Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid

Timely Analysis of Immediate Health Policy Issues

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Summary

With the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, the Patient Protection and Affordable Care Act (ACA) became law, fundamentally changing health insurance and access to health care in the United States. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimate important effects of the ACA at the state level: the increase in insurance coverage, coverage and subsidies in the new nongroup health benefit exchanges, Medicaid enrollment and costs under the expansion and total new federal spending on Medicaid and subsidies. We provide results by state, by region and by two useful groups of states. Key results are also displayed on maps. For ease of comparison, we simulate the ACA as if fully implemented in 2011 and contrast the results with HIPSM's prereform baseline results for 2011. These results complement an earlier policy brief that analyzed the national impact of health reform as if implemented in 2010.[1]

We estimate that:

- Full implementation of the ACA would lead to a 10.3 percentage point decrease in the national uninsurance rate for the nonelderly, roughly equivalent to 28 million fewer uninsured Americans. Although every state would enjoy a decline in uninsurance, the magnitude of the decrease varies significantly by state, ranging from a 1.1 percentage point decrease in Massachusetts to a 16.9 percentage point decrease in Texas.
- State-level income distributions and employer-sponsored insurance (ESI) eligibility levels affect the impact of health reform. States where lower income levels allow for higher Medicaid and exchange subsidy eligibility would see a greater decline in uninsurance rates. Likewise, states with low ESI eligibility would see a larger decrease in uninsurance than states with high ESI eligibility.
- The percent of nonelderly covered through nongroup health exchanges would vary by state. Massachusetts has the lowest coverage through nongroup exchanges at 5.4 percent, while North Dakota covers 13.9 percent of its population through the nongroup exchange, with a national average of 8.9 percent. We also observe regional differences, ranging from 7.1 percent in New England to 10.3 percent of the nonelderly in West North Central states. The variation reflects differences in income distribution and the level of ESI coverage.
- Under the ACA, exchange subsidies would total approximately $33 billion, with the majority going to those below 200 percent of the federal poverty level (FPL). Subsidies per nonelderly person, a useful measure for comparing subsidy amounts between states, are highest in the Pacific states and lowest in New England.
- Nationally, there would be 4.9 million new Medicaid enrollees who are eligible for Medicaid under current law, accounting for 8.3 percent of total new Medicaid enrollment under the ACA. Regionally, newly enrolled current eligibles make up the smallest share of total Medicaid enrollment in New England, 5.4 percent and the largest share in the mountain states, 10.5 percent. States with the highest ratio of ESI eligible residents see the lowest percentages of their total Medicaid enrollment made up by newly enrolled current eligibles, as do states with a high proportion of residents under 138 percent of the FPL.
- There would be 12.3 million newly eligible Medicaid enrollees nationwide, representing approximately a fifth of total enrollment.[2] This enrollment is driven by newly eligible adult nonparents, who account for 10.0 million of the newly eligible Medicaid enrollees. Children and adult parents make up a smaller proportion of newly eligible Medicaid enrollees. Due to the Children's Health Insurance Program (CHIP), children are already covered through a high-income threshold, so fewer gain eligibility with the general Medicaid expansion.
- Newly eligible Medicaid enrollees are less expensive, on average, than current enrollees. Although new eligibles make up about 20 percent of total enrollees, they only account for 15.4 percent of costs. This is because the newly eligible adults would be, on average, cheaper to cover than currently enrolled adults. Without reform, most states do not have an income eligibility threshold for adult nonparents, and many of those that do have

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closed their enrollment. Therefore, the adult nonparents currently enrolled gained eligibility through disability and medical need.

- There would be $82.3 billion in new federal spending on Medicaid and exchange subsidies flowing to the states. There would be considerable state variation since factors affecting both the exchanges and Medicaid are involved. West Virginia would receive $498 in new federal spending for every nonelderly person in the state, while Iowa would receive only $171. A full analysis of the economic impact of the ACA on states would have to include the distributional effects of Medicare payment cuts, new taxes on payroll and unearned income and taxes on insurers, drugs and medical device manufacturers.

Introduction

With the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, the Patient Protection and Affordable Care Act became law, fundamentally changing health insurance and access to health care in the United States. This brief provides state-level estimates of three important aspects of reform. First, while all states would see an increase in insurance coverage under the ACA, the current insurance markets in the various states differ considerably. Thus, the coverage effects of the ACA would vary significantly between states. We present state-level estimates of the percent of the nonelderly who would be uninsured without health reform and the uninsured rate among the nonelderly under the ACA. The effect of health reform on insurance coverage within a state is the difference of these two, the percentage point decline in the uninsured rate. We examine state and regional patterns in this decline.

Second, we examine coverage and subsidy costs in the new nongroup health benefit exchanges. We provide state estimates of the number of nonelderly covered in the exchanges and how the distribution of exchange coverage would vary by income group. The share of exchange coverage for those below 400 percent of the federal poverty level is particularly significant because the large majority of these would receive subsidies. This share is a result of several factors, such as the availability of ESI in addition to the distribution of income in a state. We then present income-based premium and cost-sharing subsidies in total dollars, in dollars per nonelderly person and in dollars per person with subsidized coverage. Subsidy dollars per nonelderly person provides a measure of the level of federal subsidies flowing into a state, controlling for differences in state population. The amount of subsidy dollars per subsidized person allows comparisons between states of how much an average subsidized person would cost.

Third, we present estimates of Medicaid/CHIP enrollment and costs under the Medicaid expansion, giving separate figures for adult nonparents, adult parents, children and those made newly eligible by the expansion. For each estimate, we provide results by state, region and two groups of states. Key results are also displayed on maps.

Lastly, we consider the Medicaid costs of new enrollees and estimate the share paid by the federal government. We combine this with the total exchange subsidies to estimate the total federal dollars flowing to the states.

The results presented here complement state-by-state estimates of Medicaid coverage and spending released in 2010.[3] That work dealt exclusively with Medicaid and used two take-up rate scenarios to forecast Medicaid enrollment for 2014 to 2019. This report presents 2011 estimates, as described in the Methods section below. We present state-level results from a full HIPSM simulation of the ACA. Medicaid enrollment is not based on fixed *a priori* take-up rates as in the earlier work but is simulated as described below in Methods. We focus on new federal dollars paid to states for exchange subsidies as well as Medicaid rather than on total Medicaid spending.

Methods

To estimate the effects of health reform and the individual mandate, we use the Urban Institute's Health Insurance Policy Simulation Model.[4] HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage and health insurance coverage resulting from specific reforms.[5]

We simulate the main coverage provisions of the ACA as if they were fully implemented in 2011 and compare results to the HIPSM baseline results for 2011 prior to implementation of these reforms. This approach differs from that of the Congressional Budget Office or the CMS actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of reform with the prereform baseline and of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief providing a nationwide analysis of the ACA based in 2010.[6]

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

- Two years of CPS data (survey years 2009 and 2010) were pooled together

to increase state sample size. Results for large states are based on a larger number of surveyed households than results for small states and thus have greater accuracy. Note that the CPS oversamples small states, so the number of observations is not necessarily proportional to state size. Our standard for state-level estimates was at least 100 unweighted observations; most are based on far larger numbers.

- Medical expenditures were adjusted to reflect state-level differences in health care pricing and utilization as measured in the National Health Expenditure Accounts.[7]
- Private health insurance premiums reflect both the state-level differences in expenditures from the previous item and state-specific differences in the risk pools of enrollees for a given type of insurance.
- The ACA was inspired in its general form by the comprehensive health reforms enacted in Massachusetts. The HIPSM results for Massachusetts without the ACA take into account some important provisions of that state's health reform law, though we did not comprehensively model it.

There are significant differences between insurance markets in the various states, particularly in the individual and small group markets. We did not model 51 different regulatory regimes with their various rules for premium rating, benefit package requirements and so on. The distribution of premiums in a given state is influenced both by the underlying levels of health care pricing and utilization and by the market conditions in that state. As noted, we take into account the former. For most states, the resulting distribution of average premiums is similar to that published in sources such as the MEPS-Insurance Component. However, some differences appear to be driven by differences in the structure of insurance plans and other market factors in certain states.

Modeling the private insurance market and typical plan structures available in a given state is a significant effort. We are starting to supplement the baseline used in this brief with special baselines focused on certain states. An important example was a simulation in 2009 of numerous health reform options for New York.[8] State-level estimates from the national version of HIPSM should not be considered a substitute for versions tailored to a specific state in answering technical state policy questions, particularly regarding implementation of the new health insurance exchanges.

We calibrate the behavior of our model so that a standard expansion of Medicaid and CHIP achieves take-up rates consistent with the empirical literature.[9] These baseline take-up rates for the uninsured are between 60 and 70 percent, depending on person type and income group. The ACA contains important provisions that would increase take-up. States are required to establish a web site capable of determining eligibility for Medicaid and automatically enrolling eligibles. Hospitals would be able to make presumptive eligibility determinations. There would be other new requirements for simplifying enrollment and renewal of Medicaid and CHIP. We estimate a take-up rate of about 73 percent for the uninsured who are newly eligible. This rate is higher than the baseline rate due to outreach and enrollment simplification provisions in the ACA, as well as a modest indirect effect of the individual mandate as observed in health reform in Massachusetts. Our Medicaid take-up is consistent with the enhanced outreach scenario in Holahan and Headen.[10]

To estimate modified adjusted gross income (MAGI) as defined in the ACA, we deduct the following from gross income: Social security, SSI, workers' compensation, veterans' benefits, child support and public assistance. We also impute child care expenses for families and deduct them up to the $5,000 cap defined in the tax law. Some other deductions which are part of MAGI, such as those for some types of pension benefits, cannot be computed and would be difficult to reliably impute based on CPS data. These additional deductions are unlikely to affect our results materially.

Finally, we emphasize that the estimates in this paper assume a uniform implementation of the ACA. There are many important implementation decisions within a state's authority. Few of these decisions have been made; when they are, we will be able to incorporate them into future estimates. Also, there is value in comparing the effects of a consistent policy across states.

Results

State Characteristics Relevant to the ACA

Several groupings of states will be useful in our analysis. The first is based on the state distributions of modified adjusted gross income as defined in the ACA. Since these are of independent interest and, as far as we know, have not been published elsewhere, we include a full table with cutoffs at 138 and 400 percent of the FPL (Table 1). These cutoffs are the eligibility levels for the Medicaid expansion and exchange subsidies respectively. There are distinct regional patterns. For example, in New England, nearly half of the nonelderly are at 400 percent of the FPL or above. Twenty-one percent are in the Medicaid eligibility range and 31 percent are between 138 and 400 percent of the FPL. Compare this with East South Central states, where 34 percent are below 138 percent of poverty, 38 percent between 138 and 400 percent and 28 percent above 400 percent.

Using cluster analysis, we separate states into four groups that have proven useful in analyzing our results. *Lowest impact* states are those in which about half of nonelderly adults are at or above 400 percent of the FPL. These states have a significantly lower share of the nonelderly in the Medicaid and exchange subsidy income groups (Table 1a), so these programs would be expected to have a somewhat lower impact. These states are Connecticut, Maryland, Massachusetts, New Hampshire and New Jersey (Figure 1). *Moderate impact* states

have about 40 percent of nonelderly adults at or above 400 percent of the FPL and 30 to 40 percent between 138 and 400 percent of the FPL. These are Colorado, Delaware, D.C., Illinois, Minnesota, North Dakota, Pennsylvania, Rhode Island, Vermont, Virginia and Washington. *High subsidy impact* states have more nonelderly adults between 138 and 400 percent of the FPL than in either of the other two categories and have less than a third below 138 percent of the FPL. Thus, they have a particularly large population that could potentially be affected by exchange subsidies. These are Alaska, Florida, Idaho, Iowa, Kansas, Maine, Michigan, Missouri, Montana, Nebraska, Nevada, Ohio, Oklahoma, Oregon, South Dakota, Utah, Wisconsin and Wyoming. Finally, *High Medicaid impact* states have about a third of all nonelderly adults below 138 percent of the FPL, a higher proportion than the other groups. These also generally have a larger-than-average share in the 138 to 400 percent range as well. These are Alabama, Arizona, Arkansas, California, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, New York, North Carolina, South Carolina, Tennessee, Texas and West Virginia.

Also, we identify states as having *low or high ESI eligibility* depending on whether less than 60 percent of nonelderly adults are eligible for ESI, that is, are potential policyholders (Figure 1). Those ineligible for ESI are either not in the work force or hold jobs—particularly part-time jobs—which would not have ESI as a benefit even if other workers in the firm were offered ESI. Low ESI eligibility states are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Kentucky, Louisiana, Maine, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia and Wyoming. High ESI eligibility states are Connecticut, Delaware, D.C., Hawaii, Illinois, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Vermont, Virginia and Wisconsin. Figure 1 overlays income and ESI eligibility groups. An interesting pattern emerges. High ESI eligibility states generally occur either in a cluster of low- and moderate-impact states along the Eastern seaboard or in a cluster of moderate-impact and high subsidy impact states in the Midwest.

