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Medicaid Expansion: Frequently Asked Questions

By Laura Harker and Breanna Sharer

The Affordable Care Act (ACA) permits states to expand Medicaid coverage to adults with incomes up to 138 percent of the poverty level (about \$20,780 annually for an individual or \$35,630 for a family of three). States that have adopted the expansion have dramatically lowered their uninsured rates. Extensive research finds that the people who gained coverage have grown healthier and more financially secure, while long-standing racial inequities in health outcomes, coverage, and access to care have shrunk.

To date, 40 states plus Washington, D.C. have adopted the expansion, with South Dakota and North Carolina the most recent additions in 2023. This paper answers frequently asked questions about Medicaid expansion, using the latest studies and findings from expansion states.

How Does Medicaid Expansion Affect State Budgets and the Economy?

Expansion has produced *net savings* for many states. That's because the federal government pays the vast majority of the cost of expansion coverage, while expansion generates offsetting savings and, in many states, raises revenue from the taxes that the state imposes on private health plans and providers.

Under the ACA, the federal government paid 100 percent of the cost of expansion coverage from 2014 to 2016, with the federal share then dropping gradually to 90 percent for 2020 and each year thereafter, leaving states to cover the small remaining share. For other Medicaid enrollees, by comparison, the federal government pays between 50 and 77 percent of the cost of health coverage, depending on the state.¹ To receive the 90 percent match, states must expand Medicaid to people with incomes up to 138 percent of the poverty level; states that expand coverage but not up to the 138 percent level receive only the regular Medicaid match.²

¹ KFF, Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier for FY 2024, <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier>. These matching rates do not reflect the higher matching rates made available through the Families First Coronavirus Response Act, as amended by the 2023 Consolidated Appropriations Act.

² Robin Rudowitz and MaryBeth Musumeci, "Partial Medicaid Expansion' with ACA Enhanced Matching Funds: Implications for Financing and Coverage," KFF, February 20, 2019, <https://www.kff.org/medicaid/issue-brief/partial-medicaid-expansion-with-aca-enhanced-matching-funds-implications-for-financing-and-coverage/>.

Expansion has produced savings in several areas of state budgets:

- As more people have gained coverage, hospitals' uncompensated care costs — and, for some states, payments to hospitals to help cover those costs — have fallen. In states that expanded Medicaid under the ACA before September 30, 2020, hospital uncompensated care costs in fiscal year 2020 totaled 2.7 percent of their operating expenses, well below the 7.3 percent figure for hospitals in non-expansion states.³ More recent analyses also show Medicaid expansion generally has positive economic impacts on multiple types of health care providers.⁴
- Expansion has enabled states to spend less on programs for people with mental health or substance use disorders, since federal Medicaid matching funds are now available to help pay for their treatment.
- Expansion has enabled states to lower their corrections spending as more incarcerated people became eligible for and enrolled in Medicaid. While Medicaid generally does not pay for health care costs for incarcerated individuals, Medicaid can pay for the care of Medicaid-eligible incarcerated individuals who receive services at inpatient facilities outside of the correctional institution, as long as the stay is longer than 24 hours. Thus, under Medicaid expansion, Medicaid can assume some costs for incarcerated people previously paid for by other state funds.
- States can cover some Medicaid enrollees whose costs otherwise would be matched at the *regular* Medicaid rate in the *expansion* group of adults instead, and thus receive the higher expansion matching rate for those enrollees. For example, before Medicaid expansion, states paid the regular matching rate for pregnant people; now, those states can claim the expansion matching rate for people in that group who become pregnant, and they can stay in the “expansion” category during their pregnancy. This ability to cover some enrollees at the expansion rather than the regular rate can reduce state spending on traditional Medicaid (that is, the non-expansion part of the program).
- Between 2014 and 2017, Medicaid expansion was associated with a 4.4 percent to 4.7 percent reduction in state spending on traditional Medicaid.⁵ In some states, the net cost of Medicaid expansion was negative.⁶
- In states that tax managed care plans and health care providers serving Medicaid enrollees, enrollment increases due to Medicaid expansion generate revenue gains that further offset the cost of expansion.⁷

³ Medicaid and CHIP Payment and Access Commission, “Chapter 4: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States,” March 2023, <https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf>.

⁴ Meghana Ammula and Madeline Guth, “What Does the Recent Literature Say About Medicaid Expansion?: Economic Impacts on Providers,” KFF, January 18, 2023, <https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/>.

⁵ Bryce Ward, “The Impact of Medicaid Expansion on States’ Budgets,” Commonwealth Foundation, May 5, 2020, <https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets>

⁶ *Ibid.*

⁷ Jesse Cross-Call, “Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics’ Claims,” CBPP, October 9, 2018, <https://www.cbpp.org/research/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims>.

What Additional Financial Benefits Are Available for Newly Expanding States?

The 2021 American Rescue Plan created a large new financial incentive that makes expansion an even better deal for states that haven't expanded. States that expand Medicaid after March 2021 receive a two-year, five-percentage-point increase in the federal matching rate for their *non*-expansion enrollees. Non-expansion enrollees account for most of a state's Medicaid enrollees and costs, so this increase generates substantial additional federal funding for states. South Dakota and North Carolina, the most recent states to adopt Medicaid expansion, will gain an estimated \$115 million and \$1.6 billion in additional funding over two years, respectively.⁸ The remaining non-expansion states would gain some \$13.1 billion combined in federal funding from this provision if they expanded. (See Table 1.)

TABLE 1

Additional FMAP Funding Under Rescue Plan Incentive for States That Expand Medicaid

	Additional Federal Funding From Two-Year Rescue Plan Fiscal Incentive (Millions of Dollars)
Alabama	624
Florida	2,941
Georgia*	1,254
Kansas	384
Mississippi	519
South Carolina	633
Tennessee	1,019
Texas	4,834
Wisconsin**	865
Wyoming	61

* On July 1, 2023, Georgia implemented a Section 1115 waiver that differs from an ACA Medicaid expansion; it only covers adults with incomes up to 100 percent of the poverty level who meet a work-reporting requirement of 80 hours a month. Georgia initially estimated roughly 25,000 people would enroll in the first year, rising to about 53,000 in year five, but as of February 14, 2024, only 3,499 have enrolled. In contrast, the Urban Institute estimates that adopting the full ACA Medicaid expansion would reduce the number of uninsured by 293,000 people in 2024.

** Estimates assume that childless adults now enrolled in BadgerCare are shifted to the Medicaid expansion group, allowing Wisconsin to access the higher federal match. This shift would reduce the number of people enrolled at the state's traditional matching rate, thus reducing the Rescue Plan's fiscal incentive.

