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The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review

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The tables below support the Kaiser Family Foundation February 2017 brief titled, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." (This is an update to the appendix tables associated with an earlier issue brief, "The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review," that covered studies published through May 2016.) Each table corresponds to one of the three sections in the brief (Medicaid expansion's impacts on coverage; access to care, utilization, affordability, and health outcomes; and economic outcomes). The tables provide additional details on the focus of and major findings from each individual Medicaid expansion study. Within each table, nationwide studies are displayed first followed by multi-state and then single state studies. Within those groupings, studies are listed in reverse chronological order (most recent first). Studies with findings that apply to multiple sections are included in more than one table or table sub-section.

Altogether, the tables include 108 studies of the impact of state Medicaid expansions under the ACA published between January 2014 (when the coverage provisions of the ACA went into effect) and January 2017. They include peer-reviewed studies as well as free-standing reports, government reports, and white papers published by research and policy organizations, using data from 2014 or later. The tables only include studies that examine impacts of the Medicaid expansion; they exclude studies on impacts of ACA coverage expansions generally (not specific to Medicaid expansion alone), studies investigating potential effects of expansion in states that have not (or had not, at the time of the study) expanded Medicaid, and studies published by advocacy organizations.

Table 1: Coverage Effects of Expansion

Citation	Study Focus	Major Findings
Nationwide Studies		
Aparna Soni, Michael Hendryx, and Kosali Simon, "Medicaid Expansion under the Affordable Care Act and Insurance Coverage in Rural and Urban Areas," *The Journal of Rural Health* epub ahead of print (January 2017), http://onlinelibrary.wiley.com/doi/10.1111/jrh.12234/full	**Nationwide:** Used a difference-in-differences analysis to investigate changes in the probability of low-income childless adults having health insurance in expansion vs. non expansion states, in rural vs. urban areas. Used data from the American Community Survey for years 2011-2015.	• Medicaid expansion resulted in a significant increase in the probability of having any insurance and having Medicaid for urban and rural low-income populations pooled. • The probability of having Medicaid coverage increased by 8.7 percentage points (or 68%) for childless adults and 6.8 percentage points (or 40%) for all adults in the post-expansion (2014-2015) period compared to the pre-expansion (2011-2013) period. • Childless adults living in rural areas experienced a 1.9 percentage point larger increase in the probability of having Medicaid as a result of the expansion compared to childless adults living in urban areas. • Medicaid expansion reduced the probability of having individual purchased insurance for both urban and rural low-income populations: the decrease was 1.3 percentage points (or a 13% decline from the pre-expansion level) for childless adults and 1.6 percentage points (or an 18% decline) for all adults. • The Medicaid expansion did not result in significant changes in the probability of having Medicare or employer-sponsored insurance among either rural or urban low-income populations. • Between the pre- and post-expansion periods, rural childless adults experienced a 1.5 percentage point larger decline in the probability of having individual purchased insurance compared to urban childless adults. • The overall probability of having any insurance, employer-sponsored insurance, or Medicare was not significantly different for rural and urban populations.
Kamyar Nasseh and Marko Vujicic, *Early Impact of the Affordable Care Act's Medicaid Expansion on Dental Care Use* (Health Services Research, November 2016), http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12606/full	**Nationwide:** Compared trends in dental care use among adults ages 21-64 with incomes at or below 138% FPL across four categories of states (expansion states that do and do not provide adult dental benefits and non-expansion states that do and do not provide adult dental benefits). Used 2010-2014 data from the Gallup-Healthways Wellbeing Index survey and a differences-in-differences analysis.	• Relative to the pre-reform period and non-expansion states without adult dental benefits, Medicaid coverage increased by 8.9 percentage points in expansion states with adult dental benefits by the second half of 2014. • Compared to non-expansion states without adult dental benefits, Medicaid coverage did not change by a statistically significant amount in non-expansion states with adult dental benefits.
Stacey McMorrow, Genevieve Kenney, Sharon Long, and Jason Gates, "Marketplaces Helped Drive Coverage Gains in 2015; Affordability Problems Remained," *Health Affairs* 35 no. 10 (October 2016): 1810-1815, http://content.healthaffairs.org/content/35/10/1810.full	**Nationwide:** Explored changes in continuity of coverage and affordability of care among nonelderly adult Marketplace enrollees in 2014 and 2015. Also compared characteristics of Marketplace enrollees in expansion and non-expansion states in 2015. Used early release data from the National Health Interview Survey (NHIS).	• Likely reflecting both lower incomes and higher likelihood of unstable coverage, marketplace enrollees in non-expansion states were more likely than those in expansion states to report problems affording care. • Enrollees in non-expansion states remained less likely to have been insured for the previous twelve months, compared to those in expansion states (75% versus 80%). • 22.8% of Marketplace enrollees in non-expansion states reported problems paying their family medical bills, compared to 14.5% in expansion states. • Unmet need for medical care due to cost was higher among Marketplace enrollees in non-expansion states compared to expansion states. • Marketplace enrollees in non-expansion states in 2015 were more likely than those in expansion states to have incomes of 100–138 percent FPL and to be black or Hispanic.

Robin Rudowitz, Allison Valentine, and Vernon Smith, *Medicaid Enrollment and Spending Growth: FY 2016 & 2017* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2016), http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2016-2017/	**Nationwide:** Provided an overview of Medicaid enrollment and spending growth with a focus on State Fiscal Years (FY) 2016 and 2017. Findings were based on interviews and data provided by state Medicaid directors as part of the 16th annual survey of Medicaid directors in all 50 states and DC conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.	• Medicaid enrollment and total spending in FY 2016 and FY 2017 slowed for both expansion and non-expansion states. • The typical expansion state, compared to a non-expansion state, experienced higher Medicaid enrollment and total spending growth in FY 2016, and that differential is projected to continue in FY 2017, although the size of the differential is narrowing.
Jessica Vistnes and Joel Cohen, "Gaining Coverage in 2014: New Estimates of Marketplace and Medicaid Transitions," *Health Affairs* 35 no. 10 (October 2016): 1825-1829, http://content.healthaffairs.org/content/35/10/1825.full?sid=cc385dd5-9c95-4ee1-9c58-888408d49c54	**Nationwide:** Studied changes in health insurance status for nonelderly adults using data from the Medical Expenditure Panel Survey-Household Component for the 2012-2014 period. Examined gains in Medicaid coverage among those who were uninsured for the previous calendar year.	• Among those who were uninsured during all of 2013, a larger share of those in expansion states gained Medicaid coverage in 2014 than those in non-expansion states. In expansion states, 17.4% of adults who were uninsured in 2013 gained Medicaid coverage in 2014, compared with only 5.6% in expansion states between 2012 and 2013. • There was no significant change in the rate at which uninsured adults gained Medicaid coverage in states that did not expand Medicaid over the same period. • In expansion states, previously uninsured adults who enrolled in Medicaid were more likely to be non-Hispanic white, compared to adults who remained uninsured. • About half of those in expansion states who remained uninsured were Hispanics not born in the US. By contrast, only 12.8% of those in the expansion states who enrolled in Medicaid in 2014 were Hispanics not born in the US.
Kelsey Avery, Kenneth Finegold, and Amelia Whitman, *Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage* (Office of the Assistant Secretary for Planning and Evaluation, September 2016), https://aspe.hhs.gov/sites/default/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf	**Nationwide:** Used estimates from the National Health Interview Survey to examine gains in health insurance coverage for nonelderly adults from 2010 to 2015. Also presented separate estimates of changes in the uninsured rate by income and race for expansion and non-expansion states.	• Between 2010 and 2015, the overall uninsured rate decreased from 19.9% to 10.0% in expansion states (a decline of nearly 50%) and from 25.9% to 17.7% in non-expansion states (a decline of nearly 32%). • In expansion states, the uninsured rate among non-elderly adults with incomes below 100% FPL has decreased from 37.2% to 17.1% between 2010 and 2015 (a 54% drop), compared to a decline from 49.5% to 40.0% in non-expansion states (a 19% decrease). • The uninsured rate among non-elderly Hispanics in expansion states decreased from 39.6% to 22.7% between 2010 and 2015 (a drop of nearly 43%), compared to a decline from 49.5% to 36.6% in non-expansion states (a 26% decrease). • The uninsured rate among non-Hispanic Blacks declined from 24.0% in 2010 to 9.9% in 2015 in expansion states (a nearly 59% decrease), versus a decrease from 29.8% to 18.8% in non-expansion states (a decline of nearly 37%). • The uninsured rate among non-Hispanic Whites decreased from 14.5% to 6.8% in expansion states (a reduction of 53%) between 2010 and 2015, and from 19.3% to 12.0% in non-expansion states (a nearly 38% decline). • The uninsured rate among non-Hispanic Asians in expansion states decreased from 18.3 % in 2010 to 6.9% in 2015 (a drop of 62%), compared to declining from 23.3% to 11.3% in non-expansion states (a nearly 52% decrease).

Helen Levy, Thomas Buchmueller, and Sayeh Nikpay, *Health Reform and Health Insurance Coverage of Early Retirees* (Ann Arbor, MI: University of Michigan Retirement Research Center Working Paper, September 2016), http://www.mrrc.isr.umich.edu/publications/papers/pdf/wp345.pdf	**Nationwide:** Explored the dynamics of health insurance coverage between 2008 and 2014 among early retirees, defined as individuals ages 55 to 64 who are not in the labor force. Used data from the Census Bureau's American Community Survey.	• Between 2013 and 2014, the fraction of early retirees who were uninsured droped significantly by 5.1 percentage points in expansion states and 2.5 percentage points in non-expansion states. The decline in expansion states was significantly larger than the decline in non-expansion states. • Medicaid coverage increased among early retirees by 4.6 percentage points in expansion states and 1.4 percentage points in non-expansion states. The increase in expansion states was significantly larger than that in non-expansion states. • Private, nongroup coverage increased among early retirees by 1.3 percentage points in expansion states and 2.0 percentage points in non-expansion states. The gain in non-expansion states was significantly larger than that in expansion states. • Expansion and non-expansion states both showed the same downward trend in employer-sponsored coverage among early retirees of one or two percentage points a year both prior to ACA implementation and between 2013 and 2014. • The post-ACA gains in coverage disproportionately benefited low-income early retirees, and therefore reduced the disparity in coverage with respect to income.
Andrew Mulcahy, Christine Eibner, and Kenneth Finegold, "Gaining Coverage Through Medicaid Or Private Insurance Increased Prescription Use and Lowered Out-Of-Pocket Spending," *Health Affairs* 35, no. 9 (September 2016), http://content.healthaffairs.org/content/early/2016/08/16/hlthaff.2016.0091.full	**Nationwide:** Used IMS Health prescription transaction data from 2012-2014 to measure number of prescription drug users who changed their source of coverage during the expansion period. Also tracked changes in individual prescription drug use, total drug spending, and out-of-pocket drug spending for prescription drug users following ACA expansion implementation.	• States that opted for expansion in 2014 had larger declines in uninsured rates among prescription drug users (39.1%) compared to non-expansion states (22.6%). • 12% of prescription drug users who were uninsured in 2013 gained Medicaid coverage in 2014.
Pauline Leung and Alexandre Mas, *Employment Effects of the ACA Medicaid Expansions* (Working Paper No. 22540, National Bureau of Economic Research, August 2016), http://www.nber.org/papers/w22540	**Nationwide:** Compared employment in states that did and did not expand Medicaid, before and after adoption of the policy, through a differences-in-differences analysis. Used data from the American Community Survey and the Current Population Survey.	• Medicaid coverage sharply increased in expansion states after 2014, while the increase was much smaller in non-expansion states. • The change in the share of childless adults with any insurance or with Medicaid increased by 1.6 percentage points and 3.0 percentage points more, respectively, in expansion states compared to non-expansion states. • The increase in Medicaid coverage was larger than the increase in coverage overall due to a decline in direct purchase coverage.
Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care* (Office of the Assistant Secretary for Planning and Evaluation, June 2016), https://aspe.hhs.gov/sites/default/files/pdf/205141/medicaidexpansion.pdf	**Nationwide:** Though primarily a literature review focused on the effects of expansion on coverage, access, affordability, and quality of care, also includes ASPE analysis of the Gallup-Healthways Well-Being Index survey data on changes in the uninsured rate through February 2016.	• Gallup-Healthways data indicates that among Medicaid expansion states, the uninsured rate for non-elderly adults declined 9.2 percentage points (a 49.5% decline), from 18.5% in 2012/2013 to 9.3% in the first quarter of 2016. • Over the same period, among non-expansion states, the uninsured rate for non-elderly adults declined 7.9 percentage points (a 33.8% decline), from 23.3% in 2012/2013 to 15.4% in the first quarter of 2016. • The uninsured rate was substantially lower in expansion states than in non-expansion states prior to 2014. Given this fact, the raw difference in the reduction in the uninsured rate between expansion and non-expansion states could understate the effect of Medicaid expansion.
Alanna Williamson, Larisa Antonisse, Jennifer Tolbert, Rachel Garfield, and Anthony Damico, *ACA Coverage Expansions and Low-Income Workers* (Washington, DC: Kaiser Commission on	**Nationwide:** Compared characteristics and health coverage status of nonelderly adult low-income workers (<250% FPL) with those of higher income workers	• From 2013 to 2014, the share of low-income workers (below 250% FPL) enrolled in Medicaid and other public coverage grew from 18% to 23%. Over the same period, the share of low-income workers who were uninsured dropped from 35% in 2013 to 26% in 2014.

Medicaid and the Uninsured, June 2016), http://kff.org/report-section/aca-coverage-expansions-and-low-income-workers-issue-brief/	(>250% FPL). Examined post-ACA changes in health coverage among these populations. Used data from the Census Bureau's 2014 and 2015 Annual Social and Economic Supplement to the Current Population Survey.	• In expansion states, the share of low-income workers covered by Medicaid or other public coverage increased from 22% in 2013 to 30% in 2014. • In non-expansion states, there was no significant increase between 2013 and 2014 in the share of low-income workers with Medicaid or other public coverage. • In expansion states, the uninsured rate among low-income workers declined from 31% in 2013 to 22% in 2014.
Thomas Buchmueller, Zachary Levinson, Helen Levy, and Barbara Wolfe, "Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage," *American Journal of Public Health* (May 2016), http://www.ncbi.nlm.nih.gov/pubmed/27196653	**Nationwide:** Used data from the American Community Survey from 2008 to 2014 to examine changes in the percentage of nonelderly adults who were uninsured, covered by Medicaid, or covered by private insurance. Presented overall trends by race/ethnicity and also stratified the analysis by income group and state Medicaid expansion status.	• The percent uninsured was lower in expansion states in 2013 and declined more between 2013 and 2014 in expansion states than in non-expansion states. • Uninsured rates decreased more in expansion states than in non-expansion states for all three racial/ethnic groups included in the study (Whites, Blacks, and Hispanics). • The percentage of Blacks without health insurance decreased by 5.6 percentage points in expansion states and by 4 percentage points in non-expansion states. • For Hispanic citizens, the uninsured rate decreased by 7.2 percentage points in expansion states and 5.4 percentage points in non-expansion states. For Hispanic non-citizens, the uninsured rate decreased by 7.8 and 5.1 percentage points in expansion and non-expansion states, respectively. • For Whites, the uninsured rate decreased by 3.3 percentage points in expansion states and 2.3 percentage points in non-expansion states.
Robin Cohen, Michael Martinez, and Emily Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015* (National Center for Health Statistics, May 2016), http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf	**Nationwide:** Presented selected estimates of health insurance coverage for the civilian noninstitutionalized US population based on data from the 2015 National Health Interview Survey (NHIS), along with comparable estimates from the 2010-2014 NHIS.	• In 2015, nonelderly adults residing in Medicaid expansion states were less likely to be uninsured than those residing in non-expansion states. In Medicaid expansion states, the percentage of those uninsured decreased from 18.4% in 2013 to 9.8% in 2015. In nonexpansion states, the percentage uninsured decreased from 22.7% in 2013 to 17.5% in 2015. • The percentage of adults who were uninsured dropped in both 2014 and 2015 in expansion and non-expansion states, although the percentage point declines were larger in expansion states. Compared to 2013 levels, in 2014 the uninsured rate dropped by 5.1 percentage points in expansion states and by 3.1 percentage points in non-expansion states. Compared to 2014 levels, in 2015 the uninsured rate dropped by 3.5 percentage points in expansion states and by 2.1 percentage points in non-expansion states.
Sara Collins, Munira Gunja, Michelle Doty, and Sophie Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction* (The Commonwealth Fund, May 2016), http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction	**Nationwide:** Examined the ACA's effects on insurance coverage and how people are using their coverage to get health care. Reported data from the fourth wave of the Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016.	• 62% of adults newly covered by Medicaid were uninsured before they enrolled. Of this group, 49% with Medicaid had been without insurance for a more than two years.
Michael Karpman, Jason Gates, Genevieve Kenney, Stacey McMorrow, *How Are Moms Faring under the Affordable Care Act? Evidence Through 2014,* (The Urban Institute, May 2016), http://www.urban.org/research/publication/how-are-moms-faring-under-affordable-care-act-evidence-through-2014	**Nationwide:** Examined health insurance coverage experiences under the ACA of mothers living with dependent children. Studied trends in uninsurance among mothers nationally and for mothers in states that did and did not expand Medicaid under the ACA by May 2014. Used 1997-2014 data from the National Health Interview Survey.	• Coverage gains among low-income mothers were larger in states that expanded Medicaid by May 2014 than in states that did not expand. In expansion states, the uninsured rate for low-income mothers fell 8.1 percentage points between 2013 and 2014, compared to a 4.9 percentage point drop in non-expansion states. • Among mothers of all income levels, the decline in uninsured rates between 2013 and 2014 was greater among mothers living in Medicaid expansion states than among those living in non-expansion states (although the difference in the change was only marginally significant at $p<.10$).

Genevieve Kenney, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens, *Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA,* (Washington, DC: The Urban Institute, May 2016), http://www.urban.org/research/publication/childrens-coverage-climb-continues-uninsurance-and-medicaidchip-eligibility-and-participation-under-aca	**Nationwide:** Examined coverage status, eligibility for Medicaid/CHIP, and participation in Medicaid/CHIP among children age 18 and under using the American Community Survey.	• On average, gains in participation between 2013 and 2014 were larger in states that expanded Medicaid under the ACA in 2014 (3.0%) than in non-expansion states (1.8%). The 10 states with the largest participation gains all participated in the Medicaid expansion in 2014. • Although the uninsured rate was already lower for children in expansion states in 2013, the differential between expansion and non-expansion states in uninsured rates for children grew larger in 2014.
Jessica Sharac, Rachel Gunsalus, Chi Tran, Peter Shin, and Sara Rosenbaum, *How are Migrant Health Centers and their Patients Faring Under the Affordable Care Act?* (Geiger Gibson/RCHN Community Health Foundation Research Collaborative, The George Washington University Milken Institute of Public Health, May 2016), http://www.rchnfoundation.org/wp-content/uploads/2016/05/Migrant-Health-Centers-Patients-Under-Affordable-Care-Act.pdf	**Nationwide:** Studied population characteristics of migrant and seasonal agricultural workers (MSAWs) and their dependents, changes over time in the MSAW population served by health centers, and the impacts of ACA implementation on migrant health centers. Used data from a national survey of agricultural workers as well as findings from analyses of data from the Uniform Data System that covers all health centers.	• Although migrant health centers in both Medicaid expansion and non-expansion states experienced significant decreases in their uninsured rates between 2013 and 2014, the decline was steeper in Medicaid expansion states (declined from 34% to 24% uninsured in expansion states and from 45% to 42% in non-expansion states). • Migrant health centers in Medicaid expansion states also registered a statistically significant increase in the percentage of patients with Medicaid coverage between 2013 and 2014, while migrant health centers in non-expansion states did not. • A closer, focused examination of 16 migrant health centers with the highest percentage of agricultural worker patients found that those served by migrant health centers located in non-expansion states were twice as likely to be uninsured as those served by migrant health centers located in expansion states.
Kosali Simon, Aparna Soni, and John Cawley, *The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the 2014 ACA Medicaid Expansions* (Working Paper 22265, National Bureau of Economic Research, May 2016), http://www.nber.org/papers/w22265?utm_campaign=ntw&utm_medium=email&utm_source=ntw	**Nationwide:** Examined the impact of 2014 ACA Medicaid expansions on preventative care (e.g. dental visits, immunizations, mammograms, cancer screenings) and risky health behaviors (e.g. smoking, heavy drinking, lack of exercise, obesity) among low-income (<100% FPL), childless, nonelderly adults. Used 2012-2014 data from the Behavioral Risk Factor Surveillance System and a difference-in-difference model.	• The expansion of Medicaid eligibility in 2014 increased the probability that low-income childless adults had health insurance coverage by 15.5 percentage points, or 28%, compared to the pre expansion (2012-2013) level. • Among women, the probability of coverage rose 17.1 percentage points in 2014 and among men it rose 14.2 percentage points. Both are statistically significant and the difference between the coefficients for men and women is not statistically significant.
Dmitry Tumin, Don Hayes Jr., Kenneth Washburn, Joseph Tobias, and Sylvester Black, "Medicaid Enrollment after Liver Transplantation: Effects of Medicaid Expansion," *Liver Transplantation* (May 2016), http://www.ncbi.nlm.nih.gov/pubmed/27152888	**Nationwide:** Assessed post-transplant insurance status through June 2015 of patients receiving first-time liver transplants. Used difference-in-difference multivariate competing risk models stratified on state of residence to estimate the effects of Medicaid expansion on Medicaid enrollment or use of uninsured care after liver transplantation.	• Among those who received a pre-ACA liver transplant funded by private insurance, implementation of Medicaid expansion increased the chances of enrolling in Medicaid during post-transplant care. • Medicaid expansion did not reduce the likelihood of being uninsured for post-transplant care, though uninsured rates among this population were very low even before the ACA.
Charles Courtemanche, James Marton, Benjamin Ukert, Aaron Yelowitz, and Daniela Zapata, *Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States* (Working Paper No. 22182, The National Bureau of Economic Research, April 2016), http://www.nber.org/papers/w22182	**Nationwide:** Quasi-experimental study that estimated the effects of the ACA on health insurance coverage using data from the American Community Survey. Utilized difference-in-difference-in-differences models that exploited cross-sectional variation in the intensity of treatment arising from state participation in the Medicaid expansion and local area pre-ACA uninsured	• Implementation of the full ACA with Medicaid expansion increased the proportion of residents with insurance by 5.9 percentage points in 2014, compared to 3.0 percentage points in states that did not expand Medicaid. The Medicaid expansion component of the ACA increased coverage by 2.9 percentage points in 2014. • In expansion states, the largest effects on insurance coverage occurred among those with incomes below 138% FPL. Full implementation of the ACA with Medicaid expansion is predicted to increase coverage by 10.3 percentage points for this group, from a base of 61%. This can be primarily attributed to an increase in Medicaid coverage of 8.8 percentage points.

