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State Health Care Spending on Medicaid

A 50-state study of trends and drivers of cost

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes. For additional information, visit pewtrusts.org.

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Overview

Medicaid is the largest health insurance program in the United States, covering both acute and long-term care services for over 66 million low-income Americans—children and their parents, as well as elderly and disabled individuals.*,[1] But having long served as the primary safety-net insurer for many of the most vulnerable Americans, Medicaid is undergoing its biggest change since its inception five decades ago because of the implementation of the Affordable Care Act.[2] These changes will affect which individuals—and how many—may enroll in the program and how care is delivered.[3] Policymakers in the 50 states and the District of Columbia, cautious about Medicaid's claim on state revenue, need to know how the changes will affect state budgets and residents' health.

This report, the first in a series, focuses on the impact of Medicaid on the states, including trends in spending and enrollment, and the anticipated effects of the Affordable Care Act. Tracking these trends is critical, particularly as the rollout of the new health law continues.

About the series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, is examining seven key areas of state health care spending—Medicaid, the Children's Health Insurance Program, substance abuse treatment, mental health services, prison health care, active state government employee benefits, and retired state government employee benefits. The project will provide a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research will highlight those variations and some of the key factors driving them. The project is concurrently releasing state-by-state data on 20 key health indicators to complement the programmatic spending analysis. For more information, see pewtrusts.org/healthcarespending.

Background

The Medicaid program

Medicaid, the nation's largest health insurance program, covers 66 million people—nearly 22 percent of the U.S. population in 2010—including low-income children, parents, people with disabilities, and the elderly.[4] During economic downturns, unemployment soars, state revenue shrinks, and the number of Medicaid-eligible Americans increase—a combination that places financial strain on state budgets.[5] In 2012, spending on Medicaid totaled $429 billion. By comparison, Medicare covered a smaller portion of the population at a cost of over $570 billion.[6]

The role of the federal government in Medicaid

Although Medicaid is a state-administered program, the federal government funds at least 50 percent of each state's Medicaid spending.[7] The federal contribution to the Medicaid program is the states' largest source of federal revenue and therefore plays a complicated role in state budgets because cutting state Medicaid spending triggers decreases in federal revenue to states on at least a dollar-to-dollar basis.[8] (See Figure 1.)

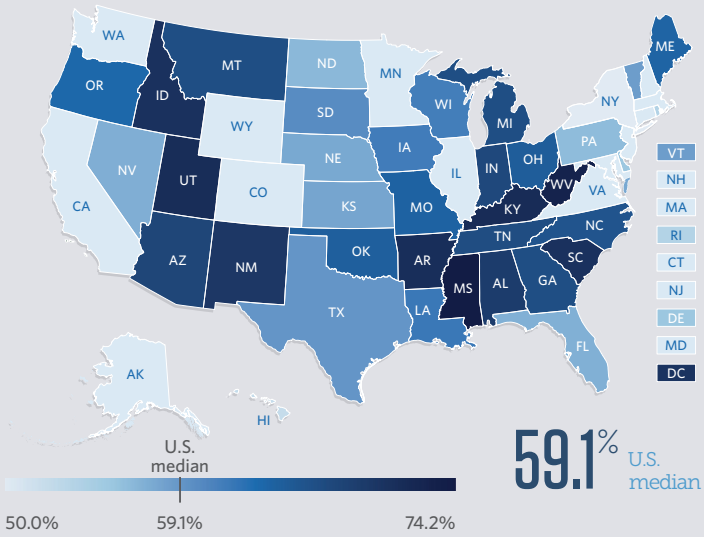
* Overall, Medicare costs slightly more than Medicaid, but it insures fewer people.

Figure 1

Medicaid's Federal-State Funding

Medicaid is funded by a combination of federal and state funds. The amount of federal funding received by each state for health care services is determined annually through a formula—the Federal Medical Assistance Percentage, or FMAP—which reflects a state's average per-capita income of residents relative to the national average.* In the federal fiscal year that ended Sept. 30, 2012, FMAP ranged from the minimum of 50 percent of Medicaid payments for services, in 14 states, to a high of 74 percent in one state.† In contrast, most administrative functions are paid equally by state and federal funds.‡

Percentage of Medicaid payments for services paid by federal funds, 2012



* National Health Policy Forum, *The Basics: Medicaid Financing* (Washington: National Health Policy Forum, 2013), accessed Feb. 12, 2014, http://www.nhpf.org/library/the-basics/Basics_MedicaidFinancing_02-13-13.pdf; Social Security Act of 1935, 42 U.S.C. § 1396d(b) (1935), accessed April 15, 2014, http://www.gpo.gov/fdsys/pkg/USCODE-2008-title42/html/USCODE-2008-title42-chap7-subchapXIX-sec1396d.htm.

† Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures: Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2011 through September 30, 2012," *Federal Register* 75, no. 217 (Nov. 10, 2010), 69082–83, accessed April 1, 2014, https://www.federalregister.gov/articles/2010/11/10/2010-28319/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for.

‡ Centers for Medicare & Medicaid Services, "Medicaid Administrative Claiming," accessed Feb. 19, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Administrative-Claiming.html.

Source: "Federal Financial Participation in State Assistance Expenditures" Federal Register 75 no. 217: 69082-83.

The federal government sets the minimum Medicaid eligibility level based on income and disability status and the minimum benefit package that all states must offer.[9] Such benefits include physician services, lab and X-ray services, inpatient and outpatient hospital services, and "early and periodic screening, diagnostic, and treatment" (or EPSDT) services for children.[10] State Medicaid programs and their spending vary greatly because, among other things, many states have made policy decisions to expand their programs along at least one of the two facets: eligibility levels or benefits offered. [11]

Variation in state Medicaid programs

States' total Medicaid spending varies widely because of several factors, some of which are controlled by state policymakers.[12] (See Table 1.)

Table 1

Factors Influencing Medicaid Spending Are Not Always Within State Policymakers' Control.

Examples of factors influencing state Medicaid program spending

Factors under the control of state policymakers	Factors outside the control of state policymakers
Breadth of program benefits: States can offer optional benefits such as prescription drug coverage, physical therapy, optometry, adult dental, and hospice services.*	**Underlying cost of services in the state:** Cost-of-living differences, provider wages, and provider market power drive differences in states' Medicaid bills.†
Income eligibility levels: States can offer full or partial Medicaid benefits to individuals earning more than the federally required minimums.‡	**Demographics of the state's population:** States with a higher proportion of people with disabilities and chronic conditions, or those who are elderly and poor, tend to have higher Medicaid enrollment and costs.§
Provider reimbursement rates: States independently set provider payment rates for services and set capitation rates with health plans.¶	**Federal contribution to Medicaid:** The share of expenditures that the state is responsible for is determined by the FMAP formula, which is based on residents' per-capita income.**
State revenue: In order to fund their share of Medicaid and other programs, states collect revenue, primarily from taxes and fees.††	

* Centers for Medicare & Medicaid Services, "Medicaid Benefits," accessed Feb. 6, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.

† Laura Snyder et al., *Why Does Medicaid Spending Vary across States: A Chart Book of Factors Driving State Spending* (Washington: Kaiser Family Foundation, 2012), accessed Feb. 19, 2014, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8378.pdf.

‡ Centers for Medicare & Medicaid Services, "Eligibility," accessed April 30, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html.

§ Snyder et al., *Why Does Medicaid Spending Vary*.

¶ Ibid. A capitation rate is the contracted monthly payment that a managed care organization receives for enrollees covered by the health plan. (Source: Patrick C. Alguire, "Understanding Capitation," American College of Physicians, accessed: April 7, 2014, http://www.acponline.org/residents_fellows/career_counseling/understandcapit.htm.)

** Alison Mitchell and Evelyne P. Baumrucker, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014* (Washington: Congressional Research Service, 2013), accessed March 14, 2014, https://www.fas.org/sgp/crs/misc/R42941.pdf.

†† Snyder et al., *Why Does Medicaid Spending Vary*.

