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Medicaid

Medicaid Expansion States Help More Working People Get Health Coverage

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Under the Affordable Care Act (ACA), starting in 2014, states have the option to extend Medicaid coverage to most low-income adults (adults with incomes below 138 percent of the federal poverty level, or $27,720 for a family of three in 2015). The federal government pays nearly all of the cost of this expanded coverage.[1] In 2014, 26 states chose to expand Medicaid, giving more working, uninsured adults the opportunity to gain health coverage; the remaining 24 states chose not to expand Medicaid that year.[2]

Compared to 2013, the number of workers who were uninsured in 2014 declined in virtually every state, but the overall rate of decline was substantially higher in states that expanded Medicaid.

- States that expanded Medicaid saw, on average, a 25 percent reduction in the number of residents who were working but uninsured.
- In states that chose not to expand Medicaid, the average reduction was 13 percent.
- The average percent reduction across expansion states was nearly twice the percent reduction across non-expansion states.

This shows a strong link between a state's decision to expand Medicaid and increases in health coverage for working residents.

A State's Decision to Expand Medicaid Is Linked to Increased Health Coverage for Its Working Residents

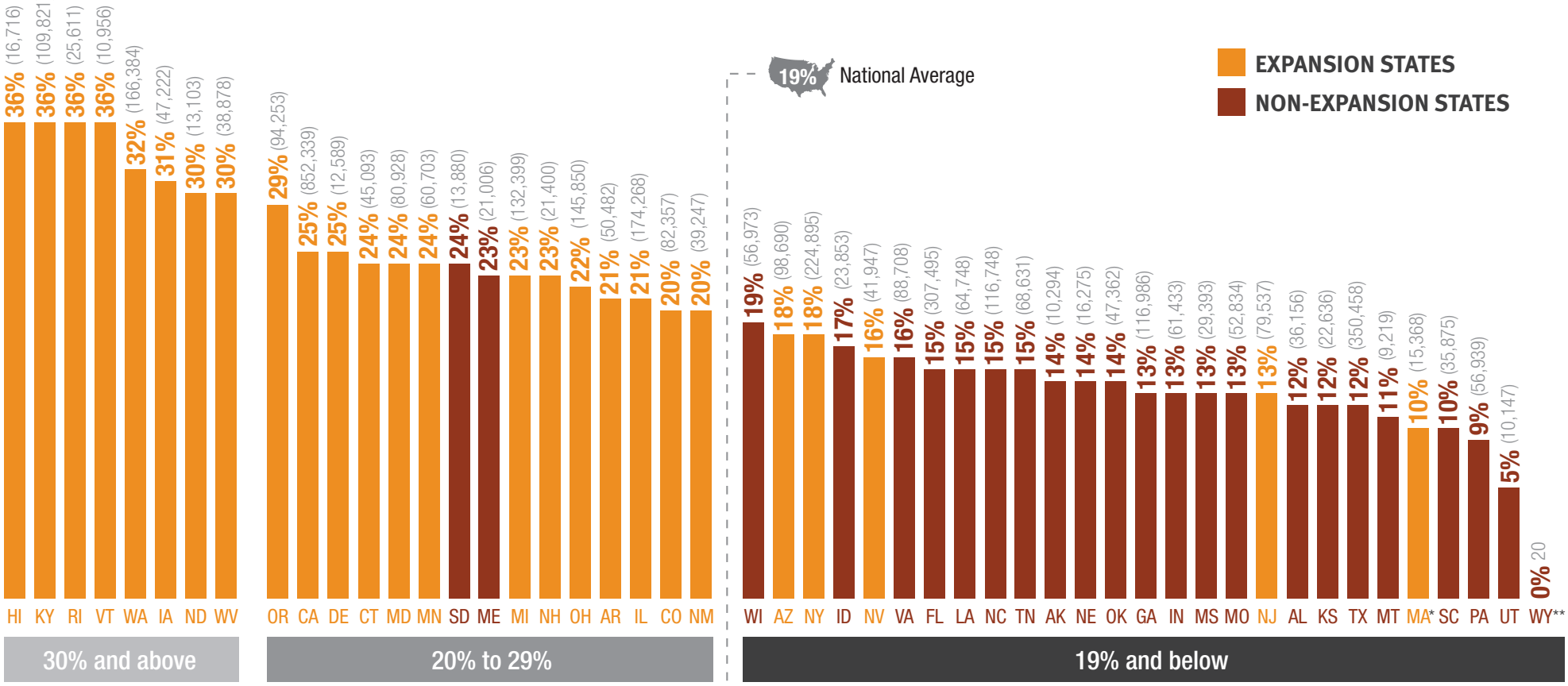
We found that with ACA implementation and the new opportunities for individuals to buy affordable coverage in the health insurance marketplaces, the number of workers who were uninsured declined in nearly all states from 2013 to 2014. However, the magnitude of that reduction was significantly higher in states that expanded Medicaid. (See the graphic on page 3).