	rates to identify the effects of the ACA in Medicaid expansion and non-expansion states. Findings presented at right are for geographic areas with average uninsured rates.	• Estimates implied that the fully implemented ACA with Medicaid expansion reduced the difference in uninsured rates between the lowest income (under 138% FPL) and highest income (over 400% FPL) groups by 8.7 percentage points, or 27%, in 2014. However, the ACA without the Medicaid expansion only lowered this gap by 11%. • The fully implemented ACA lowered the coverage disparity between Whites and Non-Whites in by 2.2 percentage points, or 14%, whereas the ACA without the Medicaid expansion increased this disparity. • The study found that Medicaid expansion reduced private coverage by 1.8 percentage points (split roughly evenly between ESI and individually purchased coverage) among the low-income subsample, but this change was not statistically significant.
Molly Frean, Jonathan Gruber, and Benjamin Sommers, *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act* (Working Paper No. 22213, National Bureau of Economic Research, April 2016), http://www.nber.org/papers/w22213?utm_campaign=ntw&utm_medium=email&utm_source=ntw	**Nationwide:** Assessed the relative contributions to insurance changes of various ACA provisions in the law's first full year using rating-area level premium data for all 50 states and microdata from the 2012-2014 American Community Survey. Employed a difference-in-difference-in-difference estimation strategy to causally identify the role of the ACA policy levers.	• The ACA increased Medicaid coverage both among newly eligible populations and those who were previously eligible for Medicaid, with the latter driven predominantly by states that expanded their programs prior to 2014. • Attributed roughly 63% of the ACA's reduction in the uninsured rate in 2014 to increased Medicaid coverage, but of that, the majority was due to enrollment of previously eligible individuals. • Found no evidence of "crowd-out" of either employer coverage or non-group private coverage by the Medicaid expansion.
Laura Wherry and Sarah Miller, "Early Coverage, Access, Utilization, and Health Effects Associated with the Affordable Care Act Medicaid Expansions: A Quasi-experimental Study," *Annals of Internal Medicine*, Epub ahead of print (April 2016), http://annals.org/article.aspx?articleid=2513980	**Nationwide:** Evaluated whether state Medicaid expansions were associated with changes in insurance coverage, access and utilization of health care, and self-reported health. Used National Health Interview Survey data and a quasi-experimental difference-in-differences design that compared changes in outcomes for residents of expansion and non-expansion states before (during the 2010 to 2013 period) and after (through the end of 2014) the expansion became effective.	• The increase in Medicaid coverage in 2014 (compared to the pre-expansion period) was 10.5 percentage points higher in expansion states relative to non-expansion states. • The decrease in the percentage without insurance in 2014 was 7.4 percentage points greater in expansion states compared to non-expansion states. • Medicaid expansions were associated with a large and significant increase (7.1 percentage points) in the portion of people reporting that their health care coverage has improved compared to the previous year.
Centers for Medicare and Medicaid Services, *Monthly Medicaid and CHIP Application, Eligibility, Determination, and Enrollment Reports*, (Centers for Medicare and Medicaid Services, March 2016), https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html	**Nationwide:** March 2016 version of a monthly report measuring eligibility and enrollment activity for the entire Medicaid and CHIP programs in all states, reflecting activity for all populations receiving comprehensive Medicaid and CHIP benefits in all states.	• Among the 49 states reporting both March 2016 enrollment data and data from July-September of 2013, over 15 million additional individuals were enrolled in Medicaid and CHIP as of March 2016, an overall 26.6% increase over the average monthly enrollment for July-September 2013. • Among states that had implemented the Medicaid expansion and were covering newly eligible adults in March 2016, Medicaid and CHIP enrollment rose by over 35.2% compared to the July-September 2013 baseline period. • States that had not expanded Medicaid reported an increase of over 11.2% over the same period. • 15,490 additional people were enrolled in Medicaid and CHIP in March 2016 as compared to February 2016 in the 51 states that reported comparable February and March 2016 data.
Matt Warfield, Barbara DiPietro, and Samantha Artiga, *How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://files.kff.org/attachment/iss	**Health Care for the Homeless Projects, Nationwide:** Studied how the first full year of Medicaid expansion affected patients who are homeless and the providers who care for them. Used data from the Uniform Data System for health centers to examine changes in insurance coverage,	• The health care coverage rate for patients at Health Care for the Homeless (HCH) projects increased by 22 percentage points in expansion states but only increased by 4 percentage points in non-expansion states.

ue-brief-how-has-the-aca-medicaid-expansion-affected-providers-serving-the-homeless-population	revenues, and costs among Health Care for the Homeless projects serving the homeless population.	
Robin Rudowitz, Samantha Artiga, Anthony Damico, and Rachel Garfield, *A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2016), http://kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/	**Nationwide:** Provided a closer look at key characteristics of the remaining nonelderly uninsured population who were eligible for Medicaid coverage and where they lived. Analysis used data from the 2015 Current Population Survey Annual Social and Economic Supplement and was based on state Medicaid expansion decisions as of January 2016, which included Louisiana's decision to adopt the expansion.	• A greater share of the uninsured were eligible for Medicaid in states that had expanded their programs under the ACA. In those states, 41% of the uninsured were eligible, versus just 13% in non-expansion states. • Because the Medicaid expansion effectively eliminated categorical eligibility requirements, more than half of the uninsured and eligible were male in expansion states, compared to only 30% in non-expansion states where the majority of the uninsured and eligible were female due to historic eligibility criteria for Medicaid. • Uninsured and eligible adults in expansion states are more likely to live in a family with a worker than those in non-expansion states. (70% vs. 50%). • States that had achieved significant enrollment success embraced a full array of outreach and enrollment strategies and approaches. Given the unique characteristics of the eligible but uninsured population in expansion states, this population may not be touched by previous outreach and enrollment avenues and so states must explore new avenues to reach these individuals.
Christopher Truffer, Christian Wolfe, and Kathryn Rennie, *2016 Actuarial Report on the Financial Outlook for Medicaid,* (Office of the Actuary, Centers for Medicare and Medicaid Services, 2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf	**Nationwide:** Analyzed past Medicaid trends and 10-year projections of expenditures and enrollment, including the impacts of the 2014 eligibility changes under the ACA.	• Medicaid enrollment is estimated to have grown by 7.6% between 2014 and 2015; excluding newly eligible adults, enrollment is estimated to have increased by 0.2%. • An estimated 11.2 million newly eligible adult enrollees were covered under expanded Medicaid eligibility in 2016 (based on 2016 data reported by the states to CMS).
Robert Kaestner, Bowen Garrett, Anuj Gangopadhyaya, and Caitlyn Fleming, *Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply* (Working Paper No. 21836, National Bureau of Economic Research, December 2015), http://www.nber.org/papers/w21836	**Nationwide:** Examined the effect of the ACA Medicaid expansions on health insurance coverage and labor supply among adults with a high school education or less. Relied on data from the American Community Survey and the Current Population Survey for the 2010 to 2014 period. Used two research designs: difference-in-differences and synthetic control.	• Medicaid expansions increased Medicaid coverage among adults with a high school education or less by approximately four percentage points, decreased the proportion uninsured by approximately three percentage points, and decreased private health insurance coverage by one percentage point. • Larger effects of the 2014 Medicaid expansion on health insurance were found for unmarried, childless adults with a high school education or less.
Peter Shin, Jessica Sharac, Julia Zur, Sara Rosenbaum, and Julia Paradise, *Health Center Patient Trends, Enrollment Activities, and Service Capacity: Recent Experience in Medicaid Expansion and Non-Expansion States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2015), http://kff.org/medicaid/issue-brief/health-center-patient-trends-enrollment-activities-and-service-capacity-recent-experience-in-medicaid-expansion-and-non-expansion-states/	**Nationwide:** Examined change between 2013 and 2014 in the volume and health coverage profile of health center patients, as well as health center enrollment activities and service capacity, comparing states that did and did not expand Medicaid in 2014. Based on 2013 and 2014 data from the federal Uniform Data System and a 2014 national survey of health centers.	• From 2013 to 2014, the number of health center patients covered by Medicaid rose by 1.85 million, or 22%. • In expansion states, the share of health center patients with Medicaid rose by 20% and the share who were uninsured fell by 29%. In non-expansion states, the share with Medicaid rose by 3% and the share who were uninsured fell by 8%.

Joan Alker and Alisa Chester, *Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements* (Washington, DC: Georgetown Center for Children and Families, October 2015), http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf	**Nationwide:** Used American Community Survey data to explore the profile of uninsured children in 2014 and examine the rate of change in coverage for children from 2013 to 2014.	• Despite having lower uninsured rates among children prior to expansion, states that expanded Medicaid had a larger decline in the uninsured rate for children compared to non-expansion states. • The uninsured rate among children in expansion states declined from 5.9% in 2013 to 4.6% in 2014 in expansion states. The uninsured rate among children declined from 8.5% to 7.5% in non-expansion states over the same period. • The percent decline in the number of uninsured children in expansion states was nearly double the percent decline in non-expansion states (21.7% vs. 11.6%). This is likely due to a robust "welcome mat" effect as parents enrolled their children when they signed up for newly available coverage.
Robin Rudowitz, Laura Snyder, and Vernon Smith, *Medicaid Enrollment and Spending Growth: FY 2015 & 2016* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2015), http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/	**Nationwide:** Provided an overview of Medicaid enrollment and spending growth with a focus on state Fiscal Years (FY) 2015 and 2016. Findings were based on interviews and data provided by state Medicaid directors as part of the 15th annual survey of Medicaid directors in all 50 states and DC conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.	• In FY 2015, expansion states reported Medicaid enrollment and total spending growth nearly three times the rate of non-expansion states. Across the 29 expansion states in FY 2015, enrollment increased on average by 18.0% and total spending increased by 17.7%; both increases were driven by increases in enrollment among adults qualifying under the new expansion group. Across the 22 non-expansion states in FY 2015, enrollment and total spending growth was 5.1% and 6.1% respectively. • In expansion states in FY 2015, growth in state general fund spending for Medicaid (average increase of 3.4%) was much slower than growth in total Medicaid spending (average increase of 17.7%)—primarily due to the enhanced federal match rate for those newly eligible for coverage. For non-expansion states, state Medicaid spending growth in FY 2015 (6.9%) slightly outpaced total Medicaid spending growth (6.1%), primarily due to annual formula-driven changes in the Federal Medical Assistance Percentage (FMAP). • Total Medicaid enrollment and spending growth was projected to slow in 2016.
Jessica Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2014* (U.S. Census Bureau, September 2015), https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf	**Nationwide:** Presented statistics on health insurance coverage in the US in 2014 and changes in coverage between 2013 and 2014 based on data from the Current Population Survey Annual Social and Economic Supplement and the American Community Survey.	• Variation in both the uninsured rate and change in the uninsured rate by state may be related to whether the state expanded Medicaid eligibility in 2014. • The uninsured rate in 2014 was 9.8% in 2014 in expansion states, compared with 13.5% in non-expansion states. • Between 2013 and 2014, decreases in the uninsured rate were in general greater in expansion states than in non-expansion states—the decrease was 3.4 percentage points in expansion states compared with 2.3 percentage points in non-expansion states.
Benjamin Sommers, Munira Gunja, Kenneth Finegold, and Thomas Musco, "Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *The Journal of the American Medical Association* 314 no. 4 (July 2015): 366-374, http://jama.jamanetwork.com/article.aspx?articleid=2411283&resultClick=3	**Nationwide:** Analyzed the 2012-2015 Gallup-Healthways Well-Being Index to estimate national changes in self-reported coverage, access to care, and health during the ACA's first two open enrollment periods, as well as to assess differences between low-income adults in states that did and did not expand Medicaid under the ACA.	• National trends in self-reported coverage were worsening prior to the ACA. These trends improved after October 2013, when the ACA's open enrollment began. • Pre-ACA trends for study outcomes did not differ significantly by expansion status (except for difficulty affording care, which was slightly worsening in expansion states relative to non-expansion states prior to 2014). • The uninsured rate declined among low-income adults in both expansion and non-expansion states in the post-ACA period (from January 2014-March 2015) compared to the pre-ACA period (from January 2012-September 2013), but there was a significantly greater reduction in the expansion states.
Robin Cohen and Michael Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2014* (National Center for Health Statistics, June 2015), http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf	**Nationwide:** Used 2014 data from the National Health Interview Survey (NHIS) to provide estimates of uninsurance, public coverage, and private coverage throughout the US. 2014 data were compared with 2013 NHIS data to show changes in coverage following the implementation of the ACA Health Insurance Marketplace and Medicaid expansion provisions.	• The percentage of nonelderly adults who were uninsured in expansion states decreased from 18.4% in 2013 to 13.3% in 2014 and decreased from 22.7% to 19.6% in non-expansion states. • The percentage of nonelderly adults with public coverage increased in expansion states from 2013 (17.7%) to 2014 (19.9%) but did not change significantly in non-expansion states (15.3% in 2014). • In 2014, nonelderly adults in expansion states were more likely to have private coverage than those in non-expansion states. The percentage of nonelderly adults with private coverage increased in expansion states from 65.2% in 2013 to 68.1% in 2014. In non-expansion states, the percentage increased from 63.2% in 2013 to 66.5% in 2014.

Stacey McMorrow, Genevieve Kenney, Sharon Long, and Nathaniel Anderson, "Uninsurance Among Young Adults Continues to Decline, Particularly in Medicaid Expansion States," *Health Affairs* 34, no. 4 (April 2015): 616-620, http://content.healthaffairs.org/content/34/4/616.full	**Nationwide:** Used data from the National Health Interview Survey (NHIS) to examine health insurance for young adults ages 19-25 from 2009 through the first two quarters of 2014.	• The share of low-income (<138% FPL) young adults without insurance declined from 39.6% to 30.7% between 2013 and early 2014. The uninsured rate fell from 26.4% to 19.6% among young adults with moderate incomes, and there was no significant change in the uninsured rate for young adults with the highest incomes. • In expansion states, the share of low-income young adults who were uninsured fell from 34.5% to 24.3% between 2013 and 2014, and the share who had public coverage increased from 29.9% to 41.1%. • In non-expansion states, increases in the shares of low-income young adults with public coverage and with private coverage were not significant. The decrease in the share of this population that was uninsured (from 46.2% to 37.7% between 2013 and 2014) was marginally significant (p<.10).
Sara Collins, Petra Rasmussen, Michelle Doty, and Sophie Beutel *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014* (The Commonwealth Fund, January 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en	**Nationwide:** Used results from the 2012 and 2014 Commonwealth Fund Biennial Health Insurance Survey to assess changes in health care coverage and affordability since the ACA took effect.	• Uninsured rates fell in 2014 in both expansion and non-expansion states, but 35% of adults with incomes under the poverty level in non-expansion states remained uninsured in 2014 compared with 19% in states that did expand. • States' decisions not to expand their Medicaid programs had a larger effect on coverage than choosing not to run their own marketplaces.
Sharon Long, Michael Karpman, Adele Shartzer, Douglas Wissoker, Genevieve Kenney, Stephen Zuckerman, Nathaniel Anderson, and Katherine Hempstead, *Taking Stock: Health Insurance Coverage under the ACA as of September 2014* (The Urban Institute, December 2014), http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.html	**Nationwide:** Examined continued changes in the uninsured rate for nonelderly adults through September 2014. Used data from the Urban Institute's Health Reform Monitoring Survey (HRMS), which had been tracking insurance coverage since the first quarter of 2013.	• The uninsured rate for adults in expansion states dropped 5.8 percentage points between September 2013 and September 2014; the rate dropped 4.8 percentage points in non-expansion states. This is a decline in the uninsured rate of 36.3% in expansion states and 23.9% in non-expansion states. • Low-income adults targeted by the Medicaid expansion (≤138% FPL) had large gains in insurance coverage in expansion states—insurance coverage among this population increased by 14.7 percentage points, or 40.2%, between September 2013 and September 2014. • Insurance coverage increased 9.2 percentage points for low-income adults in non-expansion states, with the majority of the increase occurring between June and September 2014. This increase in coverage was likely caused by a gain in Medicaid coverage: there was no evidence of an increase in employer-sponsored coverage over the period, and most of the low-income adults would not be eligible for subsidized Marketplace coverage.
Benjamin Sommers, Thomas Musco, Kenneth Finegold, Munira Gunja, Amy Burke, and Audrey McDowell, "Health Reform and Changes in Health Insurance Coverage in 2014" *The New England Journal of Medicine* 371 (August 2014): 867-874, http://www.nejm.org/doi/full/10.1056/NEJMsr1406753	**Nationwide:** Using January 2012 to June 2014 survey data primarily from the Gallup–Healthways Well-Being Index, examined whether the pattern of coverage changes in 2014 was consistent with early effects of the ACA and whether any changes in access to care were evident as of mid-2014.	• By the second quarter of 2014, the uninsured rate dropped for people with incomes below 138% FPL by 6 percentage points in expansion states and by a nonsignificant 3.1 percentage points in non-expansion states. • In an analysis directly comparing low-income adults in states with Medicaid expansion vs. those in states without, expansion was associated with a 5.1 percentage point greater reduction in the uninsured rate in 2014 compared to non-expansion states.
Multi-State Studies		
Benjamin Sommers, Robert Blendon, E. John Orav, and Arnold Epstein, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *The Journal of the American Medical Association* 176 no. 10 (October 2016): 1501-1509, http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420	**Arkansas, Kentucky, and Texas:** Surveyed adults ages 19-64 with incomes below 138% of the FPL in November and December of 2013, 2014, and 2015 to track changes in insurance coverage, utilization, preventive care, and self-reported health. Performed a differences-in-differences analysis of the survey data to assess these changes before	• The uninsured rate in Arkansas dropped from 41.8% in 2013 to 14.2% in 2015. Coverage gains were mostly due to increased enrollment in private insurance. • The uninsured rate in Kentucky dropped from 40.2% in 2013 to 8.6% in 2015. Coverage gains were mostly due to increased Medicaid enrollment. • The uninsured rate in Texas dropped from 38.5% in 2013 to 31.8% in 2015. • Comparison of survey data from AR and KY with data from TX indicated that expansion states experienced a 14.0 greater percentage point decrease in uninsured rates between 2013 and 2014 and a 22.7 greater percentage point decrease between 2013 and 2015.