State-level trends in Medicaid spending and enrollment

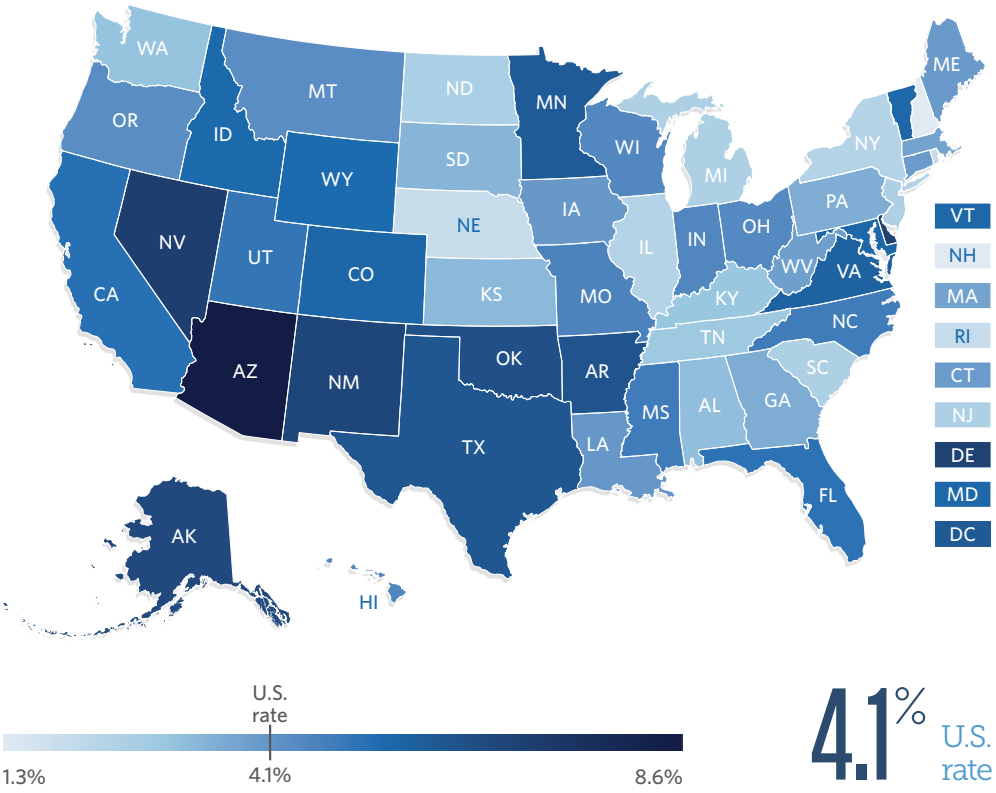
Trends in Medicaid spending

Between 2000 and 2012, total Medicaid spending—by states and the federal government—increased at a 4.1 percent compound annual growth rate, or CAGR, after adjusting for inflation.* In 2012 dollars, spending increased from $263 billion to $429 billion nationwide. Growth varied by state due to a range of factors, including state-specific policy decisions about Medicaid benefits and eligibility rules, the health status and income of residents, and the strength of the state's economy.[13] (See Figure 2.) Arizona, for example—which experienced an 8.6 percent CAGR in total Medicaid spending from 2000 to 2012—began offering full Medicaid benefits to childless adults whose incomes were below the federal poverty level, or FPL, in 2001.[14] This change in eligibility set the stage for high enrollment growth of 20 to 30 percent per year and high spending growth in the few years following this change.

Figure 2

Medicaid Spending Growth Ranged From Approximately 1-9 Percent Annually

Total Medicaid spending CAGR, inflation adjusted, 2000-12



Note: Medicaid spending data are reported by federal fiscal year.

Source: Pew analysis of data from the Centers for Medicare & Medicaid Services

* The compound annual growth rate shows the smoothed year-over-year growth in spending over a period of time. (Source: Investopedia, "Compound Annual Growth Rate—CAGR," accessed April 7, 2014, http://www.investopedia.com/terms/c/cagr.asp.)

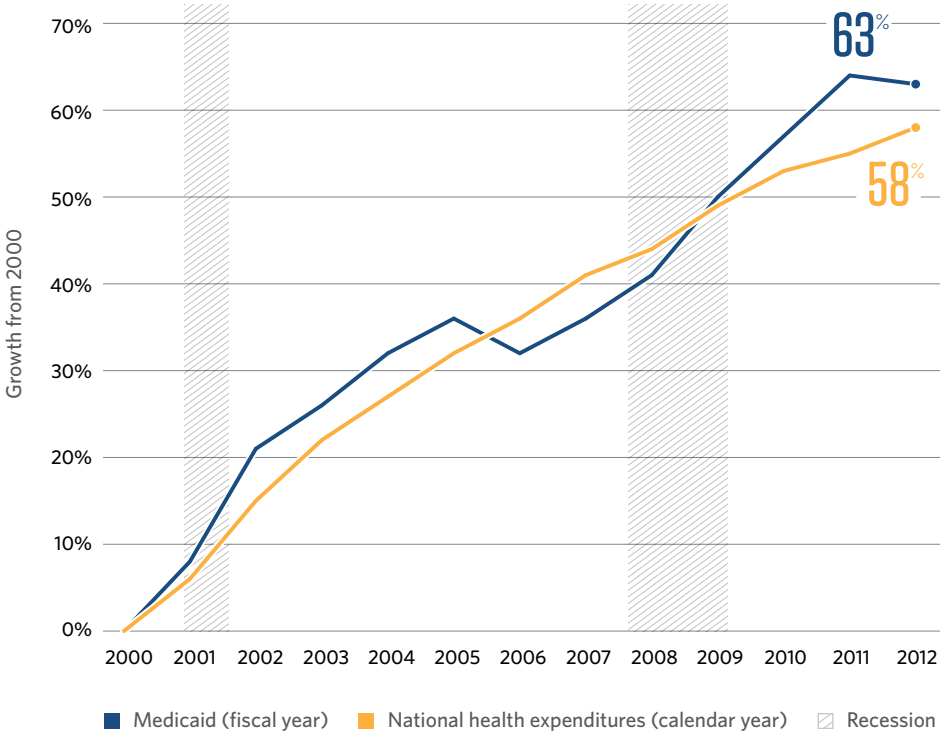
Looking at the cumulative growth over the same period, total Medicaid spending grew 63 percent after adjusting for inflation, from $263 billion to $429 billion.* This rate paralleled the 58 percent increase in overall national health care expenditures, which include public and private spending, during this time. Increased spending in Medicaid was largely driven by increases in enrollment stemming from economic downturns.[15] (See Figure 3.)

Medicaid spending is also subject to factors that affect all of the nation's health care spending, such as medical-price inflation, the introduction of new medications and technologies, the increasing prevalence of chronic disease, and the related increased use of medical services.[16]

Figure 3

Medicaid Spending Growth Paralleled That of the Nation's Overall Spending on Health Care

Total Medicaid spending and national health expenditures, inflation-adjusted growth, 2000–12



Notes: The horizontal axis represents the federal fiscal year.

Medicaid spending data are reported by federal fiscal year, while national health expenditures are reported by calendar year.

The recessions shown lasted from March to November 2001 and December 2007 to June 2009.

The dip in Medicaid spending that started in 2006 was driven by the onset of coverage of prescription drugs under Medicare Part D for "dually eligible" individuals—people with both Medicaid and Medicare coverage. This reduction was largely offset by separate "clawback" payments from states to the federal government, which are not captured in this analysis.

Source: Pew analysis of data from the Centers for Medicare & Medicaid Services

* Medicaid spending in 2000 is expressed in 2012 dollars.

Enrollment in Medicaid

Medicaid covers more than 20 percent of Americans over the course of the year. Enrollment varies across states because of factors such as poverty rates, state decisions to expand coverage above federal minimums, and the reach of employer-sponsored health insurance.[17] (See Figure 4.)