Insurance Coverage

Nationally, the ACA would decrease the number of uninsured nonelderly persons by just under 28 million, a decrease of 10.3 percentage points (Table 2). There would, however, be considerable variation by state. Massachusetts would see little change (a decrease of 1.1 percentage points) because the ACA was to a large extent based on the health reforms already operating in Massachusetts. As a result of these reforms, the state had a low uninsured rate to begin with. The states with the largest decreases would be Texas and New Mexico (16.9 and 16.0 percentage points, respectively). These states currently have much higher than average uninsured rates (29 and 28 percent, compared with a national average of 19 percent).

There are clear regional patterns in how health insurance coverage would change under the ACA. New England states would see an average decrease in the uninsured rate of only 4.3 percentage points, while West South Central states would see an average decrease of 15.8 percentage points and South Atlantic states a decrease of 12.3 percentage points. Figure 2 maps these differences. Massachusetts, the only state that has already enacted comprehensive health reform, stands out as the only state with a decrease in uninsurance under 2 percentage points. There is a large band of states which would see the greatest gains in insurance coverage under reform across the Southwestern and Southeastern states. North of this grouping, the Midwest and Northeast would experience more modest decreases in uninsurance, along with Washington and California.

There are also significant differences across income clusters as well as between ESI eligibility clusters (Table 2a). High Medicaid-impact and high subsidy-range states would see a much larger decrease in the uninsured rate than the other two groups (11.6 and 10.6 percentage points, respectively). Lowest impact states would see a decrease of only 6.2 percentage points. Low ESI eligibility states would see a decrease of 11.4 percentage points, in contrast with 8.0 percentage points for high ESI eligibility states. Health reform has the most effect in states with the lowest availability of ESI.

The Nongroup Exchanges

Nationally, 8.9 percent of the nonelderly would be covered through the nongroup health exchanges (Table 3). State by state, the percentage varies from 5.4 percent in Massachusetts to 13.9 percent in North Dakota. Groups of states that would have similar changes in rates of insurance coverage often have very different rates of exchange enrollment. For example, Georgia and Montana would experience large changes in insurance under reform, with 12.6 and 12.7 percentage point increases, respectively. However, while Georgia will cover only 7.1 percent of its population through the nongroup exchange, Montana covers 13.1 percent.

There are regional patterns in nongroup exchange enrollment. New England and East South Central states would have the lowest proportion of the nonelderly covered in their nongroup exchanges, with 7.1 and 7.7 percent, respectively. Mapping the percentages of the nonelderly with exchange coverage, we see the regions with the highest shares are West North Central, Mountain and Pacific. High rates of exchange coverage are also found in Florida, some Middle Atlantic states and some New England states. West North Central states would have the highest, 10.3 percent, closely followed by Mountain and Pacific states, both with 9.8 percent. The lowest rates are in Massachusetts, West

Virginia and Hawaii. Massachusetts has very high ESI availability and a lower than average share of people in the exchange premium subsidy income range. West Virginia has a large proportion of nonelderly adults eligible for Medicaid under the expansion. The gain in coverage under reform for West Virginians is due more to the Medicaid expansion in this state than on average.

In Table 3, we also show the income distribution of those enrolled in the exchange. The share of enrollees above 400 percent of the FPL is particularly significant; it gives a good indication of how much of the exchange risk pool is not subsidized. The exchanges would likely be an attractive option for those already enrolled in nongroup coverage, and many currently uninsured who are not offered ESI would take exchange coverage to comply with the mandate even if their income is too high to qualify for subsidies.[11] There is a little unsubsidized coverage of persons below 400 percent of the FPL, mostly those using employee choice vouchers. Regionally, the share above 400 percent varies from 41.8 percent in New England to 23.1 percent in the East South Central states.

High subsidy impact states, not surprisingly, would have the highest percentage of the nonelderly enrolled in nongroup exchanges, 9.7 percent (Table 3a). Lowest impact states would have only 7.3 percent of the nonelderly in the exchanges, due in part to the fact that these states have the lowest share of residents in the subsidy-eligible income group. High Medicaid impact and moderate impact states would be closer to average, with 8.6 and 9.2 percent, respectively. The percent of those in the exchange above 400 percent of the FPL would vary from 30.1 percent for high subsidy impact states to 42.3 percent for lowest impact states.

In Table 4, we show the amount of premium and cost-sharing subsidies that would be paid to low-income exchange enrollees in each state. Nationally, $29 billion would be paid in premium subsidies and $4.3 billion in cost-sharing subsidies. Since subsidy amounts are computed using a sliding scale of percent-of-income thresholds, most of the spending is on the lowest eligible income groups. Sixty-three percent of premium subsidy dollars would go to those below 200 percent of the FPL and 29 percent to those between 200 and 300 percent of the FPL.[12] Similarly, 91 percent of cost-sharing subsidy dollars would go to those below 200 percent of the FPL.

In Table 5, we show the total exchange subsidies that would be received by residents of each state, that is, the sum of premium and cost-sharing subsidies from Table 4. Due to the differences in state populations, these totals are unsuitable for comparisons between states. For that purpose we give two averages. First, the subsidy amount per nonelderly person measures the per capita subsidy dollars that would flow into a state. Second, the subsidy amount per person covered by a subsidized policy shows how many subsidy dollars would be received by a typical low-income person in a state's exchanges.

The lowest subsidies per nonelderly person would be in New England and the Middle Atlantic states and the highest subsidies per nonelderly person would be among West South Central, Mountain and Pacific states. This variation is largely a result of the share covered by exchanges (Table 3) and the income distribution within the subsidy eligibility range, that is, 138 to 400 percent of the FPL. For example, the Mountain region has the same share of exchange coverage as the Pacific region, but its subsidies per nonelderly person would be only $128, as opposed to $135 in the Pacific. The Pacific region has a larger share of exchange coverage below 200 percent of the FPL than the Mountain region (Table 3). As we have seen in Table 4, the bulk of subsidies go to those in this income group. A map of average subsidies per nonelderly person shows the high and low regions that we have identified. Florida and Vermont appear as isolated high subsidy states.[13]

Subsidy amounts per subsidized person are more uniform across states. Subsidy income thresholds vary by income, so differences in the income distribution between 138 and 400 percent of the FPL would be an important factor in these average subsidy amounts. State differences in underlying medical costs and premiums are an equally important factor. Since the federal government pays the difference between a benchmark premium and a percentage of income, states with higher medical costs and premiums will be eligible for higher subsidies, all else being equal. A third factor is ESI availability. There are significant state differences in who would be barred from subsidies due to an affordable ESI offer. These three factors interact and in some ways balance each other, dampening the differences between states.

Among income groups, high subsidy impact and high Medicaid impact states would have the highest subsidies per nonelderly person ($136 and $127 respective) and lowest impact states the lowest ($81). High ESI eligibility states would also have significantly lower subsidy dollars per nonelderly person ($115 versus $129). Differences in subsidy amounts per subsidized person are too small to give a significant pattern for either income or ESI eligibility clusters.

The Medicaid Expansion

Table 6 provides a state-by-state overview of enrollment in Medicaid and CHIP. Nationally, about a fifth of enrollees would be newly eligible under the Medicaid expansion. The rest were previously eligible—and the large majority were enrolled before reform. Because of the high income eligibility thresholds for children in the CHIP program in most states, few children would gain eligibility (Table 7). Less than 100,000 of the 12.3 million newly eligible enrollees would be children. These children are mostly in states with Medicaid/CHIP income thresholds for children at 200 percent of the FPL or less (not shown in tables).[14] Even for states with thresholds far above 138 percent of the FPL, the difference in income definition under the ACA would gain eligibility for a small number of children. Eligibility thresholds for adult parents

are generally lower than for children, so more would gain eligibility. Few states have general income eligibility thresholds for adult nonparents and enrollment is closed in many of these. Most adult nonparents currently enrolled in Medicaid obtained eligibility through special programs (e.g., disability or medically needy). Thus, the large majority of newly eligible Medicaid enrollees are adult nonparents (10.0 million out of 12.3 million).

For state comparisons, we will focus on the percent of Medicaid/CHIP enrollees who are made newly eligible by the expansion as well as percentages of newly enrolled current eligibles. This gives information about the mix of enrollees in public coverage and has important implications for costs, as we shall see. There are two kinds of factors to distinguish. First, current eligibility rules in the various states and, second, factors that make new eligibles more or less likely to enroll in Medicaid versus other insurance coverage options, including remaining uninsured. Current Medicaid and CHIP eligibility rules are complex and vary greatly for children, parents and adult nonparents. Also, the ACA standardizes the definition of income, modified AGI as defined in the law, to be used in the eligibility test. The states with the 20 lowest percentages of enrollees who are newly eligible are nearly all—except for Pennsylvania and Michigan—among the 25 states with the highest eligibility thresholds for parents in 2009.[15] A few states have fairly generous Medicaid thresholds for adult nonparents as well, namely Arizona, Delaware, New York, Vermont and Hawaii.

Some states offer more limited coverage than standard Medicaid benefits to adults through Section 1115 waivers. Those who have such coverage and have MAGI below 138 percent of the FPL would qualify for the newly eligible federal match rate. For this reason, we count these as newly eligible. The state with the lowest share of new eligibles among enrollees is Vermont. That state offers full Medicaid benefits to parents up to 191 percent of the FPL and to childless adults up to 160 percent. The second lowest is Massachusetts, which has already enacted comprehensive health reform. Pennsylvania has a more limited coverage program up to 213 percent of the FPL. Enrollment was closed by 2009, but there are enough existing enrollees to place that state among the 20 lowest. In fact, the 11 states with the lowest percentages all have programs with relatively high thresholds available to adult nonparents.

Regionally, New England and the Middle Atlantic have the lowest percentages of new eligibles among enrollees (11.5 and 12.4 percent) and the South Atlantic and West South Central states have the highest (28.8 and 25.7 percent). The Southern and Western regions are fairly uniformly low in their thresholds for adult parents and few have any general income eligibility programs for adult nonparents. Thus, higher than average shares of their Medicaid/CHIP enrollees are new eligibles. Exceptions such as Arizona and Washington stand out (Figure 5).

Unsurprisingly, regions with the most aggressive Medicaid enrollment outreach have the lowest percentages of newly enrolled current eligibles. New enrollment of current eligibles is lowest in eastern regions, with the lowest proportion in New England at 5.4 percent. At the other end of the spectrum, Mountain and West North Central states would see a large percentage of their Medicaid enrollment made up by residents who are eligible under current law. Individual states, however, do not necessarily conform to a regional pattern. Middle Atlantic states stand out as an example as this region contains the states with both extremes of enrollment (D.C. with 2.5 percent and New Jersey with 13.4 percent, respectively). There is little variation in new enrollment of current eligibles by income and ESI clusters, although there is a noticeable pattern. The percent of newly enrolled current eligibles increases with income levels (8.0 to 9.0 percent) and decreases with higher ESI eligibility (8.4 to 8.0 percent).

There is also a pattern across income clusters in new eligible enrollment. The share of enrollees who are new eligibles is only 15.7 percent for the lowest impact states. It is 17.7 percent for moderate impact states and 20.0 percent for high Medicaid impact states. High subsidy impact states have a noticeably higher share: 25.1 percent. This is due to generally low prereform eligibility for adults in this cluster. Additionally, the share of new eligibles in high subsidy impact states is higher than that in high Medicaid impact states due to the presence of California, Arizona and New York in the latter.

In Table 8, we show the Medicaid/CHIP spending on acute care for the nonelderly by state. Note that while nearly a fifth of enrollees would be newly eligible (Table 6), only 15.4 percent of costs would be incurred by the newly eligible. Nearly all of the newly eligible would be adults (Table 7), and these would be significantly cheaper to cover than current adult enrollees. The reason is that most current adult enrollees gain eligibility through such pathways as disability or medically needy that are closely associated with high health care costs.[16] For most states, the percent of costs incurred by new eligibles is less than the percent of newly eligible enrollees. There are exceptions, though. In states with Medicaid or Section 1115 Waiver programs for childless adults, many of those who would be newly-eligible in other states are already enrolled. The remainder would not necessarily be less expensive to cover on average.[17]

Total New Federal Spending on States

We now estimate the total federal spending on Medicaid and exchange subsidies that would go to each state (Table 9). We first show the total costs of new Medicaid enrollees and then estimate the share paid by the federal government. For newly eligible enrollees, we used a federal match rate of 90 percent. In the law, this is initially 100 percent but phases down over time to 90 percent. Some states have Section 1115 waiver programs for adults with benefits more limited than standard Medicaid. Under the ACA,

those with MAGI under 138 percent of the FPL would be enrolled in standard Medicaid and counted as new eligibles. For new enrollees who were eligible before reform, the current match rates were used. These vary by state. For Section 1115 enrollees in seven states—Arizona, Delaware, Hawaii, Maine, Massachusetts, New York and Vermont—an enhanced match of 90 percent was used.[18] These are likely to be underestimates because we use the Medicaid rates for children as well. Some would be covered under separate CHIP programs at a higher match rate. However, only the expenses of the newly enrolled and newly eligible are included here, and the vast majority of these are adults. Very few children would gain eligibility through the expansion because existing CHIP income thresholds are higher, though the change in the income definition to MAGI would gain eligibility for a few. Total exchange subsidies are repeated from Table 5.

