAL	1,288.3	1,335.6	1,629.5	47.3	3.7%	293.9	22.8%
Regional Totals³							
New England	58.4	61.6	66.7	3.2	5.5%	5.1	8.7%
Middle Atlantic	170.9	181.3	204.8	10.4	6.1%	23.5	13.8%
East North Central	134.0	140.6	183.8	6.6	4.9%	43.2	32.2%
West North Central	50.3	51.7	66.4	1.4	2.9%	14.7	29.2%
South Atlantic	184.9	190.4	252.0	5.5	3.0%	61.6	33.3%
East South Central	130.1	132.0	158.0	1.9	1.5%	25.9	19.9%
West South Central	156.9	160.9	212.0	4.0	2.5%	51.1	32.6%
Mountain	71.4	75.2	96.7	3.9	5.4%	21.5	30.1%
Pacific	331.4	341.7	389.0	10.3	3.1%	47.3	14.3%
State Totals							
Alabama	43.8	44.1	51.1	0.3	0.7%	7.0	16.0%
Alaska	2.6	2.6	3.2	0.1	2.1%	0.6	25.1%
Arizona	31.5	34.0	39.2	2.5	7.9%	5.2	16.4%
Arkansas	15.4	15.8	20.5	0.3	2.1%	4.7	30.3%
California	280.6	289.4	325.0	8.8	3.2%	35.6	12.7%
Colorado	13.9	14.1	18.1	0.3	1.9%	3.9	28.4%
Connecticut	9.0	9.4	12.0	0.5	5.1%	2.6	28.6%
Delaware	2.3	2.6	2.8	0.3	14.1%	0.3	11.1%
District of Columbia	3.7	3.8	4.3	0.0	1.2%	0.5	13.1%
Florida	49.8	51.9	74.4	2.0	4.1%	22.6	45.3%
Georgia	29.8	31.0	43.8	1.2	3.9%	12.8	42.8%
Hawaii	5.3	5.5	6.6	0.2	3.7%	1.1	19.7%
Idaho	3.5	3.5	5.0	0.0	0.0%	1.5	44.4%
Illinois	40.4	42.4	51.9	2.0	4.9%	9.5	23.5%
Indiana	10.6	10.9	20.1	0.3	3.3%	9.2	86.9%
Iowa	7.9	8.2	9.2	0.4	4.6%	1.0	12.7%
Kansas	7.9	8.2	10.7	0.2	3.1%	2.6	32.5%
Kentucky	19.3	19.6	26.1	0.3	1.6%	6.4	33.3%
Louisiana	47.7	48.1	56.0	0.3	0.7%	8.0	16.7%
Maine	6.2	6.3	7.2	0.1	1.0%	0.9	14.7%
Maryland	11.1	11.6	13.9	0.5	4.1%	2.3	21.0%
Massachusetts	37.2	39.7	39.8	2.5	6.6%	0.1	0.3%
Michigan	25.3	28.1	34.3	2.8	11.3%	6.2	24.4%
Minnesota	8.8	9.2	10.6	0.4	4.4%	1.4	15.9%
Mississippi	31.6	31.7	36.5	0.1	0.3%	4.8	15.1%
Missouri	17.0	17.2	24.0	0.2	1.3%	6.8	39.7%
Montana	2.1	2.3	3.4	0.2	10.7%	1.1	51.8%
Nebraska	5.9	6.0	7.5	0.1	1.5%	1.6	26.6%
Nevada	4.0	4.3	7.1	0.3	7.4%	2.8	70.0%
New Hampshire	1.5	1.6	2.4	0.1	3.4%	0.8	50.2%
New Jersey	18.3	19.2	24.1	0.9	4.8%	5.0	27.2%
New Mexico	12.8	13.1	16.6	0.2	1.9%	3.5	27.4%
New York	100.2	108.2	113.1	8.0	8.0%	4.9	4.9%
North Carolina	29.1	30.2	41.5	1.2	4.0%	11.3	39.0%
North Dakota	1.0	1.2	1.8	0.1	11.3%	0.6	58.3%
Ohio	44.2	45.0	59.6	0.9	2.0%	14.6	33.1%
Oklahoma	14.9	15.2	19.4	0.3	2.0%	4.1	27.5%
Oregon	10.2	10.6	17.9	0.5	4.6%	7.3	71.9%
Pennsylvania	35.3	36.0	46.6	0.7	2.0%	10.6	30.0%
Rhode Island	2.0	2.1	2.8	0.1	2.6%	0.7	34.6%
South Carolina	41.0	41.4	47.6	0.4	0.9%	6.2	15.2%
South Dakota	1.8	1.8	2.6	0.0	0.3%	0.8	44.7%
Tennessee	35.4	36.6	44.3	1.2	3.3%	7.7	21.7%
Texas	78.8	81.9	116.2	3.0	3.8%	34.3	43.6%
Utah	2.5	2.9	5.9	0.3	12.8%	3.1	120.1%
Vermont	2.4	2.6	2.6	0.2	6.3%	0.0	1.2%
Virginia	21.6	22.3	28.5	0.7	3.2%	6.2	28.7%
Washington	32.8	33.5	36.2	0.7	2.2%	2.7	8.2%
West Virginia	13.6	13.6	16.1	0.1	0.5%	2.5	18.7%
Wisconsin	13.6	14.1	17.9	0.6	4.1%	3.7	27.5%
Wyoming	1.1	1.1	1.6	0.0	4.2%	0.4	39.8%

Source: Urban Institute Analysis, HIPS 2012

¹ Note that percentages are relative to hospitals' non-ACA revenue.