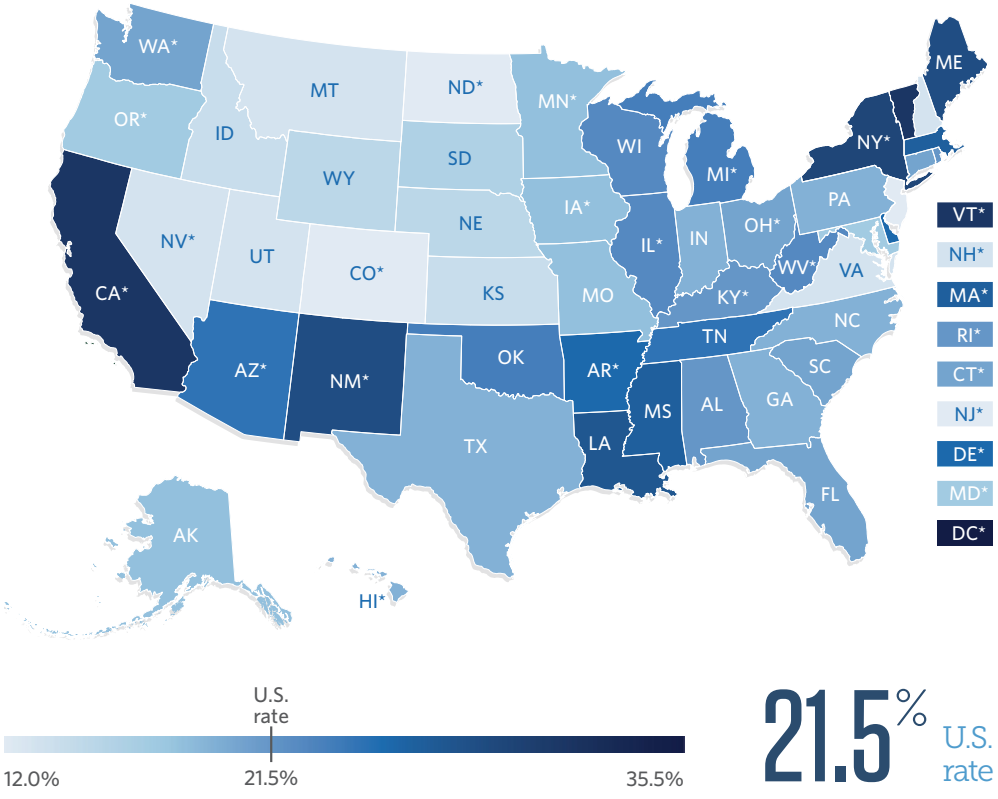
In 2010, states with the highest percentage of residents below the FPL—New Mexico, Mississippi, and the District of Columbia—also were among those with the highest percentage of residents enrolled in Medicaid.[18] Other states with high Medicaid enrollment rates provided at least limited Medicaid coverage to individuals above federal requirements.[19] California's Medicaid program, for example, covers only family planning services for 1.8 million people otherwise ineligible for Medicaid.[20] Vermont provides full Medicaid benefits to nondisabled adults at a level substantially above the federal minimum requirement.[21]

The percentage of state residents covered by Medicaid will increase dramatically starting this year in states that expand their Medicaid eligibility through the Affordable Care Act.[22]

Figure 4

State Medicaid Enrollment Varied Widely From 12–36 Percent of Residents

Percent of residents enrolled in Medicaid, 2010



* Expanding Medicaid under the Affordable Care Act, as of April 2014.

Note: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year, and the number of state residents are midyear point-in-time estimates.

Source: Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, and U.S. Census Bureau data

Comparing Medicaid enrollment trends with other health insurance coverage

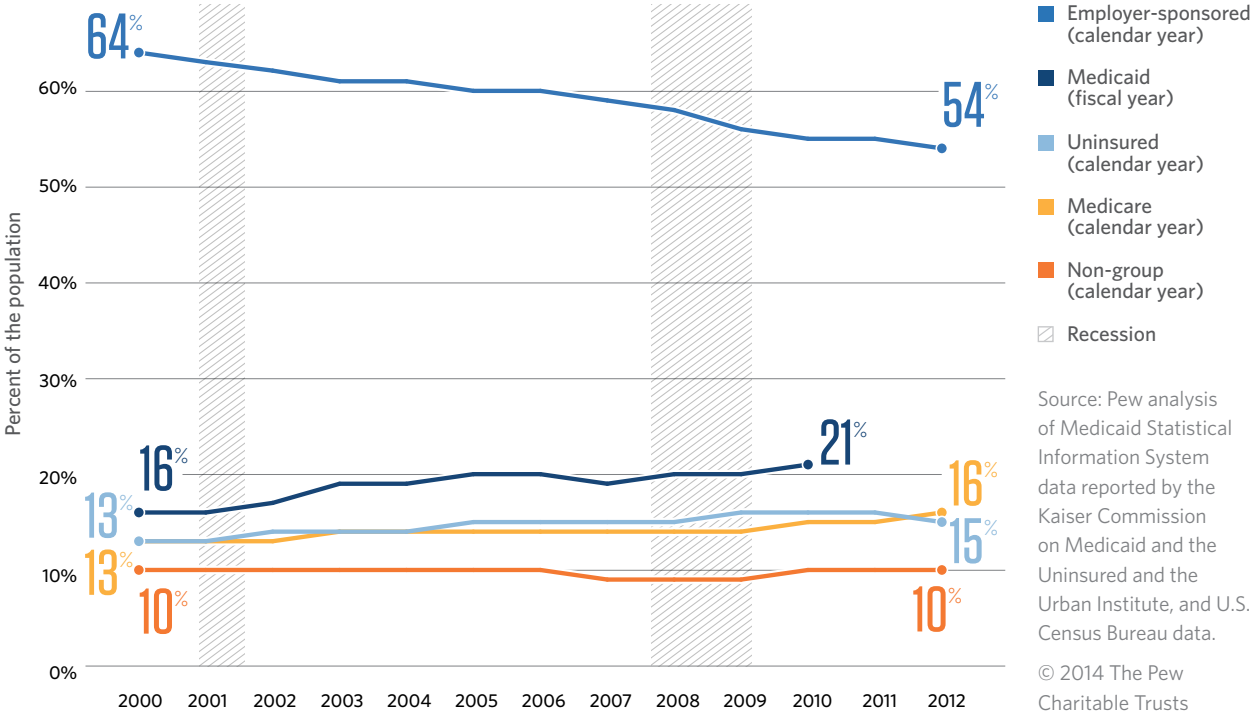
The proportion of Americans covered by employer-sponsored health insurance decreased between 2000 and 2012, with declines particularly pronounced during economic downturns. (See Figure 5.) In contrast, enrollment in Medicaid and Medicare increased during those times, as did the percentage of uninsured Americans. Although actual Medicaid enrollment data are available only through 2010, U.S. Census Bureau survey estimates show that Medicaid enrollment continued to rise in 2011 but leveled off in 2012.[23]

Medicaid enrollment increased 50 percent over the last decade, from 44 million to 66 million people. This growth is one of the major drivers of the program's increases in spending over this time.[24] Growth occurred again under the Affordable Care Act. Medicaid enrollment started to increase in 2014, especially in states that expanded their programs to cover previously ineligible low-income childless adults.[25]

Figure 5

Since 2000, Public Insurance Coverage and Uninsured Rates Increased While Employer-Sponsored Insurance Coverage Dropped

Health insurance coverage by source as a percent of the population, 2000–12



Source: Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, and U.S. Census Bureau data.

Notes: The horizontal axis represents the federal fiscal year.

Data do not add up to 100 percent because some enrollees have multiple sources of health insurance coverage. In addition, not all insurance sources, such as military coverage, are captured in this graph.

Due to lags in reporting, comparable data are not available on the number of state residents enrolled in Medicaid in 2011 and 2012.

Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year. The number of residents who are uninsured or enrolled in employer-sponsored insurance, non-group insurance, and Medicare are reported by calendar year. Population data are midyear point-in-time estimates.

The recessions shown lasted from March to November 2001 and December 2007 to June 2009.