Note: Estimates assume expansion occurs on July 1, 2024, and incorporate projected enrollment declines due to the unwinding of the Medicaid continuous coverage requirement, as described in this report. Estimates include the federal fiscal incentive only.

Source: CBPP estimates using 2022 data from the Medicaid Budget Expenditure System, May 2023 Congressional Budget Office baseline projections, the Medicaid and CHIP Payment and Access Commission's Medicaid and CHIP Data Book, and Georgia Budget & Policy Institute, "Pathways to Coverage," www.georgiapathways.org/data-tracker.

⁸ CBPP estimates using 2022 data from the Medicaid Budget Expenditure System, May 2023 Congressional Budget Office baseline projections, and the Medicaid and CHIP Payment and Access Commission's Medicaid and CHIP Data Book.

Expansion is a good financial deal for states even without the added incentives from the American Rescue Plan. According to recent Urban Institute estimates that do not include the Rescue Plan financial incentive, if the ten remaining non-expansion states fully implemented Medicaid expansion in 2024, their Medicaid spending would increase by 3 percent or \$1.5 billion. But this would be partially offset by \$457 million in state and local government savings on uncompensated care,⁹ and the remaining state spending would likely be largely or fully offset by savings in other areas and potentially by new revenue, as has occurred in other states.¹⁰

How Has Medicaid Expansion Improved Health Coverage Rates?

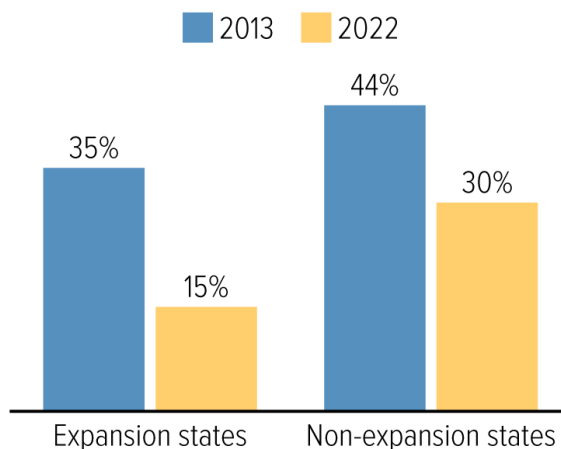
Since the ACA’s major coverage provisions took effect in 2014, states that expanded Medicaid have made far more progress in increasing health coverage rates than states that did not expand. In expansion states, the uninsured rate among low-income, non-elderly adults fell by more than half between 2013 and 2022, from 35 percent to 15 percent. In non-expansion states, it dropped only modestly, from 44 percent to 30 percent, leaving it twice the rate in expansion states.¹¹ (See Figure 1.)

Over 1.6 million uninsured people who would become eligible for Medicaid under expansion fall in a “coverage gap,” meaning their incomes are too low to qualify for subsidized marketplace coverage but too high to qualify for Medicaid.¹² (In non-expansion states, the median income limit for parents to qualify for Medicaid is just 35 percent of the poverty level, or just \$9,037 annually for

FIGURE 1

Expansion States Saw Large Drop in Uninsured Rates

Uninsured rate among non-elderly adults with incomes below 200% of poverty line



Note: Expansion states defined as those that expanded as of January 2022.

Source: CBPP analysis of 2013 and 2022 American Community Survey

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⁹ Matthew Buettgens and Urmi Ramchandani, “2.3 Million People Would Gain Health Coverage in 2024 if 10 States Were to Expand Medicaid Eligibility,” Urban Institute, October 23, 2023, <https://www.urban.org/research/publication/23-million-people-would-gain-health-coverage-2024-if-10-states-were-expand>.

¹⁰ Benjamin D. Sommers and Jonathan Gruber, “Federal Funding Insulated State Budgets from Increased Spending Related to Medicaid Expansion,” *Health Affairs*, 36 (5): 938–44. <https://doi.org/10.1377/hlthaff.2016.1666>.

¹¹ CBPP analysis of American Community Survey data. As noted later in this report, the Medicaid continuous coverage requirement was in place from March 2020 to April 2023 and prevented people from being disenrolled from Medicaid, leading to record low uninsured rates in 2022. However, the results would be similar using data from years prior to the pandemic. For example, between 2013 and 2019, the uninsured rate fell from 35 to 17 percent in expansion states and from 43 to 34 percent in non-expansion states.

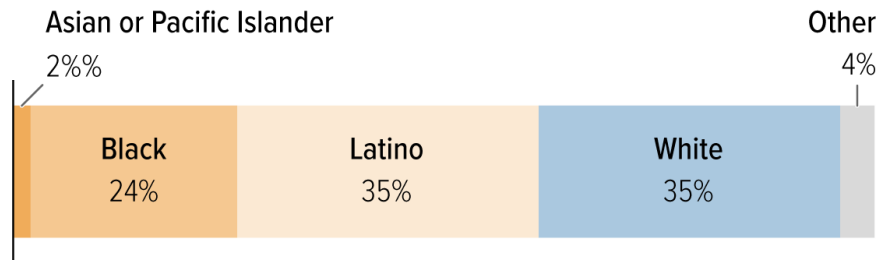
¹² CBPP analysis of 2022 American Community Survey.

a family of three, and childless adults do not qualify at all.)¹³ About 65 percent of those in the coverage gap are people of color; most of whom live in the South.¹⁴ (See Figure 2.) If the ten remaining non-expansion states adopted the expansion, some 2.3 million fewer people would be uninsured, including people in the coverage gap who would become newly eligible as well as people who currently are eligible but uninsured.¹⁵

FIGURE 2

Most Adults in the Coverage Gap Are People of Color

Uninsured adults in the coverage gap, by race/ethnicity



Note: Estimates include non-elderly adults ages 19 to 64. All race categories are non-Latino, except where otherwise noted. Latino people may be of any race. Income eligibility for Medicaid and Marketplace coverage is determined by grouping individuals into health insurance units for each program and applying eligibility rules to modified adjusted gross income (MAGI). The estimated undocumented population is excluded.