Two estimates in Table 9 are directly comparable across states: the percent of Medicaid costs for new enrollees reimbursed by the federal government and the total federal Medicaid and subsidy dollars per nonelderly person. The percent reimbursed varies from about 70 percent in Minnesota and Washington to nearly 90 percent. It cannot be higher than 90 percent given our methodology. Minnesota and Washington have low federal medical assistance percentage (FMAP) rates (50 and 50.94 percent respectively), a low percentage of Medicaid enrollees who are newly eligible (7.5 and 10.3 percent) and Medicaid programs open to low-income adults, both parents and nonparents. In contrast, four states with very high percentages—Kentucky, Louisiana, Mississippi and West Virginia—have high FMAP rates (70 to 76 percent), high percentages of enrollees who are newly eligible (22 to 29 percent) and no Medicaid programs for adult nonparents. Regionally, the lowest federal match rates would be in New England, the Middle Atlantic and the Pacific (79 to 80 percent) and the highest would be in East South Central and South Atlantic regions (87 to 88 percent).

The regions at the extremes of new federal Medicaid and subsidy dollars per nonelderly person are the same as for federal match rates. Namely, the lowest per capita federal dollars would go to New England, West North Central and Pacific states ($223 to $267), and the highest would go to the East and West South Central regions ($382 and $391). The state with the highest per capita federal dollars would be West Virginia ($498). That state has a high current FMAP rate (74 percent) and a high percentage of new eligibles among Medicaid enrollees (27.4). West Virginia has high shares of people in both the Medicaid and exchange subsidy eligibility ranges (Table 1).

The state with the lowest per capita federal dollars would be Iowa ($171). Nearly 40 percent of the nonelderly in this state would have MAGI above 400 percent of the FPL and would thus be ineligible for Medicaid and subsidies. Iowa also has a low FMAP rate (63 percent) and extended Medicaid eligibility with standard benefits for adult parents up to 116 percent of the FPL.

The states which would receive the highest per capita new federal dollars are concentrated in the East South Central and West South Central regions and the contiguous states of West Virginia and Florida (Figure 6). Additionally, Maine and Wyoming both receive per capita subsidies noticeably different from their respective regional patterns. Many of the New England states would be below $275 as well as a cluster of Mountain and West North Central states from Nevada through Nebraska. Washington, Minnesota, Iowa and Connecticut stand out as isolated low per capita dollar states. We have seen how Washington differs from its neighbors regarding Medicaid (Figure 5).

The lowest and moderate impact states have noticeably lower federal reimbursement percentages and per capita new federal dollars than the high subsidy and high Medicaid impact states (Table 9a). There is little difference in the reimbursement rates for high and low ESI states, but there is a difference in new federal dollars per capita.

Summary

Uninsurance rates would decrease in all 50 states and in Washington, D.C. Under the ACA, every state contributes to a national decline of 28 million nonelderly uninsured persons. Factors such as current insurance markets and demographic makeup play an important role in shaping the effects of the ACA reform, as the considerable state variation from the national average shows. Massachusetts, for example, has already enacted comprehensive health reform and therefore sees only a small decrease in its uninsured population. Low state ESI eligibility amplifies the effects of the ACA, as does a state income distribution that results in a high eligibility rate for Medicaid and exchange subsidies.

Enrollment in the nongroup health exchanges depends on current employer-sponsored insurance eligibility as well as state income distributions. A high enrollment in the nongroup exchange tends to correspond with low Medicaid eligibility and vice versa. This can be seen in West Virginia, which has a larger than average proportion of nonelderly persons eligible for Medicaid and as a result the proportion eligible for exchange subsidies is smaller. Nongroup enrollment is also decreased where there are high levels of ESI eligibility in a state because persons with an affordable ESI offer cannot receive subsidies in the exchanges. A main driver of nongroup enrollment is the percent of the nonelderly who are eligible for exchange subsidies. This pattern is reflected in the Mountain states, many of which are in the high subsidy impact and have high levels of nongroup exchange enrollment.

Nongroup exchange subsidies are sensitive to coverage levels, income distributions and state

specific medical costs. Income distribution within states is also an important determinant of subsidy amounts, as is the availability of ESI. Since a large proportion of exchange subsidies go to those below 200 percent of the FPL, a larger share of exchange coverage of this income group will also lead to increased subsidies. Looking at subsidies per subsidized person, or the average cost of a subsidized person, the interaction between level of exchange enrollment and percent of exchange enrollment below 200 percent of the FPL does not fully explain the regional variation. Factors such as medical costs and premium levels can change subsidies per subsidized person and contribute to the different levels among states.

The Medicaid expansion, which mainly affects adult nonparents, on average attracts cheaper and healthier enrollees. Of the 12.3 million newly eligible enrollees, 10.0 million of them are adult nonparents. These new enrollees have lower associated costs because, on average, they do not have the same health issues that allowed adult nonparents to enroll previously. Adult parents see a relatively small but substantial (2.2 million) increase in Medicaid coverage due to the new ACA income eligibility definitions as well as increased income thresholds. Children are largely unaffected by the Medicaid expansion due to the high income eligibility threshold associated with CHIP. In addition to the new eligibles, all states would experience increased enrollment of the currently eligible. State income clusters and ESI eligibility are important determinants of new enrollment of current eligibles. There is a consistent decline in the percent of newly enrolled current eligibles as income levels decline and as ESI eligibility increases.

State variation in the proportion of newly eligible Medicaid enrollees is affected by current Medicaid programs for adults. The regional similarities in Medicaid/CHIP eligibility rules are generally reflected in the proportion of newly eligible enrollees in those regions. However, states that currently have programs targeting adult nonparents tend to be exceptions. In the Southwest, for example, eligibility thresholds for adults tend to be low, so they would have a large number of new eligibles. Arizona, however, has a relatively high threshold for adult parents and a program for adult nonparents. This leads to a small proportion of newly eligible enrollees in that state.

There would be $82.3 billion total new federal Medicaid and exchange subsidy dollars flowing to the states. State differences in this amount reflect the factors discussed above for both the exchanges and Medicaid, as well as differences in current FMAP rates. Even after adjusting for population, differences across states are considerable. West Virginia would receive $498 in new federal spending for every nonelderly person in the state, while Iowa would receive only $171. States with the highest new spending per capita would be heavily concentrated in the South, while states with the lowest spending would be mainly in the Northeast and Midwest.

Table 1. Distribution of the Nonelderly Population by State and Modified Adjusted Gross Income (Thousands)

	<138% FPL		138-400% FPL		400%+ FPL		Total
	N	%	N	%	N	%	N
New England:	**2,567**	**21.1%**	**3,770**	**31.0%**	**5,829**	**47.9%**	**12,167**
Connecticut	600	19.8%	857	28.3%	1,574	51.9%	3,031
Maine	278	25.0%	425	38.2%	409	36.8%	1,112
Massachusetts	1,165	21.4%	1,612	29.7%	2,656	48.9%	5,434
New Hampshire	181	15.9%	367	32.1%	596	52.1%	1,145
Rhode Island	239	26.2%	291	31.9%	383	41.9%	914
Vermont	103	19.4%	217	40.9%	211	39.7%	531
Middle Atlantic:	**10,501**	**25.3%**	**14,040**	**33.9%**	**16,897**	**40.8%**	**41,438**
Delaware	189	25.1%	265	35.0%	301	39.9%	755
District of Columbia	160	29.5%	151	27.7%	233	42.8%	544
Maryland	1,043	20.6%	1,585	31.3%	2,437	48.1%	5,066
New Jersey	1,635	21.3%	2,418	31.5%	3,617	47.2%	7,670
New York	5,039	29.6%	5,753	33.7%	6,255	36.7%	17,047
Pennsylvania	2,434	23.5%	3,869	37.4%	4,053	39.1%	10,355
East North Central:	**10,904**	**27.1%**	**15,125**	**37.5%**	**14,279**	**35.4%**	**40,309**
Illinois	3,032	26.5%	4,133	36.1%	4,270	37.3%	11,434
Indiana	1,601	29.3%	2,090	38.3%	1,769	32.4%	5,460
Michigan	2,505	29.0%	3,093	35.8%	3,046	35.2%	8,645
Ohio	2,721	27.4%	3,824	38.5%	3,398	34.2%	9,944
Wisconsin	1,044	21.6%	1,984	41.1%	1,797	37.2%	4,825
West North Central:	**4,281**	**24.6%**	**6,590**	**37.8%**	**6,546**	**37.6%**	**17,416**
Iowa	594	22.8%	1,034	39.6%	984	37.7%	2,613
Kansas	633	26.7%	934	39.5%	800	33.8%	2,367
Minnesota	971	21.6%	1,608	35.8%	1,914	42.6%	4,492
Missouri	1,453	28.3%	1,870	36.4%	1,816	35.3%	5,139
Nebraska	354	22.6%	623	39.8%	587	37.5%	1,564
North Dakota	112	20.5%	216	39.5%	219	40.0%	548
South Dakota	164	23.7%	303	43.8%	225	32.5%	693
South Atlantic:	**12,907**	**28.9%**	**16,305**	**36.5%**	**15,401**	**34.5%**	**44,614**
Florida	4,518	29.5%	5,691	37.2%	5,096	33.3%	15,305
Georgia	2,682	30.4%	3,213	36.4%	2,933	33.2%	8,828
North Carolina	2,542	30.8%	2,964	35.9%	2,746	33.3%	8,252
South Carolina	1,152	30.0%	1,527	39.8%	1,157	30.2%	3,836
Virginia	1,505	21.8%	2,347	34.0%	3,057	44.2%	6,909
West Virginia	508	34.3%	562	37.9%	413	27.8%	1,484
East South Central:	**5,354**	**34.2%**	**5,883**	**37.5%**	**4,431**	**28.3%**	**15,668**
Alabama	1,309	32.4%	1,524	37.8%	1,202	29.8%	4,035
Kentucky	1,230	33.4%	1,364	37.0%	1,089	29.6%	3,683
Mississippi	1,022	40.2%	943	37.0%	580	22.8%	2,544
Tennessee	1,794	33.2%	2,052	38.0%	1,559	28.8%	5,406
West South Central:	**10,581**	**32.8%**	**11,988**	**37.2%**	**9,658**	**30.0%**	**32,227**
Arkansas	850	34.6%	1,031	41.9%	577	23.5%	2,457
Louisiana	1,302	33.7%	1,302	33.7%	1,257	32.6%	3,861
Oklahoma	852	27.3%	1,231	39.4%	1,042	33.4%	3,125
Texas	7,577	33.3%	8,425	37.0%	6,782	29.8%	22,783
Mountain:	**5,536**	**27.9%**	**7,523**	**38.0%**	**6,750**	**34.1%**	**19,810**
Arizona	2,024	34.0%	2,046	34.4%	1,882	31.6%	5,952
Colorado	994	22.1%	1,595	35.4%	1,921	42.6%	4,510
Idaho	342	25.5%	628	46.8%	370	27.6%	1,340
Montana	220	26.0%	332	39.2%	295	34.8%	847
Nevada	604	25.7%	997	42.4%	752	31.9%	2,353
New Mexico	692	37.6%	623	33.9%	524	28.5%	1,839
Utah	567	22.7%	1,113	44.6%	817	32.7%	2,496
Wyoming	93	19.6%	190	40.2%	191	40.3%	473
Pacific:	**13,348**	**29.6%**	**15,802**	**35.0%**	**15,963**	**35.4%**	**45,114**
Alaska	158	25.6%	256	41.4%	204	33.0%	618
California	10,624	31.1%	11,739	34.4%	11,790	34.5%	34,154
Hawaii	341	31.0%	434	39.4%	327	29.6%	1,103
Oregon	926	27.6%	1,262	37.6%	1,166	34.8%	3,354
Washington	1,299	22.1%	2,111	35.9%	2,477	42.1%	5,886
Total	**75,979**	**28.3%**	**97,028**	**36.1%**	**95,755**	**35.6%**	**268,762**

Source: Urban Institute analysis, HIPSM 2011.

Table 1a. Distribution of the Nonelderly Population by Modified Adjusted Gross Income (Thousands)

	<138% FPL		138-400% FPL		400%+ FPL		Total
	N	%	N	%	N	%	N
Income Cluster							
Lowest Impact	4,625	20.7%	6,840	30.6%	10,881	48.7%	22,346
Moderate Impact	11,039	23.5%	16,802	35.8%	19,037	40.6%	46,878
High Subsidy Impact	18,027	27.0%	25,792	38.6%	22,995	34.4%	66,814
High Medicaid Impact	42,289	31.9%	47,594	35.9%	42,842	32.3%	132,725
Eligibility Cluster							
High ESI	21,858	24.4%	32,555	36.4%	35,018	39.2%	89,431
Low ESI	54,121	30.2%	64,473	36.0%	60,737	33.9%	179,331

Source: Urban Institute analysis, HIPSM 2011.