	and after Medicaid expansion in two expansion states (KY, AR) and in one non-expansion state (TX).	
Benjamin Sommers, Rebecca Gourevitch, Bethany Maylone, Robert Blendon, and Arnold Epstein, "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many," *Health Affairs* 35 no. 10 (October 2016): 1816-1824, http://content.healthaffairs.org/content/35/10/1816.full?sid=f4835910-ffd0-4864-a76a-b4f207ccd018	**Arkansas, Kentucky, and Texas:** Explored the frequency and implications of churning (changes in insurance coverage over time) through surveys of low-income adults in KY (a traditional Medicaid expansion state), AR (a "private option" expansion state) and TX (a non-expansion state). Also compared 2015 churning rates in these states to survey data from 2013, before the ACA coverage expansions.	• Churning rates were fairly similar across the states both in 2013 and in 2015, and there were no significant changes in churning rates over time from 2013 to 2015 based on the state's expansion policy. • In 2015, nearly one quarter of respondents in each state reported one or more changes in health insurance status during the previous 12 months. • Overall, nearly 20% of those who churned did so because they gained insurance coverage. The proportion of respondents in AR and KY who gained coverage was approximately double the proportion of residents who did so in TX. • Reasons for churning differed significantly across the study states. Respondents in TX were the most likely to say that they had dropped coverage because they couldn't afford it, those in AR were the most likely to say that their plan was no longer available, and those in KY were the most likely to report trouble with the renewal process in Medicaid or Marketplace coverage as the main reason for churning. • Excluding respondents who went from uninsured to insured, churning was roughly twice as common among respondents with Marketplace coverage or nongroup private coverage compared to those with Medicaid, and churning rates were lower in AR and KY than in TX. Churning did not differ significantly between AR and KY.
Steven Wallace, Maria-Elena Young, Michael Rodriguez, Amy Bonilla, and Nadereh Pourat, *Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era* (UCLA Center for Health Policy Research, October 2016), http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/FQHC_PB-oct2016.pdf	**California, New York, Georgia, and Texas:** Explored the impact of ACA-driven changes in coverage, funding, and related policy on Community Health Centers (CHCs) in expansion vs. non-expansion state communities with high concentrations of immigrants and uninsured residents. Based on analyses of the US HRSA Uniform Data System and interviews conducted in 2014-2016 with the leadership of 31 CHCs.	• In the non-expansion states (GA and TX), the total number of uninsured CHC patients increased from 2010 to 2014. • NY experienced a modest decline in the number of uninsured patients served by CHCs, and CA showed a significant decline in this number (yet more than 1 million CA CHC patients remained uninsured). • Interview respondents in GA and TX noted that because their states did not expand, many of their current citizen or documented immigrant patients had incomes that were too high for them to qualify for Medicaid but not high enough that they could qualify for federal marketplace subsidies.
Benjamin Sommers, Robert Blendon, and E. John Orav, "Both the 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults," *Health Affairs* 35, no. 1 (January 2016): 96-105, http://content.healthaffairs.org/content/35/1/96.abstract	**Arkansas, Kentucky, and Texas:** Conducted a telephone survey of two distinct waves of low-income adults in the three states in Nov.-Dec. 2013 and then 12 months later. Compared first year impacts of traditional Medicaid expansion (KY), the private option (AR), and non-expansion (TX) on coverage, access, affordability, and self-reported health status.	• The reduction in the uninsured rate was significantly larger (by 14 percentage points) in the two expansion states pooled than in TX. • Individually, AR and KY both had significantly greater reductions in uninsured rates compared to TX: 11.3 percentage points in AR and 16.6 percentage points in KY. The changes in uninsured rates between AR and KY were not significantly different from each other. • Compared to respondents in TX, those in KY experienced greater gains in coverage via Medicaid (16.1 percentage points), while those in AR experienced greater gains via private insurance (12.4 percentage points).
Samantha Artiga and Robin Rudowitz, *How Have State Medicaid Expansion Decisions Affected the Experiences of Low-Income Adults? Perspectives from Ohio, Arkansas, and Missouri* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), http://kff.org/medicaid/issue-brief/how-have-state-medicaid-expansion-decisions-affected-the-	**Ohio, Arkansas, and Missouri:** Examined the experiences of low-income adults in three states with varied Medicaid expansion decisions. Used information collected through 10 focus groups conducted with 85 adults in Columbus, Little Rock, and St. Louis. The groups in Columbus and Little Rock were conducted	• In all three locations, participants sought coverage after the ACA was implemented. Participants in Little Rock and Columbus enrolled through varied methods. Most of the participants in St. Louis also tried to enroll in coverage but were upset and disappointed to learn they did not qualify for Medicaid or tax credit subsidies to purchase a Marketplace plan.

experiences-of-low-income-adults-perspectives-from-ohio-arkansas-and-missouri/	with previously uninsured adults who enrolled in the ACA Medicaid expansion or private option waiver, and the groups in St. Louis were conducted with uninsured low-income adults who would be eligible if Missouri expanded Medicaid.	
Samantha Artiga, Jennifer Tolbert, and Robin Rudowitz, *Year Two of the ACA Coverage Expansions: On-the-Ground Experiences from Five States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), http://kff.org/health-reform/issue-brief/year-two-of-the-aca-coverage-expansions-on-the-ground-experiences-from-five-states/	**Five states (three expansion and two non-expansion):** Provides an on-the-ground view of ACA implementation in five states (CO, KY, WA, UT, and VA) following the completion of the second open enrollment period. Findings were based on 40 in-person interviews conducted with a range of stakeholders during April and May 2015.	• There was continued Medicaid enrollment growth in the expansion states during the second open enrollment period, with some slowing in the pace of growth (KY and CO) and some increases in children as a share of new enrollees. • Stakeholders in the non-expansion states reported very little change in Medicaid enrollment. • In the expansion states, clinics that historically served uninsured populations reported an increase in their share of patients with coverage, particularly Medicaid coverage, which has led to increases in third-party reimbursements. • Clinics in the non-expansion states reported very little to no change in the share of patients they serve with coverage, because most fell into the coverage gap.
Stan Dorn, Norton Francis, Laura Snyder, and Robin Rudowitz, *The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2015), http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/	**Connecticut, New Mexico, and Washington:** Examined the early budget effects of expansion during the fall of 2014 (after states had enacted budgets for SFY 2015). Conducted interviews with budget officials and staff in each of the three states, focusing on early experiences with state savings and costs from the expansion across state budgets (within and outside of Medicaid) as well as the expansion's impact on state revenue.	• Enrollment of those newly eligible for Medicaid exceeded expectations. Enrollment among those previously eligible but not enrolled increased in each of the study states. Enrollment increases in Connecticut and New Mexico were above projections, but the increase in Washington State was below projections. • The enrollment growth among those previously eligible but not enrolled in each of these states was primarily driven by ACA changes other than the Medicaid expansion, such as the streamlining and simplifying of Medicaid enrollment processes that occurred in all states regardless of expansion decisions as well as broader outreach efforts.
Barbara DiPietro, Samantha Artiga, and Alexandra Gates, *Early Impacts of the Medicaid Expansion for the Homeless Population* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2014), http://kff.org/uninsured/issue-brief/early-impacts-of-the-medicaid-expansion-for-the-homeless-population/	**Five cities (in four expansion states and one non-expansion state):** Provided an early look at the impact of the expansion for homeless providers and the patients they serve. Used data from focus groups conducted with administrators, providers, and enrollment workers at sites serving homeless individuals in Albuquerque, NM; Baltimore, MD; Chicago, IL; Portland, OR' and Jacksonville, FL.	• Participants and data from the study sites indicated that the Medicaid expansion led to significant increases in coverage that are contributing to improved access to care and broader benefits for homeless individuals. • Participants from the non-expansion site (in Jacksonville) indicated that their patients remain uninsured and are continuing to face significant gaps in care that contribute to poor health outcomes.
Single State Studies		
The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (The Ohio Department of Medicaid, January 2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf	**Ohio:** Examined the effects of OH's 2014 Medicaid expansion on expansion (Group VIII) enrollees. When appropriate, compared Group VIII enrollees to those enrolled in OH Medicaid under pre-expansion eligibility rules. Used numerous data collection methods, including a detailed telephone survey of 7,508 expansion and pre-expansion enrollees, medical record reviews and biometric screenings of subsets of the survey sample, an analysis of	• ACA Medicaid expansion provided coverage to 702,000 low-income Ohioans in May 2016 (the sample date), the vast majority of whom were previously uninsured. • Most expansion enrollees were white (71.5%), male (55.8%), with a high school degree or less (58.1%), unmarried (83.8%), and without a child in the home (82.1%). • Employment rates were similar for expansion and pre-expansion enrollees (43.2% versus 41.5%). • As a result of being older (51.4% age 45 and older) and more often male than pre-expansion enrollees, expansion enrollees had slightly higher rates of health risk indicators—such as high blood pressure and high cholesterol—and higher rates of chronic disease diagnoses than the younger and more often female pre-expansion enrollees.

	administrative data for enrollees, focus groups of 27 enrollees, and interviews with 10 service providers and other key stakeholders.	
The Lewin Group, Inc., *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report* (The Lewin Group, Prepared for Indiana Family and Social Services Administration, July 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf	**Indiana:** Used data available as of June 2016 to evaluate the progress of the Healthy Indiana Plan (HIP) 2.0 in the first year of implementation. Report evaluates several unique features of Indiana's HIP 2.0 expansion program, including the required (for members above poverty) or encouraged contributions to the HSA-like Personal Wellness and Responsibility (POWER) Accounts. Contributions determine member enrollment into HIP Plus (a plan that includes enhanced benefits) or HIP Basic (a more limited benefit plan that requires copayments for most services).	• In the first year, nearly 73% of the population who were projected eligible for HIP 2.0 at the time of its inception were enrolled for at least one month. • At the end of the first year, about 60% of HIP 2.0 members were previously uninsured or underinsured, or experienced an income change that made them eligible for HIP 2.0. • Approximately 15% of enrollees disenrolled from HIP 2.0 in the first year; the primary reasons for disenrollment were a change in income or having secured insurance from another source. • Over 90% of HIP Plus members made their Personal Wellness and Responsibility (POWER) Account Contributions (PACs) and remained in HIP Plus. About 8% of members below poverty failed to make a subsequent required PAC payment and were moved from HIP Plus to HIP Basic (over 80% of these individuals indicated reasons other than affordability for not making PACs). • 6% of HIP Plus members with incomes above poverty were disenrolled from HIP 2.0 for not making a PAC (and subject to the program's six-month lockout period).
Mathew Davis, Achamyeleh Gebremariam, John Ayanian, "Changes in Insurance Coverage Among Hospitalized Nonelderly Adults After Medicaid Expansion in Michigan," *The Journal of the American Medical Association* 315 no. 23 (June 2016): 2617-2618, http://jamanetwork.com/journals/jama/fullarticle/2529615	**Michigan:** Compared insurance coverage for hospitalized patients during initial implementation of the Healthy Michigan Plan in April-December 2014 with corresponding months in 2012 and 2013. Also explored the consistency of the effects of expanded coverage across institutions. Used data from the Michigan Inpatient Database (compiled from a complete census of discharge data reported by acute care hospitals in MI).	• During April-December of 2012, uninsured patients represented 5.8% of nonelderly adult discharges, while they represented 6.0% of nonelderly adult discharges during April-December of 2013, and 2.0% during April-December of 2014. • The proportion of discharges for nonelderly adults with Medicaid increased from 22.9% in 2012 and 23.8% in 2013 to 29.9% in 2014. The changes in the proportions of discharges with private coverage and Medicare over the same period were smaller. • In 94% of Michigan's acute care hospitals, the proportion of discharges for uninsured patients was lower in 2014 compared with the mean proportion of uninsured discharges for 2012 and 2013. • In 88% of Michigan's acute care hospitals, the proportion of discharges for Medicaid patients in 2014 exceeded the mean proportion of discharges with Medicaid for 2012 and 2013.
John Heintzman, Steffani Bailey, Jennifer DeVoe, Stuart Cowburn, Tanya Kapka, Truc-Vi Duong, and Miguel Marino, "In Low-Income Latino Patients, Post-Affordable Care Act Insurance Disparities May Be Reduced Even More than Broader National Estimates: Evidence from Oregon," *Journal of Racial and Ethnic Health Disparities* (April 2016), http://www.ncbi.nlm.nih.gov/pubmed/27105630	**Oregon:** Used electronic health record (HER) data to compare the insurance status of 42,392 low-income (<100% FPL) patients served in 23 community health centers in Oregon, by race/ethnicity and language, before (2009-2013) and after (January-December 2014) implementation of the ACA Medicaid expansion.	• Prior to 2014, Spanish-preferring Latinos were more likely to be uninsured than English-preferring Latinos and non-Hispanic whites. • Among patients who returned for at least one visit in 2014, Spanish-preferring Latinos had the largest increase in insurance coverage rates, with an absolute change of -51.6 in the uninsured rate. Also observed a decrease (-21.3%) in the uninsured rate for English-preferring Hispanics and a slightly lower decrease (-19.2%) in the uninsured rate for non-Hispanic Whites. • Change in the proportion of uninsured patients from pre- to post-ACA for Spanish-preferring Hispanics was significantly different than the change in non-Hispanic Whites. • All three racial/ethnic/language groups had similar rates of insurance coverage post-expansion—all cohort groups had an uninsured rate of 13-14% in 2014. • Disparities between the three groups in public coverage rates were also essentially eliminated in the post-ACA period—all cohort groups had public coverage rates of 82-83% in 2014.

Joseph Benitez, Liza Creel, and J'Aime Jennings, "Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care," *Health Affairs* (February 2016), http://content.healthaffairs.org/content/early/2016/02/16/hlthaff.2015.1294	**Kentucky:** Used BRFSS data on adults ages 25-64 reporting annual household income below $25,000 to study first-year impact of KY's Medicaid expansion on insurance coverage and access to care. Low-income residents from the bordering non-expansion states Missouri, Tennessee, and Virginia served as controls.	• Preexpansion trends among the four states were roughly similar for each of the measures. The most noticeable change was the sharp decline in KY's uninsurance rate relative to those of the control states during 2013-2014. • The expansion's effect on coverage in KY was nearly immediate. There was a 45% reduction in the uninsured rate among the low-income population in the first quarter of 2014. • The expansion appeared to have the largest effect on coverage toward the end of the year, when a 25 percentage-point (70%) reduction in uninsurance among the low-income group was observed. The low-income uninsured rate fell from 35% at the end of 2013 to just below 11% by the end of 2014.
Arkansas Health Reform Legislative Task Force, *Health Care Task Force Preliminary Report,* (Arkansas Health Reform Legislative Task Force, December 2015), http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14218/Task%20Force%20report%2012-17-15%20sent%20to%20Jill.pdf	**Arkansas:** Preliminary report evaluated how efficiently Arkansas' Medicaid program, and specifically the Private Option expansion model, was working and how well-prepared the program was to meet future trends. Findings were largely based on two reports from The Stephen Group, the consultant group hired by the Legislative Task Force, that were released earlier in 2015.	• The Private Option was a substantial factor in the drop in the AR uninsured rate between 2013 and 2014. • 80% of all individuals selecting insurance through the Marketplace in AR are enrolled via the Private Option. Private Option participants are younger and thus healthier and lower cost compared to the overall Marketplace population.
Jocelyn Guyer, Naomi Shine, MaryBeth Musumeci, and Robin Rudowitz, *A Look at the Private Option in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2015), http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/	**Arkansas:** Provided an initial look at implementation of the Private Option in Arkansas. Findings came from a dozen interviews with state officials, providers, insurance carriers, and advocates, as well as early data on coverage, reductions in uncompensated care costs, and other topics.	• The reduction in AR's uninsured rate was realized largely due to the coverage pathway offered through the Private Option. • The private option nearly tripled enrollment in Arkansas's Marketplace, helping to boost the number of carriers offering Marketplace plans statewide from two in 2014 to as many as six in 2016; generating a younger and relatively healthy risk pool; and contributing to a two percent drop in the average rate of Marketplace premiums between 2014 and 2015.
Michael McCue, "The Impact of Medicaid Expansion on Medicaid Focused Insurers in California," *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 52 (July 2015), http://inq.sagepub.com/content/52/0046958015595960.full.pdf+html	**California:** Assessed the enrollment, utilization, and financial performance measures of California Medicaid focused health insurers. Compares these quarterly measures during the expansion period of 2014 to the same quarterly measures in 2013 and 2012.	• Medicaid focused insurers increased their total Medi-Cal enrollment in the last quarter of 2014 by 47%, to 7.7 million members from 5.2 million members for the last quarter of 2013.
Deloitte Development LLC, *Commonwealth of Kentucky Medicaid Expansion Report,* (Deloitte Development LLC, February 2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf	**Kentucky:** Examined progress toward the state's initial goals for its Medicaid expansion during the first 12 months of expansion (Jan. 1-Dec. 31. 2014). Also updated initial estimates from the 2013 Medicaid Expansion Whitepaper based on the first year of experience.	• A total of 310,887 Kentuckians enrolled in the Medicaid expansion by the end of State Fiscal Year 2014, which materially exceeded expectations. • KY experienced the second largest decrease of any state in its uninsured rate through the first half of calendar year 2014, dropping from 20.4% to 11.9%.

Table 2: Impact of Expansion on Access to Care, Utilization, Affordability, and Health Outcomes		
Citation	Study Focus	Major Findings
Nationwide Studies		
Ausmita Ghosh, Kosali Simon, and Benjamin Sommers, *The Effect of State Medicaid Expansions on Prescription Drug Use: Evidence from the Affordable Care Act* (Working Paper No. 23044, National Bureau of Economic Research, January 2017), http://www.nber.org/papers/w23044?utm_campaign=ntw&utm_medium=email&utm_source=ntw	**Nationwide:** Analyzed how the ACA Medicaid expansions have affected aggregate prescription drug utilization. Used a differences-in-differences regression framework and data from a large, nationally representative database of prescriptions dispensed from January 2013 through March 2015 at both retail and mail-order pharmacies.	• Within the first 15 months of expansion, Medicaid-paid prescription utilization increased by 19% in expansion states relative to states that did not expand. • The greatest increases in Medicaid prescriptions occurred among diabetes medications, which increased by 24% in expansion states relative to non-expansion states. • Other classes of medication that experienced relatively large increases in expansion relative to non-expansion states include contraceptives (22%) and cardiovascular drugs (21%), while several classes more consistent with acute conditions such as allergies and infections experienced significantly smaller increases. • Authors suggested that the pattern of results described above indicates that Medicaid expansion was particularly effective at increasing prescription drug utilization for common and potentially costly chronic medical conditions such as diabetes and heart disease. • Did not observe reductions in uninsured or privately insured prescriptions, suggesting that increased utilization under Medicaid did not substitute for other forms of payment. • Within expansion states, increases in prescription drug utilization were larger in geographical areas with higher uninsured rates prior to the ACA.
Anne DiGiulio et al., "State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage – United States, 2016," *Morbidity and Mortality Weekly Report* 65, no. 48 (December 2016), https://www.cdc.gov/mmwr/volumes/65/wr/mm6548a2.htm	**Nationwide:** Assessed smoking cessation coverage available to the Medicaid expansion population as of July 1, 2016. Used data collected by the American Lung Association on coverage of, and barriers to accessing, all evidence-based cessation treatments except telephone counseling for expansion populations.	• As of December 2015, approximately 3.3 million adult cigarette smokers were enrolled in Medicaid expansion coverage, including approximately 2.3 million adults who were newly eligible for Medicaid expansion coverage. • As of July 1, 2016, nine of the 32 expansion states covered all nine cessation treatments for all Medicaid expansion enrollees. • Of the 32 states, 17 states covered individual counseling for all Medicaid expansion enrollees, 11 covered group counseling for all enrollees, and 19 covered all seven FDA-approved cessation medications for all enrollees. • All 32 states imposed at least one barrier (e.g., copayments or prior authorization) on at least one treatment for at least some enrollees. • Several states that currently require copayments for some cessation treatments for expansion enrollees have indicated that they are planning to remove that requirement.
Tyler Winkelman, Edith Kieffer, Susan Goold, Jeffrey Morenoff, Kristen Cross, and John Ayanian, "Health Insurance Trends and Access to Behavioral Health Care Among Justice-Involved Individuals," *Journal of General Internal Medicine* 31, no. 12 (December 2016): 1523-1529, https://www.ncbi.nlm.nih.gov/pubmed/27638837	**Nationwide:** Assessed health insurance trends among justice-involved individuals before and after implementation of the ACA coverage provisions and examined the relationship between insurance and treatment for behavioral health conditions. Used 2008-2014 data from the National Survey of Drug Use and Health.	• Though Medicaid is associated with higher levels of treatment over the 2008-2014 period, overall substance use disorder treatment rates for justice-involved individuals remained low even after implementation of the ACA coverage provisions. This suggests that justice-involved individuals gaining insurance coverage under the ACA may still face barriers to care for some behavioral health conditions. • The decline in the uninsured rate among justice-involved individuals between 2013 and 2014 was due mostly to a statistically significant increase in Medicaid enrollment between 2013 and 2014.
Kamyar Nasseh and Marko Vujicic, *Early Impact of the Affordable Care Act's Medicaid Expansion on Dental Care Use* (Health Services Research, November 2016), http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12606/full	**Nationwide:** Compared trends in dental care use among adults ages 21-64 with incomes at or below 138% FPL across four categories of states (expansion states that do and do not provide adult dental benefits and non-expansion states that do and do not provide adult dental benefits). Used 2010-2014 data from the Gallup-	• Dental care use among low-income adults in expansion states with dental benefits increased by 6.2 percentage points in the second half of 2014 relative to the pre-reform period and non-expansion states with adult dental benefits. • Over the same period, the increases in dental care use among expansion states with adult dental benefits were not statistically significant relative to either expansion states or non-expansion states without adult dental benefits.