Source: CBPP estimates based on the 2022 American Community Survey

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¹³ KFF State Health Facts, “Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level,” as of January 1, 2023, [https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22alabama%22:%7B%7D,%22florida%22:%7B%7D,%22georgia%22:%7B%7D,%22kansas%22:%7B%7D,%22mississippi%22:%7B%7D,%22south-carolina%22:%7B%7D,%22tennessee%22:%7B%7D,%22texas%22:%7B%7D,%22wisconsin%22:%7B%7D,%22wyoming%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Parents%20\(in%20a%20family%20of%20three\)%22,%22sort%22:%22desc%22%7D](https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22alabama%22:%7B%7D,%22florida%22:%7B%7D,%22georgia%22:%7B%7D,%22kansas%22:%7B%7D,%22mississippi%22:%7B%7D,%22south-carolina%22:%7B%7D,%22tennessee%22:%7B%7D,%22texas%22:%7B%7D,%22wisconsin%22:%7B%7D,%22wyoming%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Parents%20(in%20a%20family%20of%20three)%22,%22sort%22:%22desc%22%7D).

¹⁴ CBPP analysis of 2022 American Community Survey.

¹⁵ Buettgens and Ramchandani, *op cit*.

Medicaid Expansion Can Help Maintain Access to Care During “Unwinding” of the Continuous Coverage Provision

In March 2020, Congress passed the Medicaid continuous coverage requirement as part of the Families First Coronavirus Response Act. In exchange for an increase in federal Medicaid matching funds, states were required to keep Medicaid enrollees in the program until the end of the month in which the public health emergency ended. This eliminated the need to reevaluate their eligibility and ensured that people retained health coverage during the pandemic.

This pause in Medicaid terminations resulted in record-high enrollment in Medicaid and the Children’s Health Insurance Program (CHIP) in all eligibility groups. As of March 2023, 24.6 million people received coverage through the Medicaid expansion.^a However, the redetermination process resumed as of April 1, 2023 (a process known as the unwinding of the continuous coverage provision), and coverage levels have declined even more quickly than experts projected. Ahead of unwinding, the Urban Institute projected that enrollment in Medicaid and CHIP could drop by 14.8 million people by the conclusion of unwinding, roughly in line with other projections.^b But by January 2024, roughly halfway through the unwinding, enrollment had already declined by about 10 million people, with the pace of future declines highly uncertain.^c

In the ten non-expansion states, the unwinding of continuous coverage will increase the number of people in the coverage gap. Postpartum people and children who turned 19 between March 2020 and March 2023 are at especially high risk of becoming uninsured if they are no longer eligible for Medicaid in their state but also don’t have incomes above 100 percent of the poverty level and thus can’t access subsidized marketplace coverage. Expansion states are better able to make sure people maintain access to affordable health coverage, which can help reduce the poor health outcomes associated with disruptions in coverage.

a CMS, “Medicaid Enrollment – New Adult Group,” November 2023, <https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9>.

b Matthew Buettgens and Andrew Green, “The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage,” Urban Institute, December 5, 2022, <https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage>; Caroline Hanson et al., “Health Insurance For People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-33,” *Health Affairs*, May 24, 2023, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00325>; Department of Health and Human Services, “Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches,” August 19, 2022, <https://aspe.hhs.gov/reports/unwinding-medicaid-continuous-enrollment-provision>.

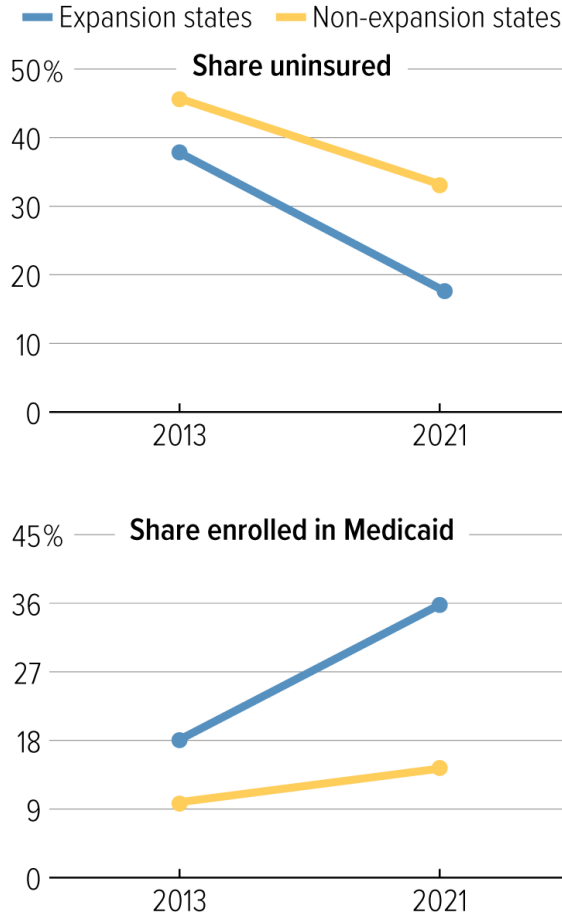
c Bradley Corallo et al., “Halfway through the Medicaid Unwinding: What Do the Data Show,” KFF, January 30, 2024, <https://www.kff.org/policy-watch/halfway-through-the-medicaid-unwinding-what-do-the-data-show/>.

Millions of workers have gained coverage through Medicaid expansion, including people working in industries that provide critical goods and services such as health care, transportation, grocery stores, food manufacturers, and child care. Many have no access to health coverage through their jobs. In expansion states, the uninsured rate among low-income workers fell from 38 percent in 2013 to 17 percent in 2022; this sharp decline coincided with a large increase in the share of low-income workers enrolled in Medicaid.¹⁶ In non-expansion states, the uninsured rate among low-income workers fell much less, from 46 percent to 31 percent. (See Figure 3.)

¹⁶ CBPP analysis of American Community Survey.

FIGURE 3

Medicaid Expansion Boosts Coverage for Low-Income Workers



Note: "Low-income workers" includes workers aged 19-64 whose incomes are below 200 percent of the poverty line
Source: CBPP analysis of 2021 and 2013 American Community Survey

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How Does Medicaid Expansion Affect People’s Health and Financial Well-Being?