Total Medicaid spending, per enrollee

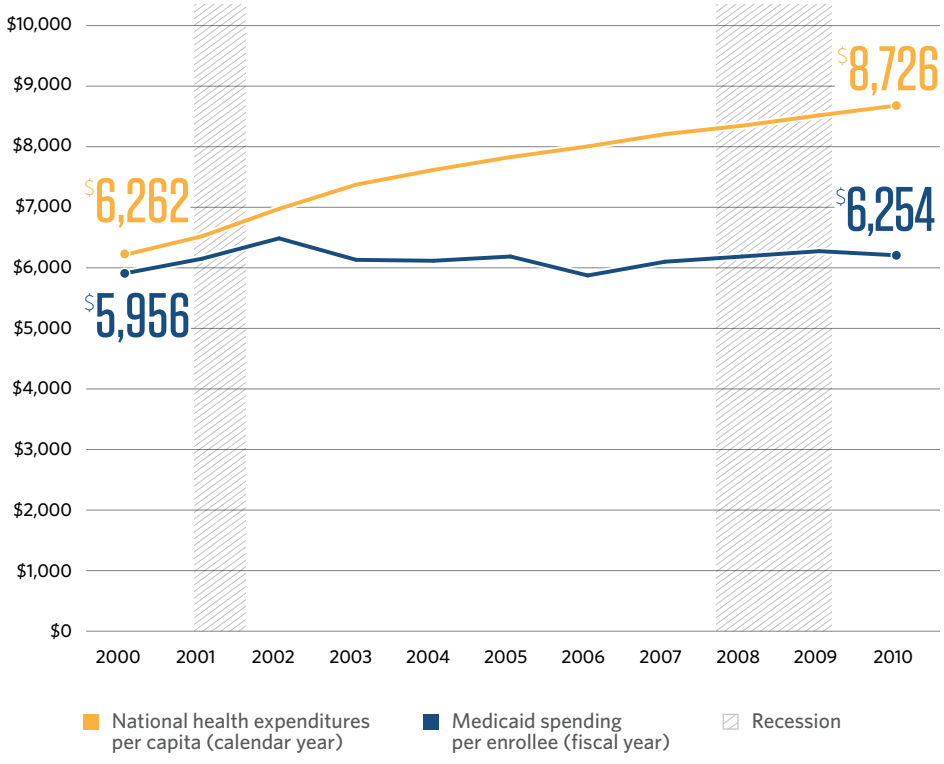
On a per-enrollee basis, Medicaid spending has remained relatively stable over the past decade, rising by only 5 percent after adjusting for inflation, from $5,956 in 2000 to $6,254 in 2010. This is substantially less than the overall health care spending per resident in the United States, which increased by 39 percent over the same period to just over $8,700 per resident. (See Figure 6.)

While spending in Medicaid is subject to many of the same cost drivers as overall health care, its costs are moderated by several factors, including low provider-reimbursement rates.[26,*] In 2012, for example, Medicaid paid physicians on average 66 percent of what Medicare paid for services, down from 72 percent in 2008. Furthermore, both Medicaid and Medicare pay providers significantly less than what they receive from private payers.[27] Low reimbursement rates decrease the willingness of providers to treat Medicaid enrollees, which sometimes limits enrollees' access to health care services.[28]

Figure 6

Medicaid Spending per Person Grew Slower Than That of the Nation's Overall Spending on Health Care

Total Medicaid spending per enrollee versus National Health Expenditure Accounts per United States resident, inflation adjusted, 2000–10



Notes: The horizontal axis represents the federal fiscal year.

Expenditures are expressed in 2012 dollars.

Medicaid spending data are reported by federal fiscal year, while national health expenditures are reported by calendar year.

The recessions shown lasted from March to November 2001 and December 2007 to June 2009.

Source: Centers for Medicare & Medicaid Services, Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, and U.S. Census Bureau data

* This statement refers specifically to provider reimbursement rates in Medicaid fee-for-service programs. In Medicaid managed care programs, states contract with managed care organizations, or MCOs, to deliver care for a set fee; data are not available on the rates at which MCOs reimburse their contracted providers. Approximately 70 percent of Medicaid enrollees are served through managed care delivery systems. (Source: Centers for Medicare & Medicaid Services, "Financing & Reimbursement," accessed April 15, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html.)

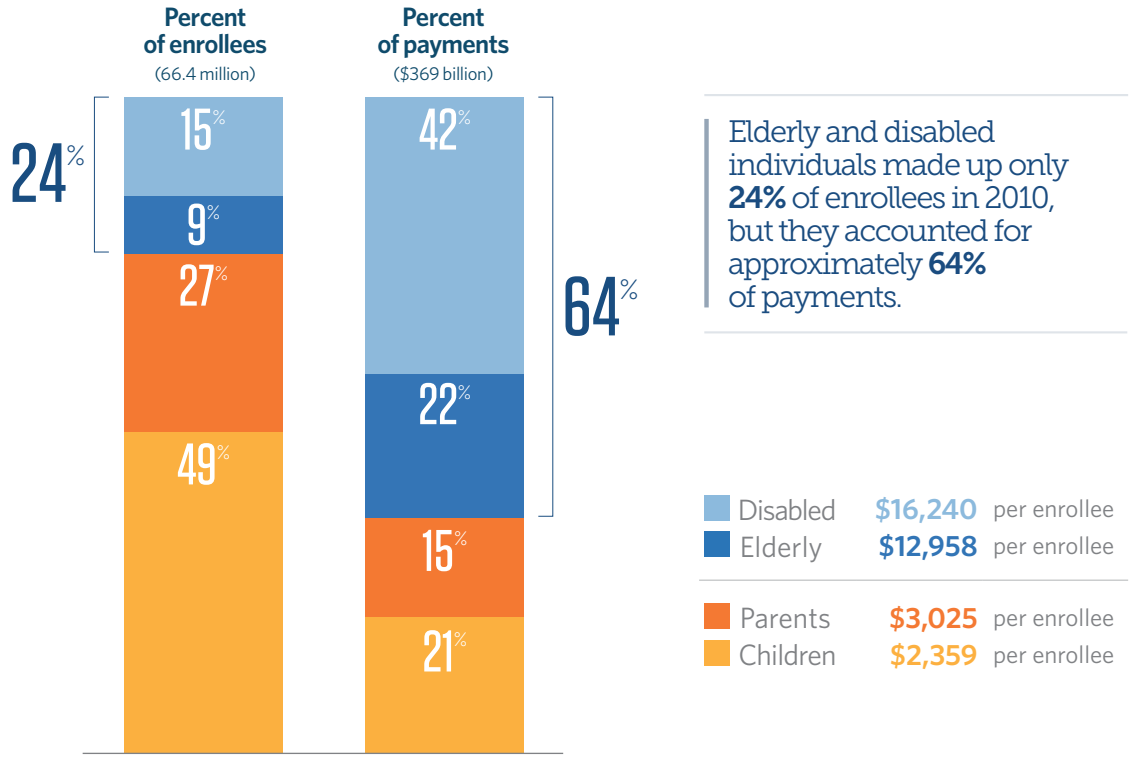
Composition of Medicaid enrollees

In practice, Medicaid functions as two separate insurance programs for low-income individuals, one for children and parents and the other for elderly and disabled individuals of all ages. Elderly and disabled individuals made up only 24 percent of all Medicaid enrollees in 2010, but they accounted for approximately 64 percent of spending on benefits because they are more likely to have complex health care needs that require costly acute and long-term care services.[29,*] (See Figure 7.) As a result of their high cost per capita, the proportion of a state's Medicaid beneficiaries who are elderly and disabled is a major driver of Medicaid spending.[30] On average, Medicaid spends over five times more on these people than on parents and children with Medicaid coverage.

Figure 7

A Small Portion of Medicaid Enrollees Accounts for the Majority of Spending

Distribution of Medicaid enrollment and payments for services by enrollment group, 2010



Note: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year, and payments for services data are reported by federal fiscal year.