- Of the 26 states that expanded Medicaid in 2014, 21 (80 percent) saw a decrease of at least 20 percent in the number of workers who were uninsured. This compares to only two of the 24 non-expansion states (8 percent) that saw a decrease of at least 20 percent.
- Eight of the Medicaid expansion states (30 percent) saw the number of working residents without insurance fall by 30 percent or more. None of the non-expansion states saw a decrease of 30 percent or more.

States that have expanded Medicaid are doing more to help working residents than states that choose not to expand Medicaid. In 2014, the first year of Medicaid expansion under the Affordable Care Act, the percent of people who were working but had no health insurance dropped by nearly twice as much across states that expanded Medicaid as it did across states that did not expand.

Decrease in the Percent of Workers Who Are Uninsured

A comparison of Medicaid expansion and non-expansion states by percentage decrease in employed but uninsured, 2013-2014



* Massachusetts expanded coverage statewide to adults in 2006, and uninsured workers were therefore not as greatly affected by the implementation of the ACA and Medicaid Expansion in 2014.

** The small sample size for Wyoming may affect data reliability.

Notes: Only states that implemented their Medicaid expansion in 2014 are included as "expansion states." Additional states have expanded Medicaid since the end of 2014. See the Methodology for more information. Washington, D.C. is not included in this analysis; demographically, it is more comparable to cities than to states.

Our Analysis Looks at Changes in Health Coverage among Workers in Every State

An earlier data analysis by Families USA found that the majority of those who could gain coverage through Medicaid expansion—57 percent—were working.[3] That analysis was based on data projections of the number and work status of people in each state who would be newly eligible for coverage if their state expanded Medicaid.

This analysis goes one step further and looks at reported changes in health coverage among uninsured working residents in every state, comparing data from 2013 (the year immediately prior to Medicaid expansion under the ACA) with data from 2014 (the first full year of ACA Medicaid expansion).[4]

In this analysis, Families USA used data from the American Community Survey, the U.S. Census Bureau's large ongoing survey of Americans. We looked at data on health coverage and employment status for each state for 2013 and 2014. This is the most current American Community Survey data available that covers the period after full implementation of the ACA.

For each state, Families USA analyzed the change in the number of employed individuals reporting that they were uninsured and compared data for states that had expanded Medicaid in 2014 with states that had not taken up the expansion.

Unlike prior analyses, this analysis shows actual changes in health coverage among state residents, rather than estimates of those who are eligible to enroll. (See the Methodology for a more detailed discussion of our data and calculations.)

Expanding Medicaid Is Not Only Good for Workers and Their Families, It Is Also Good for Businesses and State Economies

When working people have health insurance, they are more productive, take fewer sick days, and report fewer instances of disability.[5] A healthier, more productive workforce helps strengthen the businesses and industries we rely on every day.

Expanding Medicaid promotes states' economic growth in other ways, too.

Stronger Health Care Systems

People who don't have health insurance still get sick and need medical care. Many uninsured consumers, particularly those with lower incomes, are not able to pay for the care they receive.

Most hospitals that care for uninsured patients end up providing significant amounts of what is called uncompensated care—care that patients cannot pay for because they have no (or inadequate) insurance. Providing uncompensated care hurts hospital finances.

When more residents have insurance (particularly lower-income residents, who are less able to pay for health care if they are uninsured), hospitals and health care professionals do not have to provide as much uncompensated care, which saves them money. States that have expanded Medicaid saw substantially greater decreases in uncompensated care costs than states that have not expanded Medicaid.[6] That's good for the bottom lines of hospitals and health care systems.

Growth in Health Sector Employment

In most states, the health care sector, and hospitals in particular, are among the largest employers. Expanding Medicaid increases health coverage and lowers uncompensated care costs, which can give hospitals a stronger bottom line. That allows them to invest in things like hiring staff and infrastructure improvements.