² Estimates include enrollment changes that would have occurred under the ACA without the Medicaid expansion.

³ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

enrollment leads to a modest reduction in employer-sponsored insurance (ESI) and individually purchased coverage. Some of that will occur without a Medicaid expansion; as suggested earlier, Medicaid participation levels among currently eligible consumers will rise due to other ACA provisions, including publicity around health reform and the automatic routing

of health coverage applications from HIXes to Medicaid programs. But participation levels will increase much more if Medicaid eligibility expands.

If the erosion of private coverage in response to the ACA follows the patterns of earlier state reforms, then implementing the ACA with no states expanding Medicaid

would crowd out \$7.2 billion in hospitals' private reimbursement during 2013–2022; if all states expand Medicaid, hospitals would lose \$28.6 billion; so adding Medicaid expansion to the rest of the ACA would cost hospitals \$21.4 billion (Table 3). In 2016, this net loss would amount to \$2.1 billion (Appendix Table A3).

Hospitals' increased Medicaid revenue due to expansion would greatly exceed their loss of private payments.

With a Medicaid expansion, some patients would shift from private coverage to more poorly reimbursed public coverage. On average, private payment rates are 38 percent higher than Medicaid payment rates, based on a Milliman analysis of 2006 American Hospital Association Survey data.¹⁸ On the other hand, hospitals would be paid for many more patients. The net effect of these two offsetting trends is that overall hospital revenue would rise.¹⁹

Without a Medicaid expansion, the ACA would increase hospitals' Medicaid revenue by \$47.3 billion from 2013 to 2022, representing 3.7 percent of the total amount hospitals would receive in the absence of the ACA (non-ACA revenue). If all states expand Medicaid, hospitals would receive an additional \$293.9 billion, amounting to another 22.8 percent of non-ACA revenue (Table 4). *For each dollar in private revenue that a Medicaid expansion would eliminate in the average state from 2013 to 2022, the expansion would increase hospital Medicaid revenue by \$2.59* (Table 5a). In 2016, this ratio is slightly lower at 2.51, when \$27.9 billion in increased Medicaid revenue is offset by a loss of \$11.1 billion in private revenue (Table 5b).

This analysis understates the net benefits of Medicaid expansion to hospitals by assuming that plans in the HIX would pay reimbursement like that offered by current private insurance. In fact, HIXes favor plans with low premiums, since the second-lowest-cost plan with a “silver” level of actuarial value determines the amount of premium subsidies. Subsidized consumers who select a more costly plan must pay the full difference in premiums. Many observers expect HIX plans to respond to this incentive by offering coverage with

Table 5a: The Medicaid Expansion will Increase Hospital Revenues Overall, 2013-2022 (Billions)

	Incremental Impact of Medicaid Expansion			
	Hospitals' Increased Medicaid Revenues	Hospitals' Reduced Private Revenues	Net Change in Hospital Revenue	Ratio of Increased Medicaid Revenue to Decreased Private Revenue
	\$	\$	\$	N
US TOTAL	293.9	-113.6	180.3	2.59
Regional Totals¹				
New England	5.1	-1.8	3.2	2.76
Middle Atlantic	23.5	-8.6	14.9	2.72
East North Central	43.2	-16.1	27.1	2.68
West North Central	14.7	-5.6	9.1	2.64
South Atlantic	61.6	-29.9	31.7	2.06
East South Central	25.9	-8.2	17.7	3.16
West South Central	51.1	-18.7	32.4	2.73
Mountain	21.5	-8.4	13.2	2.57
Pacific	47.3	-16.2	31.1	2.92

Source: Urban Institute Analysis, HIPSIM 2012

¹ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Table 5b: The Medicaid Expansion will Increase Hospital Revenues Overall, 2016 (Billions)

	Incremental Impact of Medicaid Expansion			
	Hospitals' Increased Medicaid Revenues	Hospitals' Reduced Private Revenues	Net Change in Hospital Revenue	Ratio of Increased Medicaid Revenue to Decreased Private Revenue
	\$	\$	\$	N
US TOTAL	27.9	-11.1	16.8	2.51
Regional Totals¹				
New England	0.5	-0.2	0.3	2.48
Middle Atlantic	2.3	-0.8	1.4	2.65
East North Central	4.1	-1.6	2.5	2.61
West North Central	1.4	-0.5	0.9	2.57
South Atlantic	5.9	-2.9	2.9	2.00
East South Central	2.5	-0.8	1.7	3.07
West South Central	4.8	-1.8	3.0	2.65
Mountain	2.0	-0.8	1.2	2.49
Pacific	4.5	-1.6	2.9	2.83

Source: Urban Institute Analysis, HIPSIM 2012

¹ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

narrower, more poorly reimbursed provider networks than characterize most private insurance today—in effect, shrinking the difference between Medicaid and private reimbursement rates.