Source: Pew analysis of Medicaid Statistical Information System and CMS-64 data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute

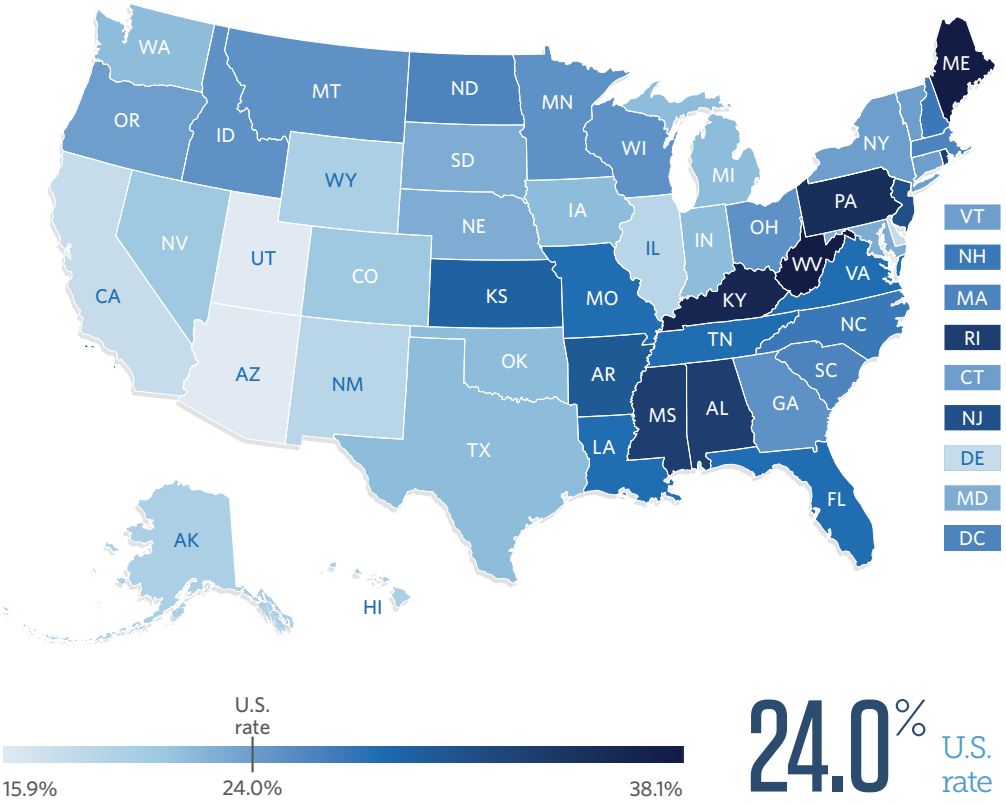
* Unlike employer-sponsored health insurance and Medicare, Medicaid covers long-term care services and supports for its enrollees. (Source: National Health Policy Forum, The Basics: National Spending for Long-Term Services and Supports (LTSS), 2012 (Washington: George Washington University, 2014), accessed April 16, 2014, http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf.)

State variation in the percentage of Medicaid enrollees who are elderly or disabled—ranging from 16 percent in Arizona to 38 percent in Maine—can be driven in part by differences in the health and demographic makeup of the state's population as well as by the Medicaid eligibility thresholds set by the state.[31] (See Figure 8.)

Figure 8

Share of Enrollees Who Are Elderly and/or Persons With Disabilities

Elderly and/or disabled enrollees as a percent of total Medicaid enrollment, 2010



Note: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year.

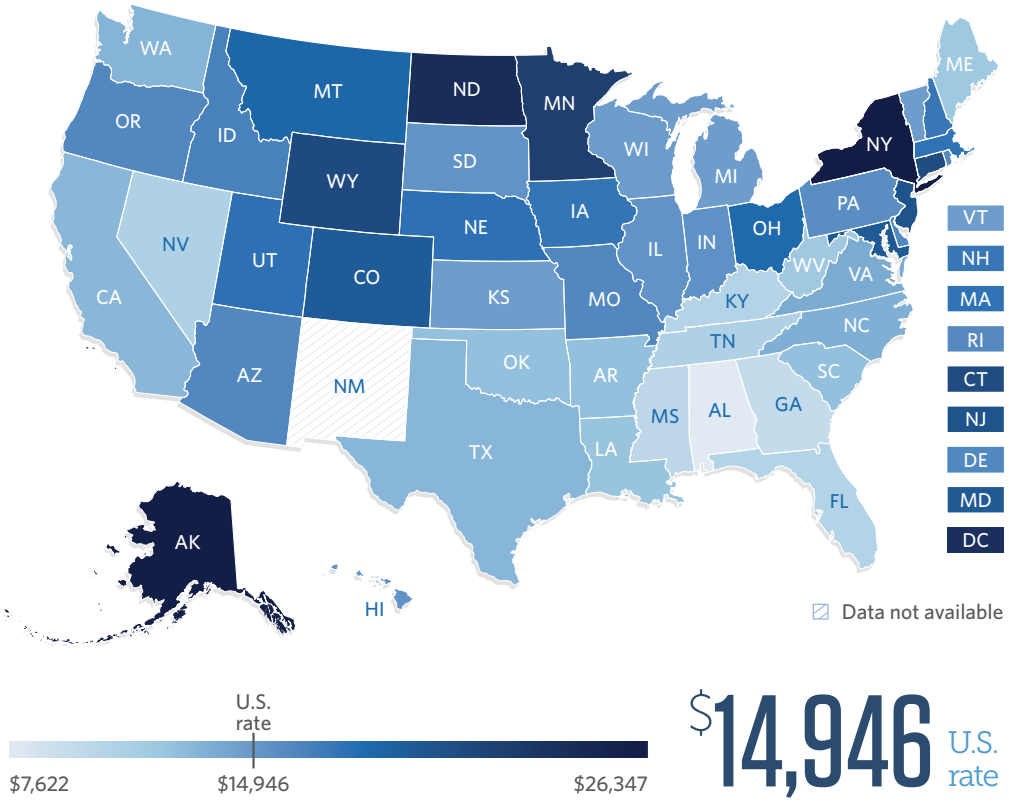
Source: Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute

In 2010, the average Medicaid expenditure per elderly and disabled enrollee was $14,946, ranging from nearly $8,000 in Alabama to nearly $27,000 in New York. (See Figure 9.) In contrast, the average Medicaid expenditure per child and parent was much lower, ranging from $1,354 in California to $5,227 in Alaska. Factors that affect this variation include program eligibility and optional benefits, provider payment rates, pharmaceutical discounts, regional differences in the cost of providing health care and the health status and poverty rate of the population.[32] Many of these factors influence variation across states in per-person spending for all insured individuals, regardless of the source of their health insurance coverage.[33]

Figure 9

The Cost Per Elderly and/or Disabled Enrollee Ranged From Approximately $8,000–26,000

Total Medicaid payments per elderly and/or disabled enrollee, 2010



Note: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year. Medicaid spending data are reported by federal fiscal year.

Source: Pew analysis of Medicaid Statistical Information System data and CMS-64 data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute

The state share of Medicaid spending

Medicaid is funded by a combination of state and federal funds.[34] In 2012, states spent $181 billion of their own funds on Medicaid. State spending on Medicaid is second only to spending on primary and secondary education, which cost states $270 billion nationwide.[35]

To put the state share of Medicaid spending in context, states spent 16 percent of their state-generated funds on Medicaid. State-generated funds—or own-source revenue—are funds that states raise on their own, primarily through taxes and fees, and do not include any federal revenue, such as matching dollars or grants.[36, *]

* In this analysis, state revenue from localities is included in own-source revenue because in some states, local funding plays a substantial role in what is considered the state share of Medicaid spending.