States that have expanded Medicaid are generally seeing larger increases in the percent of residents with insurance and larger decreases in uncompensated care than states that did not expand Medicaid.[7] Expansion states are also generally seeing a bigger increase in health care jobs than non-expansion states.[8] And increased employment means a broader tax base, stronger local and state economies, and even a stronger national economy.

What happens to low-income, uninsured workers in states that don't expand Medicaid?

Among states that have not expanded Medicaid, most do not provide Medicaid to non-disabled adults who do not have dependent children, no matter how low their income. And while every non-expansion state offers Medicaid to low-income parents with dependent children, qualifying income levels vary across states and can be shockingly low. For example, two states limit eligibility to those with a family income at or below 18 percent of poverty ($3,620 a year for a family of three); 13 states have income eligibility levels that are below 50 percent of poverty ($10,045 a year for a family of three).[9]

Low-income, working adults in non-expansion states have few options for affordable health insurance, especially if they do not have job-based coverage. Many of these adults cannot afford to buy insurance in the health insurance marketplaces because they earn too little to qualify for premium tax credits (premium tax credits are available only to individuals with incomes *above* the federal poverty level).

This leaves a large number of low-income residents in nearly every non-expansion state, including many working adults, in what is called the "coverage gap." These residents do not qualify for Medicaid (either because they do not have dependent children or because they earn too much), but they earn too little to be eligible for the tax credits that would help them afford marketplace coverage. Most of these individuals are left with no option for affordable health insurance.

State and Local Savings

Expanding Medicaid can also help state and local budgets. In every state, local and state governments pay for a portion of hospital uncompensated care costs. Many states also fund a variety of other health care programs for the uninsured, such as community mental health services and inpatient hospital stays for prison inmates.

Expanding Medicaid reduces state costs for these locally funded programs by providing coverage to people who would otherwise use these services.[10] And because the federal government—not the states—pays nearly all the costs of those newly insured through Medicaid, expanding Medicaid helps states lower their spending on uncompensated care and other state-funded programs. Many states have seen budget savings and revenue gains.[11]

A healthier workforce, stronger health care sector, increased employment, and state and local savings all contribute to stronger state economies.

Our analysis of the most recent Census Bureau data shows a strong connection between a state's decision to expand Medicaid and increased health coverage for its working residents. State legislators and governors can choose to accept federal funding and expand health coverage through Medicaid at any time, and the federal government pays nearly all of the costs for those gaining coverage. A decision to expand Medicaid supports a healthier workforce and stronger state economies.

Methodology

Data Source

To analyze state residents' employment and insurance status, Families USA used the Public Use Microdata Sample (PUMS) database. This database is derived from the American Community Survey, an ongoing public survey conducted by the U.S. Census Bureau. It is designed to give communities the current information they need to plan and invest. Both national and state data are available.

For each state, we gathered information on respondents' age, health insurance status, and work status. Families USA used data from two one-year data samples: 2013 and 2014. We did this to capture the year prior to full ACA implementation and the first year of full ACA implementation.

More information on the American Community Survey is available online at https://www.census.gov/acs/www/about_the_survey/american_community_survey/.

How We Sorted and Interpreted the Data

To identify the populations that were working in 2013 and 2014 and who would be affected by the coverage options available under the Affordable Care Act (ACA), Families USA sorted the sample to capture responses of individuals who were aged 18-64 who reported being employed. Respondents were classified as employed if they had worked at a job either full-time or part-time within the last week.[1]

To identify the populations that were insured in 2013 and 2014, we sorted the sample to capture the responses of individuals who reported having public coverage (Medicaid or Medicare), private coverage (employer-sponsored insurance or individual market insurance), or VA or TRICARE coverage within the last week. Those that did not identify a source of coverage were classified as uninsured.

Comparing 2013 to 2014

We compared data from 2013 and 2014 for people who reported being both employed but without health insurance. We calculated the relative percent decrease in the working but uninsured from 2013 to 2014 for all 50 states and then sorted the states into "expansion" and "non-expansion" groups.

Expansion States and Non-Expansion States

States were considered Medicaid expansion states if they expanded coverage at any time in calendar year 2014. Therefore, we considered both Michigan and New Hampshire to be Medicaid expansion states because they expanded Medicaid to all residents with incomes below 138 percent of the federal poverty level in 2014. (Michigan expanded beginning on April 1, 2014, and New Hampshire expanded beginning on July 1, 2014.)