Through presumptive eligibility, a Medicaid expansion could further reduce hospitals' uncompensated care costs.

Even under the ACA with a Medicaid expansion, many consumers will remain uninsured. Some will not qualify for assistance, others will be eligible for but not join insurance affordability programs, and still others will be offered ESI that they refuse. As a result, hospitals will continue to face uncompensated care burdens. During the 2013–2022 period, an estimated 46 percent of all hospital uncompensated care will be provided to consumers with incomes at or below 138 percent of FPL (data not shown). In a state that expands Medicaid to that income level, a significant portion of these remaining uncompensated care costs could be covered through hospital-based presumptive eligibility.

Under ACA Section 2202, each hospital participating in the Medicaid program can choose to be a “qualified entity” that gives its patients short-term, presumptive Medicaid eligibility whenever the hospital receives “preliminary information” showing the patient’s financial eligibility. States cannot prevent such hospitals from assuming this role, as long as they follow state procedures for establishing presumptive eligibility.²⁰

This short-term coverage encompasses all Medicaid services, including outpatient and ambulatory care.¹⁹ It is not limited to emergencies. It is available from the date of service, whenever that falls within the month. As a result, a hospital need not forgo revenue while the patient waits for the

first day of the month, the traditional start date for commercial coverage.

How long presumptive eligibility lasts depends on whether the patient applies for regular Medicaid. Presumptive eligibility ends if the patient fails to apply by the end of month following the month in which presumptive eligibility began. For example, if a patient qualifies as presumptively eligible on a February day and the patient does not apply for regular Medicaid by the end of March, presumptive eligibility ends after March 31. If a patient submits a timely application for regular Medicaid, presumptive eligibility continues until the patient’s eligibility for regular Medicaid is determined.²⁰

In states that implement the Medicaid expansion, hospitals can extend presumptive eligibility to any uninsured person under age 65 whose income, based on preliminary information, appears to fall below 138 percent of FPL. However, under CMS’s proposed regulations,²³ a state Medicaid program can:

- require not just preliminary information showing financial eligibility, but also patient attestations of citizenship or satisfactory immigration status;²⁴
- limit hospital-based presumptive eligibility to Medicaid categories based on modified adjusted gross income or extend it to other categories as well, such as for people with disabilities;
- require hospitals, when they grant presumptive eligibility, to help their patients complete an application for regular Medicaid coverage; and
- limit presumptive eligibility to hospitals that meet state-specified standards for a minimum percentage of presumptively eligible patients who submit regular Medicaid applications or who receive ongoing Medicaid.

States may implement additional policies that prevent presumptive eligibility from covering all uncompensated care furnished to patients with Medicaid-level incomes. For example, states may (and perhaps must) limit the number of presumptive eligibility periods a patient can receive during the year.²⁵ Indigent, uninsured patients who are repeatedly hospitalized may thus incur uncompensated care costs after the first or second spell of illness that cannot be covered by presumptive eligibility. But presumptive eligibility can still result in offsetting much of the uncompensated care that would be provided to those with Medicaid-level income.

Conclusion

Federal lawmakers who passed the ACA offered hospitals an implicit bargain: help fund the ACA’s coverage expansions by giving up some Medicaid and Medicare reimbursement, and in return receive new revenue when formerly uninsured patients enroll in Medicaid or private coverage.

Last June, the Supreme Court placed the fate of this implicit bargain in state hands. Regardless of what each state decides, its hospitals will help pay for the ACA. But whether hospitals receive the ACA’s promised financial rewards depends on state decisions about Medicaid expansion. Although expansion would reduce hospitals’ private payments, the accompanying boost to Medicaid revenue is over 2.5 times the size of those losses in the average state, even without considering the potentially significant benefits of hospital-based presumptive eligibility in further reducing uncompensated care burdens.

Put simply, hospitals’ financial pain from the ACA remains mandatory. But the extent of their offsetting gains now depends significantly on whether state leaders decide to expand Medicaid.

Methodological Appendix

To estimate the effects of health reform and the Medicaid expansion, we use the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM).²⁶ As detailed in previous work,²⁷ we analyze the effect of the Medicaid expansion by simulating three scenarios: no ACA, ACA with no states implementing the Medicaid expansion, and ACA with all states implementing the Medicaid expansion. Our “No ACA” baseline is derived from published CBO projections²⁸ of Medicaid expenditures under current law and the impact of the ACA, as well as state-level data from the Medicaid Statistical Information System (MSIS).