The proportion of states' own-source revenue spent on Medicaid varies greatly, from 5 percent in North Dakota to 26 percent in New York. (See Figure 10.) This variation is attributable not only to state Medicaid policy decisions—the breadth of health care services covered, eligible populations, and provider payment rates—but also tax and other policy decisions that determine states' revenues.[37]

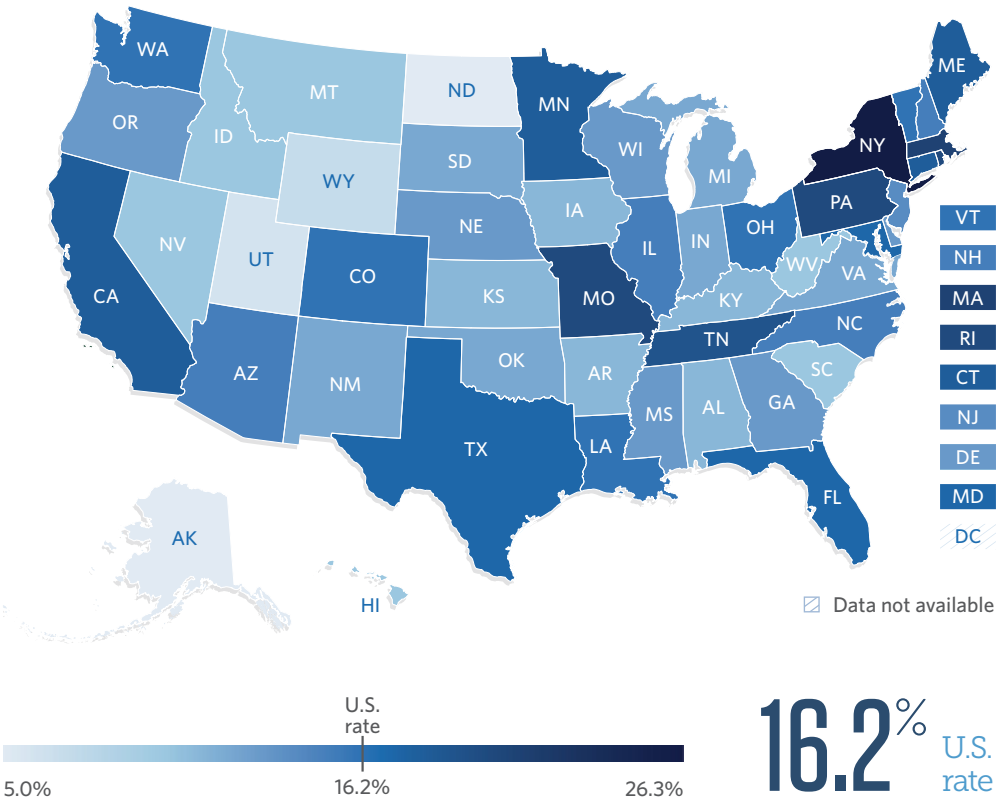
Variation is also driven by factors outside of policymakers' control, such as state economic performance, demographics, state resident health status, and regional differences in the cost of providing health care services.[38]

As a percentage of own-source revenue, New York's and Massachusetts' Medicaid spending is among the highest in the nation. These states also have among the highest Medicaid enrollments—at least 25 percent of their populations—relatively generous benefit packages, very high costs of health care services, and the minimum federal matching rates (50 percent).[39] In contrast, North Dakota and Alaska have the country's highest own-source revenue per resident, largely due to energy-related income, which makes Medicaid spending a smaller portion of the states' revenues.[40]

Figure 10

States Spent Between 5-26 Percent of Their Own Funds on Medicaid

State-funded Medicaid expenditures as a percent of state own-source revenue, 2012



* Data were not available for the District of Columbia.

Note: Medicaid spending data are reported by federal fiscal year, while state revenue data reflect each state's fiscal year.

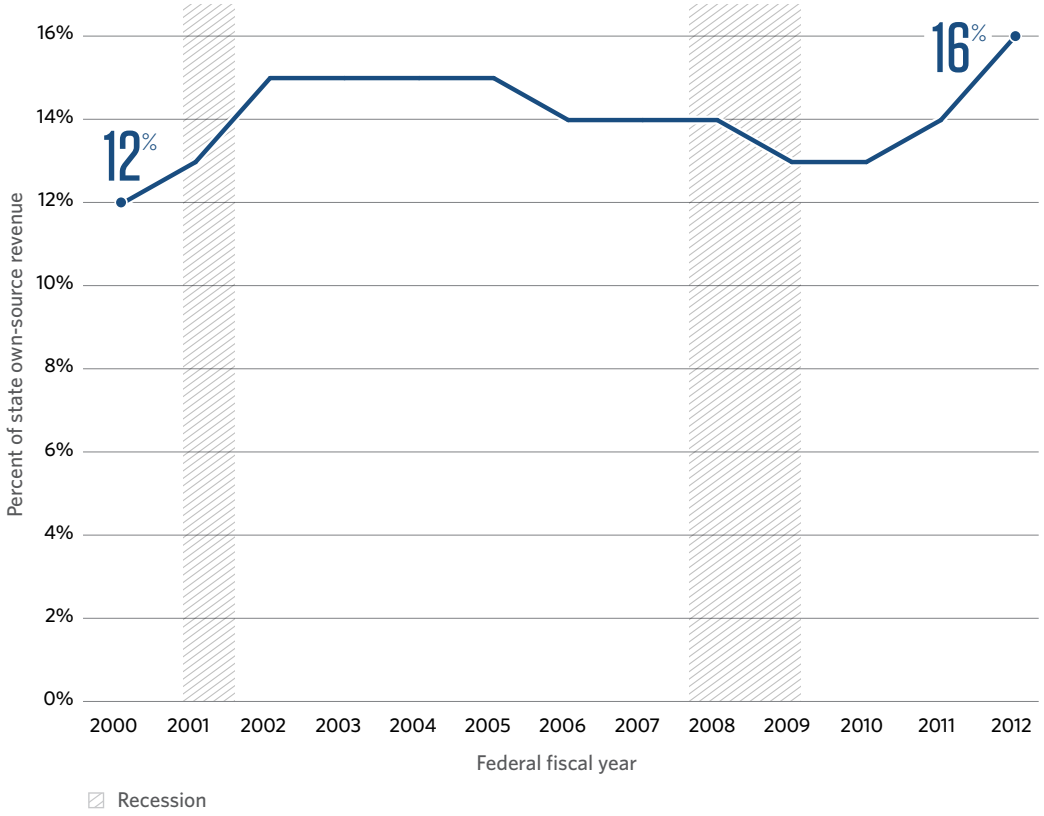
Source: Pew analysis of data from the Centers for Medicare & Medicaid Services, and the U.S. Census Bureau

State spending on Medicaid increased from 12 percent of states' own-source revenues to 16 percent between 2000 and 2012. (See Figure 11.) Most of this growth occurred in the wake of economic downturns during which unemployment rates soared, state revenue shrank, and enrollment in Medicaid increased.[41] During the Great Recession of 2007-09, this effect in the states was delayed because the federal government helped fund increased Medicaid enrollment by temporarily enhancing its funding for the program under the American Recovery and Reinvestment Act of 2009.[42] This enhanced federal funding was phased out between December 2010 and June 2011, but with enrollment remaining high, states' Medicaid spending as a percentage of their own-source revenue began to rise.[43]

Figure 11

The Share of State-Generated Revenues Spent on Medicaid Increased

State-funded Medicaid expenditures as a percent of state own-source revenue, 2000–12



Notes: Medicaid spending data are reported by federal fiscal year, while state revenue data reflect each state's fiscal year.

The recessions shown lasted from March to November 2001 and December 2007 to June 2009.

The dip in Medicaid spending starting in 2006 was driven by the onset of coverage of prescription drugs under Medicare Part D for "dually eligible" individuals who have both Medicaid and Medicare coverage. The reduction was largely offset by separate "clawback" payments from states to the federal government, which are not captured in this analysis.