	Healthways Wellbeing Index survey and a differences-in-differences analysis.	
James Kirby and Jessica Vistnes, “Access to Care Improved for People Who Gained Medicaid or Marketplace Coverage in 2014,” *Health Affairs* 35 no. 10 (October 2016): 1830-1834, http://content.healthaffairs.org/content/35/10/1830.full	**Nationwide:** Explored the extent to which people who obtained coverage through the Marketplaces or Medicaid under the ACA experienced improved access to care between 2013 and 2014, relative to those who remained uninsured. Used longitudinal data from the Medical Expenditure Panel Survey-Household Component (MEPS-HC).	• Compared to people who were uninsured throughout both 2013 and 2014, more of those who gained Medicaid coverage in 2014 went from not having preventive care or a usual source of care in 2013 to having such care in 2014. • 26% of people who gained Medicaid coverage went from not having an annual checkup in 2013 to having one in 2014, compared to 14% of those who remained uninsured. • 22% of people who gained Medicaid coverage went from not having a blood pressure screening in 2013 to having one in 2014, compared to 13% of those who remained uninsured. • 17% of people who gained Medicaid coverage went from not having a flu shot in 2013 to having one in 2014, compared to 6% of those who remained uninsured. • Conversely, across most measures (aside from the percentage obtaining flu shots), fewer individuals who gained Medicaid coverage went from having preventive care or a usual source of care in 2013 to not having such care in 2014, compared to those who remained uninsured. • Improvements in access associated with gaining Marketplace coverage were not significantly different from those associated with gaining Medicaid coverage.
Jessica Vistnes and Joel Cohen, “Gaining Coverage in 2014: New Estimates of Marketplace and Medicaid Transitions,” *Health Affairs* 35 no. 10 (October 2016): 1825-1829, http://content.healthaffairs.org/content/35/10/1825.full?sid=cc385dd5-9c95-4ee1-9c58-888408d49c54	**Nationwide:** Studied changes in health insurance status for nonelderly adults using data from the Medical Expenditure Panel Survey-Household Component for the 2012-2014 period. Examined gains in Medicaid coverage among those who were uninsured for the previous calendar year.	• Uninsured adults in expansion states who enrolled in Medicaid in 2014 were more likely to report being in fair or poor health and were about twice as likely to have at least one chronic condition, compared to those who remained uninsured. • Previously uninsured adults in expansion states who enrolled in Medicaid were more likely to have had at least one office visit, a usual source of care, or both in 2013, and a previous source of coverage in 2011 or 2012.
Andrew Mulcahy, Christine Eibner, and Kenneth Finegold, “Gaining Coverage Through Medicaid Or Private Insurance Increased Prescription Use and Lowered Out-Of-Pocket Spending,” *Health Affairs* 35, no. 9 (September 2016), http://content.healthaffairs.org/content/early/2016/08/16/hlthaff.2016.0091.full	**Nationwide:** Used IMS Health prescription transaction data from 2012-2014 to measure number of prescription drug users who changed their source of coverage during the expansion period. Also tracked changes in individual prescription drug use, total drug spending, and out-of-pocket drug spending for prescription drug users following ACA expansion implementation.	• Previously uninsured prescription drug users who gained Medicaid coverage had, on average, 13.3 more prescription fills compared to when they were uninsured, a 79% increase. • Previously uninsured prescription drug users who gained Medicaid coverage saw, on average, a $205 reduction in annual out-of-pocket spending in 2014. • People with one of the chronic conditions included in the study who gained Medicaid coverage benefited from larger reductions in out-of-pocket spending ($279) compared to those without a study chronic condition who gained coverage ($152). Reductions in out-of-pocket spending among people with chronic conditions were larger for those who gained Medicaid than those who gained private coverage. • Previously uninsured individuals who gained Medicaid coverage paid 58% less out-of-pocket per prescription in 2014 compared to 2013.
Hefei Wen, Tyrone Borders, and Benjamin Druss, ”Number of Medicaid Prescriptions Grew, Drug Spending was Steady in Medicaid Expansion States,” *Health Affairs* 35, no. 12 (September 2016): 1604-1607, http://content.healthaffairs.org/content/35/9/1604.full	**Nationwide:** Explored changes in Medicaid drug spending and numbers of prescriptions between the pre-expansion period (2011-2013) and the post-expansion period (2014), comparing expansion and non-expansion states. Used sixteen waves of quarterly state-aggregate data from the Medicaid State Drug Utilization Data files of the Centers for Medicare and Medicaid Services (CMS).	• There were significant increases in 2014 compared to the pre-expansion 2011-2013 period in the amount of Medicaid drug spending per resident in the 23 non- or late-expansion states ($3.21 per quarter) and in the 26 expansion states ($4.75 per quarter). • The difference between the two groups of states in the spending increases was not significant, indicating that implementation of the Medicaid expansions did not affect total Medicaid drug spending. • There was no discernible change over time in the number of Medicaid prescriptions per resident in the non- or late-expansion states; a significant increase in prescriptions (0.06 per resident per quarter) in the expansion states was observed. • Additional findings suggest that, on average, Medicaid enrollees in expansion states may have been prescribed drugs at a rate no different from those in the non- or late-expansion states, but the drugs prescribed for enrollees in the expansion states may have been less expensive than those prescribed for enrollees in the other states.
Jesse M. Pines, Mark Zocchi, Ali Moghtaderi, Bernard Black, Steven	**Nationwide:** Examined Medicaid expansion’s impact	• Medicaid expansion changed the insurance payer mix of ED visits.

A. Farmer, Greg Hufstetler, Kevin Klauer and Randy Pilgrim, "Medicaid Expansion In 2014 Did Not Increase Emergency Department Use But Did Change Insurance Payer Mix," *Health Affairs* 35, no. 8 (August 2016), http://content.healthaffairs.org/content/35/8/1480.full	on overall emergency department (ED) visits and the mix of payers during the first year of expansion. Collected data from 478 hospital-based EDs in 36 states from 2012-2014. The EDs included in the sample were located in 344 counties that together contain 35% of the US population.	• Compared to those in non-expansion states, EDs in expansion states experienced a larger increase in Medicaid-paid visits (27.1%), a larger decrease in uninsured visits (−31.4%), and a bigger drop in privately insured visits (−6.7%) during the first year of expansion. • Overall, total ED visits grew by less than 3% in 2014 compared to 2012-2013, with no significant difference between expansion and non-expansion states.
Sara Collins, Munira Gunja, Michelle Doty, and Sophie Beutel, Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction (The Commonwealth Fund, May 2016), http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction	**Nationwide:** Examined the ACA's effects on insurance coverage and how people are using their coverage to get health care. Reported data from the fourth wave of the Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016.	• 72% of adults enrolled in a marketplace plan or newly enrolled in Medicaid said they had used their coverage to go to a doctor, hospital, or other health care provider or to fill a prescription. 70% of adults enrolled in Medicaid said they would not have been able to access or afford this care prior to getting their new coverage. • 93% of Medicaid enrollees who have had coverage for two months or less said their ability to get health care had improved or stayed the same since getting their insurance. 4% of those with new Medicaid coverage said their ability to obtain care had gotten worse. • 56% of Medicaid enrollees who had Medicaid for less than three years and needed to see a specialist were able to secure a specialist appointment within two weeks. • Over the three years of the ACA coverage expansions, the experience of marketplace and Medicaid enrollees in finding doctors and getting appointments is similar to that reported by insured Americans as a whole. • In each of the three years since the ACA's major coverage expansions, majorities of new Medicaid enrollees have reported that they are satisfied with their new health insurance overall. In 2016, 88% of those newly enrolled in Medicaid were very or somewhat satisfied with their health insurance. When asked to rate their insurance, 77% of new Medicaid enrollees said their coverage was good, very good, or excellent.
Kosali Simon, Aparna Soni, and John Cawley, *The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the 2014 ACA Medicaid Expansions* (Working Paper 22265, National Bureau of Economic Research, May 2016), http://www.nber.org/papers/w22265?utm_campaign=ntw&utm_medium=email&utm_source=ntw	**Nationwide:** Examined the impact of 2014 ACA Medicaid expansions on preventative care (e.g. dental visits, immunizations, mammograms, cancer screenings) and risky health behaviors (e.g. smoking, heavy drinking, lack of exercise, obesity) among low-income (<100% FPL), childless, nonelderly adults. Used 2012-2014 data from the Behavioral Risk Factor Surveillance System and a difference-in-difference model.	• Expansions increased certain types of preventative care among low-income, childless adults, particularly dental visits (20% increase compared to 2012-2013 period), breast exams (14% increase), and mammograms (16% increase). Expansion had no detectable effect on flu shots, HIV tests, or Pap tests. • Despite the fact that the number of preventive services and routine doctor visits were decreasing in the treatment states prior to the expansions, results indicate that the expansions increased those significantly (e.g. the probability of a routine checkup rose by 10% compared to the 2012-2013). • Expansion reduced the proportion of adults who reported cost as a barrier to care by 2.7 percentage points (or 7%) from pre-expansion level. The effect varied significantly by sex: among men, the probability of reporting cost as a barrier to care fell by 5.2 percentage points but for women, the point estimate is small and positive (0.1 percentage points) and not statistically significant. • Medicaid did not affect the probability of having a personal doctor for either men, women, or the pooled sample. • Found little evidence that the expansions affected risky health behaviors such as smoking, lack of exercise, or obesity. There is some evidence that expansion may have reduced the probability of heavy drinking, but the magnitude of the reduction (31%) may be too large to be plausible. • Expansions resulted in modest improvements in self-rated health (3%) and decreases in the number of work days missed due to poor health (8%).

Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong, *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being* (Working Paper No. 22170, National Bureau of Economic Research, April 2016), http://www.nber.org/papers/w22170?utm_campaign=ntw&utm_medium=email&utm_source=ntw	**Nationwide:** Examined the effect of the ACA Medicaid expansions on financial outcomes using the synthetic control approach of Abadie et al. (2010). Used credit report data for all quarters from 2010 through 2015 from the Federal Reserve Bank of New York Consumer Credit Panel/Equifax.	• Medicaid expansions significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies among individuals living in the top quartile of zip codes ranked by the proportion of poor and uninsured persons. • Estimates indicated that the 2014 Medicaid expansions were associated with a reduction in the amount of collections of between \$51 and \$85, with a mean estimate of \$69. • Estimates implied a reduction in collection balances of around \$600 to \$1,000 among those who gain Medicaid coverage due to the ACA. • Did not find evidence that the ACA Medicaid expansions had any effect on other measures of debt and debt past due.
Laura Wherry and Sarah Miller, "Early Coverage, Access, Utilization, and Health Effects Associated with the Affordable Care Act Medicaid Expansions: A Quasi-experimental Study," *Annals of Internal Medicine*, Epub ahead of print (April 2016), http://annals.org/article.aspx?articleid=2513980	**Nationwide:** Evaluated whether state Medicaid expansions were associated with changes in insurance coverage, access and utilization of health care, and self-reported health. Used National Health Interview Survey data and a quasi-experimental difference-in-differences design that compared changes in outcomes for residents of expansion and non-expansion states before (during the 2010 to 2013 period) and after (through the end of 2014) the expansions became effective.	• There were larger increases in visits with a general physician and overnight hospital stays in the previous 12 months in the expansion states versus the non-expansion states. • Found that no significant changes in other utilization measures (such as visits with a specialist or visits to a hospital emergency department) were associated with the expansions. • Did estimate a significant increase in ED visits when sample was restricted to adults aged 26 years or older who did not benefit from changes in rules on dependent coverage during the study period. • Found no significant differences between expansion and non-expansion states in changes in measures related to access (including delaying care, forgoing care, or not having a usual source of care because of cost), health status (self-reporting being in excellent or very good health and self-reporting that health is better than 12 months before), or mental health (mentioning depression as a health problem) in the expansion states compared with the non-expansion states. • Found significant increases in respondents reporting diagnoses of diabetes (5.2 percentage points) and high cholesterol (5.7 percentage points) associated with the expansions but no significant change in hypertension diagnoses.
Josh Gray, Anna Zink, and Tony Dreyfus, *Effects of the Affordable Care Act Through 2015,* (athenaResearch and Robert Wood Johnson Foundation ACA View Report, March 2016), http://www.athenahealth.com/~/media/athenaweb/files/pdf/acaview_tracking_the_impact_of_health_care_reform	**Nationwide:** Analyzed how the experiences of patients in three categories (Medicaid, commercially insured, and uninsured patients), as well as the economics of primary care practice, changed following implementation of the ACA's coverage expansions. Used ACAView data (which tracks provider activity among practice locations on athenahealth's network) through the end of 2015.	• In states that expanded Medicaid, primary care physicians (PCPs) are seeing substantially more Medicaid patients. • Study found a 12 percent increase in the total number of primary care visits by Medicaid-covered patients. • Among Medicaid patients who visited a PCP for the first time in the first half of 2014, 67% returned to the practice within 18 months for a second visit. This rate exceeds the comparable rate for commercial patients (60%). • Return rates are even higher for patients diagnosed with chronic diseases during the first primary care visit. • Average visit times for Medicaid patients is the same as for patients with commercial insurance or Medicare. • Divided physician practices into four groups: those that saw small, modest, significant, and large shares of Medicaid patients in 2013. Found that the four practice groups increased their Medicaid volume significantly in 2014 by 42, 26, 20, and 4%, respectively.
Adele Shartzer, Sharon Long, and Nathaniel Anderson, "Access To Care and Affordability have Improved Following Affordable Care Act Implementation; Problems Remain," *Health Affairs* (December 2015), http://content.healthaffairs.org/content/early/2015/12/14/hlthaff.2015.0755.full	**Nationwide:** Used data from the Health Reform Monitoring Survey to describe changes in access and affordability for nonelderly adults from September 2013 to March 2015. Study is focused on broad effects of the ACA but includes comparisons of results in expansion vs. non-expansion states.	• Overall, health care access and affordability improved for adults at all income levels and for adults in both Medicaid expansion and non-expansion states during the study period (Sept. 2013-March 2015). • There was a 4.9 percentage point increase in the share of adults in expansion states with a usual source of care; the small increase among adults in non-expansion states was not statistically significant. • The share of nonelderly adults who had a routine checkup in the past 12 months increased in both expansion and non-expansion states, although the increase in non-expansion states was not statistically significant ($p<.05$). • The decreases in unmet need for care because of cost seen in both expansion and non-expansion states were not statistically significant. • Reports of problems paying family medical bills declined by 4.8 percentage points in expansion states and 2.8 percentage points in non-expansion states.

Peter Shin, Jessica Sharac, Julia Zur, Sara Rosenbaum, and Julia Paradise, *Health Center Patient Trends, Enrollment Activities, and Service Capacity: Recent Experience in Medicaid Expansion and Non-Expansion States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2015), http://kff.org/medicaid/issue-brief/health-center-patient-trends-enrollment-activities-and-service-capacity-recent-experience-in-medicaid-expansion-and-non-expansion-states/	**Nationwide:** Examined change between 2013 and 2014 in the volume and health coverage profile of health center patients, as well as health center enrollment activities and service capacity, comparing states that did and did not expand Medicaid in 2014. Based on 2013 and 2014 data from the federal Uniform Data System and a 2014 national survey of health centers.	• Health centers in expansion states were significantly more likely than those in non-expansion states to report having expanded their capacity for dental services (37% vs 31%) and mental health services (42% vs 35%) since the start of 2014. • Health centers in expansion states were more likely to report increased wait times for appointments compared to non-expansion states (35% vs. 20%), possibly reflecting greater increases in demand for services associated with larger gains in coverage among health center patients in these states.
Benjamin Sommers, Munira Gunja, Kenneth Finegold, and Thomas Musco, "Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *The Journal of the American Medical Association* 314 no. 4 (July 2015): 366-374, http://jama.jamanetwork.com/article.aspx?articleid=2411283&resultClick=3	**Nationwide:** Analyzed the 2012-2015 Gallup-Healthways Well-Being Index to estimate national changes in self-reported coverage, access to care, and health during the ACA's first two open enrollment periods, as well as to assess differences between low-income adults in states that did and did not expand Medicaid under the ACA.	• Pre-ACA trends for study outcomes did not differ significantly by expansion status, except for difficulty affording care, which was slightly worsening in expansion states relative to non-expansion states prior to 2014. • The share of low-income adults lacking a personal physician and lacking easy access to medicine both declined significantly more in expansion states than in non-expansion states. • Inability to afford care declined among low-income adults from 35.5% to 33.1% in expansion states, but this decline was not significantly different from the decline in non-expansion states. • Did not find statistically significant differences in changes in self-reported health (fair/poor health or activity limitations due to health) between Medicaid expansion and non-expansion states.
Harvey Kaufman, Zhen Chen, Vivian Fonseca, and Michael McPhaul, "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act," *Diabetes Care* 38, no. 5 (May 2015): 833, http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334.full.pdf+html	**Nationwide:** Examined the impact of Medicaid expansion on the number of Medicaid patients with newly identified diabetes among enrollees (19-64 years of age) who had laboratory testing through Quest Diagnostics. Used the first half of 2014 as the study period and the first half of 2013 as the control period.	• Overall (among the total population), observed a 1.6% increase in newly identified diabetes in the first half of 2014 compared to the first half of 2013. • A total of 26,237 Medicaid-enrolled patients were newly identified with diabetes in the control period vs. 29,673 Medicaid-enrolled patients in the study period, an increase of 13%. In comparison, the number of non-Medicaid patients with newly identified diabetes increased by only .03%. • The number of Medicaid patients with newly identified diabetes increased by 23% in expansion states between the control and study periods, compared to an increase of only 0.4% in non-expansion states.
IMS Institute for Healthcare Informatics, *Medicines Use and Spending Shifts: A Review of the Use of Medicines in the US in 2014* IMS Institute for Healthcare Informatics, April 2015), http://www.imshealth.com/en/thought-leadership/ims-institute/reports/medicines-use-in-the-us-2014	**Nationwide:** Reviewed the use of Medicines in the US in 2014 with the goal of bringing context and perspective to the complex interplay of factors that determine the level of spending on medicines and their role in the US healthcare system. Findings were based on data from on a range of IMS Health services sources.	• Medicaid was the leading driver of retail prescription growth in the first year of expanded coverage under the ACA. Total retail prescriptions rose 2.4% while overall Medicaid prescriptions increased 16.8% in 2014. Medicaid prescriptions accounted for 70% of the growth in retail prescription demand. • Medicaid prescriptions increased 25.4% in 2014 in states that expanded Medicaid coverage and 2.8% in states that did not expand Medicaid. • Cash prescriptions, typically filled by uninsured patients, declined 5.5% overall in 2014. • Although Medicaid expansion increased enrollment by 10-15% in 2014, nearly a quarter of Medicaid prescriptions in 2014 were filled by newly enrolled patients, suggesting that many of them were carrying significantly higher disease burdens than existing patients.
Josh Gray, Iyue Sung, and Stewart Richardson, *Observations on the Affordable Care Act: 2014* (athenaResearch and Robert Wood Johnson Foundation ACA View Report, February 2015), http://www.athenahealth.com/~/media/athenaweb/files/pdf/acaview_year_end_2014.pdf	**Nationwide:** Based on a sample of nearly 16,000 health care providers, explores changes that occurred in 2014 (compared to before implementation of ACA coverage expansions) in areas such as insurance rates, patient health needs, and new patient rates in physician practices.	• In expansion states, the proportion of visits with Medicaid patients increased quickly, from 12.2% in December 2013 to 15% in March 2014, and hit a 2014 peak in September when Medicaid patients made up 16.7% of all visits. • The number of Medicaid-covered PCP visits in expansion states increased from 12.8% of visits to 15.6% between 2013 and 2014. • Despite a 1.5 million increase in the number of individuals enrolled in Medicaid in non-expansion states (largely due to increased media attention on health insurance surrounding the ACA), the number of Medicaid enrollees seen in physicians' offices in non-expansion states decreased by 10.8% in 2014.