In simulating implementation of the ACA with and without the Medicaid expansion, the sole difference between scenarios is the presence of the Medicaid expansion. Both scenarios include other provisions of the ACA that affect the enrollment of current Medicaid eligibles, such as the individual mandate, the no-wrong-door interface and eligibility simplification. As such, there is an increase in Medicaid enrollment even without an expansion. Comparing these two simulations provides us with an estimate of the incremental impact of the expansion.

Instead of applying uniform assumptions about Medicaid participation rates and costs, we allow these factors to vary based on individual characteristics such as health status and non-ACA coverage. In other words, participation rates and average costs are not model inputs, but rather outcomes. We find that Medicaid take-up increases from approximately 64 percent without the

ACA to about 72 percent under the ACA with all states implementing Medicaid. Average costs grow from \$5,440 in 2016 to \$7,399 in 2022. Per capita costs among currently eligible adults are higher than those of newly eligible adults. However, since the currently eligible population includes more children, the average costs of new eligibles are higher than those of current eligibles overall.

As part of understanding the fiscal impact of the expansion, we model both state and federal shares of Medicaid costs. Under the ACA with and without the expansion, states continue to receive their current federal medical assistance percentage (FMAP) for new enrollment of current eligibles. We also assume that the matching rate for the Children’s Health Insurance Program (CHIP) will increase by 23 percentage points, to a maximum of 100 percent, as specified in the ACA. If states do implement the Medicaid expansion, newly eligible adults will draw an enhanced FMAP (100 percent from 2014 to 2016 then phasing down to 90 percent in 2020 and beyond). Additionally, we identify 11 states²⁹ that have enacted limited benefits Medicaid programs: Connecticut, Hawaii, Indiana, Iowa, Maryland, Minnesota, New Mexico, Oregon, Utah, Washington, and Wisconsin. These states will receive the new eligible rate for the adults who qualify for those limited benefit programs. States that have expanded Medicaid eligibility to include all adults below 100 percent of FPL will also receive a higher FMAP for the childless adults (gradually rising to 93 percent in 2019 and 90 percent in

2020 and thereafter). Seven states fall into this category: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont.

Our estimates of hospital expenditure are based on three years of data from the 2005–2007 Medical Expenditure Panel Survey (MEPS). The MEPS provides hospital expenditure by coverage type, which we aggregate into a measure of total expenditure. In order to estimate how hospitalization expenditure would change if an individual switches coverage types, we employ a two-stage regression approach: first, we predict the probability of having any hospital expenditure after a coverage switch; second, conditional on having a nonzero expenditure, we predict the level of that expenditure in the second stage. This “other-state” approach has been explained in detail in previous work.³⁰

According to a Milliman analysis of 2006 American Hospital Association Survey data, commercial payment rates are 138 percent of Medicaid payment rates.³¹ The results of our “other state” regression show that, if the analysis controls for population risk factors such as age, gender, and health status, the difference in hospital expenditures between Medicaid and private tends to be less than the payment differential. Even with access constraints, the lower cost-sharing of Medicaid leads to somewhat higher use of hospital services. However, we use the full payment rate differential for this report in order to illustrate that hospital revenue would be higher under the Medicaid expansion even without considering this moral hazard effect.

Appendix Tables

Table A1: The Medicaid Expansion Is an Important Lever for Decreasing the Uninsured Population, 2016 (Thousands)