Figure 1: Map of Income Clusters with ESI Eligibility

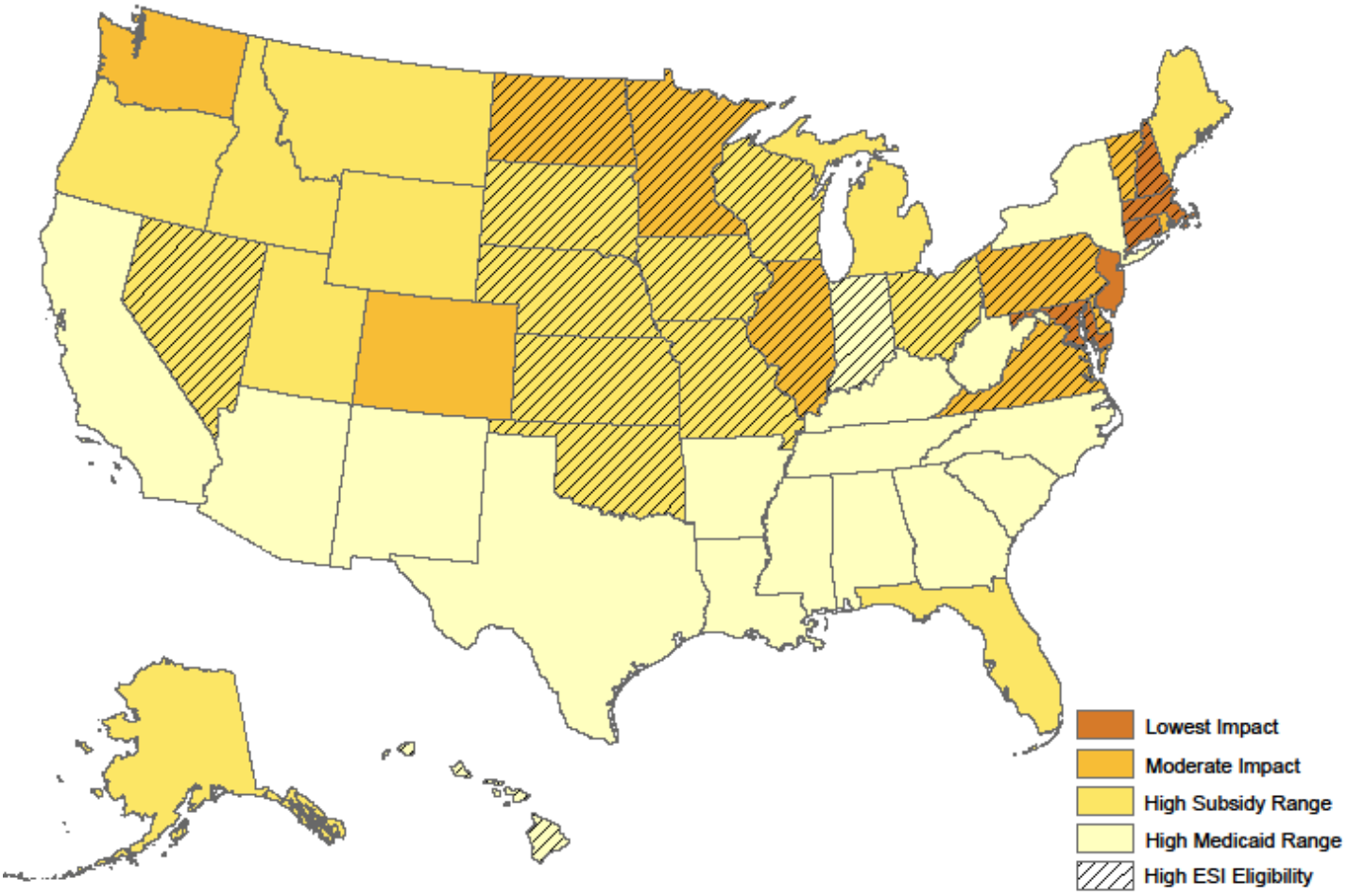

Table 2. Change in Nonelderly Uninsured Under the ACA

		Before Reform		After Reform		Change	
Population (thousands)	Total nonelderly	Total nonelderly uninsured		Total nonelderly uninsured		Total nonelderly uninsured	
		N	%	N	%	N	Pct Pts
New England:	**12,167**	**1,083**	**8.9%**	**556**	**4.6%**	**-527**	**-4.3%**
Connecticut	3,031	397	13.1%	197	6.5%	-200	-6.6%
Maine	1,112	147	13.2%	66	5.9%	-81	-7.3%
Massachusetts	5,434	216	4.0%	158	2.9%	-58	-1.1%
New Hampshire	1,145	136	11.9%	50	4.3%	-87	-7.6%
Rhode Island	914	124	13.6%	53	5.8%	-71	-7.8%
Vermont	531	62	11.7%	32	6.1%	-30	-5.6%
Middle Atlantic:	**41,438**	**6,416**	**15.5%**	**3,270**	**7.9%**	**-3,146**	**-7.6%**
Delaware	755	116	15.4%	64	8.5%	-53	-7.0%
District of Columbia	544	67	12.2%	35	6.5%	-31	-5.8%
Maryland	5,066	743	14.7%	363	7.2%	-380	-7.5%
New Jersey	7,670	1,342	17.5%	683	8.9%	-659	-8.6%
New York	17,047	2,814	16.5%	1,599	9.4%	-1,215	-7.1%
Pennsylvania	10,355	1,334	12.9%	526	5.1%	-808	-7.8%
East North Central:	**40,309**	**6,210**	**15.4%**	**2,515**	**6.2%**	**-3,695**	**-9.2%**
Illinois	11,434	1,814	15.9%	768	6.7%	-1,046	-9.1%
Indiana	5,460	870	15.9%	326	6.0%	-544	-10.0%
Michigan	8,645	1,363	15.8%	613	7.1%	-750	-8.7%
Ohio	9,944	1,591	16.0%	562	5.7%	-1,028	-10.3%
Wisconsin	4,825	572	11.9%	246	5.1%	-327	-6.8%
West North Central:	**17,416**	**2,340**	**13.4%**	**1,037**	**6.0%**	**-1,303**	**-7.5%**
Iowa	2,613	296	11.3%	171	6.6%	-125	-4.8%
Kansas	2,367	365	15.4%	167	7.1%	-198	-8.4%
Minnesota	4,492	461	10.3%	234	5.2%	-227	-5.0%
Missouri	5,139	803	15.6%	284	5.5%	-520	-10.1%
Nebraska	1,564	229	14.7%	106	6.8%	-123	-7.9%
North Dakota	548	75	13.6%	33	6.1%	-41	-7.5%
South Dakota	693	110	15.9%	41	5.9%	-69	-10.0%
South Atlantic:	**44,614**	**9,650**	**21.6%**	**4,173**	**9.4%**	**-5,477**	**-12.3%**
Florida	15,305	3,979	26.0%	1,741	11.4%	-2,238	-14.6%
Georgia	8,828	2,006	22.7%	892	10.1%	-1,114	-12.6%
North Carolina	8,252	1,596	19.3%	734	8.9%	-861	-10.4%
South Carolina	3,836	768	20.0%	289	7.5%	-479	-12.5%
Virginia	6,909	1,033	14.9%	439	6.3%	-594	-8.6%
West Virginia	1,484	268	18.0%	77	5.2%	-190	-12.8%
East South Central:	**15,668**	**2,983**	**19.0%**	**1,168**	**7.5%**	**-1,815**	**-11.6%**
Alabama	4,035	707	17.5%	266	6.6%	-440	-10.9%
Kentucky	3,683	735	20.0%	251	6.8%	-484	-13.1%
Mississippi	2,544	539	21.2%	214	8.4%	-325	-12.8%
Tennessee	5,406	1,003	18.5%	437	8.1%	-566	-10.5%
West South Central:	**32,227**	**8,747**	**27.1%**	**3,664**	**11.4%**	**-5,083**	**-15.8%**
Arkansas	2,457	558	22.7%	201	8.2%	-357	-14.5%
Louisiana	3,861	822	21.3%	292	7.6%	-530	-13.7%
Oklahoma	3,125	608	19.5%	260	8.3%	-348	-11.1%
Texas	22,783	6,758	29.7%	2,911	12.8%	-3,847	-16.9%
Mountain:	**19,810**	**4,172**	**21.1%**	**2,088**	**10.5%**	**-2,084**	**-10.5%**
Arizona	5,952	1,328	22.3%	802	13.5%	-526	-8.8%
Colorado	4,510	829	18.4%	372	8.2%	-457	-10.1%
Idaho	1,340	244	18.2%	110	8.2%	-134	-10.0%
Montana	847	182	21.5%	74	8.8%	-108	-12.7%
Nevada	2,353	557	23.7%	274	11.7%	-283	-12.0%
New Mexico	1,839	515	28.0%	220	12.0%	-295	-16.0%
Utah	2,496	433	17.3%	201	8.0%	-232	-9.3%
Wyoming	473	84	17.7%	35	7.3%	-49	-10.4%
Pacific:	**45,114**	**9,299**	**20.6%**	**4,818**	**10.7%**	**-4,482**	**-9.9%**
Alaska	618	130	21.1%	53	8.5%	-78	-12.5%
California	34,154	7,561	22.1%	3,930	11.5%	-3,631	-10.6%
Hawaii	1,103	104	9.5%	53	4.8%	-51	-4.7%
Oregon	3,354	683	20.4%	303	9.0%	-380	-11.3%
Washington	5,886	821	13.9%	480	8.2%	-341	-5.8%
Total	**268,762**	**50,900**	**18.9%**	**23,289**	**8.7%**	**-27,611**	**-10.3%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 2a. Change in Nonelderly Uninsured Under the ACA

		Before Reform		After Reform		Change	
Population (thousands)	Total nonelderly	Total nonelderly uninsured		Total nonelderly uninsured		Total nonelderly uninsured	
		N	%	N	%	N	Pct Pts
Income Cluster							
Lowest Impact	22,345,634	2,835	12.7%	1,451	6.5%	-1,384	-6.2%
Moderate Impact	46,878,448	6,735	14.4%	3,036	6.5%	-3,699	-7.9%
High Subsidy Impact	66,813,663	12,378	18.5%	5,308	7.9%	-7,070	-10.6%
High Medicaid Impact	132,724,638	28,951	21.8%	13,494	10.2%	-15,458	-11.6%
Eligibility Cluster							
High ESI	89,430,928	12,561	14.0%	5,390	6.0%	-7,171	-8.0%
Low ESI	179,331,455	38,338	21.4%	17,899	10.0%	-20,439	-11.4%

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 2: Percentage Point Decline in the Uninsurance Rate Due to Reform