Multi-State Studies		
MaryBeth Musumeci, Robin Rudowitz, Petry Ubri, and Elizabeth Hinton, *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* (Washington, DC: The Kaiser Family Foundation, January 2017), http://kff.org/medicaid/issue-brief/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana/	**Michigan and Indiana:** Explored the key components of and early implementation experiences with the Section 1115 Medicaid expansion waivers used in MI and IN. Findings were based on 22 in-person and telephone interviews conducted in July and August, 2016 with state officials, providers, health plans, beneficiary advocates, and enrollment assistors in MI and IN; data and reports from the state Medicaid agencies and other publicly available sources; and four focus groups (two in each state) with beneficiaries enrolled in waiver coverage.	• Beneficiaries were able to access needed health care services with their new Medicaid coverage, although challenges remain in certain areas. • Medicaid expansion design, whether through state plan authority or waivers, is highly dependent on the features of a state's underlying Medicaid program. • Implementation of complex programs involves collaboration with a variety of stakeholders, sophisticated IT systems, and administrative costs. • Premium costs and complex enrollment policies can deter eligible people from enrolling in coverage. • Health accounts can be confusing for beneficiaries. • Beneficiary and provider education and tangible incentives appear central to implementing healthy behavior incentive programs.
Megan Hoopes, Heather Angier, Rachel Gold, Steffani Bailey, Nathalie Huguet, Miguel Marino, and Jennifer DeVoe, "Utilization of Community Health Centers in Medicaid Expansion and Nonexpansion States, 2013-2014," *Journal of Ambulatory Care Management* 39 no. 4 (October 2016): 290-298, https://www.ncbi.nlm.nih.gov/pubmed/26765808	**Nine states (five expansion and four non–expansion):** Examined longitudinal changes in community health center (CHC) visit rates from 2013 through 2014 in Medicaid expansion (CA, MN, OH, OR, WA) vs. non-expansion (AK, IN, MT, NC) states. Included visits from 219 CHCs across the nine states. Used electronic health record data.	• Rates of Medicaid-insured visits increased 46% for total expansion state CHCs post-expansion and 12% in non-expansion state CHCs. • Uninsured visit rates were 47% lower in 2014 compared to 2013 in combined expansion state CHCs. Uninsured rates also dropped in non-expansion state CHCs, but to a lesser degree. • Overall CHC visit rates increased by 6% in 2014 compared with 2013 in expansion states; visit rates remained unchanged across the entire group of CHCs in non-expansion states. • Despite some variation between states, utilization of several CHC visit types increased significantly post- vs. pre-expansion in expansion state CHCs: new patient (14%), primary care (6%), preventive care (41%), and limited service (23%) visits all increased in expansion states. None of these rates changed significantly in the group of non-expansion state CHCs.
Benjamin Sommers, Robert Blendon, E. John Orav, Arnold Epstein, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *The Journal of the American Medical Association* 176 no. 10 (October 2016): 1501-1509, http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420	**Arkansas, Kentucky, and Texas:** Surveyed adults ages 19-64 with incomes below 138% of the FPL in November and December of 2013, 2014, and 2015 to track changes in insurance coverage, utilization, preventive care, and self-reported health. Performed a differences-in-differences analysis of the survey data to assess these changes before and after Medicaid expansion in two expansion states (KY, AR) and in one non-expansion state (TX).	• The increase in the number of people with primary physicians between 2013 and 2015 was 12 percentage points higher in AR and KY (pooled) compared to TX. Reliance on EDs decreased by 6.1 percentage points in the two expansion states compared to TX. • The decrease in cost- related barriers to care in the expansion states was 18.2 percentage points larger than in TX. The expansion states also experienced decreases in skipping prescription medications, difficulty with medical bills and a reduction in out-of-pocket medical spending that were 11.6, 14.0 and 29.5 percentage points larger than TX, respectively. • Compared to TX, the number of adults with office visits in expansion states increased by 0.69 more percentage points per individual and the likelihood of a checkup increased by 16.1 more percentage points overall. • Expansion states experienced an increase in the number of adults receiving consistent care for a chronic condition following expansion that was 12 percentage points greater than TX. • There were improvements in receipt of checkups, care for chronic conditions, and quality of care even in areas with primary care shortages, suggesting that insurance expansions can have a demonstrable positive impact even in areas with relative shortages. • There were no significant differences in trouble obtaining a primary care or specialist appointment between private insurance (AR) and Medicaid (KY) expansions. • In the expansion states compared with TX, the number of adults that reported excellent health increased significantly by 4.8 percentage points and the number of adults reporting fair or poor quality of care declined significantly by 7.1 percentage points.

		• Expansion states saw significant increases in coverage among racial minorities as well as increases in affordability and number of check-ups following expansion. The number of ED visits among racial minorities also decreased.
Samantha Artiga, Robin Rudowitz, Jennifer Tolbert, Julia Paradise, and Melissa Majerol, *Findings from the Field: Medicaid Delivery Systems and Access to Care in Four States in Year Three of the ACA* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2016), http://kff.org/medicaid/issue-brief/findings-from-the-field-medicaid-delivery-systems-and-access-to-care-in-four-states-in-year-three-of-the-aca/	**Colorado, Connecticut, Kentucky, and Washington:** Conducted case studies and focus groups in four expansion states to provide an on-the-ground view of Medicaid delivery systems and enrollees' experiences accessing care as of Spring 2016, three years after implementation of the Medicaid expansion.	• Stakeholders indicated that Medicaid expansion has significantly increased individuals' access to specialty services. They noted that while individuals could access primary care through clinics while uninsured, it was very different for them to obtain specialty care. • Findings suggested that some access challenges remain, including providers not accepting Medicaid patients, problems associated with managed care plan provider networks and formularies, and transportation issues in rural areas. However, these challenges were not unique to the expansion population—similar challenges were observed for Medicaid enrollees outside of the expansion group as well as Marketplace enrollees. • CHCs in the study states reported they have made a variety of investments to expand access to care, in part, due to enhanced revenues from the Medicaid expansion. Examples of enhancements include adding clinical staff, including behavioral health providers; building dental clinics and expanding dental service capacity; providing intensive care management; addressing social determinants of health (e.g., housing); and adding case managers. • Some health centers cited challenges to meeting increased demands for care and continued growth, including increasing competitive pressures for clinical staff.
Simon Basseyn, Brendan Saloner, Genevieve Kenney, Douglas Wissoker, Daniel Polsky, and Karin Rhodes, *Primary Care Appointment Availability for Medicaid Patients: Comparing Traditional and Premium Assistance Plans,* (Penn Leonard Davis Institute of Health Economics, July 2016), http://ldi.upenn.edu/brief/primary-care-appointment-availability-medicaid-patients-comparing-traditional-and-premium	**Arkansas and Iowa**: Used audit methodology, or "secret shoppers" to assess the availability of primary care appointments under the premium assistance expansion models employed in AR and IA. Researchers examined whether the rate of appointment availability or appointment wait-times differed between Medicaid and Marketplace coverage.	• Callers with Marketplace plan coverage had higher appointment rates than Medicaid callers. In AR, Marketplace appointment rates were 27.7 percentage points higher than traditional Medicaid appointment rates (83.2% vs. 55.5%); in IA, Marketplace appointment rates were 12 percentage points higher (86.3% vs. 74.3%). • Once an appointment was offered, the median wait-time was seven days for both groups.
Jane Wishner, Patricia Solleveld, Robin Rudowitz, Julia Paradise, and Larisa Antonisse, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured and The Urban Institute, July 2016), http://kff.org/medicaid/issue-brief/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/	**Kansas, Kentucky, and South Carolina:** Through case studies of three rural hospital closures (one in an expansion and two in non-expansion states), analyzed the factors that contribute to rural hospital closures and the impact of closures on access to health care in rural communities. Each case study involved 6-8 interviews with a range of stakeholders and a review of publically-available materials related to the closures.	• Medicaid expansion increases access to care in rural communities. In Fulton, Kentucky (the location of Parkway Regional Hospital until it closed in March 2015), many uninsured adults gained coverage when KY implemented Medicaid expansion, giving them access to services they were previously unable to afford. • Respondents reported that Medicaid coverage of non-emergency medical transportation is very important in rural communities and even more so in the event of a local hospital closure, because residents more often have to travel to get care. • Respondents in Kansas and South Carolina reported that the tendency of uninsured residents in rural communities to forgo preventive care and to delay treatment until their health conditions worsen can be exacerbated by the loss of a local hospital, and they said that a decision by their state to expand Medicaid would have increased access to needed care for the low-income uninsured population.

Adam Searing and Jack Hoadley, *Beyond the Reduction in Uncompensated Care: Medicaid Expansion is Having a Positive Impact on Safety Net Hospitals and Clinics* (Washington, DC: Georgetown University Center for Children and Families, June 2016), http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf	**Seven states (four expansion and three non–expansion):** Investigated impact of Medicaid expansion on safety net hospitals and clinics through interviews with leaders of hospital systems and federally qualified health centers (FQHCs) in seven states (AR, CO, KY, MO, NV, TN, UT). Selected states with common borders in order to better compare state experiences.	• Hospital and health center leaders in expansion states reported an increased ability to move toward integrating care through new systems and relationships due to expansion-driven financial security and increasing margins. Improvements cited included better integration of behavioral health and primary care, expanded access to dental services, and expanded access to prescription medications. • Executives in both expansion and non-expansion states identified access to specialists as a particular problem for the low-income Medicaid populations they serve. • Executives in expansion states noted efforts to address the issue with new collaborative programs, new hiring, and new initiatives directed at increasing access to specialists for Medicaid enrollees. In cases where these programs and initiatives started before expansion, executives explained that efforts were bolstered by the expansion coverage.
Stephen Berry et al., "Healthcare Coverage for HIV Provider Visits before and after Implementation of the Affordable Care Act," *Clinical Infectious Diseases*, (May 2016), http://www.ncbi.nlm.nih.gov/pubmed/27143660	**Ten adult HIV care sites in six states:** Compared coverage pre (2011-2013) versus post (first half of 2014) ACA among a total of 28,374 persons living with HIV in 4 HIV provider sites in Medicaid expansion states (CA, OR, MD), 4 in a state (NY) that the study classified as expanding Medicaid in 2001, and 2 in non-expansion states (TX, FL).	• In expansion state sites, Ryan White HIV/AIDS Program support, local charities, or uncompensated care (RWHAP/Uncomp) decreased (from 28% pre-ACA to 13% post-ACA). Medicaid coverage increased (23% pre-ACA to 38% post-ACA) and private coverage was unchanged (21% pre-ACA to 19% post-ACA). • In non-expansion state sites, RWHAP/Uncomp (57% pre-ACA and 52% post-ACA) and Medicaid (18% pre and 18% post-ACA) were unchanged, while private coverage increased (4% pre and 7% post-ACA).
Benjamin Sommers, Robert Blendon, and E. John Orav, "Both the 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults," *Health Affairs* 35, no. 1 (January 2016): 96-105, http://content.healthaffairs.org/content/35/1/96.abstract	**Arkansas, Kentucky, and Texas:** Conducted a telephone survey of two distinct waves of low-income adults in the three states in Nov.-Dec. 2013 and then 12 months later. Compared first year impacts of traditional Medicaid expansion (KY), the private option (AR), and non-expansion (TX) on coverage, access, affordability, and self-reported health status.	• Found a significantly greater decline in skipping medications because of cost and trouble paying medical bills in the two expansion states compared to the non-expansion state. • Among adults with chronic conditions, found a significantly greater increase (11.6 percentage points) in the proportion of respondents in expansion states who had regularly received care for those conditions than the increase in TX. • There was a greater reduction in trouble paying medical bills in KY than in AR. Otherwise, there were no significant differences in access measures between KY's traditional expansion and AR's private option, suggesting that both approaches improved access among low-income adults. • Did not find significant impacts of expansion on numbers of office visits, emergency department visits, and overnight hospitalizations.
Samantha Artiga and Robin Rudowitz, *How Have State Medicaid Expansion Decisions Affected the Experiences of Low-Income Adults? Perspectives from Ohio, Arkansas, and Missouri* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), http://kff.org/medicaid/issue-brief/how-have-state-medicaid-expansion-decisions-affected-the-experiences-of-low-income-adults-perspectives-from-ohio-arkansas-and-missouri/	**Ohio, Arkansas, and Missouri:** Examined the experiences of low-income adults in three states with varied Medicaid expansion decisions. Used information collected through 10 focus groups conducted with 85 adults in Columbus, Little Rock, and St. Louis. The groups in Columbus and Little Rock were conducted with previously uninsured adults who enrolled in the ACA Medicaid expansion or private option waiver, and the groups in St. Louis were conducted with uninsured low-income adults who would be eligible if Missouri expanded Medicaid.	• Participants in all three locations described how they delayed or went without needed care while uninsured, which sometimes led to worsening of conditions. • After gaining coverage, adults in Little Rock and Columbus obtained needed care, leading to improvements in their health and quality of life. • Some participants in Little Rock and Columbus identified remaining challenges after gaining coverage, including difficulty finding a primary care provider and certain types of specialists, as well as significant dental and vision needs. • Adults in St. Louis described how remaining uninsured after implementation of the ACA contributed to daily stress and anxiety and caused them to continue to delay or go without needed care.

Samantha Artiga, Jennifer Tolbert, and Robin Rudowitz, *Year Two of the ACA Coverage Expansions: On-the-Ground Experiences from Five States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), http://kff.org/health-reform/issue-brief/year-two-of-the-aca-coverage-expansions-on-the-ground-experiences-from-five-states/	**Five states (three expansion and two non-expansion):** Provides an on-the-ground view of ACA implementation in five states (CO, KY, WA, UT, and VA) following the completion of the second open enrollment period. Findings were based on 40 in-person interviews conducted with a range of stakeholders during April and May 2015.	• In the expansion states, enrollees are generally able to access needed care, although there are access challenges for certain services and providers. • In CO, stakeholders commented that the increased demand for care has led to longer wait times in some cases, particularly for specialty services. Stakeholders in WA and KY similarly noted difficulty finding providers for certain specialties and behavioral health services.
Government Accountability Office, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States* (Washington, DC: Government Accountability Office, June 2015), http://www.gao.gov/assets/680/670894.pdf	**Ten states (six expansion and four non-expansion):** In six expansion (CT, KY, MD, MI, NV, WV) and four non-expansion (MO, MT, TX, WI) states, reviewed documents and interviewed state officials to understand how uninsured and Medicaid-enrolled adults receive behavioral health treatment.	• State officials in expansion states reported that Medicaid expansion increased the availability of behavioral health treatment, although some access concerns (mainly concerns related to behavioral health professional shortages and expansion-related budget reductions for state behavioral health agencies) continue. • Expansion states generally managed behavioral health and physical health benefits separately for newly eligible Medicaid enrollees through carve-outs or separate contracts. • Health plans for newly eligible Medicaid enrollees were generally aligned with Medicaid state plans, resulting in comparable behavioral health benefits for newly eligible and existing Medicaid enrollees. • State BHAs in the non-expansion states offered various behavioral health treatment options for low-income, uninsured adults. Those states identified priority populations to focus care on adults with the most serious conditions and used waiting lists for those with more modest behavioral health needs.
Barbara DiPietro, Samantha Artiga, and Alexandra Gates, *Early Impacts of the Medicaid Expansion for the Homeless Population* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2014), http://kff.org/uninsured/issue-brief/early-impacts-of-the-medicaid-expansion-for-the-homeless-population/	**Five cities (in four expansion states and one non-expansion state):** Provided an early look at the impact of the expansion for homeless providers and the patients they serve. Used data from focus groups conducted with administrators, providers, and enrollment workers at sites serving homeless individuals in Albuquerque, NM; Baltimore, MD; Chicago, IL; Portland, OR' and Jacksonville, FL.	• Providers reported having access to a broader array of treatment options as a result of their patients' coverage gains. Gains in Medicaid coverage have enabled patients to access many services that they could not obtain while uninsured, particularly specialty services, behavioral health services, medications, and medical supplies and equipment. Some providers described instances of individuals receiving life-saving or life-changing surgeries or treatments that they could not obtain while uninsured. • Participants from the non-expansion site (in Jacksonville) indicated that without insurance, individuals continue to rely on limited pro bono services, have difficulty accessing needed treatments and specialty services, and utilize the emergency room for dental emergencies and acute mental health stabilization. • Gains in Medicaid revenue (particularly in the expansion states) facilitated strategic and operational improvements focused on quality, care coordination, and information technology. • Some challenges were emerging as homeless patients gained Medicaid coverage and were enrolled in managed care (e.g. some patients were being auto-assigned to providers with whom they did not have an existing relationship and/or they may have difficulty accessing due to lack of transportation).
Single State Studies		
The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (The Ohio Department of Medicaid, January 2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf	**Ohio:** Examined the effects of OH's 2014 Medicaid expansion on expansion (Group VIII) enrollees. When appropriate, compared Group VIII enrollees to those enrolled in OH Medicaid under pre-expansion eligibility rules. Used numerous data collection methods, including a detailed telephone survey of 7,508 expansion and pre-expansion enrollees, medical record reviews and biometric	• Expansion enrollees overwhelmingly reported that access to medical care had become easier since enrolling in Medicaid—these gains were largest for those who were previously uninsured. • Nearly half of expansion enrollees (43.3%) reported a decline in unmet health care needs, while only 8.3% reported an increase, with the remainder reporting no unmet needs or no change in the level of unmet needs. • Emergency department use decreased for expansion enrollees. Survey results and medical records analyses showed that expansion participants were better integrated into the health care system, increasingly connecting to a usual and appropriate source of health care. • Nearly half of expansion enrollees (47.7%) reported improvement in their overall health status since enrolling in

	screenings of subsets of the survey sample, an analysis of administrative data for enrollees, focus groups of 27 enrollees, and interviews with 10 service providers and other key stakeholders.	Medicaid, compared to 3.5% who said their health had worsened. • A review of 430 expansion enrollees' medical records showed that the individuals studied had lower levels of high blood pressure or high cholesterol since enrolling in Medicaid. • Since enrollment in Medicaid, 44.0% of expansion enrollees reported better access to mental health services. • Expansion enrollees with depression and anxiety reported greater improvement in access to care (68.5%) and prescriptions (71.2%) than those without depression or anxiety (62.4% and 62.5%, respectively). • Expansion enrollees with opioid use disorders reported greater improvement in their access to care than other expansion enrollees (75.4% vs. 64.0% for overall access to care; 82.7% vs. 64.8% for access to prescription medications; and 59.3% vs. 32.2% for access to mental health care). • A small percentage of expansion enrollees reported having unmet medical needs or challenges accessing certain services (e.g., dental care). Follow up interviews with providers and stakeholders confirmed challenges with the low Medicaid payment rates which limited the pool of providers, an issue that predates Medicaid expansion. • More than half of expansion enrollees (58.6%) reported that it was now easier to buy food, 48.1% stated that it was easier to pay their rent or mortgage, and 43.6% said it was easier to pay off other debts than before they had Medicaid. • The percentage of expansion enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study).
Jeffrey Horn et al., "New Medicaid Enrollees See Health and Social Benefits in Pennsylvania's Expansion," *INQUIRY: the Journal of Health Care Organization, Provision, and Financing* 53 (October 2016): 1-8, http://journals.sagepub.com/doi/full/10.1177/0046958016671807#	**Pennsylvania:** Explored the health care experiences and expectations of new Medicaid expansion beneficiaries in the immediate post-enrollment period. Conducted semistructured, qualitative interviews with a random sample of 40 adults in Philadelphia who had completed an application for Medicaid through a comprehensive benefits organization after January 1, 2015, when the Medicaid expansion in Pennsylvania took effect. Conducted an inductive, applied thematic analysis of interview transcripts to understand their motivations for obtaining coverage, perceived health and health care needs, and early experiences navigating the health care system at a time of rapid health system change.	• While many participants spoke of having deferred a wide range of health care needs prior to gaining expansion coverage, including treatment for chronic medical conditions, filling prescriptions, or undergoing surgical procedures, they overwhelmingly described a need for dental care. • 33 of 40 participants spontaneously discussed a need for dental care, without prompting from the interviewer, revealing a demand that had been building over years of inadequate dental coverage. • Participants described how their new Medicaid coverage offered a reduction in stress and the hope of improved financial security. • Participants described prior stigma and discrimination while uninsured as a negative influence on access, but they felt that new insurance would be a social equalizer and allow them to be treated similarly to other insured patients. • Despite being recently enrolled in insurance, many participants described a persistent feeling of health care insecurity. Several participants feared that their new insurance would be taken away suddenly, particularly if their income increased.
The Lewin Group, Inc., *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report* (The Lewin Group, Prepared for Indiana Family and Social Services Administration, July 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf	**Indiana:** Used data available as of June 2016 to evaluate the progress of the Healthy Indiana Plan (HIP) 2.0 in the first year of implementation. Report evaluates several unique features of Indiana's HIP 2.0 expansion program, including the required (for members above poverty) or encouraged contributions to the HSA-like Personal Wellness and Responsibility (POWER) Accounts.	• 16% of HIP Plus members *always* worried about not being able to afford their PAC payment, 29% worried *usually* or *sometimes*, and 52% worried *rarely* or *never*. • About 1% of Plus members and 2% of basic members reported missing appointments due to cost. • A majority of HIP 2.0 members surveyed were unaware that preventive care is provided at no cost to the member. • Utilization was higher for the Plus members below poverty compared to those above poverty, regardless of whether members had chronic physical or behavioral health conditions. • Plus members were about 42% more likely to utilize preventive care services than Basic members. Chronic conditions are more prevalent in Plus than Basic members.