Source: Pew analysis of data from the Centers for Medicare & Medicaid Services, and the U.S. Census Bureau

Anticipated effects of the Affordable Care Act

The new health care law will result in substantial changes to state and federal Medicaid spending over the next several years.[44] The extent of these changes is difficult to predict, though it is clear that the main causes will include expanded Medicaid eligibility and increased enrollment, as well as reduced spending by hospitals as the number of uninsured patients declines.[45]

Medicaid expansion

Enrollment in Medicaid is expected to rise sharply in the 26 states and the District of Columbia that had chosen, as of April 2014, to expand their Medicaid eligibility under the Affordable Care Act.[46,*] Before this law, few states offered coverage to childless adults without disabilities regardless of their income, and the eligibility level for parents varied substantially.[47] Now, adults younger than 65 in the states expanding their Medicaid programs can qualify for the coverage as long as they earn 138 percent of the FPL or less, which in 2014 works out to about $16,000 for an individual and $33,000 for a family of four.[48]

The federal government is covering 100 percent of the costs for these newly eligible enrollees in 2014, which will gradually drop to 90 percent by 2020.[49] States can provide "traditional" Medicaid benefits to newly eligible Medicaid enrollees, or a specified benchmark or alternative set of benefits which include the essential health benefits.[50,†]

In the 24 states that chose not to expand their Medicaid programs as of April 2014, enrollment is still expected to rise because of new applications by previously eligible individuals who are applying because of heightened public attention to Medicaid and other health insurance coverage, and a substantially more user-friendly Medicaid application process.[51] For these people, however, states will receive only their current Medicaid match from the federal government of 50 to 74 percent of health care costs—not the much higher match that will be paid for the newly eligible.[52]

There is much debate about the Affordable Care Act's impacts on Medicaid costs. States that expand will incur increased expenses resulting from the greater participation of previously eligible individuals who had not enrolled.[53] In addition, as the federal government reduces funding for newly eligible enrollees from 100 percent to 90 percent over the remainder of this decade, states will have to fund the balance.[54] Such concerns are cited by some states that have chosen not to expand.[55] On the other hand, states that are expanding hope to improve the health of their residents over time and shrink state costs for their care by significantly increasing public insurance for poor, childless adults and others previously ineligible.[56] Ideally, the easier availability of routine, coordinated care will result in a reduced reliance on costly episodic, acute care and, more broadly, lead to a healthier, more-productive workforce and better performance in health indicators.[57]

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* In June 2012, the U.S. Supreme Court invalidated the provision of the Affordable Care Act that eliminated federal Medicaid funding to states that did not expand Medicaid. In effect, this decision gave states the option to expand Medicaid. (Source: National Federation of Independent Business et al. v. Kathleen Sebelius et al., 132 U.S. 2566(2012), accessed April 15, 2014, http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.)

† Essential health benefits include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. (Source: Centers for Medicare & Medicaid Services, "Glossary: Essential Health Benefits" accessed April 28, 2014, https://www.healthcare.gov/glossary/essential-health-benefits/.)

Medicaid eligibility

The Affordable Care Act extended a key element of the American Recovery and Reinvestment Act of 2009, which prohibited states from enacting more-restrictive eligibility criteria and enrollment standards for adults and children beyond what was in place when the Affordable Care Act was first enacted.[58] This "maintenance-of-effort" requirement is in effect for children through 2019.[59] For adults, however, it ended Jan. 1, 2014, when Medicaid expansion was originally expected to provide coverage for eligible childless adults in all states. [60]

The maintenance-of-effort requirement ensures that those Americans previously eligible could still access these health insurance programs in the wake of the Great Recession of 2007-09 and the resulting state budget constraints that might otherwise have led states to restrict Medicaid eligibility.[61] It also ensures that eligibility is not diminished as states and the federal government move to increase health insurance coverage through Medicaid and the health insurance marketplaces.[62]

The Affordable Care Act also effectively eliminated "categorical eligibility" criteria from federal minimum eligibility requirements as of Jan. 1, 2014, for enrollees who do not have a disability and are not elderly.[63] Previously, categorical eligibility stipulated that applicants not only had to fall into an eligible group to qualify—such as child, parent, pregnant woman, senior, or person with disabilities—but also had to meet income requirements that varied by group. As a result, not all low-income people would qualify.[64] The new eligibility criteria are simpler and require that applicants earning 138 percent of the FPL or less—including adults without children in states that have chosen to expand Medicaid to them—qualify for the program.[65]

Before the new law, the rules for counting income and resources varied among states and groups.[66] The Affordable Care Act simplifies and streamlines how states calculate Medicaid applicants' income. It stipulates that Medicaid, the Children's Health Insurance Program, and subsidies for the health insurance marketplaces use the same income calculation methodology—an applicant's modified adjusted gross income, or MAGI, which does not take into consideration an individual's assets—when making income eligibility determinations.[67] The MAGI methodology applies to parents, children, and newly eligible adults, but it does not apply to elderly enrollees, individuals who qualify for Medicaid based on their disability status, or those seeking coverage of long-term services and supports.[68] This provision will simplify the application process across multiple programs.[69]

Reductions in federal Disproportionate Share Hospital payments

Medicaid payments by the federal government to hospitals for uncompensated care, known as Disproportionate Share Hospital payments, will also be affected by the Affordable Care Act.[70] As the expansion of Medicaid and the introduction of subsidies through the new health insurance marketplaces reduce the number of uninsured individuals, particularly in states that expand Medicaid eligibility, hospitals are expected to incur lower uncompensated care costs.[71] As a result, Medicaid's Disproportionate Share Hospital payments will decline accordingly.[72]

The Affordable Care Act mandated reductions to Disproportionate Share Hospital payments that, after amendments from subsequent legislation, range from $1.8 billion to $5 billion a year from fiscal 2017 to 2024 for a total of $35.1 billion.[73] Hospitals in the states that do not expand Medicaid coverage under the Affordable Care Act may be hard-hit by these funding cuts because the numbers of uninsured residents, and thus the volume of uncompensated care provided, will not drop as much as in states that are expanding coverage.[74]

Conclusion

Although Medicaid spending has grown since 2000, this growth has been on par with overall health care spending in the country. Medicaid's spending growth has been driven primarily by increases in enrollment during economic downturns, when incomes fell, unemployment soared, and many Americans lost their employer-sponsored health insurance coverage.[75] Correcting for enrollment and population changes, the growth in overall health care spending per U.S. resident has significantly outpaced Medicaid spending per enrollee between 2000 and 2012.

Because Medicaid is administered by states, programs vary across the nation. Many factors drive these differences—from state decisions about the types of health care benefits offered and to whom they are offered, to the health of a state's population and the status of its economy.[76] As states continue implementing provisions of the Affordable Care Act, variation across state programs will continue. The State Health Care Spending Project will build upon the baseline data presented here to track future trends in Medicaid enrollment and spending as the rollout of the new health law continues.

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Appendix A: Methodology

21 A.1 Definitions

23 A.2 Data and sources for spending and enrollment

24 A.3 Methodologies by figure

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A.1 Definitions

The following are definitions of terms used in this report.

Disproportionate Share Hospital, or DSH, Payments: Lump sum payments from the Medicaid program intended to provide additional reimbursement to hospitals that have qualified by serving a large number of Medicaid enrollees and uninsured individuals.[1]

Enrollees: Individuals who are enrolled in Medicaid over the course of the fiscal year, regardless of whether they use services. Enrollees are presumed to be unduplicated (each person is only counted once).[2]

Enrollment group:

- **Children:** Generally nondisabled Medicaid enrollees ages 18 and younger.[3,*]
- **Elderly:** Medicaid enrollees ages 65 and older, regardless of their disability status.[4,†] Elderly Medicaid enrollees may also be covered under Medicare.[5]
- **Parents:** Generally nondisabled Medicaid enrollees ages 19-64, most of whom are parents, caretakers of a child, or pregnant women.[6,‡]
- **People with disabilities:** Medicaid enrollees under age 65 who are reported as eligible for the program due to a disability.