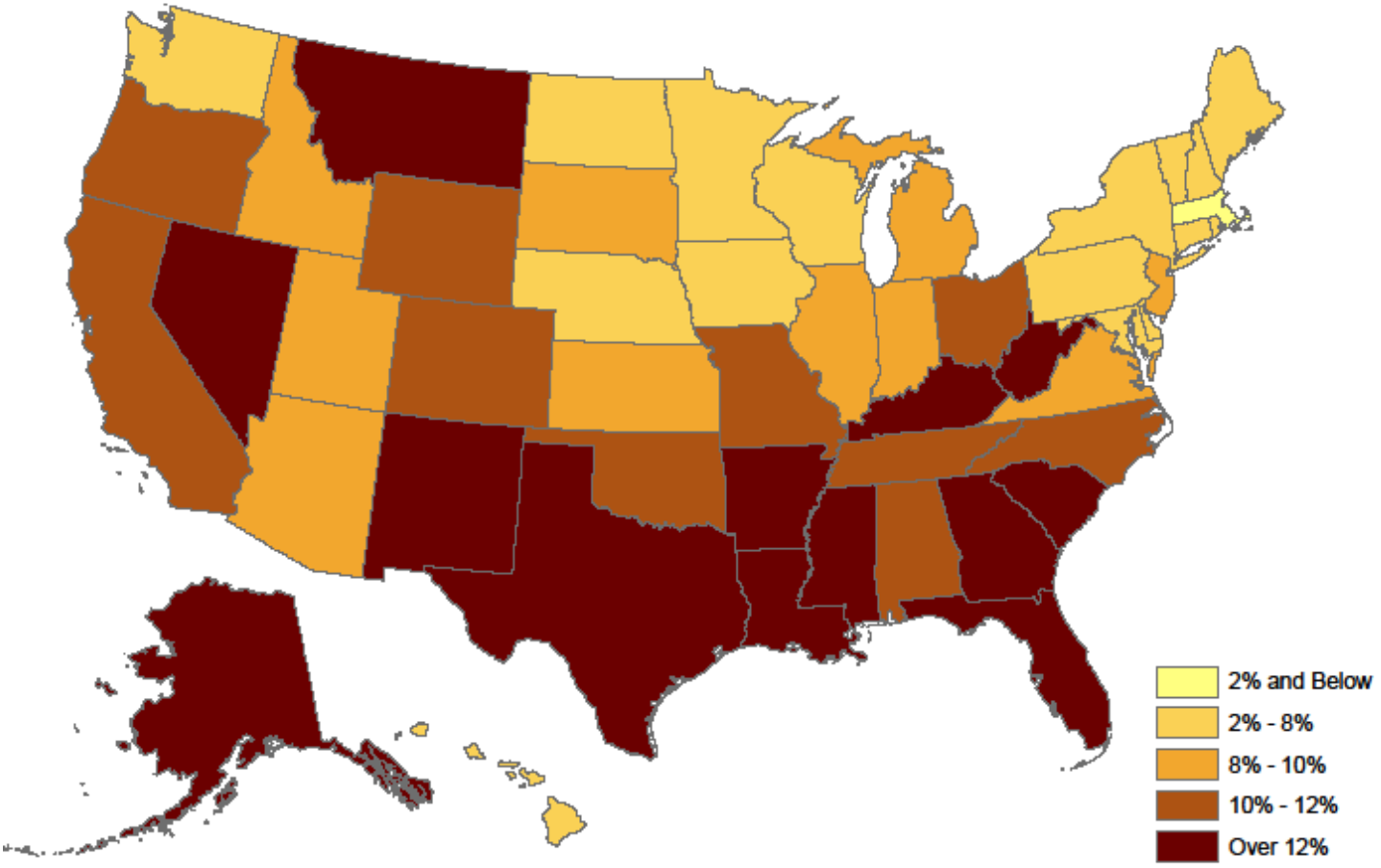

Table 3. Coverage in the Nongroup Exchanges

	Total nonelderly (thousands)	Total covered in nongroup exchanges		Income distribution (% of total covered)			
		N (thousands)	% of nonelderly	<200% FPL	200-300% FPL	300-400% FPL	400%+ FPL
New England:	**12,167**	**865**	**7.1%**	**28.6%**	**17.8%**	**11.8%**	**41.8%**
Connecticut	3,031	246	8.1%	30.3%	18.9%	6.5%	44.3%
Maine	1,112	98	8.8%	30.8%	19.8%	13.1%	36.3%
Massachusetts	5,434	296	5.4%	27.4%	17.3%	13.8%	41.4%
New Hampshire	1,145	95	8.3%	22.7%	15.5%	17.8%	44.0%
Rhode Island	914	83	9.0%	28.5%	17.6%	11.2%	42.6%
Vermont	531	48	9.0%	34.4%	15.2%	13.2%	37.2%
Middle Atlantic:	**41,438**	**3,558**	**8.6%**	**33.5%**	**20.6%**	**12.1%**	**33.8%**
Delaware	755	61	8.1%	26.9%	21.4%	12.4%	39.3%
District of Columbia	544	49	9.1%	38.8%	13.1%	15.1%	33.1%
Maryland	5,066	405	8.0%	29.1%	15.4%	15.8%	39.6%
New Jersey	7,670	597	7.8%	28.2%	18.3%	10.1%	43.4%
New York	17,047	1,415	8.3%	36.4%	23.5%	10.5%	29.6%
Pennsylvania	10,355	1,030	9.9%	34.4%	20.2%	13.8%	31.6%
East North Central:	**40,309**	**3,519**	**8.7%**	**32.3%**	**23.5%**	**13.9%**	**30.2%**
Illinois	11,434	957	8.4%	33.0%	20.5%	13.2%	33.4%
Indiana	5,460	406	7.4%	30.2%	23.6%	13.7%	32.5%
Michigan	8,645	792	9.2%	27.8%	26.2%	15.0%	31.0%
Ohio	9,944	941	9.5%	36.3%	24.6%	12.2%	26.9%
Wisconsin	4,825	423	8.8%	32.5%	22.7%	18.0%	26.8%
West North Central:	**17,416**	**1,786**	**10.3%**	**32.0%**	**21.9%**	**13.3%**	**32.8%**
Iowa	2,613	252	9.7%	34.1%	22.6%	10.4%	32.9%
Kansas	2,367	248	10.5%	28.7%	22.9%	16.3%	32.1%
Minnesota	4,492	426	9.5%	32.4%	20.0%	9.4%	38.2%
Missouri	5,139	528	10.3%	33.5%	24.2%	14.1%	28.2%
Nebraska	1,564	174	11.1%	29.5%	18.3%	17.4%	34.8%
North Dakota	548	76	13.9%	27.2%	16.9%	18.2%	37.7%
South Dakota	693	82	11.9%	33.2%	22.9%	15.5%	28.4%
South Atlantic:	**44,614**	**3,734**	**8.4%**	**34.9%**	**24.3%**	**11.0%**	**29.9%**
Florida	15,305	1,516	9.9%	33.0%	26.6%	12.4%	28.1%
Georgia	8,828	630	7.1%	38.7%	23.4%	7.2%	30.6%
North Carolina	8,252	640	7.8%	34.3%	20.5%	10.3%	34.8%
South Carolina	3,836	309	8.0%	33.0%	26.2%	18.4%	22.3%
Virginia	6,909	546	7.9%	37.7%	23.5%	7.2%	31.6%
West Virginia	1,484	93	6.3%	32.4%	15.8%	15.9%	35.9%
East South Central:	**15,668**	**1,211**	**7.7%**	**39.6%**	**24.0%**	**13.2%**	**23.1%**
Alabama	4,035	275	6.8%	38.9%	22.2%	12.8%	26.0%
Kentucky	3,683	306	8.3%	31.5%	28.1%	10.9%	29.5%
Mississippi	2,544	203	8.0%	41.8%	26.0%	14.0%	18.2%
Tennessee	5,406	427	7.9%	44.9%	21.4%	14.8%	18.9%
West South Central:	**32,227**	**2,772**	**8.6%**	**36.0%**	**23.8%**	**10.7%**	**29.5%**
Arkansas	2,457	216	8.8%	37.8%	28.8%	11.0%	22.4%
Louisiana	3,861	317	8.2%	36.2%	15.3%	14.5%	34.0%
Oklahoma	3,125	259	8.3%	32.8%	22.5%	16.7%	28.0%
Texas	22,783	1,981	8.7%	36.2%	24.8%	9.3%	29.7%
Mountain:	**19,810**	**1,949**	**9.8%**	**31.6%**	**22.9%**	**15.5%**	**30.1%**
Arizona	5,952	503	8.5%	34.6%	19.0%	18.7%	27.8%
Colorado	4,510	482	10.7%	28.1%	20.6%	17.7%	33.5%
Idaho	1,340	170	12.7%	29.0%	23.1%	14.6%	33.3%
Montana	847	111	13.1%	29.8%	26.5%	13.6%	30.0%
Nevada	2,353	198	8.4%	35.7%	25.3%	11.3%	27.7%
New Mexico	1,839	177	9.6%	33.1%	28.7%	10.1%	28.0%
Utah	2,496	250	10.0%	29.0%	27.6%	13.9%	29.5%
Wyoming	473	58	12.2%	37.7%	22.2%	11.9%	28.2%
Pacific:	**45,114**	**4,440**	**9.8%**	**35.6%**	**19.9%**	**12.0%**	**32.5%**
Alaska	618	61	9.9%	29.2%	25.6%	14.1%	31.1%
California	34,154	3,435	10.1%	36.6%	19.3%	11.4%	32.7%
Hawaii	1,103	64	5.8%	28.7%	21.1%	12.8%	37.4%
Oregon	3,354	342	10.2%	35.9%	23.0%	12.4%	28.8%
Washington	5,886	538	9.1%	31.1%	20.4%	15.3%	33.2%
Total	**268,762**	**23,835**	**8.9%**	**34.1%**	**22.2%**	**12.4%**	**31.3%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 3a. Coverage in the Nongroup Exchanges

	Total nonelderly (thousands)	Total covered in nongroup exchanges		Income distribution (% of total covered)			
		N (thousands)	% of nonelderly	<200% FPL	200-300% FPL	300-400% FPL	400%+ FPL
Income Cluster							
Lowest Impact	22,346	1,639	7.3%	28.3%	17.4%	12.1%	42.3%
Moderate Impact	46,878	4,296	9.2%	32.9%	20.5%	13.0%	33.6%
High Subsidy Impact	66,814	6,504	9.7%	32.5%	24.6%	13.7%	29.1%
High Medicaid Impact	132,725	11,396	8.6%	36.3%	22.1%	11.5%	30.1%
Eligibility Cluster							
High ESI	89,431	7,811	8.7%	32.9%	21.4%	13.1%	32.6%
Low ESI	179,331	16,024	8.9%	34.7%	22.6%	12.1%	30.7%

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 3: Percent of Nonelderly Covered in Nongroup Exchanges