	Contributions determine member enrollment into HIP Plus (a plan that includes enhanced benefits) or HIP Basic (a more limited benefit plan that requires copayments for most services).	• Members with chronic conditions and medically frail members in either Plus or Basic were more likely to use preventive and primary care services than were healthier members. • Basic members show higher rates of Emergency Department use overall and non-emergency use of the ED, compared to Plus members.
Renuka Tipirneni et al., "Primary Care Appointment Availability and Nonphysician Providers One Year After Medicaid Expansion," *The American Journal of Managed Care* 22 no. 6 (June 2016): 427-431, http://www.ajmc.com/journals/issue/2016/2016-vol22-n6/primary-care-appointment-availability-and-nonphysician-providers-one-year-after-medicaid-expansion	**Michigan:** Follow-up to a July 2015 simulated patient study (using secret shoppers) assessing accessibility of routine new patient appointments in a random sample of Michigan primary care practices before versus four, eight, and 12 months after Medicaid expansion. Michigan's expansion has a unique requirement that new Medicaid beneficiaries be seen by a primary care provider within 90 days of enrollment.	• The proportion of clinics with available appointments for new Medicaid patients increased from 49% before expansion to 55% by 12 months after expansion. Appointment availability for new privately insured patients decreased from 88% of clinics to 86% 12 months after expansion. • Changes in appointment availability for both Medicaid and privately insured groups at 12 months post-expansion remained stable compared with the 4-month post-expansion findings. • The percentage of appointments scheduled with non-physician providers (nurse practitioners or physician assistants) before expansion compared to 12 months post-expansion increased from 8% to 21% for Medicaid appointments and from 11% to 19% for private insurance appointments. • In clinics that accepted patients with Medicaid, median wait times for new Medicaid patients remained stable over the 12-month period while median wait times for new privately insured patients in the same clinics increased slightly from 7-10 days. There was no significant difference between wait times for new Medicaid and new privately insured patients throughout the study period. • Safety net clinics were much more likely than non–safety net clinics to accept new Medicaid patients at baseline; however, only non–safety net clinics had significantly increased appointment availability after expansion. • Clinics in urban locations were less likely to accept new Medicaid patients than clinics in nonurban locations at baseline, but only urban clinics had increased Medicaid appointment availability post expansion.
Joseph Benitez, Liza Creel, and J'Aime Jennings, "Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care," *Health Affairs* (February 2016), http://content.healthaffairs.org/content/early/2016/02/16/hlthaff.2015.1294	**Kentucky:** Used BRFSS data on adults ages 25-64 reporting annual household income below $25,000 to study first-year impact of KY's Medicaid expansion on insurance coverage and access to care. Low-income residents from the bordering non-expansion states Missouri, Tennessee, and Virginia served as controls.	• By the end of 2014, low-income Kentuckians experienced a 16 percentage point (40%) reduction in unmet medical need because of cost relative to the preexpansion period. Over the same period, there was a modest, statistically insignificant increase in the fraction experiencing financial barriers in the control states. • The effect of the expansion on having a regular source of care was largely positive but more mixed, with the most substantial effects occurring in 2014's second and third quarters.
Arkansas Health Reform Legislative Task Force, *Health Care Task Force Preliminary Report,* (Arkansas Health Reform Legislative Task Force, December 2015), http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14218/Task%20Force%20report%2012-17-15%20sent%20to%20Jill.pdf	**Arkansas:** Preliminary report evaluated how efficiently Arkansas' Medicaid program, and specifically the Private Option expansion model, was working and how well-prepared the program was to meet future trends. Findings were largely based on two reports from The Stephen Group, the consultant group hired by the Legislative Task Force, that were released earlier in 2015.	• Private Option participants have access to substantially more providers than through traditional Medicaid due to access to the private insurance company provider networks. • Private Option beneficiaries utilized Emergency Department (ED) services at a rate greater than traditional Medicaid beneficiaries, despite being a healthier population. This is partially attributed to a lack of understanding of how to use the health care system by newly insured individuals and to a lack of incentives for using more appropriate care. • Physician licensure rates appeared largely to not be impacted by the Private Option.

Jocelyn Guyer, Naomi Shine, MaryBeth Musumeci, and Robin Rudowitz, *A Look at the Private Option in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2015), http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/	**Arkansas:** Provided an initial look at implementation of the private option in Arkansas. Findings came from a dozen interviews with state officials, providers, insurance carriers, and advocates, as well as early data on coverage, reductions in uncompensated care costs, and other topics.	• Stakeholders reported that Private Option enrollees were generally able to access services and that beneficiaries appreciate having the same commercial insurance card as other Marketplace enrollees and the access to doctors, hospitals, clinics, and specialists that these plans offer. • The access to specialists was highlighted as a particularly important benefit of the private option coverage expansion, since traditional Medicaid beneficiaries can often secure primary and preventative care from community health centers but may encounter more challenges accessing specialists. • Early reports indicated that Private Option beneficiaries were receiving wrap-around protections for premiums and cost-sharing that exceed Medicaid limits, while access to wrap-around benefits required by Medicaid but not covered in the Marketplace was more mixed.
Michael McCue, "The Impact of Medicaid Expansion on Medicaid Focused Insurers in California," *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 52 (July 2015), http://inq.sagepub.com/content/52/0046958015595960.full.pdf+html	**California:** Assessed the enrollment, utilization, and financial performance measures of California Medicaid focused health insurers. Compares these quarterly measures during the expansion period of 2014 to the same quarterly measures in 2013 and 2012.	• Medi-Cal members' utilization patters changed in response to expansion. The first and fourth quarters' ambulatory care encounters per member per month (PMPM) were reduced by more than .06 encounter PMPM from 2013 to 2014. Starting in the second quarter of 2014, inpatient days per thousand were substantially lower than their respective prior quarters of 2012 and 2013, with the greatest difference occurring in the fourth quarter with a reduction of 56 days from 279 days in 2013 to 223 days in 2014.
Renuka Tipirneni et al. "Primary Care Appointment Availability For New Medicaid Patients Increased After Medicaid Expansion In Michigan," *Health Affairs* (July 2015), http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2014.1425.full	**Michigan:** Conducted a simulated patient study to assess primary care appointment availability and wait times for new patients with Medicaid or private insurance before and after implementation of Michigan's expansion in 2014 (Michigan's expansion has a unique requirement that new Medicaid beneficiaries be seen by a primary care provider within 60-90 days of enrollment).	• Appointment availability for primary care increased by 6 percentage points (from 49% in the pre-expansion (March 2014) calls to 55% in the post-expansion (July-August 2014) calls) for new Medicaid patients and decreased by 2 percentage points for new privately insured patients over the same period. While the disparity between the two groups declined over time, appointments were still much more commonly available after expansion for new privately insured patients than for new Medicaid patients. • Wait times remained stable, at 1-2 weeks for both groups.
Deloitte Development LLC, *Commonwealth of Kentucky Medicaid Expansion Report,* (Deloitte Development LLC, February 2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf	**Kentucky:** Examined progress toward the state's initial goals for its Medicaid expansion during the first 12 months of expansion (Jan. 1-Dec. 31. 2014). Also updated initial estimates from the 2013 Medicaid Expansion Whitepaper based on the first year of experience.	• The KY expansion population accessed preventative services at a rate equal to, and in some instances greater than, the traditional Medicaid population during 2014. • More than 300 new behavioral health providers enrolled in KY Medicaid and at least 13,000 individuals with a substance use disorder received related treatment services during the first year of expansion.

Table 3: Economic Effects of Expansion		
Citation	Study Focus	Major Findings
Impacts on State Budgets and Economies		
Nationwide Studies		
Lucas Goodman, "The Effect of the Affordable Care Act Medicaid Expansion on Migration," *Journal of Policy Analysis* 36, no. 1 (November 2016): 211-238, http://onlinelibrary.wiley.com/doi/10.1002/pam.21952/abstract	**Nationwide:** Investigated whether individuals migrate in order to gain access to Medicaid expansion benefits. Used public use microdata from the American Community Survey and an empirical model.	• Migration from non-expansion states to expansion states did not increase in 2014 relative to migration in the reverse direction. • Estimates were sufficiently precise to rule out a migration effect that would meaningfully affect the number of enrollees in expansion states, which suggested that Medicaid expansion decisions do not impose a meaningful fiscal externality on other states.
Robin Rudowitz, Allison Valentine, and Vernon Smith, *Medicaid Enrollment and Spending Growth: FY 2016 & 2017* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2016), http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2016-2017/	**Nationwide:** Provided an overview of Medicaid enrollment and spending growth with a focus on State Fiscal Years (FY) 2016 and 2017. Findings were based on interviews and data provided by state Medicaid directors as part of the 16th annual survey of Medicaid directors in all 50 states and DC conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.	• Medicaid enrollment and total spending in FY 2016 and FY 2017 slowed for both expansion and non-expansion states. • The typical expansion state, compared to a non-expansion state, experienced higher Medicaid enrollment and total spending growth in FY 2016, and that differential is projected to continue in FY 2017, although the size of the differential is narrowing. • Largely due to the 100% Federal Medical Assistance Percentage (FMAP) for newly eligible enrollees in expansion states, state spending for Medicaid across all states increased slower than total spending in both FY 2015 and FY 2016. In FY 2015, the differential in these growth rates was large (3.8% state Medicaid spending growth compared to 10.5% total Medicaid spending growth). The differential narrowed in FY 2016. • In FY 2017, state Medicaid spending and total Medicaid spending are projected to grow at a nearly identical pace across all states. • Growth in state Medicaid spending in expansion states has been lower relative to non-expansion states, but an uptick is projected in FY 2017 primarily due to the phase-down in the FMAP for the expansion population from 100% to 95%. • Eight expansion states (AR, AZ, CO, IL, IN, LA, NH, and OH) reported plans to use provider taxes or fees to fund all or part of the state share of expansion costs, while other states will use general funds.
Aditi Sen and Thomas DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums* (Office of the Assistant Secretary for Planning and Evaluation, August 2016), https://aspe.hhs.gov/sites/default/files/pdf/206761/McaidExpMktplcPrem.pdf	**Nationwide:** Used geographic matching analysis to compare 2015 premiums across border counties that are within a unified geographic area but located in states that made different Medicaid expansion decisions. Included only counties in HealthCare.gov states.	• Estimated that Marketplace premiums are about 7% lower in expansion compared to non-expansion states, controlling for differences in demographic characteristics, pre-ACA uninsured rates, health care costs, and state policy decisions other than Medicaid expansion. • Higher marketplace premiums in non-expansion compared to expansion states reflect a different risk pool. Low-income individuals with incomes between 100 and 138% FPL make up a greater share of Marketplace enrollment in Medicaid non-expansion states than in expansion states (this population represents close to 40% of total enrollment in non-expansion states).
Laura Snyder, Katherine Young, Robin Rudowitz, and Rachel Garfield, *Medicaid Expansion Spending and Enrollment in Context: An Early Look at CMS Claims Data for 2014* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2016), http://kff.org/medicaid/issue-brief/medicaid-expansion-spending-and-enrollment-in-context-an-early-look-at-cms-claims-data-for-2014/	**Nationwide:** Used preliminary data from CMS' Medicaid Budget and Expenditure System (MBES) for January-December 2014 to put spending and enrollment for the new adult eligibility group under the ACA Medicaid expansion into the context of total Medicaid spending and enrollment.	• The new adult eligibility group, including those newly eligible for Medicaid under the ACA expansion and those previously eligible that were matched at traditional rates but now receive a higher federal match, represented a relatively small share (10%) of total Medicaid spending across all states in 2014. • Spending for the new adult group made up 16% of total Medicaid spending in expansion states. • 94% of spending for the new adult group was federal dollars in 2014. • The new adult group made up a relatively small share (13%) of total enrollment in 2014, and a larger share (23%) of enrollment in expansion states. • Spending per enrollee for the new adult group was significantly lower than spending per enrollee across all groups ($4,513 vs. $7,150).

Christopher Truffer, Christian Wolfe, and Kathryn Rennie, *2016 Actuarial Report on the Financial Outlook for Medicaid,* (Office of the Actuary, Centers for Medicare and Medicaid Services, 2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf	**Nationwide:** Analyzed past Medicaid trends and 10-year projections of expenditures and enrollment, including the impacts of the 2014 eligibility changes under the ACA.	• Per enrollee spending is estimated to have increased 4.0% between 2014 and 2015, reflecting a large enrollment increase in newly eligible adults, whose average costs were less than the average of all other Medicaid enrollees. • Per enrollee costs for newly eligible adults are estimated to have decreased from $6,365 in 2015 to $5,926 in 2016 (6.9%). • Total Medicaid outlays increased 11.6% between 2014 and 2015 and Federal Medicaid outlays increased by 16.0%, due primarily to the ACA Medicaid eligibility expansion. • The Federal share of all Medicaid expenditures is estimated to have remained at 63% in 2016. State Medicaid expenditures are estimated to have increased 3.8% to $212.5 billion. • Most states covered newly eligible adults through managed care programs and used risk mitigation strategies (most commonly risk corridors and minimum medical loss ratios) to offset the risks that the costs of the newly eligible adults were greater, or less, than projected. • For newly eligible adults, health care costs in 2014 and 2015 are expected to be less than projected in the managed care capitation rates, based on amounts paid back by plans through 2016 and amounts expected to be paid in 2017.
Robin Rudowitz, Laura Snyder, and Vernon Smith, *Medicaid Enrollment and Spending Growth: FY 2015 & 2016* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2015), http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/	**Nationwide:** Provided an overview of Medicaid enrollment and spending growth with a focus on state Fiscal Years (FY) 2015 and 2016. Findings were based on interviews and data provided by state Medicaid directors as part of the 15th annual survey of Medicaid directors in all 50 states and DC conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.	• In FY 2015, expansion states reported Medicaid enrollment and total spending growth nearly three times the rate of non-expansion states. Across the 29 expansion states in FY 2015, enrollment increased on average by 18.0% and total spending increased by 17.7%; both increases were driven by increases in enrollment among adults qualifying under the new expansion group. Across the 22 non-expansion states in FY 2015, enrollment and total spending growth was 5.1% and 6.1% respectively. • In expansion states in FY 2015, growth in state general fund spending for Medicaid (average increase of 3.4%) was much slower than growth in total Medicaid spending (average increase of 17.7%)—primarily due to the enhanced federal match rate for those newly eligible for coverage. For non-expansion states, state Medicaid spending growth in FY 2015 (6.9%) slightly outpaced total Medicaid spending growth (6.1%), primarily due to annual formula-driven changes in the Federal Medical Assistance Percentage (FMAP). • Of the 29 states with expanded Medicaid programs in FY 2015, slightly more than half (17 states) noted that enrollment initially increased faster than expected. • Nearly two-thirds of expansion states reported that per member per month costs for the expansion population were at or below projections. • Total Medicaid enrollment and spending growth was projected to slow in 2016. • For FY 2015 and FY 2016, a number of Medicaid directors reported savings in areas including behavioral health, uncompensated care, and criminal justice as well as increased revenue as a result of implementing the Medicaid expansion.
Multi-State Studies		
Deborah Bachrach, Patricia Boozang, Avi Herring, and Dori Glanz Reyneri, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains,* (Manatt Health Solutions, prepared by the Robert Wood Johnson Foundation's State Health Reform Assistance Network, March 2016), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097	**11 expansion states:** This update to the April 2015 brief examined the budget impact of expansion in a sample of 11 states (AR, CA, CO, KY, MI, NM, OR, MD, PA, WA, WV) and DC. Using budget information provided by state officials, the authors documented state budget implications for SFY or CY 2014 and projected savings for SFY or CY 2015 in several categories of expenditures.	• Some study states are seeing savings from accessing enhanced federal matching funds and by replacing general funds with Medicaid funds particularly in mental and behavioral health programs, public health programs, and health care services for prisoners. • Some study states are experiencing revenue gains. Nearly all states raise revenue through assessments or fees on providers and/or health plans. As provider and health plan revenues increase with expansion, this translates into additional revenue for states.

Stan Dorn, Norton Francis, Laura Snyder, and Robin Rudowitz, *The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2015), http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/	**Connecticut, New Mexico, and Washington:** Examined the early budget effects of expansion during the fall of 2014 (after states had enacted budgets for SFY 2015). Conducted interviews with budget officials and staff in each of the three states, focusing on early experiences with state savings and costs from the expansion across state budgets (within and outside of Medicaid) as well as the expansion's impact on state revenue.	• Medicaid programs in all three states reported savings, as beneficiaries who otherwise would have qualified for pre-ACA Medicaid categories at the state's regular match enrolled in the new expansion group and were eligible for the higher ACA enhanced match rate. • All three states experienced savings in areas of the state budget beyond Medicaid, such as state-funded behavioral health services and corrections. • The impact on state revenue was primarily reflected in increased provider and premium taxes. New Mexico was the only one of the study states to account for the increased economic activity from expansion in general revenue forecasts. • Washington, the only study state to produce net estimates, projected that state savings from expansion would exceed costs, resulting in net fiscal gains. During FY 2015, net gains of expansion were estimated to equal 1.7% of total General Fund spending.
Single State Studies		
John Ayanian, Gabriel Ehrlich, Donald Grimes, and Helen Levy, "Economic Effects of Medicaid Expansion in Michigan," *The New England Journal of Medicine* epub ahead of print (January 2017), http://www.nejm.org/doi/full/10.1056/NEJMp1613981	**Michigan:** Assessed the effects of Medicaid expansion on economic outcomes in Michigan. Used the PI+ software developed by Regional Economic Models to estimate how increased federal funding for health care services covered by the Medicaid expansion affects employment, personal income, and state tax revenues in Michigan.	• State expenditures from 2014 through 2016 were limited to new administrative costs of $20 million annually. • Projections: State expenditures are projected to increase to $152 million in 2017, when the state covers 5% of the expansion costs, and $399 million in 2021, when it covers 10%. Between 2014 and 2021 the added economic activity is projected to yield approximately $145 million to $153 million annually in new state tax revenue. This additional state tax revenue offsets nearly all of the state's projected new spending for Medicaid expansion in 2017 and about 37% of these costs in 2021. After further accounting for the projected $235 million in annual state budget savings for mental health and other programs arising from Medicaid expansion and up to $200 million annually in state taxes and contributions from health plans and hospitals, found that the state costs of Medicaid expansion will be fully covered through 2021 and are very likely to be so in subsequent years as well.
The Colorado Health Institute, *Medicaid Expansion in Colorado: An Analysis of Enrollment, Costs and Benefits—and How They Exceeded Expectations* (The Colorado Health Institute, May 2016), http://www.coloradohealthinstitute.org/uploads/postfiles/MK_Expansion_Report.pdf	**Colorado:** Examined the costs to date of Medicaid expansion in Colorado and expectations for future costs, as well as benefits the state and enrollees have experienced as a result of expansion. Used data published by the Colorado Department of Health Care Policy and Financing in December 2015.	• Expansion costs added up to nearly $1.6 billion during the first two years—29% more than the $1.2 billion forecast. Nearly all of these costs were covered by the federal government. • Costs exceeded projections primarily due to the unexpectedly high enrollment, with caseload growth 71% higher than anticipated. • Per capita costs were lower than predicted. On average, each expansion enrollee cost approximately $4,100 annually in the first two years compared with the anticipated annual cost of $5,200. • Newly eligible low-income adults without dependent children accounted for 77% of the expansion enrollees but 86% of expansion spending. They averaged about $4,600 in annual costs. • Projections: Colorado will pay $222 million in state funds in FY 2020-2021 for Medicaid expansion (in those years the 10% state share will be in full effect). Costs are expected to be at least this high in subsequent years.
The Colorado Health Foundation, *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado,* (The Colorado Health Foundation, March 2016), http://www.coloradohealth.org/studies.aspx	**Colorado:** Updated a 2013 study and examined actual results of the expansion after two years of experience in CO. Forecasted the economic and budgetary impacts of expansion out to FY 2034-2035.	• As of FY 2015-2016, CO's economy (as measured by state GDP) is $3.82 billion (1.14%) larger as a result of Medicaid expansion. • In FY 2015-2016, the increase in General Fund revenue is $102.4 million. • Projections: By FY 2034-2035, the economy is expected to be $8.53 billion (1.38%) larger. The state's General fund will not incur any expenses associated with Medicaid expansion. CO's larger economy will result in increased General Fund revenue from greater income, sales, and use taxes. In FY 2034-2035 the increase in general fund revenue will grow to $248.3 million.

Lee A. Reynis, *Economic and Fiscal Impacts of the Medicaid Expansion in New Mexico,* (The University of New Mexico Bureau of Business and Economic Research, February 2016), http://bber.unm.edu/media/publications/Medicaid_Expansion_Final2116R.pdf	**New Mexico:** Examined the economic and fiscal impact of Medicaid expansion in the NM, updating a previous report published prior to implementation of the Medicaid expansion in NM. Includes both analysis of impacts of the expansion to date and explanation of anticipated future impacts.	• In FY 2014, NM experienced a $37.7 million gain in the state general fund after accounting for new revenues, cost savings and offset by new costs. • Projections: Overall, the Medicaid expansion and associated programs generate a surplus of over $300 million for the General Fund between FY 2014-FY 2021 with General Fund gains predicted from FY 2015 through FY 2019. Small deficits of $20.9 million predicted in FY 2020 and just over $50 million in FY 2021 (year that state share reaches 10%). However, estimates of revenues were conservative, focusing on direct effects of expansion and excluding both indirect effects and estimates of the gross receipts taxes on the spending of newly hired health care workers.
Abby Evans, John Folkemer, Joel Menges, Amira Mouna, Nick Pantaleo, Emily Ricci, and Poornima Sigh, *Assessment of Medicaid Expansion and Reform, Initial Analysis* (The Menges Group, January 2016), https://www.adn.com/sites/default/files/Menges%20Group%20Medicaid%20Expansion%20Report.pdf	**Alaska:** This independent analysis of Medicaid expansion and Medicaid reform initiatives was prepared for the Alaska Legislative Budget and Audit Committee. Among other topics, the analysis focused on the expected state fund impacts of expansion, potential cost reductions in other areas as a result of expansion, and whether the state would likely experience a "woodwork effect" or provider "crowd-out."	• Following expansion, AK taxpayers collectively moved from experiencing an annual loss of $90 million (in federal taxes paying for other states' expansions) to an annual net gain of over $170 million. • Projections: State fund expansion costs will reach approximately $24 million during FFY 2020. However, large scale opportunities exist to reduce state Medicaid costs over the longer term to offset expansion costs.
Chris Brown and John Bennett, *Economic Impacts of the Arkansas Private Option* (Regional Economic Models, Inc., August 2015), http://www.arkhospitals.org/Misc.%20Files/August2015APOEconomicImpacts.pdf	**Arkansas:** Examines the economic impact that the federal expansion dollars (over $990 million in 2014) had in the state of Arkansas in 2014 and the potential impact in each following year through 2020. Used PI+ economic policy model to evaluate the impact in the state as a whole and in seven sub-state regions.	• Intermediate demand for goods and services increased by $230 million in 2014, largely going to local professional services and real estate. • Federal funds contributed nearly $511 million to GDP, or 0.41% growth, in 2014. Real disposable personal income grew by approximately $245 million. • Projections: However the state chooses to fund its share of expansion costs beginning in 2017, the state will still see positive economic growth into the future.
Deloitte Development LLC, *Commonwealth of Kentucky Medicaid Expansion Report,* (Deloitte Development LLC, February 2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf	**Kentucky:** Examined progress toward the state's initial goals for its Medicaid expansion during the first 12 months of expansion (Jan. 1-Dec. 31. 2014). Also updated initial estimates from the 2013 Medicaid Expansion Whitepaper based on the first year of experience.	• Based on KY's Medicaid claims data, the state's health care system and overall economy realized an infusion of $1.16 billion in CY 2014. • In SFY 2014, KY experienced a positive net budget impact of $49.6 million due to the Medicaid expansion. • Projections: Medicaid expansion was estimated to have a positive cumulative impact of $30.1 billion on KY's economy through State Fiscal Year (SFY) 2021, with a positive cumulative fiscal impact of $819.6 million by SFY 2021.
Impacts on Payer Mix for Hospitals and Clinics		
Nationwide Studies		
Fredric Blavin, "Association Between the 2014 Medicaid Expansion and US Hospital Finances," *The Journal of the American Medical Association* 316 no. 14 (October 2016): 1475-1483, http://jamanetwork.com/journals/jama/article-abstract/2565750	**Nationwide:** Comparing hospitals in expansion (excluding early-expansion states) and non-expansion states, assessed changes from FY 2011-2014 in uncompensated care costs, uncompensated care costs as a percentage of total hospital expenses, Medicaid revenue, Medicaid revenue as a percentage of total hospital revenue, operating margins, and excess margins. Used multivariable difference-in-difference regression analyses and data from the American Hospital Association Annual Survey and the Health Care Cost	• Prior to ACA Medicaid expansion implementation, there were no differences in uncompensated care (UCC) costs, Medicaid revenues, or hospital margins between expansion and non-expansion states. • Between FY 2013 and 2014, the mean annual uncompensated care costs declined by $2.0 million among hospitals in states with Medicaid expansion and increased by $180,000 among hospitals in non-expansion states. • Between FY 2013 and 2014, UCC costs as a percentage of total expenses declined by 1.1 percentage points among expansion states but declined by only 0.1 percentage points among non-expansion states. • Between FY 2013 and 2014, mean annual Medicaid revenue increased by $2.3 million among hospitals in expansion states compared with $300,000 among hospitals in non-expansion states. • In the same period, Medicaid revenue as a percentage of total revenue increased by 1.4 percentage points among expansion states and decreased by 0.1 percentage points among non-expansion states.