Health coverage through Medicaid expansion makes people healthier and more financially secure by improving their access to preventive and primary care, providing care for serious diseases, preventing premature deaths, and reducing cases of catastrophic out-of-pocket medical costs, a large body of research shows.¹⁷ The benefits, also shown in Figure 4, include:

¹⁷ Madeline Guth and Meghana Ammula, “Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021,” KFF, May 6, 2021, <https://www.kff.org/medicaid/report/building-on-the->

- **Improved access to care.** Medicaid expansion improved access to care and use of high-value services for millions of Medicaid enrollees, without reducing access or quality for those enrolled in another type of insurance.¹⁸ Medicaid expansion increased access to primary and preventive care (e.g., having a personal doctor, getting a check-up in the past year) for adults with low incomes.¹⁹ In expansion states, people without dependent children who could be in the coverage gap if their state had not expanded were 6.7 percentage points more likely than those in non-expansion states to have a mammogram, and about 5 percentage points more likely to be tested for cholesterol, high blood sugar, or diabetes.²⁰ And for people with chronic diseases, Medicaid expansion is associated with greater access to treatment and more timely treatment, including for non-elderly women with gynecologic cancer.²¹

In addition, Medicaid expansion enrollees in Michigan reported less forgone care and better access to care after enrolling. And the share of enrollees relying on the emergency room as their regular source of care dropped from 16.2 percent to 1.7 percent after they enrolled in Medicaid.²²

Medicaid expansion also is associated with a significant rise in patients taking their medications as directed and with a decrease in low-income adults skipping their medication due to cost.²³

- **Improved health outcomes.** Medicaid expansion is associated with improvements in overall self-reported health among adults with low incomes.²⁴ Among people with chronic disease, it

[evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/](#); Madeline Guth, Rachel Garfield, and Robin Rudowitz, “The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020,” KFF, March 17, 2020, <https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>.

¹⁸ Aaron Parzuchowski *et al.*, “Evaluating the accessibility and value of U.S. ambulatory care among Medicaid expansion states and non-expansion states, 2012–2015,” BMC Health Services Research, July 3, 2023, <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09696-x>. The study uses ten measures of high-value care based on a review of the research; one definition is providing “the best care for the patient, with the optimal results for the circumstances, delivered at the right price.” Mark Smith *et al.*, *Best Care at a Lower Cost: The Path to Continuously Learning Health Care in America*, National Academies Press, 2013, <https://www.ncbi.nlm.nih.gov/books/NBK207237/>.

¹⁹ Benjamin D. Sommers *et al.*, “Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults,” *Health Affairs*, June 2017, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0293>.

²⁰ Sherry Glied and Mark Weiss, “Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility,” Commonwealth Fund, September 11, 2023, <https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not>

²¹ Benjamin B. Albright *et al.*, “Impact of Medicaid expansion on women with gynecologic cancer: a difference-in-difference analysis,” *American Journal of Obstetrics and Gynecology*, August 7, 2020, [https://www.ajog.org/article/S0002-9378\(20\)30835-8/fulltext](https://www.ajog.org/article/S0002-9378(20)30835-8/fulltext).

²² Susan Dorr Goold *et al.*, “Primary Care, Health Promotion, and Disease Prevention with Michigan Medicaid Expansion,” *Journal of General Internal Medicine*, December 2019, <https://link.springer.com/article/10.1007%2Fs11606-019-05370-3>.

²³ Sommers *et al.*, *op cit.*

²⁴ Kevin N. Griffith and Jacob H. Bor, “Changes in Health Care Access, Behaviors, and Self-reported Health Among Low-income US Adults Through the Fourth Year of the Affordable Care Act,” *Medical Care*, Vol. 58, No. 6, June 2020, <https://doi.org/10.1097/MLR.0000000000001321>.

is associated with improved access to care, better health outcomes and disease management, and decreased mortality.²⁵ Medicaid expansion also is linked to earlier detection, diagnosis, and treatment of serious medical conditions, such as breast cancer, and is associated with a decrease in late-stage breast cancer detection.²⁶ Among patients with newly diagnosed breast, colorectal, or lung cancers, Medicaid expansion is associated with decreased mortality.²⁷

In addition, patients with end-stage renal disease who live in a Medicaid expansion state have lower one-year mortality rates than those in non-expansion states, and Black patients experienced the greatest decline in mortality rates after expansion.²⁸ Medicaid expansion also is associated with improvement in one-year survival among patients with ovarian cancer and with improved cancer outcomes in young adults generally.²⁹

- **Improved outcomes for people with substance use disorders (SUD).** Medicaid expansion is associated with increased insurance coverage among adults with SUD,³⁰ and with reductions in total opioid overdose deaths and in deaths involving heroin.³¹
- **Improved mental health outcomes.** Medicaid expansion is associated with improved access to care and medications for adults with depression.³² Among individuals with serious psychological distress, expanded Medicaid eligibility led to a decrease in people delaying and/or forgoing necessary care.³³ One study found that expansion was associated with improvements in self-reported mental health among low-income adults.³⁴

²⁵ Guth and Ammula, *op. cit.*

²⁶ Justin M. Le Blanc *et al.*, “Association of Medicaid Expansion Under the Affordable Care Act with Breast Cancer Stage at Diagnosis,” *JAMA Surgery*, July 2020, <https://jamanetwork.com/journals/jamasurgery/article-abstract/2767686>.

²⁷ Miranda B. Lam *et al.*, “Medicaid Expansion and Mortality Among Patients With Breast, Lung, and Colorectal Cancer,” *JAMA Network*, November 2020, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772535>.

²⁸ Shailender Swaminathan *et al.*, “Association of Medicaid Expansion With 1-Year Mortality Among Patients With End-Stage Renal Disease,” *JAMA*, December 2018, <https://jamanetwork.com/journals/jama/fullarticle/2710505>.

²⁹ Xu Ji *et al.*, “Survival in Young Adults With Cancer Is Associated With Medicaid Expansion Through the Affordable Care Act,” *Journal of Clinical Oncology*, April 1, 2023, <https://pubmed.ncbi.nlm.nih.gov/36525612/>.

³⁰ Mark Olfson *et al.*, “Medicaid Expansion and Low-Income Adults with Substance Use Disorders,” *Journal of Behavioral Health Services and Research*, November 6, 2020, <https://link.springer.com/article/10.1007/s11414-020-09738-w>.

³¹ Nicole Kravitz-Wirtz *et al.*, “Association of Medicaid Expansion With Opioid Overdose Mortality in the United States,” *JAMA Network*, January 10, 2020, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476>.

³² Carrie E. Fry and Benjamin D. Sommers, “Effect of Medicaid Expansion on Health Insurance Coverage and Access to Care Among Adults With Depression,” *Psychiatric Services*, August 28, 2018, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800181>.

³³ Priscilla Novak, Andrew C. Anderson, and Jie Chen, “Changes in Health Insurance Coverage and Barriers to Health Care Access Among Individuals with Serious Psychological Distress Following the Affordable Care Act,” *Administration and Policy in Mental Health*, November 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6477535/>.

³⁴ Griffith and Bor, *op. cit.*

ACA Medicaid Expansion Improving Access to Care, Health, and Financial Security, Research Finds



Access to care: More adults with low incomes getting **check-ups and other preventive care**, and getting regular **care for chronic conditions**; greater access to **mental health care**, including treatment for **depression**.