	Reduction in the Uninsured ¹					
	No ACA	ACA with No States Expanding Medicaid		ACA with All States Expanding Medicaid ²		Incremental Impact of Medicaid Expansion
	Total Uninsured	N	%	N	%	N
US TOTAL	52,005	13,236	25.5%	22,406	43.1%	9,170
Regional Totals³						
New England	1,074	202	18.8%	332	30.9%	130
Middle Atlantic	6,536	1,682	25.7%	2,478	37.9%	796
East North Central	6,156	1,596	25.9%	2,922	47.5%	1,326
West North Central	2,331	536	23.0%	1,002	43.0%	466
South Atlantic	9,819	2,555	26.0%	4,578	46.6%	2,022
East South Central	2,961	821	27.7%	1,562	52.8%	741
West South Central	9,227	2,837	30.7%	4,434	48.1%	1,597
Mountain	4,292	1,144	26.7%	1,687	39.3%	543
Pacific	9,608	1,862	19.4%	3,411	35.5%	1,548
State Totals						
Alabama	694	189	27.2%	404	58.2%	215
Alaska	133	39	29.3%	63	47.3%	24
Arizona	1,386	352	25.4%	398	28.7%	46
Arkansas	560	160	28.5%	290	51.8%	130
California	7,869	1,527	19.4%	2,788	35.4%	1,261
Colorado	848	212	25.0%	355	41.9%	144
Connecticut	395	81	20.5%	159	40.2%	78
Delaware	117	36	30.8%	43	36.3%	7
District of Columbia	68	4	5.4%	22	31.6%	18
Florida	4,082	1,092	26.8%	1,878	46.0%	786
Georgia	2,057	518	25.2%	959	46.6%	441
Hawaii	112	14	12.5%	50	44.9%	36
Idaho	245	60	24.4%	111	45.1%	51
Illinois	1,816	429	23.6%	795	43.8%	366
Indiana	846	188	22.2%	428	50.6%	240
Iowa	292	47	16.0%	64	21.9%	17
Kansas	374	68	18.3%	161	43.1%	93
Kentucky	722	199	27.5%	359	49.7%	161
Louisiana	856	221	25.8%	466	54.4%	245
Maine	143	39	27.4%	65	45.5%	26
Maryland	762	166	21.9%	289	38.0%	123
Massachusetts	219	10	4.6%	-15	-6.8%	-25
Michigan	1,339	361	26.9%	559	41.7%	198
Minnesota	456	121	26.5%	159	34.8%	38
Mississippi	549	140	25.5%	291	53.0%	151
Missouri	786	205	26.1%	436	55.5%	231
Montana	179	52	29.0%	88	48.9%	36
Nebraska	233	56	24.2%	100	43.0%	44
Nevada	572	139	24.3%	234	40.9%	95
New Hampshire	135	33	24.4%	57	42.2%	24
New Jersey	1,381	319	23.1%	526	38.1%	207
New Mexico	543	160	29.4%	248	45.7%	89
New York	2,883	816	28.3%	974	33.8%	158
North Carolina	1,612	355	22.0%	703	43.6%	348
North Dakota	78	11	14.6%	31	40.0%	20
Ohio	1,588	466	29.4%	877	55.2%	411
Oklahoma	631	198	31.3%	310	49.1%	113
Oregon	674	141	21.0%	312	46.3%	171
Pennsylvania	1,325	342	25.8%	625	47.2%	284
Rhode Island	123	24	19.3%	47	38.5%	24
South Carolina	757	207	27.4%	388	51.3%	181
South Dakota	113	28	24.5%	51	45.4%	23
Tennessee	996	294	29.5%	509	51.1%	214
Texas	7,180	2,258	31.5%	3,368	46.9%	1,110
Utah	431	143	33.1%	212	49.2%	69
Vermont	60	16	26.0%	19	31.5%	3
Virginia	1,045	293	28.0%	487	46.6%	194
Washington	820	141	17.2%	197	24.0%	56
West Virginia	266	89	33.6%	162	60.8%	73
Wisconsin	567	152	26.9%	263	46.4%	111
Wyoming	87	27	30.6%	41	47.2%	14

Source: Holahan et al, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," November 2012, Kaiser Commission for Medicaid and the Uninsured

¹ Note that uninsurance depends not only on new Medicaid enrollment, but also other coverage transitions such as movement into the exchanges or ESI take-up.

² Estimates include enrollment changes that would have occurred under the ACA without the Medicaid expansion.

³ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Table A2: Hospitals' Private Revenues Decline Due to Decreased HIX Enrollment Between 100%-138% FPL if All States Expand Medicaid, 2016 (Billions)

	Lost Hospital Revenue	
	\$	
US TOTAL		-9.0
Regional Totals¹		
New England		-0.2
Middle Atlantic		-0.6
East North Central		-1.3
West North Central		-0.4
South Atlantic		-2.5
East South Central		-0.6
West South Central		-1.6
Mountain		-0.7
Pacific		-1.2

Source: Urban Institute Analysis, HIPSM 2012

Note: In allotting HIX premiums to hospital care, we used the projected distribution of private insurance payments, by service, from National Health Expenditure future estimates released by the CMS Office of the Actuary.

¹ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Table A3: Crowd-Out Under the Medicaid Expansion will Cause a Small Reduction in Hospitals' Private Insurance Revenues, 2016 (Billions)

	Lost Private Hospital Revenue Due to Crowd-Out		
	Under the ACA with No States Expanding Medicaid	Under the ACA with All States Expanding Medicaid ¹	Incremental Impact of Medicaid Expansion
	\$	\$	\$
US TOTAL	-0.7	-2.8	-2.1
Regional Totals²			
New England	-0.1	-0.1	-0.0
Middle Atlantic	-0.2	-0.4	-0.2
East North Central	-0.1	-0.4	-0.3
West North Central	0.0	-0.2	-0.2
South Atlantic	-0.1	-0.5	-0.4
East South Central	0.0	-0.2	-0.2
West South Central	0.0	-0.2	-0.2
Mountain	0.0	-0.2	-0.1
Pacific	-0.1	-0.5	-0.4

Source: Urban Institute Analysis, HIPSM 2012

¹ Estimates include enrollment changes that would have occurred under the ACA without the Medicaid expansion.