	Report Information System from CMS.	• Medicaid expansion was significantly associated with improved excess margins but not improved operating margins.
Brystana Kaufman, Kristin Reiter, George Pink, and George Holmes, "Medicaid Expansion Affects Rural and Urban Hospitals Differently," *Health Affairs* 35 no. 9 (September 2016): 1665-1672, http://content.healthaffairs.org/content/35/9/1665.full?sid=4aea494e-8e02-4c66-8298-3c828bfc313b	**Nationwide:** Used a difference-in-differences approach to evaluate the average effect of Medicaid expansion in 2014 on payer mix and profitability for urban and rural hospitals, controlling for secular trends. Primary data sources were the Health Care Cost Report Information System and Claritas population facts reports.	• On average among urban hospitals, the change in the percentage of discharges covered by Medicaid in 2014 was 1.52 percentage points greater in expansion states than in non-expansion states, though this difference was not significant after adjusting for trends before January 1, 2014, and hospital and market characteristics. • Among rural hospitals, the adjusted change in Medicaid discharges was a significant 2.45 percentage points greater in expansion states than in non-expansion states. • There was a significant reduction in uncompensated care costs as a result of Medicaid expansion among urban hospitals in expansion states. However, this reduction did not translate into improved operating margins for urban hospitals. • Medicaid expansion had no significant effect on uncompensated care costs or operating margins for rural hospitals. • Among urban hospitals, there was no significant change in Medicaid revenue between expansion and non-expansion states in either the unadjusted or the adjusted model. • The unadjusted change in percentage of Medicaid revenue for rural hospitals was significantly greater in expansion than in non-expansion states (1.63 percentage points), but the adjusted difference was not significant (1.02 percentage points). • Urban hospitals in expansion states experienced a 9% decline in net patient revenues, a significantly greater decline than non-expansion states. Operating expenses among urban hospitals in expansion states declined by 10%.
Mary Anderson, Jeffrey Glasheen, Debra Anoff, "Impact of State Medicaid Expansion Status on Length of Stay and In-Hospital Mortality for General Medicine Patients at US Academic Medical Centers," *Journal of Hospital Medicine* Epub ahead of print (August 2016), http://onlinelibrary.wiley.com/wol1/doi/10.1002/jhm.2649/citedby	**Nationwide:** Explored the impact of state Medicaid expansion status on payer mix, length of stay (LOS), and in-hospital mortality at academic medical centers and affiliated hospitals. Used the University HealthSystem Consortium Clinical Data Base/Resource Manager to obtain hospital level insurance, LOS, and mortality data for inpatients discharged from a general medicine service between October 1, 2012 and September 30, 2015.	• Hospitals in expansion states experienced a significant 3.7 percentage point increase in Medicaid discharges and a 2.9 percentage point decrease in uninsured discharges after ACA implementation, representing an approximately 19% increase and 60% drop in Medicaid and uninsured discharges, respectively. • Hospitals in non-expansion states saw no significant change in the proportion of discharges by payer after ACA implementation. • The overall LOS index remained unchanged pre- to post-ACA implementation for both Medicaid expansion and non-expansion hospitals. LOS indices for each payer type also remained unchanged. • The overall mortality index significantly improved pre- to post-ACA implementation for both expansion and non-expansion state hospitals. Among hospitals in both expansion and non-expansion states, the mortality index significantly improved for Medicare, commercial and Medicaid discharges but not for uninsured or other discharges.
David Dranove, Craig Garthwaite, and Christopher Ody, "Uncompensated Care Decreased At Hospitals In Medicaid Expansion States But Not At Hospitals In Nonexpansion States," *Health Affairs* 35 no. 8 (August 2016): 1471-1479, http://content.healthaffairs.org/content/35/8/1471.full	**Nationwide:** Utilized data from 2011-2014 Medicare Hospital Cost Reports to examine how the ACA's coverage expansions affected uncompensated care costs at a diverse sample of 1,249 hospitals. Analysis distinguished between hospitals in states that had expanded Medicaid as of January 1, 2014 and in those that had not.	• Hospitals that were at the 50th and 75th percentile for uncompensated care in the non-expansion states experienced larger bad debt and charity care expenses than hospitals in the same percentiles in expansion states both before and after 2014. Hospitals at the 25th percentile experienced similar levels of bad debt and charity care expenses regardless of expansion status. • Between 2013 and 2014, uncompensated care costs decreased by roughly 0.85, 1.32, and 1.75 percentage points of operating costs for hospitals at the 25th, 50th, and 75th percentiles in expansion states, respectively. • Any changes in uncompensated care costs for hospitals between 2013 and 2014 in non-expansion states were less

		than 0.2 percentage points of operating costs for all three percentiles. • In expansion states, uncompensated care costs decreased more in 2014 for hospitals that had higher uncompensated care costs in 2013. In non-expansion states, there was little decrease in uncompensated care costs regardless of the demand for uncompensated care in 2013. • In expansion states, the decreases from 2013 to 2014 in uncompensated care as a percentage of operating costs were 0.4 percent, 1.5 percent, and 1.6 percent for the hospitals categorized as having low, medium, and high shares of childless adults predicted to gain eligibility, respectively. There was no change in trends in non-expansion states.
Peter Cunningham, Robin Rudowitz, Katherine Young, Rachel Garfield, and Julia Foutz, *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2016), http://kff.org/medicaid/issue-brief/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes/	**Nationwide:** Provided an overview of Medicaid payments for hospitals and explored the implications of the ACA Medicaid expansion as well as payment policy changes on hospital finances. Drew on existing literature and published reports, information collected from semi-structured interviews with hospital associations and federal agencies, and data from the 2013 and 2014 Medicare cost reports.	• Analysis of the Medicare Cost Report data showed overall declines in uncompensated care from $34.9 billion in 2013 to $28.9 billion in 2014 nationwide. • Nearly all of this decline occurred in expansion states, where uncompensated care costs were $10.8 billion in 2014, $5.7 billion or 35% less than in 2013. • In non-expansion states, the change in uncompensated care was nearly flat between 2013 and 2014, dropping just 1% (or $0.2 billion) to $17.9 billion in 2014. • While hospitals expected to benefit financially from the Medicaid expansion, they expected some gains from the reduction in uncompensated care to be offset by volume-generated increases in Medicaid payments that may be lower than cost. The data were not reliable enough to support nationwide analysis of the extent to which this has occurred, and the effect would vary across hospitals.
Matt Warfield, Barbara DiPietro, and Samantha Artiga, *How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://files.kff.org/attachment/issue-brief-how-has-the-aca-medicaid-expansion-affected-providers-serving-the-homeless-population	**Health Care for the Homeless Projects, Nationwide:** Studied how the first full year of Medicaid expansion affected patients who are homeless and the providers who care for them. Used data from the Uniform Data System for health centers to examine changes in insurance coverage, revenues, and costs among Health Care for the Homeless projects serving the homeless population.	• HCH projects in expansion states had larger gains in revenue and smaller increases in costs compared to those in non-expansion states. • For HCH projects in expansion states, third-party payments increased as a share of total revenue due to coverage gains among patients. HCH projects in non-expansion states experienced little change in third-party payments as a share of revenue and remain heavily reliant on grant funding. • The distribution of costs by service type at HCH projects remained fairly stable between 2013 and 2014 in both expansion and non-expansion states.
Deborah Bachrach, Patricia Boozang, and Mindy Lipson, *The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States*, (Manatt Health Solutions, prepared by the Robert Wood Johnson Foundation's State Health Reform Assistance Network, June 2015), https://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/State-Network-Manatt-Impact-of-Medicaid-Expansion-on-Uncompensated-Care-Costs-June-2015.pdf	**Nationwide:** Examines early data on expansion-related decreases in uncompensated care costs and related state budget implications, including impending reductions in federal support for Medicaid Disproportionate Share (DSH) payments and waiver pools.	• Hospitals in expansion states experienced substantially greater declines in the volume of admissions or discharges by uninsured patients. • Early data from hospital associations have shown up to a 46.5% decrease in admissions by uninsured patients and up to a 59.7% decrease in hospital uncompensated care costs following ACA implementation.
Josh Gray, Iyue Sung, and Stewart Richardson, *Observations on the Affordable Care Act: 2014* (athenaResearch and Robert Wood Johnson Foundation ACA View Report, February 2015), http://www.athenahealth.com/~/media/athenaweb/files/pdf/acaview_year_end_2014.pdf	**Nationwide:** Based on a sample of nearly 16,000 health care providers, explores changes that occurred in 2014 (compared to before implementation of ACA coverage expansions) in areas such as insurance rates, patient health needs, and new patient rates in physician practices.	• The proportion of physician visits by uninsured patients declined by 39% in expansion states between 2013 and 2014, compared to a decline of 11% in non-expansion states.

Thomas DeLeire, Karen Joynt, and Ruth McDonald, *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014* (Office of the Assistant Secretary for Planning and Evaluation, September 2014), https://aspe.hhs.gov/sites/default/files/pdf/77061/ib_UncompensatedCare.pdf	**Nationwide:** Report summarized research on the effect of the major insurance coverage expansions under the ACA on the drivers of uncompensated care and on hospital uncompensated care costs.	• Early hospital financial reporting and member surveys from hospital associations indicated that through the second quarter of 2014, volumes of uninsured/self-pay admissions and emergency department visits fell substantially, particularly in expansion states. The volume of hospital admissions for patients covered by Medicaid increased, but only in expansion states.
PricewaterhouseCoopers LLP Health Research Institute, *Medicaid 2.0: Health System Haves and Have Nots* (PwC Health Research Institute, September 2014), http://www.pwc.com/us/en/health-industries/health-research-institute/assets/pwc-hri-medicaid-report-final.pdf	**Nationwide:** Explored the Medicaid expansion's impact on the nation's $2.8 trillion health sector. Analyzed financial data from the nation's five largest for-profit health systems: HCA Holdings, LifePoint Hospitals, Tenet Healthcare, Community Health Systems, and Universal Health Services. Also used information from several mid-sized hospitals, government reports, industry surveys, and executive interviews.	• In expansion states, an influx of newly insured patients helped reverse long-running hospital trends such as declining admissions and a rise in uncompensated care. • Medicaid admissions in expansion states increased by a range of 10.4% to 32% across the country's three largest health systems through the first half of 2014 (compared to the first half of 2013). Hospitals saw corresponding declines of about 47% over the first half of the year in uninsured or self-pay admissions. • Hospitals in non-expansion states continued to see flat or sagging admission rates and little reduction in the number of uninsured through the first half of 2014.
Multi-State Studies		
Laurie Felland, Peter Cunningham, Annie Doubleday, and Cannon Warren, *Effects of the Affordable Care Act on Safety Net Hospitals* (Washington, DC: Mathematica Policy Research, prepared for the Assistant Secretary for Planning and Evaluation, November 2016), https://aspe.hhs.gov/sites/default/files/pdf/255491/SafetyNetHospital.pdf	**10 Safety Net Hospitals:** Studied the early effects of the ACA on 10 safety net hospitals in expansion states (6 hospitals) and non-expansion states (4 hospitals). Primarily a qualitative research study conducted between September 2013 and March 2016, provided an on-the-ground assessment of the extent and nature of early changes in patient demand for services; hospital capacity; preparations for payment and delivery system reforms; and changes in hospital revenue, costs, and overall financial status.	• Study hospitals in states that expanded Medicaid experienced considerable patient volume increases from Medicaid enrollment expansions, whereas they experienced little volume change from the ACA's expansion of private coverage through the Marketplaces. • Despite concerns that they might lose many newly insured patients to other providers, study hospitals in expansion states largely retained existing patients and gained new ones. The growth in patient volume was especially notable for outpatient care, and there were corresponding marked increases in the proportion of their patients with insurance coverage. • On average, safety net hospitals in expansion states are treating significantly more insured and fewer uninsured patients than in 2013, and this shift has helped the hospitals financially. • In contrast, study hospitals in states that did not expand Medicaid experienced, on average, more modest increases in patient volumes and no overall change in patient mix, with many of their patients remaining uninsured. • On average, safety net hospitals in non-expansion states experienced greater financial challenges compared to the hospitals in states that expanded Medicaid; these challenges increased over the study period.
Steven Wallace, Maria-Elena Young, Michael Rodriguez, Amy Bonilla, and Nadereh Pourat, *Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era* (UCLA Center for Health Policy Research, October 2016), http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/FQHC_PB-oct2016.pdf	**California, New York, Georgia, and Texas:** Explored the impact of ACA-driven changes in coverage, funding, and related policy on Community Health Centers (CHCs) in expansion vs. non-expansion state communities with high concentrations of immigrants and uninsured residents. Based on analyses of the US HRSA Uniform Data System and interviews conducted in 2014-2016 with the leadership of 31 CHCs.	• Analysis found that the expansion of Medicaid is critical to the financial stability of CHCs. More insured patients translate into more stable revenue streams, allowing CHCs to provide and expand needed services rather than devoting resources to fundraising. • Respondents in non-expansion states reported that any Medicaid expansion, whether through a waiver or a state plan amendment, is the most important policy change needed by their organizations.
Jane Wishner, Patricia Solleveld, Robin Rudowitz, Julia Paradise, and Larisa Antonisse, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* (Washington,	**Kansas, Kentucky, and South Carolina:** Through case studies of three rural hospital closures (one in an expansion and two in non-expansion states), analyzed	• Respondents in all three states suggested that although Medicaid expansion can bring increased revenues into struggling hospitals, it is only one of many factors that impact hospitals' financial stability and cannot alone overcome the financial challenges facing rural hospitals.

DC: Kaiser Commission on Medicaid and the Uninsured and The Urban Institute, July 2016), http://kff.org/medicaid/issue-brief/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/	the factors that contribute to rural hospital closures and the impact of closures on access to health care in rural communities. Each case study involved 6-8 interviews with a range of stakeholders and a review of publicly-available materials related to the closures.	
Adam Searing and Jack Hoadley, *Beyond the Reduction in Uncompensated Care: Medicaid Expansion is Having a Positive Impact on Safety Net Hospitals and Clinics* (Washington, DC: Georgetown University Center for Children and Families, June 2016), http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf	**Seven states (four expansion and three non-expansion):** Investigated impact of Medicaid expansion on safety net hospitals and clinics through interviews with leaders of hospital systems and federally qualified health centers (FQHCs) in seven states (AR, CO, KY, MO, NV, TN, UT). Selected states with common borders in order to better compare state experiences.	• Leaders of hospital systems and FQHCs in expansion states consistently emphasized that their patient mix was shifting to include fewer uninsured patients. Leaders in non-expansion states saw little change, no change, or increased numbers of patients without insurance. • The financial impact of expansion has been dramatic on the overall bottom lines of safety net institutions studied in expansion states. These institutions reported using the increase in reimbursement to hire new clinical staff, open new health centers and clinics, buy new equipment, and improve existing facilities. • Non-expansion state health executives were much more likely to say there had been little reduction in uncompensated care amounts delivered and no measurable change in their institution's situation. Some non-expansion state executives noted the lack of expansion was leading to layoffs and closures. • Hospital and health center leaders in expansion states reported an increased ability to move toward integrating care through new systems and relationships due to expansion-driven financial security and increasing margins. Improvements cited included better integration of behavioral health and primary care, expanded access to dental services, and expanded access to prescription medications.
Sayeh Nikpay, Thomas Buchmueller, and Helen Levy. "Affordable Care Act Medicaid Expansion Reduced Uninsured Hospital Stays in 2014," *Health Affairs* 35, no.1 (January 2016): 106-110, http://content.healthaffairs.org/content/35/1/106.full	**15 States (nine expansion and six non-expansion):** Analyzed discharge data from the Agency for Healthcare Research and Quality to compare changes in hospital payer mix before and after coverage expansions between states that did and did not expand.	• In states that expanded Medicaid, uninsured hospital stays decreased sharply (6-percentage-point drop, 50% decrease in discharges) and Medicaid-covered stays increased sharply (7-percentage-point jump, 20% increase in discharges) in the first two quarters of 2014 compared to the "before expansion" period (the first quarter of 2009 through the third quarter of 2013). • There was no significant change in payer mix between the "before expansion" and "after expansion" time periods in states that did not adopt the expansion.
Fred Hellinger, "In Four ACA Expansion States, The Percentage of Uninsured Hospitalizations for People With HIV Declined, 2012-14," *Health Affairs* 34, no. 12 (December 2015): 2061-2068, http://search.proquest.com/docview/1749932806/627DA95CDEA44BE7PQ/77?accountid=39486#	**Six states (four expansion and two non-expansion):** In HI, KY, MN, NJ, GA, and VA, examined the influence of the Medicaid expansion/non-expansion on insurance coverage and health outcomes for patients with HIV. Used data from the State Inpatient Databases of the Healthcare Cost and Utilization Project for all hospitalizations for patients with HIV from 2012 through the first six months of 2014.	• The percentage of hospitalizations of uninsured people with HIV in the four expansion states fell from 13.7% to 5.5% in the study period (2012 through the first six months of 2014), while the percentage in the two nonexpanding states increased from 14.5% to 15.7%. • Hospitalizations of people with HIV covered by Medicaid increased by 6.3% in HI and 13.8% in KY, but declined by 2.5% in MN and 0.1% in NJ. Author noted that three of the four expansion states (HI, MN, and NJ) already covered adults without children prior to 2014, so effects of expansion were muted. Additionally, the data covered only the first half of 2014 and therefore did not reflect the final 2014 trend. • Hospitalized patients with HIV who did not have insurance were 40% more likely to die during their hospital stays than comparable patients with insurance.
Robin Rudowitz and Rachel Garfield, *New Analysis Shows States with Medicaid Expansion Experienced Declines in Uninsured Hospital Discharges* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2015), http://kff.org/health-reform/issue-brief/new-analysis-shows-states-with-medicaid-	**16 states (10 expansion and six non-expansion):** Used data from the Healthcare Cost and Utilization Project (HCUP) to examine changes in discharges by payer through the second quarter of 2014 for states that did and did not expand Medicaid under the ACA.	• Prior to the ACA's major coverage expansions, growth rates for inpatient stays in expansion and non-expansion states moved in tandem. Patterns diverged beginning in 2014, when expansion states showed sharp increases in inpatient stays for Medicaid and sharp declines for uninsured compared to non-expansion states. • Comparing inpatient stays by payer for 2013 and 2014 shows sharp increases for Medicaid and sharp declines in uninsured for expansion states. While inpatient stays declined by 3.4% for a typical expansion state from 2013 to 2014, Medicaid inpatient stays increased by 16.3% and uninsured stays decreased by 36.9%. A typical non-