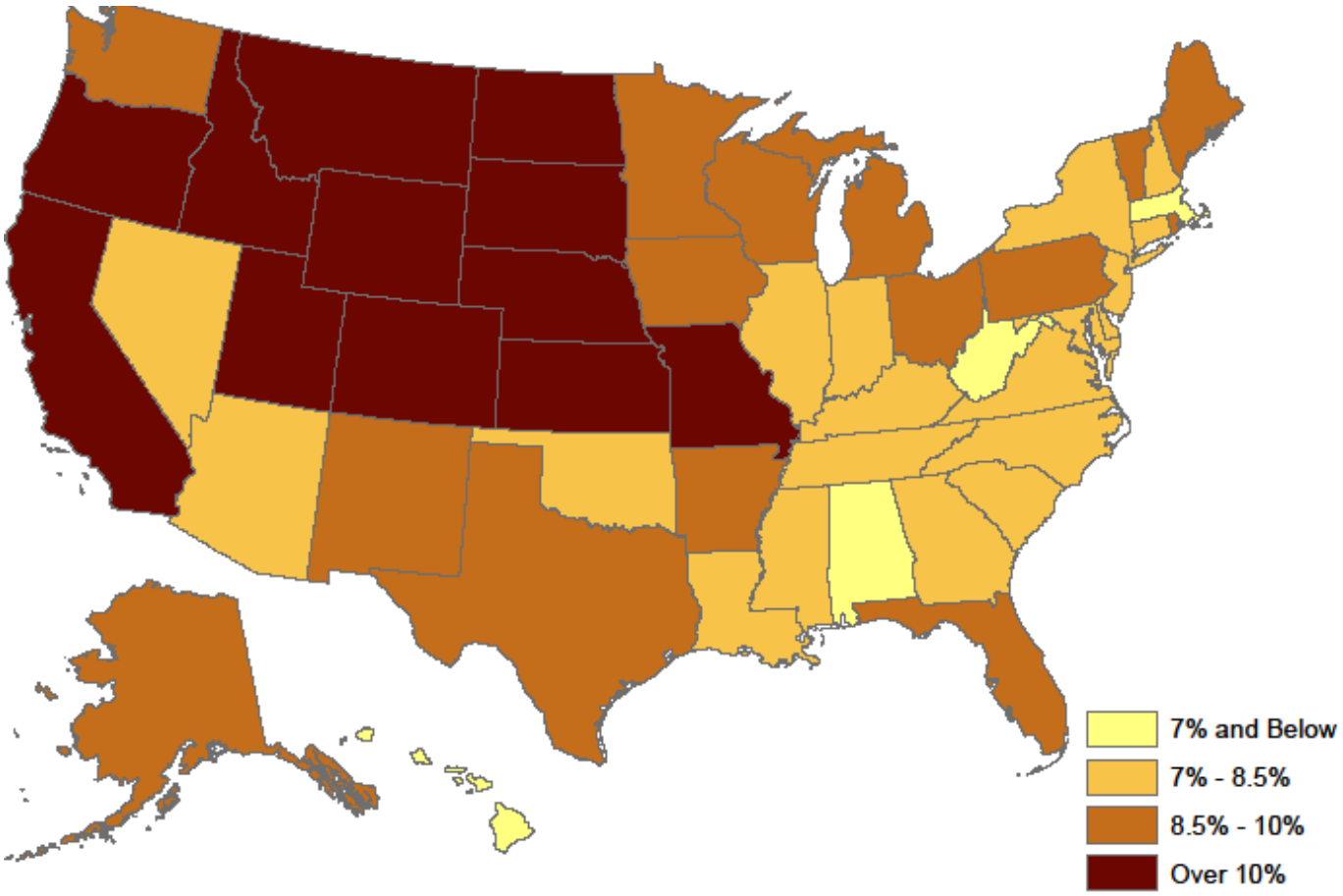

Table 4. Premium and Cost-Sharing Subsidies in the Nongroup Exchanges

	Premium subsidies ($ thousands)				Cost-sharing subsidies ($ thousands)		
	<200% FPL	200-300% FPL	300-400% FPL	Total	<200% FPL	200-250% FPL	Total
New England:	**479,594**	**290,914**	**99,352**	**869,860**	**155,369**	**13,081**	**168,451**
Connecticut	131,899	102,509	13,818	248,226	43,512	3,730	47,242
Maine	69,527	44,668	13,037	127,232	19,160	2,431	21,590
Massachusetts	132,078	87,061	43,847	262,986	50,844	3,588	54,432
New Hampshire	51,932	22,085	17,842	91,859	7,058	880	7,938
Rhode Island	58,177	27,234	5,168	90,578	20,993	1,958	22,951
Vermont	35,981	7,356	5,641	48,978	13,803	494	14,297
Middle Atlantic:	**2,574,336**	**1,142,048**	**300,035**	**4,016,419**	**558,007**	**64,017**	**622,024**
Delaware	35,399	15,414	4,460	55,274	9,407	902	10,309
District of Columbia	33,550	5,121	4,637	43,308	10,382	172	10,554
Maryland	263,087	43,798	28,382	335,268	62,695	3,229	65,925
New Jersey	368,849	181,889	58,100	608,838	82,273	9,050	91,323
New York	1,098,532	532,917	139,607	1,771,056	230,969	25,102	256,071
Pennsylvania	774,918	362,907	64,849	1,202,674	162,280	25,562	187,842
East North Central:	**2,558,342**	**1,309,634**	**482,668**	**4,350,644**	**576,593**	**55,347**	**631,939**
Illinois	686,728	324,259	106,472	1,117,459	152,272	15,080	167,352
Indiana	317,444	135,629	47,913	500,986	85,283	2,986	88,268
Michigan	474,343	317,278	153,985	945,606	95,416	13,264	108,680
Ohio	768,981	317,396	65,764	1,152,142	170,186	11,970	182,156
Wisconsin	310,845	215,072	108,534	634,452	73,436	12,048	85,483
West North Central:	**1,049,873**	**605,813**	**208,918**	**1,864,604**	**270,780**	**26,900**	**297,680**
Iowa	123,675	78,780	29,162	231,617	41,862	2,260	44,122
Kansas	118,476	90,060	50,339	258,875	22,255	4,478	26,733
Minnesota	282,164	126,601	28,939	437,704	101,352	6,921	108,273
Missouri	327,318	231,493	34,934	593,745	53,951	9,568	63,519
Nebraska	116,971	35,180	32,996	185,147	27,727	887	28,614
North Dakota	33,652	16,459	18,277	68,388	10,337	772	11,109
South Dakota	47,618	27,239	14,271	89,128	13,295	2,014	15,309
South Atlantic:	**3,070,028**	**1,429,043**	**264,898**	**4,763,969**	**701,637**	**57,687**	**759,324**
Florida	1,291,249	651,732	108,537	2,051,518	250,009	18,143	268,152
Georgia	566,332	181,651	33,079	781,062	100,446	10,640	111,086
North Carolina	574,875	224,528	47,013	846,416	179,909	14,865	194,774
South Carolina	172,296	130,903	45,676	348,875	43,052	4,809	47,861
Virginia	397,652	213,721	6,459	617,831	110,878	8,366	119,245
West Virginia	67,625	26,508	24,134	118,266	17,343	863	18,206
East South Central:	**979,736**	**457,487**	**119,256**	**1,556,478**	**233,561**	**18,462**	**252,023**
Alabama	214,716	60,700	19,346	294,761	48,836	5,308	54,143
Kentucky	258,232	106,280	5,313	369,825	34,781	5,490	40,271
Mississippi	160,155	99,532	25,319	285,006	45,488	1,860	47,348
Tennessee	346,633	190,974	69,278	606,886	104,457	5,804	110,261
West South Central:	**2,748,922**	**1,084,335**	**210,839**	**4,044,096**	**453,383**	**66,173**	**519,556**
Arkansas	198,464	100,305	14,284	313,053	43,113	3,161	46,273
Louisiana	206,636	95,458	39,089	341,183	35,903	9,429	45,331
Oklahoma	198,850	96,566	52,918	348,335	45,308	3,245	48,553
Texas	2,144,971	792,006	104,548	3,041,525	329,060	50,338	379,398
Mountain:	**1,283,316**	**731,968**	**265,664**	**2,280,948**	**238,421**	**25,224**	**263,646**
Arizona	331,709	160,322	78,093	570,125	69,294	2,122	71,416
Colorado	261,335	153,183	64,171	478,689	42,899	5,770	48,669
Idaho	82,579	84,973	23,076	190,628	18,480	2,392	20,872
Montana	72,538	36,436	22,318	131,293	10,798	986	11,784
Nevada	162,325	82,082	10,158	254,565	27,464	5,909	33,373
New Mexico	187,012	113,473	19,598	320,082	27,968	2,514	30,482
Utah	135,517	77,894	37,575	250,986	32,704	5,019	37,723
Wyoming	50,300	23,605	10,676	84,581	8,814	513	9,327
Pacific:	**3,459,250**	**1,399,607**	**448,617**	**5,307,474**	**697,991**	**62,132**	**760,123**
Alaska	38,337	14,713	975	54,025	14,609	1,822	16,431
California	2,793,487	1,105,411	307,422	4,206,321	539,011	41,327	580,339
Hawaii	30,486	17,622	1,069	49,176	11,302	668	11,971
Oregon	272,363	85,421	42,914	400,698	64,529	4,367	68,896
Washington	324,577	176,440	96,237	597,254	68,538	13,947	82,485
Total	**18,203,397**	**8,450,848**	**2,400,247**	**29,054,492**	**3,885,742**	**389,023**	**4,274,765**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 4: Average Subsidy Amount per Nonelderly Person

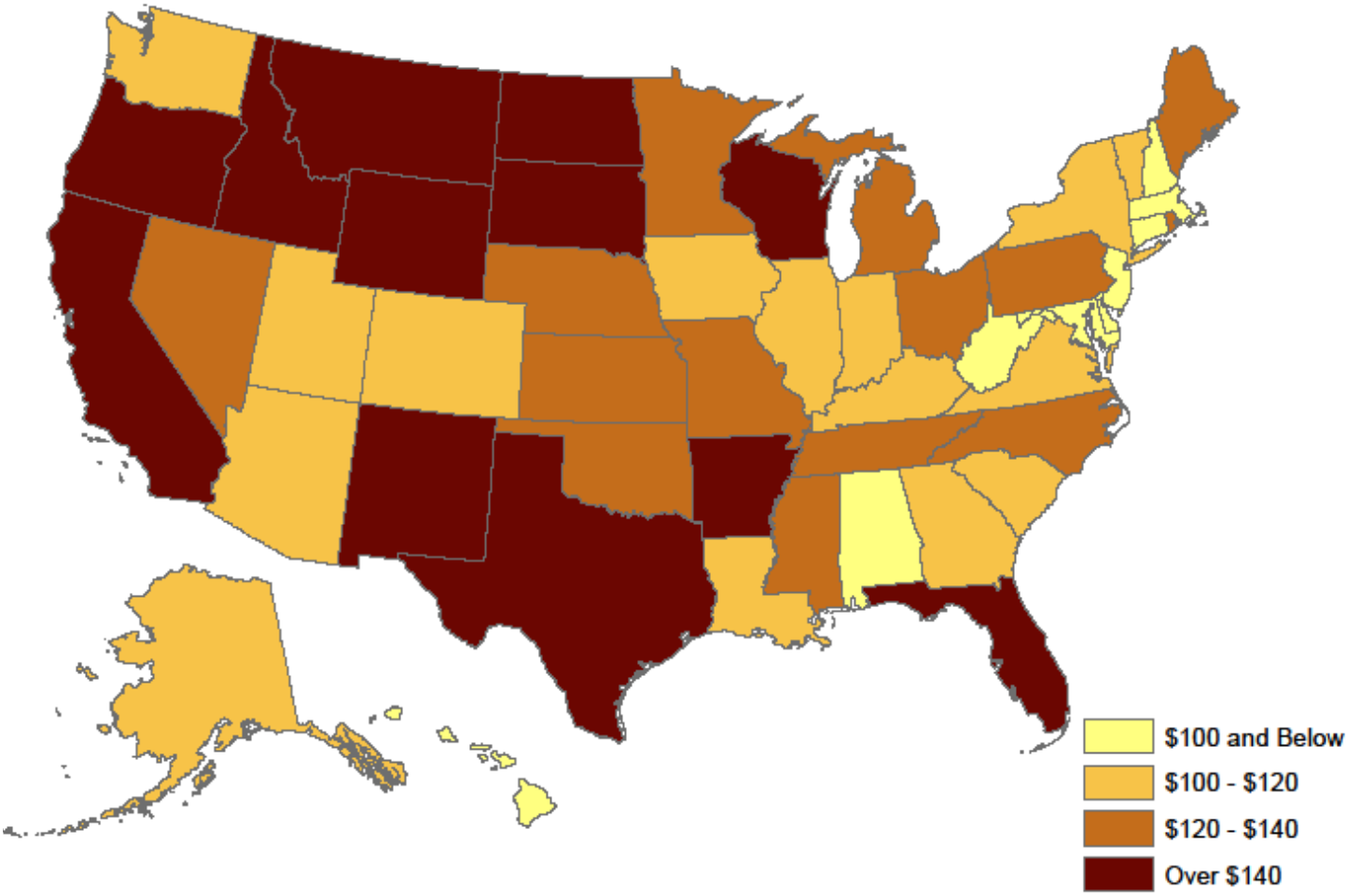

Table 5a. Nongroup Exchange Subsidies per Person

	Premium and Cost-Sharing Subsidies		
	Total	Per nonelderly person	Per person with subsidized coverage
Income Cluster			
Lowest Impact	$1,814,037,099	$81.18	$2,708.52
Moderate Impact	$5,541,225,707	$118.20	$2,920.10
High Subsidy Impact	$9,075,890,164	$135.84	$2,826.59
High Medicaid Impact	$16,898,104,094	$127.32	$3,001.21
Eligibility Cluster			
High ESI	10,260,743,412	$114.73	$2,901.62
Low ESI	23,068,513,652	$128.64	$2,930.27

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 5. Nongroup Exchange Subsidies per Person

	Premium and Cost Sharing Subsidies		
	Total	Per nonelderly person	Per person with subsidized coverage
New England:	**$1,038,311,112**	**$85.34**	**$2,865.96**
Connecticut	$295,468,348	$97.48	$3,054.03
Maine	$148,822,683	$133.77	$3,138.99
Massachusetts	$317,418,410	$58.42	$2,519.73
New Hampshire	$99,796,853	$87.19	$2,726.76
Rhode Island	$113,529,721	$124.25	$3,274.77
Vermont	$63,275,097	$119.17	$3,028.53
Middle Atlantic:	**$4,638,442,944**	**$111.94**	**$2,967.89**
Delaware	$65,583,629	$86.86	$2,788.06
District of Columbia	$53,861,859	$98.95	$2,910.51
Maryland	$401,192,556	$79.19	$2,595.72
New Jersey	$700,160,933	$91.29	$2,736.36
New York	$2,027,127,375	$118.91	$3,010.49
Pennsylvania	$1,390,516,592	$134.28	$3,181.51
East North Central:	**$4,982,583,112**	**$123.61**	**$2,895.23**
Illinois	$1,284,811,005	$112.36	$2,983.21
Indiana	$589,254,089	$107.91	$3,053.48
Michigan	$1,054,285,492	$121.96	$2,725.72
Ohio	$1,334,297,349	$134.18	$2,690.73
Wisconsin	$719,935,177	$149.21	$3,354.34
West North Central:	**$2,162,283,805**	**$124.15**	**$2,770.95**
Iowa	$275,739,122	$105.54	$2,663.09
Kansas	$285,608,531	$120.65	$2,492.53
Minnesota	$545,977,110	$121.53	$2,931.75
Missouri	$657,264,378	$127.90	$2,773.90
Nebraska	$213,761,491	$136.65	$3,162.11
North Dakota	$79,496,960	$145.14	$2,432.14
South Dakota	$104,436,213	$150.74	$2,695.06
South Atlantic:	**$5,523,292,592**	**$123.80**	**$2,963.03**
Florida	$2,319,669,751	$151.56	$2,938.73
Georgia	$892,147,868	$101.06	$2,866.41
North Carolina	$1,041,190,025	$126.18	$3,327.29
South Carolina	$396,736,204	$103.41	$2,380.83
Virginia	$737,076,361	$106.69	$3,005.38
West Virginia	$136,472,383	$91.96	$3,529.43
East South Central:	**$1,808,501,498**	**$115.42**	**$2,849.25**
Alabama	$348,904,258	$86.46	$2,517.09
Kentucky	$410,096,154	$111.35	$2,653.71
Mississippi	$332,353,989	$130.63	$2,763.44
Tennessee	$717,147,097	$132.67	$3,240.45
West South Central:	**$4,563,651,711**	**$141.61**	**$3,090.61**
Arkansas	$359,326,418	$146.23	$2,743.70
Louisiana	$386,514,451	$100.10	$2,649.92
Oklahoma	$396,888,269	$127.00	$2,819.43
Texas	$3,420,922,573	$150.15	$3,230.26
Mountain:	**$2,544,593,295**	**$128.45**	**$2,698.93**
Arizona	$641,540,455	$107.78	$2,715.79
Colorado	$527,357,962	$116.94	$2,420.51
Idaho	$211,500,176	$157.86	$2,374.67
Montana	$143,076,950	$168.98	$2,797.04
Nevada	$287,937,200	$122.36	$2,931.76
New Mexico	$350,564,490	$190.67	$3,411.22
Utah	$288,708,703	$115.66	$2,431.50
Wyoming	$93,907,359	$198.45	$3,262.48
Pacific:	**$6,067,596,994**	**$134.50**	**$2,939.74**
Alaska	$70,456,830	$114.01	$2,482.80
California	$4,786,659,451	$140.15	$2,988.96
Hawaii	$61,146,813	$55.46	$2,590.75
Oregon	$469,594,488	$140.03	$2,929.18
Washington	$679,739,412	$115.48	$2,716.32
Total	**$33,329,257,063**	**$124.01**	**$2,921.39**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 5: New Medicaid Eligibles Enrolled as a Percent of Total Enrollees