Because of the unique nature of the District of Columbia, which is a city and not demographically comparable to states, we excluded it from this analysis.

We considered Wisconsin to be a non-expansion state because it has declined federal funds to expand Medicaid to all residents with incomes below 138 percent of poverty. However, the state has used its existing Medicaid program to close its coverage gap by raising Medicaid eligibility levels to cover adults without dependent children who have incomes up to 100 percent of poverty, thus making more people eligible for health insurance. It should also be noted that the state dropped Medicaid coverage for parents who had incomes above the federal poverty level.

States that expanded Medicaid in 2015, notably Alaska, Indiana, and Montana, were all counted as non-expansion states, as they had not expanded in 2014.

Data Limitations and Outlier States

Because there is only one year's worth of data that captures full ACA implementation (2014), this analysis uses one-year ACS samples rather than three- or five-year samples. The data we used represent the most up-to-date information on insurance and work status post ACA implementation. However, because of the smaller sample size, our results are less reliable, particularly for sparsely populated states (e.g., South Dakota and Wyoming). Nevertheless, the difference between the average decreases for expansion and non-expansion states is sufficiently compelling for us to strongly infer an effect on workers' health insurance status.

Several factors can affect the results for an individual state. While the report's findings of a significantly greater decline in uninsured workers in expansion states versus non-expansion states from 2013 to 2014 holds true for most states, there are some outliers.

Results for Massachusetts were affected by the fact that the state expanded coverage for all residents in 2006. Because the state offered universal coverage prior to 2013, the effects of the ACA were less significant.

Among expansion states, those that had previously offered Medicaid coverage to childless adults (either through a waiver or as part of their standard Medicaid program), as well as those that had higher income eligibility levels for parents, showed smaller declines in uninsured workers because the states offered broader coverage prior to the ACA.[2] This group includes states like Arizona, New Jersey, and New York.[3]

State policy decisions about health coverage can affect the results for non-expansion states as well. For example, in 2013, Maine cut Medicaid for parents with family incomes above the federal poverty level (the state had offered coverage to parents with family incomes up to 200 percent of poverty). The state's uninsured rate later increased.[4] This is a group that is eligible for premium tax credits to help buy marketplace coverage, and many parents in this income group may have regained their coverage in 2014 when marketplace coverage became available. Wisconsin, as noted above, declined federal Medicaid expansion funds but did extend Medicaid coverage for childless adults in 2014. In both states, these decisions likely increased the number of working residents who gained coverage in 2014.

Endnotes

1 Prior to 2014, most states offered very limited Medicaid coverage to non-disabled adults under age 65. In states that choose to expand Medicaid to cover adults with incomes up to 138 percent of poverty, the federal government pays all of the cost of covering newly eligible individuals through 2016. Beginning in 2017, the federal share gradually declines until it reaches 90 percent in 2020, where it stays. This federal matching rate is significantly more generous than matching rates in the traditional Medicaid program, where the federal share ranges from 50 to 75 percent, averaging 59 percent of Medicaid costs.

2 We counted states that implemented their Medicaid expansion at any point in 2014 as "expansion states" for the purposes of this analysis. In 2015, Alaska, Indiana, and Montana expanded their Medicaid programs. Since they did not implement their Medicaid expansions in 2014, we considered them to be "non-expansion" states for the purposes of this analysis. In addition, because of the unique nature of the District of Columbia, which is not demographically comparable to states, we excluded it from our analysis.

3 Families USA, *Medicaid: Providing Vital Health Coverage to Low-Income Adults* (Washington, DC: Families USA, October 2015), available online at http://familiesusa.org/sites/default/files/product_documents/MCD_Fed%20Defense_Factsheet_Medicaid%20Adults_web.pdf. Families USA calculation based on an analysis of American Community Survey (Census) data of the work status of uninsured adults (ages 19-64) with incomes below 138 percent of poverty. This is the group that benefits from Medicaid expansion. Data are for 2010-2012.

4 Because there is only one year's worth of data that captures full-ACA implementation (2014), our analysis compares two single-year data sets rather than three- or five-year samples. Using multi-year samples improves data reliability, particularly for sparsely populated states. Nevertheless, the differences between the results for expansion and non-expansion states are sufficiently compelling for us to strongly infer an effect on workers' health insurance status. Several factors can affect the results for individual states, such as state Medicaid policies and state laws that regulate the insurance industry. For a more extensive discussion of our data and the factors that affected outlier states, see our Methodology.