expansion-experienced-declines-in-uninsured-hospital-discharges/		expansion state experienced a decline in inpatient stays of 4.0% with small (0.5%) increases in Medicaid stays and slight (2.9%) declines in uninsured inpatient stays. • Increases in Medicaid discharges and declines in uninsured discharges for expansion states were especially pronounced for mental health.
Samantha Artiga, Jennifer Tolbert, and Robin Rudowitz, *Year Two of the ACA Coverage Expansions: On-the-Ground Experiences from Five States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), http://kff.org/health-reform/issue-brief/year-two-of-the-aca-coverage-expansions-on-the-ground-experiences-from-five-states/	**Five states (three expansion and two non-expansion):** Provides an on-the-ground view of ACA implementation in five states (CO, KY, WA, UT, and VA) following the completion of the second open enrollment period. Findings were based on 40 in-person interviews conducted with a range of stakeholders during April and May 2015.	• Clinics and hospitals in the non-expansion states identified a range of financial challenges due to the coverage gap and reductions in funding. • Per enrollee costs of care for Medicaid expansion adults were lower than anticipated in the three expansion states.
Peter Cunningham, Rachel Garfield, and Robin Rudowitz, *How Are Hospitals Faring Under the Affordable Care Act? Early Experiences from Ascension Health* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2015), http://kff.org/health-reform/issue-brief/how-are-hospitals-faring-under-the-affordable-care-act-early-experiences-from-ascension-health/	**Ascension Health hospitals in expansion and non-expansion states:** Examined changes in discharge volumes, hospital finances, and other outcomes between the last three quarters of 2013 and the first three quarters of 2014. Ascension Health, a Catholic healthcare system with service to the poor as an explicit part of their mission, owns facilities in 23 states and DC. This analysis compared changes among Ascension hospitals in expansion vs. non-expansion states.	• Compared to hospitals in non-expansion states, Ascension Health hospitals in expansion states experienced larger increases in Medicaid discharge volumes and decreases in uninsured/self-pay volume from 2013 to 2014. • Looking at total revenue, Ascension hospitals in expansion states saw an increase (8.2% in Medicaid revenue from 2013 to 2014 and a decrease (63.2%) in revenue from self-pay. Ascension hospitals in non-expansion states saw a decline (9.4%) in Medicaid revenue over the same period and a slight increase (2.6%) in revenue from self-pay. • Despite somewhat smaller increases in patient revenue, hospitals in expansion states had larger relative increases in operating margins from 2013 to 2014 compared to hospitals in non-expansion states. • Hospital charity care costs decreased by 40.1% in expansion states compared to a 6.2% decrease in non-expansion states. • For hospitals in expansion states, the decrease in charity care costs was greater than the increase in Medicaid shortfalls. For hospitals in non-expansion states, the amount of the increase in Medicaid shortfalls exceeded the decrease in charity care by a considerable amount, resulting in a large increase in the cost of care for low-income patients.
Colorado Hospital Association, *Impact of Medicaid Expansion on Hospital Volumes* (Colorado Hospital Association Center for Health Information and Data Analytics, June 2014), http://www.cha.com/documents/press-releases/cha-medicaid-expansion-study-june-2014.aspx	**30 states (15 expansion and 15 non-expansion):** Reported the preliminary impact of the ACA Medicaid expansion on hospitals in both expansion and non-expansion states, with a focus on volume trends through changes in charges and payer mix. Used data collected by the Colorado Hospital Association in DATABANK, included data from 465 hospitals across 30 states.	• The Medicaid proportion of patient volume at hospitals in expansion states increased substantially in the first quarter of 2014. • In the first quarter of 2014, the proportion of self-pay and overall charity care declined in expansion-state hospitals. • Medicaid, self-pay, and charity care showed no change outside normal variation for hospitals in non-expansion states in 2014. • Urban, rural, and critical access hospitals in Colorado, specifically, also demonstrated similar increases in Medicaid volume and decreases in self-pay volume and charity care. The magnitude of the changes that occurred in Colorado hospitals was greater than the national trend.
Single State Studies		
Natalia Chalmers, Jane Grover, and Rob Compton, "After Medicaid Expansion in Kentucky, Use of Hospital Emergency Departments for Dental Conditions Increased," *Health Affairs* 35, no. 12 (December 2016), http://content.healthaffairs.org/content/35/12/2268.full#xref-ref-32-1	**Kentucky:** Examined the impact of Medicaid expansion on adult Medicaid enrollees' use of hospital emergency departments for conditions related to dental or oral health in the period 2010-2014. Used KY data from the State Emergency Department Databases.	• Out of all adult emergency department (ED) discharges for conditions related to dental or oral health in KY, the share of discharges for those with Medicaid coverage increased from 18% in 2013 to 50% in 2014; the percentage of uninsured discharges for those conditions decreased from 57% in 2013 to 21% in 2014 and the percentage covered by private insurance increased only slightly. • Between 2013 and 2014, costs to Medicaid for ED discharges for conditions related to dental or oral health among adults increased markedly from $1.93 million to

		$6.15 million; costs incurred by people with private insurance for these discharges increased from $2.09 million to $2.82, and costs incurred by the uninsured decreased from $5.98 million to $2.47 million. • Among adult Medicaid enrollees, the proportion of ED discharges for conditions related to dental or oral health that could be classified as preventable with primary dental care rose from 22% in 2010 to 33% in 2014, while the proportion of diagnoses for these conditions that were considered to be of low severity decreased from 48% to 38%. • Adults covered by Medicaid who used the emergency department for treatment of oral health conditions in 2014 had high levels of chronic comorbidities and were more likely to be male and nonwhite than those in earlier years.
The University of Michigan Institute for Healthcare Policy & Innovation, *The Healthy Michigan Plan: 2015 Report on Uncompensated Care and Insurance Rates* (The University of Michigan Institute for Healthcare Policy & Innovation, prepared for the Michigan Department of Health and Human Services and the Michigan Department of Insurance and Financial Services, December 2016), http://www.michigan.gov/documents/mdhhs/2015_Report_on_Uncompensated_Care_and_Insurance_Rates-HMP_547720_7.pdf	**Michigan:** Report provides annual update to the baseline estimate of uncompensated care borne by Michigan hospitals, examining effects of implementation of the state's expansion program, the Healthy Michigan Plan. Uncompensated care findings relied mainly on cost reports submitted by hospitals annually to the Michigan Department of Health and Human Services.	• The cost of uncompensated care provided by Michigan hospitals fell dramatically after the implementation of the Healthy Michigan Plan. Comparing data for 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50%. • For the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. • Over 90% of hospitals submitting data for both FY 2013 and FY 2015 saw a decline in uncompensated care between those two years. • As a percentage of total hospital expenses, uncompensated care decreased from 5.2% in 2013 to 2.9% in 2015. • There was no evidence from interviews and rate filings that the Healthy Michigan Plan affected health plan premium rates.
Abby Evans, John Folkemer, Joel Menges, Amira Mouna, Nick Pantaleo, Emily Ricci, and Poornima Sigh, *Assessment of Medicaid Expansion and Reform, Initial Analysis* (The Menges Group, January 2016), https://www.adn.com/sites/default/files/Menges%20Group%20Medicaid%20Expansion%20Report.pdf	**Alaska:** This independent analysis of Medicaid expansion and Medicaid reform initiatives was prepared for the Alaska Legislative Budget and Audit Committee. Among other topics, the analysis focused on the expected state fund impacts of expansion, potential cost reductions in other areas as a result of expansion, and whether the state would likely experience a "woodwork effect" or provider "crowd-out."	• Expansion creates hundreds of millions of dollars in revenue for providers in AK, and Medicaid is a "reasonably solid payer" in the state. Researchers did not anticipate that AK's providers will become less financially viable due to Medicaid expansion.
Arkansas Health Reform Legislative Task Force, *Health Care Task Force Preliminary Report,* (Arkansas Health Reform Legislative Task Force, December 2015), http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14218/Task%20Force%20report%2012-17-15%20sent%20to%20Jill.pdf	**Arkansas:** Preliminary report evaluated how efficiently Arkansas' Medicaid program, and specifically the Private Option expansion model, was working and how well-prepared the program was to meet future trends. Findings were largely based on two reports from The Stephen Group, the consultant group hired by the Legislative Task Force, that were released earlier in 2015.	• Uninsured hospital admissions dropped 48.7% between 2013 and 2014, uninsured ED visits dropped 38.8%, and uninsured outpatient visits dropped 45.7%.
Jocelyn Guyer, Naomi Shine, MaryBeth Musumeci, and Robin Rudowitz, *A Look at the Private Option in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2015), http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/	**Arkansas:** Provided an initial look at implementation of the private option in Arkansas. Findings came from a dozen interviews with state officials, providers, insurance carriers, and advocates, as well as early data on coverage, reductions in uncompensated care costs, and other topics.	• The Arkansas Hospital Association reported that hospitals were experiencing a dramatic drop in uninsured patients and uncompensated care costs. • In 2014, inpatient visits by uninsured patients dropped 48.7%, uninsured emergency room visits by 38.8%, and uninsured outpatient clinic visits by 45.7% (compared to 2013). • Hospitals also experienced corresponding gains in financial stability, with uncompensated care losses related to uninsured patients falling by 55.1%, or $149 million, from 2013 to 2014. • Community health centers were also seeing more insured patients, but some reported challenges due to delays in

		cost-based reimbursement payments from the state or noted that new clinics established by Marketplace plans could "skim off" their insured patients. • Despite early concerns, the private option appeared on track to meet or even outperform federal budget neutrality requirements.
Christine Jones, Serena Scott, Debra Anoff, Read Pierce, Jeffrey Glasheen, "Changes in Payer Mix and Physician Reimbursement After the Affordable Care Act and Medicaid Expansion," *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 52 (August 2015), http://inq.sagepub.com/content/52/0046958015602464.full	**University of Colorado Hospital:** Evaluated whether payer mix and physician reimbursement by encounter changed between 2013 and 2014 in an academic hospitalist practice in a Medicaid expansion state.	• Among 37,540 and 40,397 general medicine inpatient encounters in 2013 and 2014, respectively, Medicaid encounters increased from 17.3% to 30.0%, uninsured encounters decreased from 18.4% to 6.3%, and private payer encounters decreased from 14.1% to 13.3%. • The median reimbursement/encounter increased 4.2% from $79.98/encounter in 2013 to $83.36/encounter in 2014. • In a sensitivity analysis, changes in length of stay, proportions in encounter type by payer, payer mix, and reimbursement for encounter type by payer accounted for −0.7%, 0.8%, 2.0%, and 2.3% of the reimbursement change, respectively.
Michael McCue, "The Impact of Medicaid Expansion on Medicaid Focused Insurers in California," *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 52 (July 2015), http://inq.sagepub.com/content/52/0046958015595960.full.pdf+html	**California:** Assessed the enrollment, utilization, and financial performance measures of California Medicaid focused health insurers. Compares these quarterly measures during the expansion period of 2014 to the same quarterly measures in 2013 and 2012.	• The medical loss ratio for the Medicaid focused insurers trended downward each quarter in 2014 and declined to 86.6% for the fourth quarter of 2014, which was 330 basis points lower than the ratio for the 2013 fourth quarter. • Quarterly administrative cost ratios decreased over the four quarters of 2014 and were more than 100 basis points lower for three out of four quarters in 2013. • Quarterly profit margin ratios grew from 3.55% in the first quarter to 9.36% in the fourth quarter of 2014 compared with 1.99% in the first quarter and 4.79% in the last quarter of 2013.
Deloitte Development LLC, *Commonwealth of Kentucky Medicaid Expansion Report*, (Deloitte Development LLC, February 2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf	**Kentucky:** Examined progress toward the state's initial goals for its Medicaid expansion during the first 12 months of expansion (Jan. 1-Dec. 31. 2014). Also updated initial estimates from the 2013 Medicaid Expansion Whitepaper based on the first year of experience.	• KY hospitals experienced a reduction of $1.15 billion in uncompensated care charges when comparing the first three quarters of CY 2013 to the same period in CY 2014.
Arkansas Hospital Association, "Survey Reveals Private Option Impact on Hospitals," *The Notebook* 21, no. 33 (November 2014), http://www.arkhospitals.org/archive/notebookpdf/Notebook_11-03-14.pdf	**Arkansas:** Explained results of a survey conducted jointly by the Arkansas Hospital Association and the Arkansas Chapter of the Healthcare Financial Management Association in August and September on the impact of the private option expansion on the state's hospitals in terms of uninsured patient volumes and uncompensated care costs.	• During the first six months of 2014, the hospitals that responded to the survey (facilities that account for 80% of all hospital care provided in the state) reported marked reductions in the number of uninsured visits across all service settings. Uninsured inpatient visits decreased by 46.5%, uninsured emergency department visits decreased by 35.5%, and uninsured hospital outpatient clinic visits decreased by 36%. • A combination of higher numbers of insured patients and lower uninsured volumes caused hospitals' uninsured patient uncompensated care losses to fall by 56.4%, dropping from $122.6 million in 2013 to $53.4 million in 2014, yielding a total six-month benefit of $69.2 million.
Impacts on Employment and the Labor Market		
Nationwide Studies		
Jean Hall, Adele Shartzer, Noelle Kurth, and Kathleen Thomas, "Effect of Medicaid Expansion on Workforce Participation for People with Disabilities," *American Journal of Public Health* epub ahead of print (December 2016), http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303543?journalCode=ajph	**Nationwide:** Examined differences in employment among community-living, working-age adults with disabilities who live in expansion and non-expansion states. Used a difference-in-differences approach and 10 rounds of data (spanning the first quarter of 2013 through the third quarter of 2015) from the Urban Institute's Health Reform Monitoring Survey.	• After ACA implementation, adults with disabilities living in expansion states were significantly more likely to be employed compared with those in non-expansion states (38.0% vs. 31.9%). • After ACA implementation, adults with disabilities living in expansion states were significantly less likely to be unemployed because of disability compared with those in non-expansion states (39.7% vs. 48.4%). • Authors conclude that adults with disabilities in expansion states are able to access and maintain Medicaid coverage while earning at levels that would have made them ineligible for Medicaid coverage prior to expansion.

Pauline Leung and Alexandre Mas, *Employment Effects of the ACA Medicaid Expansions* (Working Paper No. 22540, National Bureau of Economic Research, August 2016), http://www.nber.org/papers/w22540	**Nationwide:** Compared employment in states that did and did not expand Medicaid, before and after adoption of the policy, through a differences-in-differences analysis. Since the primary source of private coverage is employer-sponsored coverage, study also examined whether Medicaid expansion caused crowd out of private insurance. Used data from the American Community Survey and the Current Population Survey.	• There was no statistically significant difference in employment rates, part-time employment (<20 hours/week), employment lock, or wages in expansion states compared to non-expansion states.
Angshuman Gooptu, Asako Moriya, Kosali Simon, and Benjamin Sommers, "Medicaid Expansion Did Not Result in Significant Employment Changes or Job Reductions in 2014," *Health Affairs* 35, no. 1 (January 2016): 111-118, 1-12, http://content.healthaffairs.org/content/35/1/111.short	**Nationwide:** Analyzed labor-market participation among adults below 138% FPL, comparing Medicaid expansion and non-expansion states and Medicaid-eligible and ineligible groups for the pre-ACA period (2005-2013) and the first 15 months of the expansion (January 2014-March 2015). Used Current Population Survey (CPS) basic monthly data.	• Found no significant changes in transitions from employment to nonemployment, the rate of job switches, or transitions from full- to part-time employment among low-income nonelderly adults in ACA expansion states, compared to those in non-expansion states. • The above results hold across a variety of subgroup and sensitivity analyses. When those who were likely eligible for Medicaid before the ACA were excluded, Medicaid expansion was associated with a 1.6-percentage-point increase (of borderline significance) in the likelihood of transitioning out of employment, while the effects on the rate of job switching and the likelihood of transitioning from full- to part-time employment were not statistically significant. When all parents were excluded, found that the results among childless adults were similar to those in the main specification (first bullet above, no significant changes).
Robert Kaestner, Bowen Garrett, Anuj Gangopadhyaya, and Caitlyn Fleming, *Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply* (Working Paper No. 21836, National Bureau of Economic Research, December 2015), http://www.nber.org/papers/w21836	**Nationwide:** Examined the effect of the ACA Medicaid expansions on health insurance coverage and labor supply among adults with a high school education or less. Relied on data from the American Community Survey and the Current Population Survey for the 2010 to 2014 period. Used two research designs: difference-in-differences and synthetic control.	• Medicaid expansions had little effect on labor supply among adults with a high school education or less as measured by employment, usual hours worked per week, and the probability of working 30 or more hours per week. • Most estimates suggested that the expansions increased employment among adults with a high school education or less slightly, although not significantly. • Found very little evidence that Medicaid expansions decreased work effort, and confidence intervals associated with estimates ruled out large behavioral responses in this area.
Bowen Garrett and Robert Kaestner, *Recent Evidence on the ACA and Employment: Has the ACA Been a Job Killer?* (Washington, DC: The Urban Institute and the Robert Wood Johnson Foundation, August 2015), http://www.urban.org/research/publication/recent-evidence-aca-and-employment-has-aca-been-job-killer/view/full_report	**Nationwide:** Examined the overall effects of the ACA on four measures of labor supply for nonelderly adults: labor force participation, employment, part-time employment, and the usual number of hours worked per week among workers. Also examined the effects of ACA Medicaid expansions specifically on the same four measures. Used data from the monthly files of the Current Population Survey from January 2000 to December 2014.	• The ACA had virtually no adverse effect on labor force participation, employment, or usual hours worked per week through 2014. This conclusion was true for ACA policies overall and for the Medicaid expansions in particular, and it applied to the full sample of nonelderly persons as well as the subgroup of nonelderly persons with a high school education or less who are more likely to be affected by the ACA. • For nonelderly adults with a high school education or less, employment in 2014 was 1.8 percentage points higher than what would be expected given the rates of unemployment, demographic characteristics, and pre-existing time trends. • Part-time employment for nonelderly adults with a high school education or less was 0.5 percentage points higher than expected. With this small difference, the researchers found no evidence of a change in the number of hours worked in 2014 and thus no overall change in labor supply beyond what would be expected. • The ACA's Medicaid expansions had virtually no effect on labor market outcomes through the end of 2014.
Single State Studies		

John Ayanian, Gabriel Ehrlich, Donald Grimes, and Helen Levy, "Economic Effects of Medicaid Expansion in Michigan," *The New England Journal of Medicine* epub ahead of print (January 2017), http://www.nejm.org/doi/full/10.1056/NEJMp1613981	**Michigan:** Assessed the effects of Medicaid expansion on economic outcomes in Michigan. Used the PI+ software developed by Regional Economic Models to estimate how increased federal funding for health care services covered by the Medicaid expansion affects employment, personal income, and state tax revenues in Michigan.	• Estimated additional employment associated with increased Medicaid spending peaked at over 39,000 jobs in 2016. • About two-thirds of the additional jobs created by expansion are outside the health care sector. • Projections: Between 2014 and 2021, the increased personal income associated with new employment is expected to be relatively stable, at $2.2 billion to $2.4 billion per year. Between 2014 and 2021 the added economic activity is projected to yield approximately $145 million to $153 million annually in new state tax revenue.
The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (The Ohio Department of Medicaid, January 2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf	**Ohio:** Examined the effects of OH's 2014 Medicaid expansion on expansion (Group VIII) enrollees. When appropriate, compared Group VIII enrollees to those enrolled in OH Medicaid under pre-expansion eligibility rules. Used numerous data collection methods, including a detailed telephone survey of 7,508 expansion and pre-expansion enrollees, medical record reviews and biometric screenings of subsets of the survey sample, an analysis of administrative data for enrollees, focus groups of 27 enrollees, and interviews with 10 service providers and other key stakeholders.	• Employment rates were similar for expansion and pre-expansion enrollees (43.2% versus 41.5%). • Most study participants reported that enrollment in Medicaid made it easier to work and to seek work. • Three-quarters of the expansion enrollees (74.8%) who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. For those who were currently employed, 52.1% reported that Medicaid enrollment made it easier to continue working.
The Colorado Health Foundation, *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado,* (The Colorado Health Foundation, March 2016), http://www.coloradohealth.org/studies.aspx	**Colorado:** Updated a 2013 study and examined actual results of the expansion after two years of experience in CO. Forecasted the economic and budgetary impacts of expansion out to FY 2034-2035.	• As of FY 2015-2016, CO's economy supports 31,074 additional jobs due to Medicaid expansion. As of FY 2015-2016, average annual household earnings in CO are $643 higher—this change is associated with the stimulative effect of the Medicaid expansion. • Projections: By FY 2034-2035, that number will grow to 43,018, resulting in total employment that is 1.35% larger than it would be without Medicaid expansion. By FY 2034-2035 average household earnings will be $1,033 higher.
Deloitte Development LLC, *Commonwealth of Kentucky Medicaid Expansion Report,* (Deloitte Development LLC, February 2015), http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf	**Kentucky:** Examined progress toward the state's initial goals for its Medicaid expansion during the first 12 months of expansion (Jan. 1-Dec. 31. 2014). Also updated initial estimates from the 2013 Medicaid Expansion Whitepaper based on the first year of experience.	• Medicaid expansion created more than 12,000 jobs in SFY 2014 including 5,400 health care and social service jobs. • Projection: Medicaid expansion will create more than 40,000 jobs in KY through SFY 2021 with an average salary of about $41,000.