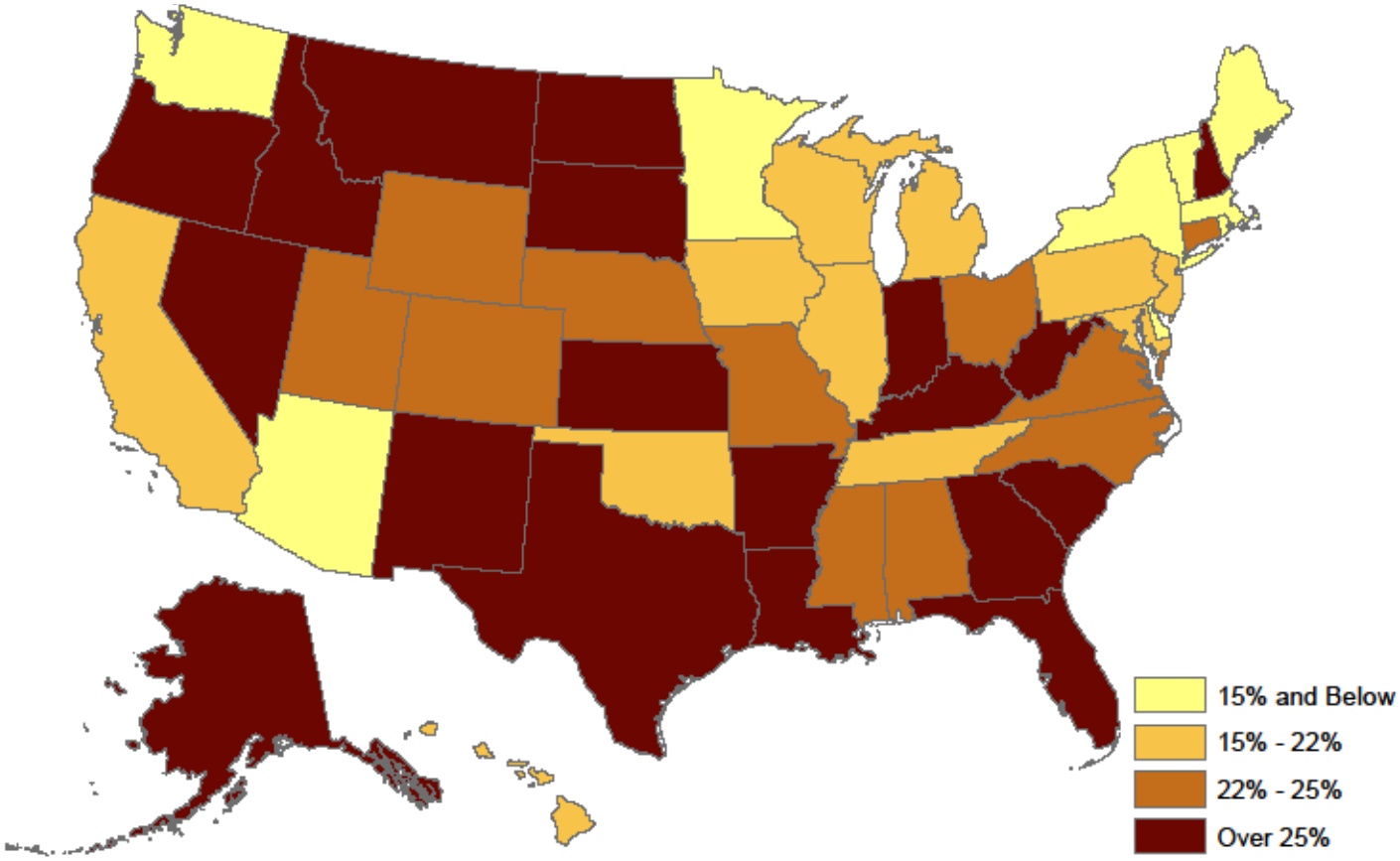

Table 6a. Enrollment in Medicaid/CHIP

Nonelderly persons (thousands)	Total Enrollment				Newly Enrolled Current Eligibles		New Eligibles Enrolled	
	Total	Adult non-parents	Adult parents	Children	Total	% of Enrollees	N	% of Enrollees
Income Cluster								
Lowest Impact	3,737	1,377	529	1,831	338	9.0%	585	15.7%
Moderate Impact	9,050	2,956	1,398	4,696	773	8.5%	1,601	17.7%
High Subsidy Impact	13,866	4,746	2,251	6,870	1,180	8.5%	3,484	25.1%
High Medicaid Impact	32,975	10,305	5,343	17,327	2,644	8.0%	6,580	20.0%
Eligibility Cluster								
High ESI	17,707	5,854	2,819	9,034	1,424	8.0%	3,557	20.1%
Low ESI	41,922	13,530	6,703	21,689	3,510	8.4%	8,694	20.7%

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 6. Enrollment in Medicaid/CHIP

Nonelderly persons (thousands)	Total Enrollment				Newly Enrolled Current Eligibles		New Eligibles Enrolled	
	Total	Adult non-parents	Adult parents	Children	Total	% of Enrollees	N	% of Enrollees
New England:	**2,319**	**870**	**396**	**1,052**	**126**	**5.4%**	**266**	**11.5%**
Connecticut	456	169	67	220	40	8.8%	107	23.4%
Maine	275	105	56	114	7	2.5%	37	13.4%
Massachusetts	1,103	439	190	474	45	4.1%	51	4.6%
New Hampshire	149	49	23	77	11	7.2%	39	25.9%
Rhode Island	214	67	43	105	14	6.4%	32	14.8%
Vermont	121	41	17	62	10	8.0%	1	1.1%
Middle Atlantic:	**8,768**	**2,980**	**1,394**	**4,393**	**809**	**9.2%**	**1,087**	**12.4%**
Delaware	139	44	28	67	14	10.1%	13	9.1%
District of Columbia	144	61	19	64	4	2.5%	17	11.9%
Maryland	750	247	97	406	70	9.3%	149	19.9%
New Jersey	1,279	474	152	653	172	13.4%	240	18.8%
New York	4,251	1,334	809	2,108	361	8.5%	207	4.9%
Pennsylvania	2,205	822	289	1,094	188	8.5%	461	20.9%
East North Central:	**8,947**	**2,842**	**1,574**	**4,532**	**683**	**7.6%**	**1,874**	**20.9%**
Illinois	2,504	774	420	1,310	193	7.7%	466	18.6%
Indiana	1,326	376	236	714	85	6.4%	334	25.2%
Michigan	1,894	618	348	928	141	7.5%	332	17.6%
Ohio	2,228	751	402	1,075	189	8.5%	527	23.7%
Wisconsin	996	323	167	505	74	7.4%	215	21.6%
West North Central:	**3,288**	**1,004**	**534**	**1,749**	**334**	**10.1%**	**651**	**19.8%**
Iowa	425	113	60	252	32	7.6%	71	16.8%
Kansas	443	138	68	238	37	8.4%	118	26.7%
Minnesota	795	241	132	422	99	12.5%	60	7.5%
Missouri	1,119	349	200	570	125	11.2%	272	24.3%
Nebraska	287	91	42	154	21	7.3%	69	24.2%
North Dakota	81	29	13	39	7	8.6%	23	28.5%
South Dakota	137	44	20	74	11	8.1%	37	26.6%
South Atlantic:	**9,350**	**3,388**	**1,375**	**4,587**	**735**	**7.9%**	**2,688**	**28.8%**
Florida	3,286	1,319	462	1,506	295	9.0%	1,055	32.1%
Georgia	1,888	616	249	1,023	176	9.3%	544	28.8%
North Carolina	1,900	632	298	971	118	6.2%	474	25.0%
South Carolina	862	330	148	384	60	7.0%	263	30.5%
Virginia	1,020	350	152	518	67	6.6%	244	23.9%
West Virginia	393	141	67	185	18	4.5%	108	27.4%
East South Central:	**4,160**	**1,486**	**649**	**2,025**	**238**	**5.7%**	**957**	**23.0%**
Alabama	976	333	146	496	54	5.5%	232	23.8%
Kentucky	988	364	164	460	42	4.2%	265	26.8%
Mississippi	816	291	116	410	48	5.9%	180	22.1%
Tennessee	1,380	498	223	659	95	6.9%	280	20.3%
West South Central:	**8,223**	**2,331**	**1,267**	**4,625**	**730**	**8.9%**	**2,114**	**25.7%**
Arkansas	687	197	115	375	39	5.7%	182	26.5%
Louisiana	1,044	345	149	549	86	8.2%	304	29.1%
Oklahoma	675	191	97	387	37	5.4%	147	21.8%
Texas	5,817	1,597	906	3,314	568	9.8%	1,481	25.5%
Mountain:	**3,936**	**1,152**	**658**	**2,125**	**413**	**10.5%**	**715**	**18.2%**
Arizona	1,398	366	258	774	155	11.1%	79	5.7%
Colorado	722	229	124	369	69	9.6%	171	23.7%
Idaho	271	76	45	150	25	9.4%	69	25.6%
Montana	161	53	29	79	18	11.5%	43	26.4%
Nevada	378	140	48	191	50	13.3%	95	25.1%
New Mexico	563	163	84	315	36	6.4%	148	26.3%
Utah	359	98	59	203	53	14.9%	89	24.8%
Wyoming	84	27	11	45	5	6.1%	21	24.9%
Pacific:	**10,638**	**3,329**	**1,675**	**5,634**	**867**	**8.1%**	**1,899**	**17.8%**
Alaska	117	44	17	56	10	8.3%	32	26.9%
California	8,460	2,646	1,344	4,470	690	8.2%	1,456	17.2%
Hawaii	225	73	32	120	12	5.5%	42	18.9%
Oregon	730	266	121	342	46	6.4%	255	34.9%
Washington	1,106	299	161	646	108	9.7%	114	10.3%
Total	**59,629**	**19,384**	**9,522**	**30,723**	**4,934**	**8.3%**	**12,251**	**20.5%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Figure 6: New Federal Medicaid and Exchange Dollars per Nonelderly

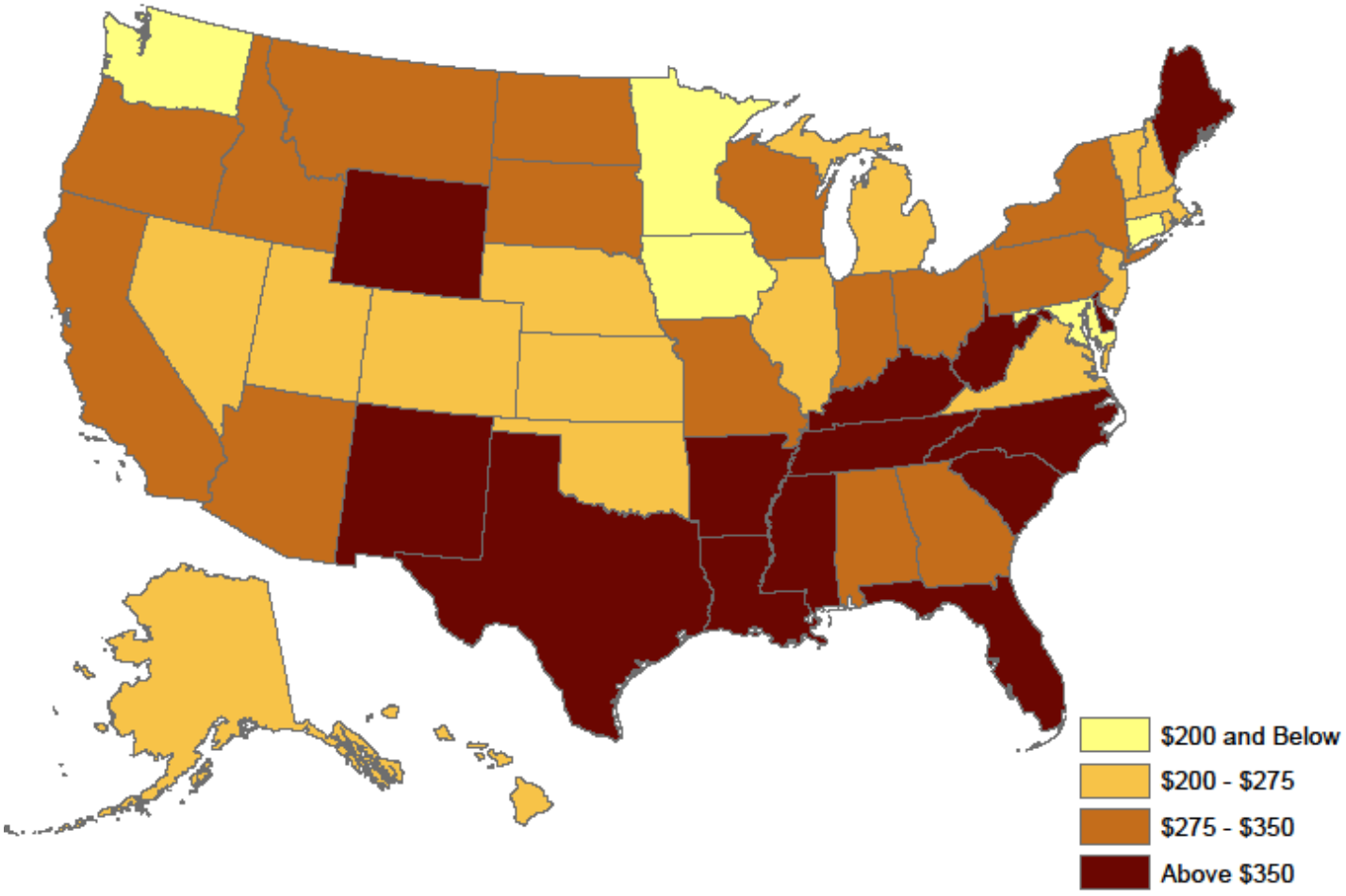

Table 7. Enrollment in Medicaid/CHIP

	Enrollment by Person Type			
Nonelderly persons (thousands)	Total	Adult non-parents	Adult parents	Children
Total	59,629	19,384	9,522	30,723
Newly Enrolled Current Eligibles	4,934	376	850	3,708
Newly Eligible Enrollees	12,251	9,984	2,207	60