² The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Table A4: The Medicaid Expansion will Lead to a Significant Increase in Medicaid Hospital Revenues, 2016 (Billions)

	Total Medicaid Payments to Hospitals			Increase in Medicaid Hospital Revenues Under the ACA ¹			
	No ACA	ACA with No States Expanding Medicaid	ACA with All States Expanding Medicaid ²	Increase in Revenues with No States Expanding Medicaid		Incremental Impact of Medicaid Expansion on Revenues	
	\$	\$	\$	\$	%	\$	%
US TOTAL	119.1	123.5	151.5	4.4	3.7%	27.9	23.4%
Regional Totals³							
New England	5.4	5.7	6.2	0.3	5.6%	0.5	8.9%
Middle Atlantic	15.8	16.8	19.0	1.0	6.2%	2.3	14.3%
East North Central	12.4	13.0	17.1	0.6	5.0%	4.1	33.1%
West North Central	4.7	4.8	6.2	0.1	2.9%	1.4	30.2%
South Atlantic	17.1	17.6	23.5	0.5	3.0%	5.9	34.2%
East South Central	12.0	12.2	14.7	0.2	1.5%	2.5	20.4%
West South Central	14.5	14.9	19.7	0.4	2.6%	4.8	33.3%
Mountain	6.6	7.0	9.0	0.4	5.5%	2.0	30.9%
Pacific	30.6	31.6	36.1	1.0	3.1%	4.5	14.7%
State Totals							
Alabama	4.1	4.1	4.7	0.0	0.7%	0.7	16.3%
Alaska	0.2	0.2	0.3	0.0	2.1%	0.1	25.7%
Arizona	2.9	3.1	3.6	0.2	8.0%	0.5	16.7%
Arkansas	1.4	1.5	1.9	0.0	2.2%	0.4	31.0%
California	25.9	26.8	30.2	0.8	3.2%	3.4	13.1%
Colorado	1.3	1.3	1.7	0.0	1.9%	0.4	29.4%
Connecticut	0.8	0.9	1.1	0.0	5.1%	0.2	28.9%
Delaware	0.2	0.2	0.3	0.0	14.4%	0.0	11.5%
District of Columbia	0.3	0.3	0.4	0.0	1.2%	0.0	13.7%
Florida	4.6	4.8	6.9	0.2	4.2%	2.1	46.6%
Georgia	2.8	2.9	4.1	0.1	4.0%	1.2	44.0%
Hawaii	0.5	0.5	0.6	0.0	3.6%	0.1	20.2%
Idaho	0.3	0.3	0.5	0.0	0.0%	0.1	45.8%
Illinois	3.7	3.9	4.8	0.2	4.9%	0.9	24.3%
Indiana	1.0	1.0	1.9	0.0	3.3%	0.9	88.2%
Iowa	0.7	0.8	0.9	0.0	4.7%	0.1	13.0%
Kansas	0.7	0.8	1.0	0.0	3.2%	0.2	33.7%
Kentucky	1.8	1.8	2.4	0.0	1.6%	0.6	34.0%
Louisiana	4.4	4.4	5.2	0.0	0.7%	0.8	17.2%
Maine	0.6	0.6	0.7	0.0	1.0%	0.1	15.2%
Maryland	1.0	1.1	1.3	0.0	4.0%	0.2	21.5%
Massachusetts	3.4	3.7	3.7	0.2	6.7%	0.0	0.3%
Michigan	2.3	2.6	3.2	0.3	11.4%	0.6	25.0%
Minnesota	0.8	0.9	1.0	0.0	4.5%	0.1	16.7%
Mississippi	2.9	2.9	3.4	0.0	0.3%	0.5	15.5%
Missouri	1.6	1.6	2.2	0.0	1.3%	0.6	40.8%
Montana	0.2	0.2	0.3	0.0	10.8%	0.1	53.7%
Nebraska	0.5	0.6	0.7	0.0	1.5%	0.1	27.4%
Nevada	0.4	0.4	0.7	0.0	7.5%	0.3	71.9%
New Hampshire	0.1	0.1	0.2	0.0	3.4%	0.1	51.8%
New Jersey	1.7	1.8	2.2	0.1	4.8%	0.5	28.0%
New Mexico	1.2	1.2	1.5	0.0	1.9%	0.3	27.8%
New York	9.3	10.0	10.5	0.8	8.1%	0.5	5.0%
North Carolina	2.7	2.8	3.9	0.1	4.0%	1.1	39.9%
North Dakota	0.1	0.1	0.2	0.0	11.4%	0.1	60.6%
Ohio	4.1	4.2	5.6	0.1	2.0%	1.4	34.0%
Oklahoma	1.4	1.4	1.8	0.0	2.0%	0.4	28.2%
Oregon	0.9	1.0	1.7	0.0	4.7%	0.7	72.8%
Pennsylvania	3.3	3.3	4.3	0.1	2.0%	1.0	31.2%
Rhode Island	0.2	0.2	0.3	0.0	2.7%	0.1	35.8%
South Carolina	3.8	3.8	4.4	0.0	1.0%	0.6	15.6%
South Dakota	0.2	0.2	0.2	0.0	0.3%	0.1	46.3%
Tennessee	3.3	3.4	4.1	0.1	3.4%	0.7	22.4%
Texas	7.3	7.6	10.8	0.3	3.9%	3.2	44.5%
Utah	0.2	0.3	0.6	0.0	13.0%	0.3	122.0%
Vermont	0.2	0.2	0.2	0.0	6.3%	0.0	1.3%
Virginia	2.0	2.1	2.7	0.1	3.3%	0.6	29.6%
Washington	3.0	3.1	3.4	0.1	2.3%	0.3	8.5%
West Virginia	1.3	1.3	1.5	0.0	0.5%	0.2	19.1%
Wisconsin	1.3	1.3	1.7	0.1	4.1%	0.4	28.6%
Wyoming	0.1	0.1	0.1	0.0	4.3%	0.0	41.2%