Health outcomes: Fewer **premature deaths** among older adults, with **at least 19,000 lives saved** in the first four years of expansion; improvements in overall **self-reported health**; decreases in **opioid overdose deaths**; for chronic conditions, better **disease management** and decreased **mortality**; increases in **early-stage cancer diagnoses**; decreases in rates of **maternal and infant mortality**.



Financial security: Reductions in share of low-income adults **struggling to pay medical bills**; \$1,140 reduction in **debt per person**; reductions in **evictions** among low-income renters.



Economic mobility: Better access to **credit**, including **lower-interest mortgages and auto and other loans**, with annual interest savings amounting to \$280 per adult gaining coverage; majorities of adults gaining coverage through expansion in Michigan and Ohio report coverage makes it **easier for them to work or look for work**.



Reducing uncompensated care: Hospital **uncompensated care costs** are less than half as large in expansion states as in non-expansion states; improvements in **hospital budgets** and reductions in closures, especially for rural hospitals.

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- **Premature deaths prevented.** Medicaid expansion prevents thousands of premature deaths each year, saving the lives of at least 19,200 adults aged 55 to 64 between 2014 and 2017, a landmark study found. Conversely, 15,600 older adults died prematurely due to state decisions *not* to expand Medicaid.³⁵ (See Figure 5.) Older adults who gained coverage through Medicaid expansion experienced an estimated 39 to 64 percent reduction in annual mortality rates.³⁶

³⁵ Sarah Miller *et al.*, “Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data,” *Quarterly Journal of Economics*, January 30, 2021, <https://academic.oup.com/qje/article-abstract/136/3/1783/6124639?redirectedFrom=fulltext>.

³⁶ Matt Broaddus and Aviva Aron-Dine, “Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds,” CBPP, November 6, 2019, <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>.

FIGURE 5

State Decisions to Expand Medicaid a Matter of Life and Death, Research Shows

Cumulative impact on mortality among older adults, 2014-2017



Note: Older adults are those aged 55 to 64 at the onset of the study period, 2014.

Source: Miller et al., "Medicaid and Mortality," 2021

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- **Decrease in maternal and infant mortality rates.** Medicaid expansion improves access to health care before, during, and after pregnancy, thereby improving maternal and infant health.³⁷ It has reduced maternal mortality, preventing over 200 deaths in 2017 alone.³⁸ Medicaid expansion is also linked to reduced infant mortality.³⁹ While infant mortality fell in both expansion and non-expansion states between 2010 and 2016, it fell 50 percent more in expansion states. Racial disparities in infant mortality rates fell in expansion states as well.⁴⁰

In addition, Medicaid expansion led to improved postpartum health for low-income populations. One recent study found that expansion states saw a 17 percent reduction, relative to non-expansion states, in hospitalizations during the first 60 days postpartum.⁴¹ Medicaid expansion also has driven more pre-conception health counseling and more use of the most effective birth control measures after childbirth.⁴²

³⁷ Before the ACA, low-income women were eligible for Medicaid while pregnant and for 60 days postpartum, but eligibility before and after pregnancy was very restrictive.

³⁸ Erica Eliason, "Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality," *Women's Health Issues*, February 2020, [https://www.whijournal.com/article/S1049-3867\(20\)30005-0/fulltext](https://www.whijournal.com/article/S1049-3867(20)30005-0/fulltext).

³⁹ Joanne Constantin and George L. Wehby, "Effects of Recent Medicaid Expansions on Infant Mortality by Race and Ethnicity," *American Journal of Preventative Medicine*, March 2023, <https://www.sciencedirect.com/science/article/abs/pii/S0749379722004986>.

⁴⁰ Chintan B. Bhatt and Consuelo M. Beck-Sagué, "Medicaid Expansion and Infant Mortality in the United States," *American Journal of Public Health*, April 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5844390/>.

⁴¹ Maria W. Steenland and Laura R. Wherry, "Medicaid Expansion Led To Reductions In Postpartum Hospitalizations," *Health Affairs*, January 2023, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00819>.

⁴² Rebecca Myerson, Samuel Crawford, and Laura R. Wherry, "Medicaid Expansion Increased Preconception Health Counseling, Folic Acid Intake, and Postpartum Contraception," *Health Affairs*, November 2020, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00106>.

- **Improved financial well-being.** Medicaid expansion protects enrollees from catastrophic out-of-pocket medical costs and improves their overall financial well-being. In its first two years, Medicaid expansion reduced medical debt sent to third-party collections by \$3.4 billion and reduced bankruptcies nationwide by 50,000.⁴³ Between 2013 and 2020, new medical debt dropped by 34 percentage points more than in states that expanded Medicaid in 2014 than in states that did not expand Medicaid over this period.⁴⁴ After enrolling in Medicaid expansion coverage, low-income adults had about \$1,140 less in overall unpaid debt sent to third-party collections, a study found.⁴⁵ And enrollees in Virginia’s Medicaid expansion program reported decreased worry about paying for housing, food, monthly bills, and minimum loan payments one year after enrolling.⁴⁶

In addition, by preventing medical debt and bankruptcies, Medicaid expansion provides indirect financial benefits to low-income adults by way of improved credit scores and, in turn, better terms for credit cards, mortgages, and other loans.⁴⁷ California’s Medicaid expansion, for example, drove a 21-percentage-point decrease in payday loan borrowing among adults aged 18 to 34, a 2017 study showed.⁴⁸ Medicaid expansion also reduces evictions.⁴⁹

⁴³ Kenneth Brevoort, Daniel Grodzicki, and Martin Hackmann, “Medicaid and Financial Health,” National Bureau of Economic Research Working Paper 24002, November 2017, https://www.nber.org/system/files/working_papers/w24002/w24002.pdf.

⁴⁴ Raymond Kluender *et al.*, “Medical Debt in the US, 2009-2020,” *JAMA*, July 20, 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8293024>.

⁴⁵ Luojia Hu *et al.*, “The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing,” National Bureau of Economic Research Working Paper 22170, February 2018, https://www.nber.org/system/files/working_papers/w22170/w22170.pdf.

⁴⁶ Hannah Shadowen, “Virginia Medicaid Expansion: New Members Report Reduced Financial Concerns During The COVID-19 Pandemic,” *Health Affairs*, July 20, 2022, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01910>.

⁴⁷ Brevoort, Grodzicki, and Hackmann, *op. cit.*

⁴⁸ Heidi Allen *et al.*, “Early Medicaid Expansion Associated With Reduced Payday Borrowing In California,” *Health Affairs*, October 2017, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0369>.

⁴⁹ Heidi Allen *et al.*, “Can Medicaid Expansion Prevent Housing Evictions?” *Health Affairs*, September 2019, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05071>.