5 For a discussion of the link between workers' health and productivity, see Centers for Disease Control and Prevention, *Workplace Health Promotion*, *Worker Productivity*, available online at http://www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html, page last updated on October 23, 2013. Also see R. Leoppke et al., "Health and Productivity as a Business Strategy," *Journal of Occupational and Environmental Medicine* 49, no. 7 (2007): 712-721, available online at http://www.acoem.org/uploadedFiles/Healthy_Workplaces_Now/HPM%20As%20a%20Business%20Strategy.pdf.

6 Colorado Hospital Association, *Impact of Medicaid Expansion on Hospital Volumes* (Greenwood Village, CO: Colorado Hospital Association, June 2014), available online at http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014.aspx.

7 For a discussion of comparative changes in uninsured rates, see Sarah Kliff and Soo Oh, "*Here's How much Obamacare Has Cut the Uninsured Rate in Every State*," *VOX*, January 16, 2016, available online at http://www.vox.com/2016/1/6/10685676/uninsured-decline-rate?_hsenc=p2ANqtz-9B9LDcoR-kZRiHO0n0G8MddreJOM53k9fmCZ5qTZ7JIv4UZams2CfKl8jbYRw8TWX7641AsMJb0H-XmvnwpUlgx5EwcA&_hsmi=25058049. For a discussion of the comparative reduction in uncompensated care costs, see Deborah Bachrach et al., *The Impact of Medicaid Expansion on Uncompensated Care Costs* (Princeton, NJ: State Health Reform Assistance Network, June 2015), available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420741.

8 Fitch Ratings, *Health Care Jobs Grew Faster in Medicaid Expansion States*, February 19, 2015, available online at https://www.fitchratings.com/gws/en/fitchwire/fitchwirearticle/Healthcare-Jobs-Grew?pr_id=980053; Patrick Willard, *Medicaid Expansion States See Financial Savings and Health Care Jobs Growth*, Families USA blog, March 24, 2015, available online at http://familiesusa.org/blog/2015/03/ medicaid-expansion-states-see-financial-savings-and-health-carejobs-growth.

9 Kaiser Family Foundation, State Health Facts, *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level* (Washington, DC: Kaiser Family Foundation, data current as of November 2015), available online at http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/#. Income calculations are based on 2015 poverty levels.

10 Deborah Bacharach et al., *States Expanding Medicaid See Significant Budget Savings and Revenue Gains* (New Jersey: The Robert Wood Johnson Foundation and Manatt Health Solutions, April 2015), available online at http://www.rwjf.org/en/library/research/2015/04/states-expanding-medicaid-see-significant-budget-savings-and-rev.html; Stan Dorn, Norton Francis, Robin Rudowitz, and Laura Snyder, *The Effect of Medicaid Expansion on State Budgets: An Early Look in Select States* (Menlo Park, CA: Kaiser Family Foundation, March 11, 2015), available online at http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.

11 Ibid.

Methodology Endnotes

1 *American Community Survey and Puerto Rico Community Survey 2014 Subject Definitions*, available online at http://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2014_ACSSubjectDefinitions.pdf, accessed on January 5, 2016.

2 Robin Rudowitz et al., A *Look at Section 1115 Medicaid Demonstration Waivers under the ACA: A Focus on Childless Adults*, Appendix B (Washington, DC: Kaiser Family Foundation, October 9, 2013), available online at https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8499-appendix-b.pdf.

3 Healthinsurance.org, *New York Medicaid*, available online at https://www.healthinsurance.org/new-york-medicaid, accessed on January 8, 2016.

4 Kaiser Family Foundation, *Medicaid Income Eligibility Limits for Parents 2002-2015*, available online at http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents-2002-2015/#, accessed on January 11, 2015; Matthew Stone, "Feds Allow Limited Cuts to Medicaid, Not to Level LePage Wanted," *The Bangor Daily News*, January 8, 2013, available online at http://bangordailynews.com/2013/01/08/politics/feds-allow-limited-cuts-to-medicaid-not-to-level-sought-by-lepage/.

A selected list of relevant publications to date:

Medicaid: Supporting Doctors, Hospitals, and the Communities They Serve (December 2015)

Medicaid Expansion Helps Low-Wage Workers: Expansion States (October 2015)

Medicaid: An Essential Program for States and Their Residents (September 2015)

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