Source: Urban Institute Analysis, HPSM 2012

¹ Note that percentages are relative to hospitals' non-ACA revenue.

² Estimates include enrollment changes that would have occurred under the ACA without the Medicaid expansion.

³ The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

Endnotes

- ¹ 132 S. Ct. 2566 (2012).
- ² See, e.g., Crisp E, “Hospitals sound warnings about bypassing Medicaid expansion,” *St. Louis Post-Dispatch*, August 06, 2012, http://www.stltoday.com/news/local/govt-and-politics/hospitals-sound-warnings-about-bypassing-medicaid-expansion/article_0267a239-d5e3-5178-8780-f385a8867208.html; Nave RL, “Jackson Health Exec Touts Medicaid Expansion Benefits,” *Jackson Free Press*, March 8, 2013, <http://www.jacksonfreepress.com/news/2013/mar/08/jackson-health-exec-touts-medicaid-expansion-benefit/>.
- ³ *Health Care Finance in Texas, 2013-2014: A Patchwork of Payers and Priorities*. Austin: Texas Hospital Association, 2013. http://www.tha.org/HealthCareProviders/Issues/FinanceandReimburse098F/THA_Health_Care_Finance_White_Paper_Feb2013.pdf.
- ⁴ Rayno G, “Report says Medicaid expansion would spur state’s economy,” *New Hampshire Union Leader*, January 11, 2013, <http://www.unionleader.com/article/20130111/NEWS06/130119799/-1/politics06>.
- ⁵ Holahan J, Buettgens M, Carroll C and Dorn S. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*. Washington: Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, 2012.
- ⁶ For information about HIPSM, see the methods section in Holahan et al. See also HIPSM Methodology Documentation, <http://www.urban.org/publications/412471.html>.
- ⁷ *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*. Washington: Congressional Budget Office (CBO), 2012. CBO subtracted various offsets (including penalty payments and payments resulting from a tax on high-cost insurance plans) to reach a net cost estimate of \$1.1 trillion for ACA’s insurance coverage provisions.
- ⁸ *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*. Washington: CBO, 2012, footnote 17.
- ⁹ Elmendorf DM. “Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012” Washington: CBO, July 24, 2012. Table 2 shows that Medicare and Medicaid DSH reductions, together, total \$56 billion. Subtracting \$22 billion in Medicaid DSH payments yields \$34 billion in Medicare DSH cuts.
- ¹⁰ Elmendorf, p. 14.
- ¹¹ Shatto JD and Clemens MK. *Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers*. Washington: CMS Office of the Actuary, 2012; Foster RS. *Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act’, as Amended*. Washington: CMS Office of the Actuary, 2010.
- ¹² Shatto and Clemens.
- ¹³ ACA Section 3133.
- ¹⁴ ACA Section 2551.
- ¹⁵ Hadley J, Holahan J, Coughlin T, and Miller D. “Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs.” *Health Affairs*, 27(5):w399-w415, 2008.
- ¹⁶ *2009 Annual Report – Health Safety Net*. Boston: Massachusetts Division of Health Care Finance and Policy, 2009. *Access to Health Care in Massachusetts: Results from the 2008 and 2009 Massachusetts Health Insurance Survey*. Boston: Massachusetts Division of Health Care Finance and Policy, 2009.
- ¹⁷ As a general rule, the ACA limits eligibility for HIX subsidies to consumers with incomes between 100 percent and 400 percent of FPL who are ineligible for Medicaid and the Children’s Health Insurance Program (CHIP). If Medicaid eligibility expands to 138 percent of FPL, HIX subsidies will cover people between 138 percent and 400 percent of FPL. If there is no Medicaid expansion, and eligibility for adults ends below the poverty line, HIX subsidies will cover people between 100 percent and 400 percent of FPL. Note that consumers must also satisfy other eligibility requirements to qualify for HIX subsidies. In particular, if someone is offered employer-sponsored insurance (ESI) that the ACA deems “affordable,” the consumer is ineligible for HIX subsidies, regardless of income. Such ESI offers are irrelevant to Medicaid eligibility. Many consumers between 100 percent and 138 percent FPL who would qualify for Medicaid under an expansion would, without an expansion, be eligible for HIX subsidies, but some would lose eligibility for all assistance because of ESI offers.
- ¹⁸ *Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*. Seattle: Millman, 2008. <http://publications.milliman.com/research/health-rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf>. Avalere Health also produced a relevant analysis of American Hospital Association Survey data. Whereas Millman examines hospital operating margins, Avalere assesses payment-to-cost ratios and finds that the differential between private and Medicaid payment rates is 39.8 percent in 2011. As explained below, the actual discrepancy is likely to be less than this amount, both because of how HIXes are structured and because of the “moral hazard” effect resulting from lower Medicaid cost-sharing.
- ¹⁹ This factor of 38 percent clearly varies among states, but private payments would have to exceed Medicaid payments, including supplemental payments and disproportionate share payments, by a factor of more than three to offset the gains from Medicaid expansion.