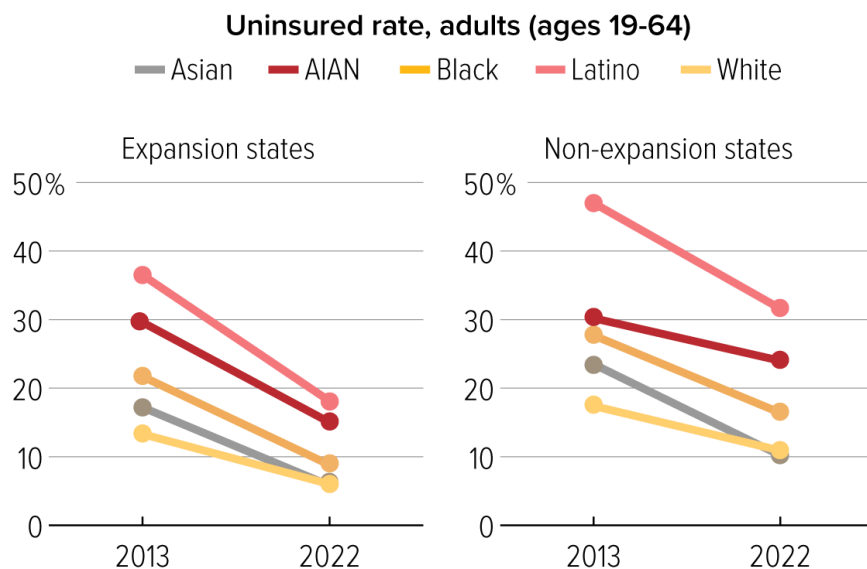
How Has Medicaid Expansion Advanced Racial Health Equity?

The nation’s long-standing racial inequities in health coverage, access to care, and health outcomes reflect a number of factors, including racism, historical and current inequities in economic and health systems, and restrictions on immigrants’ eligibility for Medicaid and other public health coverage. While still large, these inequities have narrowed since the ACA’s major coverage provisions took effect in 2014.

Between 2013 and 2022, the gap in uninsured rates between white and Black adults under age 65 shrank by 67 percent in expansion states (versus 47 percent in non-expansion states), while the gap between white and Latino adults shrank by 48 percent in expansion states (versus 30 percent in non-expansion states).⁵⁰ (See Figure 6.) Medicaid expansion has also improved coverage among American Indians and Alaska Natives; their uninsured rate among non-elderly adults fell from 30 percent in 2013 to 15 percent in 2022 in expansion states, while falling from 30 percent to 24 percent in non-expansion states.⁵¹

FIGURE 6

Racial and Ethnic Disparities in Health Coverage Narrowed More in Medicaid Expansion States



Note: Latino can include any race; other race categories are non-Latino, single race only except for American Indian and Alaska Native (AIAN), who may be AIAN alone or in combination with other races and Latino.

Source: CBPP analysis of 2013 and 2022 American Community Survey

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⁵⁰ CBPP analysis of 2013 and 2022 American Community Survey data. Black and white categories include individuals classified as single race, not Latino. The Latino category can include people who identify as any race.

⁵¹ *Ibid.* The American Indian and Alaska Native (AIAN) category may be AIAN alone or in combination with other races and ethnicities.

Expansion is also improving health outcomes for people of color, evidence suggests. Mortality rates from end-stage renal disease fell more in expansion than non-expansion states, with Black people (who are at higher risk for kidney failure) experiencing particularly large improvements.⁵² Also, among all women, there was a lower rate of maternal deaths in expansion states than non-expansion states, and the largest drop in maternal deaths after expansion occurred among Black women.⁵³

In addition, disparities in preventable hospitalizations and emergency department visits between non-Latino Black and white non-elderly adults fell by 10 percent or more in expansion states between 2011 and 2018.⁵⁴ Another study found that expansion is associated with reduced disparity in in-hospital mortality between Black and white young adult trauma patients.⁵⁵ And, in the initial years of Michigan's Medicaid expansion, Black people experienced the largest drop in the number of days of poor physical health of any racial or ethnic group.⁵⁶

Also of note, nearly 60 percent of those who the Urban Institute projected would gain coverage if the remaining states adopted the Medicaid expansion are people of color.⁵⁷

How Has Expansion Helped Children and People With Disabilities?

Medicaid expansion drives gains in health coverage and improved access to care even among who might be eligible for traditional Medicaid, including children and people with disabilities. Most children in families with low incomes were eligible for Medicaid before the ACA, but Medicaid eligibility for parents was limited and varied considerably across states. Parents' median pre-ACA income eligibility limit was just 64 percent of the poverty level.⁵⁸ (In 2023, the median limit in the ten remaining non-expansion states was 35 percent of the poverty level, with the lowest rates in Texas and Alabama at 16 percent and 18 percent of poverty, respectively.)⁵⁹

Medicaid expansion produces a “welcome mat” effect, research has found, so that extending coverage to adults increases children's coverage as well. Children in states that extended Medicaid coverage to parents before the ACA, for instance, participated in Medicaid at a rate that was 20

⁵² Swaminathan *et al.*, *op. cit.*

⁵³ Erica L. Eliason, “Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality,” *Women's Health Issues*, February 25, 2020, [https://www.whijournal.com/article/S1049-3867\(20\)30005-0/fulltext](https://www.whijournal.com/article/S1049-3867(20)30005-0/fulltext).

⁵⁴ Asako S. Moriya and Sujoy Chakravarty, “Racial And Ethnic Disparities In Preventable Hospitalizations And ED Visits Five Years After ACA Medicaid Expansions,” *Health Affairs*, January 2023, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00460>.

⁵⁵ Gregory A Metzger *et al.*, “Association of the Affordable Care Act Medicaid Expansion with Trauma Outcomes and Access to Rehabilitation among Young Adults: Findings Overall, by Race and Ethnicity, and Community Income Level,” *Journal of the American College of Surgeons*, December 2021, <https://pubmed.ncbi.nlm.nih.gov/34656739/>.

⁵⁶ Minal R. Patel *et al.*, “Examination of Changes in Health Status Among Michigan Medicaid Expansion Enrollees From 2016 to 2017,” *JAMA Network*, July 10, 2020, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768102>.