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 8. Medicaid/CHIP Spending on Acute Care for the Nonelderly

($ millions)	Total costs[1]	Total costs of new eligibles[2]	Percent of costs incurred by new eligibles	Percent of enrollees who are new eligibles
New England:	**14,934**	**891**	**6.0%**	**11.5%**
Connecticut	2,233	367	16.4%	23.4%
Maine	1,943	157	8.1%	13.4%
Massachusetts	7,730	81	1.0%	4.6%
New Hampshire	864	159	18.4%	25.9%
Rhode Island	1,506	118	7.8%	14.8%
Vermont	657	9	1.4%	1.1%
Middle Atlantic:	**55,532**	**4,769**	**8.6%**	**12.4%**
Delaware	1,010	124	12.3%	9.1%
District of Columbia	1,188	102	8.6%	11.9%
Maryland	3,342	588	17.6%	19.9%
New Jersey	6,127	896	14.6%	18.8%
New York	28,754	682	2.4%	4.9%
Pennsylvania	15,110	2,377	15.7%	20.9%
East North Central:	**46,977**	**6,732**	**14.3%**	**20.9%**
Illinois	12,689	1,320	10.4%	18.6%
Indiana	7,764	1,299	16.7%	25.2%
Michigan	9,764	1,151	11.8%	17.6%
Ohio	12,488	1,874	15.0%	23.7%
Wisconsin	4,272	1,088	25.5%	21.6%
West North Central:	**18,496**	**2,057**	**11.1%**	**19.8%**
Iowa	1,882	363	19.3%	16.8%
Kansas	2,269	245	10.8%	26.7%
Minnesota	4,260	184	4.3%	7.5%
Missouri	7,362	854	11.6%	24.3%
Nebraska	1,381	178	12.9%	24.2%
North Dakota	383	96	25.2%	28.5%
South Dakota	958	136	14.2%	26.6%
South Atlantic:	**46,016**	**11,953**	**26.0%**	**28.8%**
Florida	16,596	4,549	27.4%	32.1%
Georgia	8,307	2,134	25.7%	28.8%
North Carolina	10,279	2,804	27.3%	25.0%
South Carolina	3,541	953	26.9%	30.5%
Virginia	5,004	877	17.5%	23.9%
West Virginia	2,288	636	27.8%	27.4%
East South Central:	**24,643**	**4,544**	**18.4%**	**23.0%**
Alabama	5,229	1,062	20.3%	23.8%
Kentucky	6,565	1,123	17.1%	26.8%
Mississippi	3,882	675	17.4%	22.1%
Tennessee	8,968	1,684	18.8%	20.3%
West South Central:	**32,791**	**7,016**	**21.4%**	**25.7%**
Arkansas	2,699	645	23.9%	26.5%
Louisiana	4,190	1,214	29.0%	29.1%
Oklahoma	3,960	410	10.4%	21.8%
Texas	21,942	4,747	21.6%	25.5%
Mountain:	**15,439**	**2,585**	**16.7%**	**18.2%**
Arizona	5,260	420	8.0%	5.7%
Colorado	3,129	727	23.2%	23.7%
Idaho	1,198	225	18.8%	25.6%
Montana	636	123	19.3%	26.4%
Nevada	1,443	261	18.1%	25.1%
New Mexico	1,876	519	27.7%	26.3%
Utah	1,466	216	14.7%	24.8%
Wyoming	429	94	22.0%	24.9%
Pacific:	**45,729**	**5,705**	**12.5%**	**17.8%**
Alaska	601	84	13.9%	26.9%
California	37,363	4,425	11.8%	17.2%
Hawaii	983	156	15.9%	18.9%
Oregon	2,501	750	30.0%	34.9%
Washington	4,282	289	6.8%	10.3%
Total	**300,556**	**46,252**	**15.4%**	**20.5%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.
[1]Spending on acute care for the nonelderly.
[2]Does not include spending on newly-enrolled current eligibles.

Table 9. Federal Medicaid and Exchange Subsidy Dollars

($ millions)	Costs of New Medicaid Enrollees			Additional federal payments for existing enrollees[3]	Total exchange subsidies	Total new federal dollars	Total new federal dollars per nonelderly
	Total costs[1]	Federal payments[2]	Percent reimbursed				
New England:	**1,063**	**848**	**79.8%**	**823**	**1,038**	**2,709**	**223**
Connecticut	242	190	78.5%	78	295	563	186
Maine	213	178	83.2%	72	149	399	358
Massachusetts	216	165	76.3%	619	317	1,102	203
New Hampshire	184	156	84.5%	0	100	255	223
Rhode Island	170	133	78.4%	0	114	247	270
Vermont	38	27	71.5%	54	63	144	271
Middle Atlantic:	**6,143**	**4,865**	**79.2%**	**1,995**	**4,638**	**11,498**	**277**
Delaware	141	120	85.2%	121	66	306	406
District of Columbia	111	98	88.3%	0	54	152	279
Maryland	710	590	83.1%	0	401	991	196
New Jersey	1,416	1,066	75.3%	0	700	1,766	230
New York	1,678	1,260	75.1%	1,627	2,027	4,914	288
Pennsylvania	2,087	1,731	82.9%	248	1,391	3,369	325
East North Central:	**7,579**	**6,324**	**83.4%**	**208**	**4,983**	**11,515**	**286**
Illinois	1,790	1,424	79.6%	0	1,285	2,709	237
Indiana	1,251	1,095	87.5%	44	589	1,728	316
Michigan	1,474	1,231	83.5%	0	1,054	2,285	264
Ohio	2,347	1,981	84.4%	0	1,334	3,315	333
Wisconsin	716	594	82.9%	164	720	1,478	306
West North Central:	**2,416**	**1,955**	**80.9%**	**93**	**2,162**	**4,210**	**242**
Iowa	116	88	75.9%	84	276	448	171
Kansas	290	246	85.0%	0	286	532	225
Minnesota	388	258	66.6%	9	546	813	181
Missouri	1,113	932	83.8%	0	657	1,590	309
Nebraska	245	200	81.7%	0	214	414	264
North Dakota	119	101	84.8%	0	79	181	330
South Dakota	144	128	88.4%	0	104	232	335
South Atlantic:	**13,230**	**11,521**	**87.1%**	**0**	**5,523**	**17,045**	**382**
Florida	5,080	4,372	86.1%	0	2,320	6,692	437
Georgia	2,437	2,116	86.8%	0	892	3,008	341
North Carolina	2,998	2,649	88.4%	0	1,041	3,690	447
South Carolina	1,107	966	87.2%	0	397	1,362	355
Virginia	932	817	87.7%	0	737	1,554	225
West Virginia	676	602	89.0%	0	136	738	498
East South Central:	**4,876**	**4,311**	**88.4%**	**0**	**1,809**	**6,120**	**391**
Alabama	1,149	1,014	88.2%	0	349	1,362	338
Kentucky	1,162	1,038	89.3%	0	410	1,448	393
Mississippi	733	649	88.5%	0	332	981	386
Tennessee	1,832	1,611	87.9%	0	717	2,328	431
West South Central:	**8,056**	**6,944**	**86.2%**	**0**	**4,564**	**11,508**	**357**
Arkansas	705	624	88.5%	0	359	984	400
Louisiana	1,326	1,173	88.4%	0	387	1,559	404
Oklahoma	446	393	88.1%	0	397	790	253
Texas	5,579	4,754	85.2%	0	3,421	8,175	359
Mountain:	**3,209**	**2,678**	**83.4%**	**422**	**2,545**	**5,645**	**285**
Arizona	786	649	82.7%	376	642	1,667	280
Colorado	812	697	85.8%	0	527	1,224	271
Idaho	249	219	88.0%	0	212	431	322
Montana	157	134	85.2%	0	143	277	327
Nevada	411	310	75.4%	0	288	598	254
New Mexico	336	296	88.1%	41	351	688	374
Utah	361	286	79.3%	4	289	579	232
Wyoming	98	87	88.6%	0	94	181	382
Pacific:	**7,340**	**5,859**	**79.8%**	**112**	**6,068**	**12,038**	**267**
Alaska	109	88	80.9%	0	70	158	256
California	5,882	4,695	79.8%	0	4,787	9,481	278
Hawaii	191	161	84.0%	39	61	261	237
Oregon	689	600	87.1%	36	470	1,106	330
Washington	469	315	67.2%	37	680	1,032	175
Total	**53,912**	**45,305**	**84.0%**	**3,653**	**33,329**	**82,287**	**306**

Source: Urban Institute analysis, HIPSM 2011.

Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

[1]Spending on acute care for the nonelderly.

[2]Medicaid match rules were used for the expenses of children. We did not attempt to separate enrollment in stand-alone CHIP programs from Medicaid programs for children or CHIP-funded Medicaid programs. Since the large majority of new enrollees are adults, this leads to a modest underestimate.

[3]Includes section 1115 enrollees below 138 percent of the FPL in enhanced match states and 1115 enrollees below 138 percent of the FPL in states with limited-benefit Medicaid programs for adults.

Table 9a. Federal Medicaid and Exchange Subsidy Dollars

($ millions)	Costs of New Medicaid Enrollees			Additional federal payments for existing enrollees[3]	Total exchange subsidies	Total new federal dollars	Total new federal dollars per nonelderly
	Total costs[1]	Federal payments[2]	Percent reimbursed				
Income Cluster							
Lowest Impact	2,768	2,167	78.3%	697	1,814	4,678	209
Moderate Impact	7,056	5,721	81.1%	468	5,541	11,730	250
High Subsidy Impact	14,259	12,067	84.6%	361	9,076	21,504	322
High Medicaid Impact	29,829	25,350	85.0%	2,127	16,898	44,376	334
Eligibility Cluster							
High ESI	14,229	11,804	83.0%	1,459	10,261	23,524	263
Low ESI	39,683	33,501	84.4%	2,194	23,069	58,763	328

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.
[1]Spending on acute care for the nonelderly.
[2]Medicaid match rules were used for the expenses of children. We did not attempt to separate enrollment in stand-alone CHIP programs from Medicaid programs for children or CHIP-funded Medicaid programs. Since the large majority of new enrollees are adults, this leads to a modest underestimate.
[3]Includes section 1115 enrollees below 138 percent of the FPL in enhanced match states and 1115 enrollees below 138 percent of the FPL in states with limited-benefit Medicaid programs for adults.

Notes

1 Matthew Buettgens, Bowen Garrett and John Holahan, "America under the Affordable Care Act" (Washington, DC: The Urban Institute, 2010).

2 This is lower than the 16.0 million projected by CBO and 15.9 million projected by Holahan and Headen primarily because it is a 2011 estimate rather than a forecast for 2019. John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% Poverty" (Washington, DC: The Urban Institute, 2010), http://www.kff.org/healthreform/8076.cfm.

3 Holahan and Headen, 2010.

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

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

6 Buettgens, Garrett and Holahan, 2010.

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

8 Blumberg, et al., "Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options," (Washington, DC: The Urban Institute, 2009) http://www.urban.org/url.cfm?ID=411925

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

10 Holahan and Headen, 2010.

11 There are other reasons why the unsubsidized might enroll in the exchanges, e.g., those eligible for employee choice vouchers.

12 There will be some below 138 percent of the FPL who are eligible for subsidies, namely legal immigrants who have been residents less than five years. They are not eligible for Medicaid.

13 Florida, as we have seen, would see the largest decline in its uninsurance rate of any state. The decline is noticeably higher than that of any of its neighbors. Much of the gain in coverage is in the nongroup exchanges, so we should not be surprised that it stands out here as well. Vermont has substantially higher than average per capita health costs and would have a significantly higher than average share of its exchange enrollment in the subsidy eligibility range. Average per capita health costs are from National Health Expenditure Accounts, CMS Office of the Actuary.

14 "Income eligibility levels for children's regular Medicaid and children's CHIP-funded Medicaid expansions by annual incomes as a percent of the federal poverty level (FPL), December 2009," http://www.statehealthfacts.org, Kaiser Family Foundation and "Income eligibility levels for children's separate CHIP programs by annual incomes as a percent of the federal poverty level (FPL), December 2009," http://www.statehealthfacts.org, Kaiser Family Foundation

15 "Medicaid and state funded coverage income eligibility limits for low-income adults, 2009," http://www.statehealthfacts.org, Kaiser Family Foundation

16 For more detailed figures at the national level, see Matthew Buettgens, Bowen Garrett and John Holahan, "America under the Affordable Care Act" (Washington, DC: The Urban Institute, 2010)

17 Delaware and Hawaii, two states in which the share of expenses incurred by the newly eligible would be much higher than the share of newly eligible enrollees, have Medicaid-level benefit programs for childless adults and also have per capita health care costs significantly higher than the national average.

18 For further details on the separation of federal and state Medicaid costs, see Holahan and Headen (2010).

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