- ²⁰ This language provides that hospital-based presumptive eligibility shall apply “in the same manner, and subject to the same requirements, as apply to the State options with respect to” presumptive eligibility for children, pregnant women, and women with breast or cervical cancer. ACA Section 2022 further provides that hospital-based presumptive eligibility is available, whether or not a state extends presumptive eligibility to these other populations. See 42 CFR 435.1110, cited below, for CMS’s proposed regulation governing hospital-based presumptive eligibility.
- ²¹ As originally proposed by the Chairman of the Senate Finance Committee, this provision gave states the authority to determine the scope of services provided during presumptive eligibility periods and to decide whether hospitals could serve as “qualified entities” capable of granting presumptive eligibility. Sen. Max Baucus (D-MT), “Chairman’s Mark: America’s Healthy Future Act of 2009” (September 2009). By the time the bill was reported out of Committee, however, these features had changed. Hospitals were given the right to serve as qualified entities, without any state veto authority, and without any state discretion to limit the services covered during the presumptive eligibility period. Senate Committee on Finance. “America’s Healthy Future Act of 2009,” Section 1622 (October 19, 2009). Those same policy decisions were reflected in the final language of Section 2022, which gives hospitals, not states, the choice of whether to serve as a “qualified entity,” and which specifies that presumptively eligible individuals receive “medical assistance,” without limitation.
- ²² In addition, for patients who submit regular Medicaid applications and qualify, Medicaid extends “retroactive eligibility” to cover services furnished during the three months before the month in which the regular Medicaid application was filed.
- ²³ See 42 CFR 435.1110 in CMS, “Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule,” *Federal Register*, Vol. 78, No. 14, Tuesday, January 22, 2013, 4594-4724 (CMS Proposed Rule). For a broader discussion of presumptive eligibility, see Brooks T. “Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage” (Washington: Georgetown University Health Policy Institute, Center for Children and Families, 2011).
- ²⁴ A state can also require patients to affirm that they are state residents—that is, present in the state and intending to remain indefinitely.
- ²⁵ States that provide children with presumptive eligibility must “adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.” 42 CFR 435.1102(c). States typically limit children to one presumptive eligibility period per year (Brooks 2011). While states may be required to impose reasonable limits on hospital-based presumptive eligibility, they could presumably allow more presumptive eligibility periods for hospital-based services than for children’s coverage. The specific issue of periodicity is not addressed in proposed rules governing hospital-based presumptive eligibility; however, those rules do require consistency with the policies and procedures used for children’s presumptive eligibility, as noted above. See CMS Proposed Rule, 42 CFR 435.1110(a).
- ²⁶ For a full description of HIPSM methodology, see <http://www.urban.org/publications/412471.html>.

²⁷ Holahan et al.

²⁸ *Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline*. Washington: CBO, 2012; *Updated Estimates for the Increasing Coverage Provision of the Affordable Care Act*. Washington: CBO, 2012.

²⁹ Due to survey data limitations, we are not able to model all limited benefits programs. For example, our data would not allow us to model the limited benefits program in Michigan or Washington, DC. Additionally, we did not model states in which limited benefits are available only through premium assistance, such as Arkansas, Idaho and Oklahoma, due to the difficulty of identifying premium assistance enrollees from survey data and the small enrollment in most such programs. It is worth noting that in states such as New Mexico, which provide limited benefits partly through premium assistance and partly through other mechanisms, we model only the limited benefits program that does not result from the premium assistance pathway. We also did not model limited benefits programs that are not statewide, such as in California or Missouri. In general, we use eligibility guidelines from 2009 as criteria for establishing MOE requirements and as such did not model any early expansion programs, such as in New Jersey.

³⁰ See, for example, the approach to estimating hospital stays under various coverage types in Buettgens M, Bovbjerg R, Carroll C, et al. *The ACA Medicaid Expansion in Washington*. Washington: The Urban Institute, 2012. <http://www.urban.org/publications/412581.html>.

³¹ Milliman.

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