⁵⁷ Buettgens and Ramchandani, *op. cit.*

⁵⁸ KFF State Health Facts, *op. cit.*

⁵⁹ *Ibid.*

percentage points higher than children in states with no such extensions.⁶⁰ The ACA's Medicaid expansion has had a similar impact, with enrollment increasing disproportionately among children of *parents* who became newly eligible. Over 700,000 children who were previously eligible but not enrolled in Medicaid gained coverage from 2013 to 2015, and the gains were twice as large in expansion states as in non-expansion states.⁶¹

Coverage gains for parents, and the associated coverage gains for children, also improve children's access to care and their overall well-being. A 2017 study found that children are 29 percentage points likelier to have an annual well-child visit if their parents are enrolled in Medicaid.⁶² Parents' access to coverage and care improves children's well-being by improving the family's financial security and enabling the parents to receive treatment for health conditions like maternal depression, which can harm children's cognitive and social-emotional development.⁶³

Medicaid expansion also benefits people with disabilities, especially people who don't qualify for traditional Medicaid on the basis of disability. People with disabilities who receive Supplemental Security Income generally also qualify for Medicaid, but more than 6 in 10 non-elderly adults with disabilities qualify for Medicaid on another basis, including the Medicaid expansion. That's because many people with a disability don't meet strict state or federal standards for disability, yet they gain access to health care coverage through Medicaid expansion based on their income.⁶⁴ As a result, Medicaid expansion has helped improve coverage and access to care among people with disabilities, enabling them to lead healthier lives and have more employment options.

Among adults overall who gained Medicaid coverage through expansion, those with disabilities had larger improvements in full-year insurance coverage and use of primary and preventive care than those without disabilities.⁶⁵ People with disabilities who live in expansion states are more likely to be employed than those in non-expansion states because many of them are able to enter the workforce or increase their earnings without losing their coverage.⁶⁶ Some states have even used the budget

⁶⁰ Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," Health Services Research, October 7, 2003, <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.00177>.

⁶¹ Julie Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects on Their Children," *Health Affairs*, September 2017, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0347?journalCode=hlthaff>.

⁶² Maya Venkataramani *et al.*, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics*, December 2017, <https://pediatrics.aappublications.org/content/140/6/e20170953>.

⁶³ Jessica Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children," CBPP, updated June 14, 2021, <https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and>.

⁶⁴ MaryBeth Musumeci and Kendal Orgera, "People with Disabilities Are At Risk of Losing Medicaid Coverage Without the ACA Expansion," KFF, November 2, 2020, <https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/>.

⁶⁵ Timothy B. Creedon *et al.*, "Effects of Medicaid expansion on insurance coverage and health services use among adults with disabilities newly eligible for Medicaid," Health Services Research, December 2022, <https://pubmed.ncbi.nlm.nih.gov/35811358/>.

⁶⁶ Jean P. Hall *et al.*, "Effect of Medicaid Expansion on Workforce Participation for People With Disabilities," *American Journal of Public Health*, February 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227925/>.

savings generated by expansion to improve access to services for people with disabilities and people with chronic conditions, including long-term services and supports.⁶⁷

Opponents of Medicaid expansion have falsely claimed that expansion harms the “truly needy” by forcing seniors and people with disabilities on to waiting lists for Medicaid.⁶⁸ In reality, there are no waiting lists to enroll in Medicaid. States must enroll all eligible enrollees, including children, seniors, people with disabilities, and adults, without exception. Dating back to the early 1980s, states could (and many still do) have waiting lists for seniors and people with disabilities to receive home- and community-based services (HCBS) — i.e., care in the community for people who would otherwise have to go into a nursing home or other institution. But as of 2023, 71 percent of the people on a waiting list for HCBS services lived in a *non*-expansion state.⁶⁹

How Does Medicaid Expansion Affect Employment?

Ninety-one percent of non-elderly Medicaid adults in 2022 worked full or part time, acted as caregivers for family members or loved ones, attended school, or had an illness or disability affecting their ability to work; 61 percent were employed.⁷⁰ Most people enrolled in Medicaid expansion who *can* work *do* work; their jobs generally don’t offer employer-based coverage or pay enough for them to cover the costs of individual market coverage.

While expansion critics often claim that Medicaid is a disincentive to work, expansion has not reduced labor force participation among those who become eligible for Medicaid.⁷¹ Medicaid, in fact, is an important work support because health coverage makes it easier for enrollees to look for a job and to work. Enrollees also say that having Medicaid coverage makes them better at their jobs. In surveys in Ohio and Michigan, 84 percent and 69 percent of working Medicaid expansion

⁶⁷ Molly O’Malley Watts, MaryBeth Musumeci, and Priya Chidambaram, “State Variation in Medicaid LTSS Policy Choices and Implications for Upcoming Debates,” KFF, February 26, 2021, <https://www.kff.org/medicaid/issue-brief/state-variation-in-medicaid-ltss-policy-choices-and-implications-for-upcoming-policy-debates/>.

⁶⁸ Jesse Cross-Call, “Opponents Recycling Falsities About Medicaid Expansion’s Impact on Seniors, People With Disabilities,” CBPP, October 11, 2018, <https://www.cbpp.org/blog/opponents-recycling-falsities-about-medicaid-expansions-impact-on-seniors-people-with->

⁶⁹ Alice Burns, Maiss Mohamed, and Molly O’Malley Watts, “A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2023,” KFF, November 29, 2023, <https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023>; KFF, “Medicaid HCBS Waiver Waiting List Enrollment, by Target Population and Whether States Screen for Eligibility,” <https://www.kff.org/medicaid/state-indicator/medicaid-hcbs-waiver-waiting-list-enrollment-by-target-population-and-whether-states-screen-for-eligibility/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷⁰ Madeline Guth *et al.*, “Understanding the Intersection of Medicaid & Work: A Look at What the Data Say,” KFF, April 24, 2023, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/>. Includes adults under age 65 who were not receiving Supplemental Security Income or Medicare. CBPP analysis of 2023 March Current Population Survey.

⁷¹ For example, one study found that low-income workers in expansion states did not lose jobs, switch jobs, or change from full- to part-time work more frequently than low-income workers in non-expansion states. Angshuman Gooptu *et al.*, “Medicaid Expansion Did Not Result In Significant Employment Changes Or Job Reductions In 2014,” *Health Affairs*, January 2016, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0747>.

enrollees, respectively, said health coverage made it easier to work or helped them do a better job at work.⁷²

Also, as noted above, Medicaid expansion is a work support for people with disabilities and chronic conditions; those in expansion states are likelier to be employed than those in non-expansion states.⁷³

Some states have pushed to add policies taking Medicaid coverage away from people not meeting work requirements. But these initiatives have been counterproductive, taking coverage away from working people and vulnerable populations without increasing employment. In Arkansas, the one state to fully implement such a harsh work requirement policy, 18,000 Medicaid enrollees — nearly 1 in 4 adults subject to the requirements — lost their coverage.⁷⁴ Those losing coverage included working people as well as vulnerable populations such as people living with a disability or serious health condition and those caring for ill, aging, or disabled family members. In focus groups, Arkansas enrollees explained that coverage losses resulting from the new requirement led to worsening of their health conditions, higher stress, and hindrances to work.⁷⁵ In New Hampshire, about 40 percent of adults subject to work requirements would have lost their coverage if the state had not put the policy on hold.

When people lose coverage due to work requirements, it is primarily because they struggle to complete burdensome paperwork, not because they are not working or do not qualify for an exemption.⁷⁶ Also, evidence from Arkansas' failed Medicaid work requirement policy and from work requirements in other federal programs shows that taking away assistance does little to improve long-term employment outcomes.⁷⁷

Currently, Georgia is implementing a Medicaid waiver that offers coverage to adults with incomes only up to the poverty level (not the full Medicaid expansion group) and requires them to report 80 hours a month of qualifying activities to receive and maintain coverage. The program is only reaching a tiny fraction of the state's estimated number of people who could be eligible, and the

⁷² Ohio Department of Medicaid, "2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment," August 2018, <https://medicaid.ohio.gov/static/Resources/Reports/Annual/Group-VIII-Final-Report.pdf>; Renuka Tipirneni *et al.*, "Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: A Mixed Methods Study," *Journal of General Internal Medicine*, Vol. 34, No. 2, February 15, 2019, <https://pubmed.ncbi.nlm.nih.gov/30519839/>.

⁷³ Jean P. Hall *et al.*, "Effect of Medicaid Expansion on Workforce Participation for People With Disabilities," *American Journal of Public Health*, February 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227925/>.

⁷⁴ Laura Harker, "Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model," CBPP, August 8, 2023, <https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be>

⁷⁵ *Ibid.*

⁷⁶ *Ibid.*

⁷⁷ LaDonna Pavetti *et al.*, "Expanding Work Requirements Would Make It Harder for People to Meet Basic Needs," CBPP, March 15, 2023, <https://www.cbpp.org/research/poverty-and-inequality/expanding-work-requirements-would-make-it-harder-for-people-to-meet>.

state is paying five times more per enrollee than it would have under a standard Medicaid expansion model.⁷⁸

How Does Medicaid Expansion Affect Hospitals?

Medicaid expansion reduces the uncompensated care burdens of hospitals and improves their operating margins, particularly for rural and safety net hospitals.⁷⁹ Hospitals and other providers have seen improvements in their payer mix (a decline in uninsured patients and/or increase in patients covered by Medicaid) and an increase in their overall revenue.⁸⁰

From 2013 to 2015, Medicaid expansion reduced uncompensated care costs by an estimated \$6.2 billion across the 31 states (plus the District of Columbia) that expanded during that time. Of every dollar of uncompensated care costs that hospitals had in 2013, expansion had eliminated 41 cents by 2015.⁸¹ Researchers have found that immediately after a state expands Medicaid, the state's hospitals experience increases in both their Medicaid revenue and their overall operating margins.⁸² Thus, it is not surprising that hospitals in expansion states are about 84 percent less likely to close than hospitals in non-expansion states.⁸³

Medicaid expansion is especially important to *rural* hospitals, whose operating margins are often so low that uncompensated care costs — which are typically higher when more people in the area lack insurance — can prove catastrophic. While the uninsured rate has come down in all states under the ACA, the sharpest declines in rural uninsured rates have occurred in expansion states.⁸⁴

A recent review found that rural hospitals had median operating margins of 3.9 percent in expansion states between July 2021 and June 2022, but just 2.1 percent in non-expansion states. If federal pandemic-related aid is disregarded, rural hospitals still had positive operating margins in

⁷⁸ Leah Chan, “Money Matters: Comparing the Costs of Full Medicaid Expansion to the Pathways to Coverage Program,” GBPI, January 11, 2023, <https://gbpi.org/money-matters-comparing-the-costs-of-full-medicaid-expansion-to-the-pathways-to-coverage-program/>.

⁷⁹ Uncompensated care refers to “health care or services provided by hospitals or other health care providers that don’t get reimbursed.” (Retrieved from <https://www.healthcare.gov/glossary/uncompensated-care/>.) Operating margin refers to “net income from patient care (operating revenue minus operating expenses) divided by revenue from patient care.” (Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10114034/>.)

⁸⁰ Ammula and Guth, *op. cit.*

⁸¹ David Dranove, Craig Garthwaite, and Christopher Ody, “The Impact of the ACA’s Medicaid Expansion on Hospitals’ Uncompensated Care Burden and the Potential Effects of Repeal,” Commonwealth Fund, May 2017, <https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care>.

⁸² Fredric Blavin and Christal Ramos, “Medicaid Expansion: Effects on Hospital Finances and Implications for Hospitals Facing COVID-19 Challenges,” *Health Affairs*, January 2021, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00502>.

⁸³ Richard C. Lindrooth *et al.*, “Understanding The Relationship Between Medicaid Expansions And Hospital Closures,” *Health Affairs*, January 2018, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976>.

⁸⁴ Joan Alker and Jack Hoadley, “Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion,” Georgetown University Center for Children and Families and the University of North Carolina NC Rural Health Research Program, September 2018, https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf.

expansion states but not in non-expansion states.⁸⁵ Since 2010, 82 rural hospitals have completely closed across the country, mostly in non-expansion states;⁸⁶ data for the 2010-2019 period show that a rural hospital is 62 percent less likely to close on average if it is in an expansion state.⁸⁷ When rural hospitals close, a critical source of health care and employment disappears in rural communities, and strain falls on surrounding hospitals.⁸⁸

⁸⁵ Zachary Levinson, Jamie Godwin, and Scott Hulver, “Rural Hospitals Face Renewed Financial Challenges, Especially in States That Have Not Expanded Medicaid,” KFF, February 23, 2023, <https://www.kff.org/health-costs/issue-brief/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid/>.

⁸⁶ Cecil G. Sheps Center for Health Services Research, “Rural Hospital Closures,” accessed February 1, 2024, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

⁸⁷ Michael Topchik *et al.*, “The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability,” Chartis Center for Rural Health, February 2020, <https://www.chartis.com/sites/default/files/documents/Rural%20Hospital%20Vulnerability-The%20Chartis%20Group.pdf>.

⁸⁸ American Hospital Association, “Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care,” February 2019, <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>; National Institutes of Health, “Rural Hospital Closures Fuel Rising Demand and Costs at Nearby Hospitals,” March 7, 2023, <https://ncats.nih.gov/news-events/news/rural-hospital-closures-fuel-rising-demand-and-costs-at-nearby-hospitals>.