Payments for services: Total state and federal expenditures for Medicaid services delivered to enrollees.[7] Medicaid Statistical Information System, or MSIS, data exclude DSH payments to hospitals and administrative expenditures.[8]

Reporting year:

- **Federal fiscal year (FY):** Oct. 1 of the prior year through Sept. 30.
- **State fiscal year (SFY):** July 1 of the prior year through June 30. States with different fiscal years are Alabama

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* According to the Kaiser Family Foundation, "some people age 19 and older may be classified as "children" depending on why they qualify for the program and each state's practices." (Source: Kaiser Family Foundation's State Health Facts, "Distribution of Medicaid Enrollees by Enrollment Group, FY 2010," Data source: Medicaid Statistical Information System, FY 2010, accessed Jan. 29, 2014, http://kff.org/medicaid/state-indicator/distribution-by-enrollment-group/). This can include individuals residing in institutions or foster care, or who are wards of the state. See Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth* (Washington: National Academy for State Health Policy, 2008), accessed March 20, 2014, http://nashp.org/sites/default/files/transitional_youth.pdf?q=files/transitional_youth.pdf.

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and Michigan (Oct. 1 through Sept. 30), New York (April 1 through March 31), and Texas (Sept. 1 through Aug. 31).[9]

- **Calendar year (CY):** Jan. 1 through Dec. 31.

State: The 50 states and the District of Columbia. U.S. territories were excluded from this analysis because the federal financing structures for their Medicaid programs differ from those of the 50 states and the district.[10]

State own-source revenue: Funds that states raise primarily through taxes and fees. These funds do not include any federal revenue, such as matching dollars or grants. State revenue from localities is included in own-source revenue.[11]

State share of Medicaid spending: All state-funded spending for Medicaid as reported in the CMS-64 Quarterly Expense reports, which include expenditures on payments for services to recipients, administrative expenses, and DSH payments. In a handful of states, local funding is a substantial part of the state share of Medicaid spending.[12]

Total Medicaid spending: All state and federal spending for Medicaid as reported in the CMS-64 Quarterly Expense reports, which include payments for services, administrative expenses, and DSH payments.

A.2 Data and sources for spending and enrollment

Spending

National Health Expenditures. Data from the National Health Expenditure Accounts from the Centers for Medicare & Medicaid Services include annual U.S. expenditures for health care goods and services, public health activities, government administration, investment related to health care, and the net cost of health insurance. This includes private health insurance, Medicare, Medicaid, the Children's Health Insurance Program, the Department of Defense, and the Department of Veterans Affairs expenditures, as well as individuals' out-of-pocket costs.[13]

Payments for services and payments for services per enrollee by enrollment group. Data on (1) total Medicaid payments for services and (2) payments for services per enrollee by enrollment group are from analyses by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, or KCMU/UI, of CMS data from Medicaid Statistical Information System and the CMS-64 Quarterly Expense reports. Payments for services include both state and federal spending for services to Medicaid enrollees, but do not include DSH payments. The per-enrollee figures represent the average (mean) level of payments for services for Medicaid enrollees in each enrollment group.[14]

State own-source revenue. The U.S. Census Bureau's Annual Survey of State Government Finances provides a comprehensive summary of annual survey findings for state governments, including revenue by source and state fiscal year.[15]

State share and total Medicaid spending. State share and total Medicaid spending data are from the Centers for Medicare & Medicaid Services' CMS-64 Quarterly Expense reports.[16] This dataset includes state and federal Medicaid expenditures by expenditure type for each fiscal year.

Enrollment

Health insurance coverage data. The U.S. Census Bureau's Current Population Survey Annual Social and Economic Supplements, or CPS ASEC, includes survey data on national survey data on national and state-by-state health insurance coverage.[17] Percentages by coverage type do not add up to 100 percent because some residents have multiple sources of health insurance coverage.[18] Health insurance coverage numbers are calendar year data estimated using a survey instrument in the year following the reporting year.[19]

Population estimates. Population data used in this study are mid-year point-in-time estimates from the U.S. Census Bureau. Analyses for 2000-10 are taken from the Intercensal Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico for analyses of 2000-10 data.[20] Analyses for 2011 and 2012 use Census Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico because the Intercensal Estimates for after 2010 are not yet available.[21]

Total Medicaid enrollment and enrollment by group. Enrollment data are from the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, or KCMU/UI, analyses of CMS MSIS data and represent the number of individuals enrolled over the course of the fiscal year, not at a particular point in time. The enrollment estimates differ slightly from similar estimates posted by the Centers for Medicare & Medicaid Services because adjustments to the data have been made for several states in which some individuals appeared to be categorized incorrectly. The most common adjustment KCMU/UI made was to shift people age 65 and older to the elderly category who were previously categorized as disabled, and the second most common adjustment was to shift individuals under age 65 out of the elderly category and into the category for persons with disabilities.[22]

A. 3 Methodologies by figure

Figure 2: Total Medicaid spending CAGR, inflation adjusted, 2000-12

Pew used the total computable total net expenditures for the medical assistance program and administration components of the CMS-64 data to calculate the total Medicaid spending CAGR for FY 2000-12. Expenditures were adjusted to 2012 dollars using the Bureau of Economic Analysis' 2012 Gross Domestic Product implicit price deflator.[23]

Figure 3: Total Medicaid spending and national health expenditures, inflation-adjusted growth, 2000-12

Pew calculated cumulative growth in total Medicaid spending for FY 2000-12. Total Medicaid spending was the total computable total net expenditures for the medical assistance program and administration components of the CMS-64 data. Pew also calculated cumulative growth in total national health expenditures for CY 2000-12 from CMS' National Health Expenditure Accounts data. All expenditures were adjusted to 2012 dollars using the Bureau of Economic Analysis' 2012 Gross Domestic Product implicit price deflator.[24]

Figure 4: Percent of residents enrolled in Medicaid over the course of the year, 2010

Pew calculated the percent of residents enrolled in Medicaid for FY 2010 from total Medicaid enrollment from MSIS data reported by KCMU/UI and Census population estimates for 2010. Pew calculated the percent of uninsured residents in 2010 based on the number of residents not covered by health insurance in CY 2010 from CPS ASEC and Census population estimates for 2010.

Data notes:

- Because 2010 MSIS enrollment data were unavailable, KCMU/UI used 2009 data for Colorado, Idaho, Missouri, North Carolina, and West Virginia.[25]
- Due to data quality issues, Medicaid enrollees with disabilities in Maine who were enrolled only in the fourth quarter of FY 2010 are not included in KCMU/UI data on state or national totals.[26]

Figure 5: Health insurance coverage by source as a percent of the population, 2000-12

Pew calculated the percent of residents enrolled in Medicaid for FY 2000-10 based on Medicaid enrollment data from MSIS reported by KCMU/UI and Census population estimates for 2000-10. Due to lags in reporting, Medicaid enrollment data are not available from KCMU/UI to calculate the number of residents enrolled in Medicaid in FY 2011 and FY 2012.

Pew also analyzed data from the CPS ASEC on health insurance enrollment for CY 2000-12 and Census population estimates for 2000-12 to calculate the percent of uninsured residents and the percent of residents enrolled in employer-sponsored insurance, direct purchase non-group insurance, and Medicare for 2000-12. Pew used actual Medicaid enrollment data from MSIS reported by KCMU/UI as opposed to survey data from the CPS ASEC 1) in order to maintain consistency with other analyses in our report, 2) because CPS ASEC survey data are prone to under-count all insurance sources, and 3) because CPS ASEC Medicaid enrollment includes Children's Health Insurance Program enrollees.[27]

Data notes:

- KCMU/UI rounded Medicaid enrollment estimates for FY 2000 to the nearest 100.[28]

- Because Hawaii did not provide Medicaid enrollment data for FY 2000, KCMU/UI used FY 1999 data.[29]
- Medicaid enrollment data were not available for Georgia in 2002 and are not included in KCMU/UI data on state or national totals.[30]
- Because 2003 Medicaid enrollment data were unavailable for Maryland, KCMU/UI used 2002 enrollment data.[31]
- Because of a limitation in the FY 2003 and FY 2004 West Virginia MSIS data, a select number of Medicaid enrollees may have been omitted from the West Virginia enrollment numbers.[32]
- Beginning in 2004, Census revised their estimates of the number of employer-sponsored insurance enrollees and the number of uninsured based on improvements to the algorithm that assigned coverage to dependents.[33]
- Because 2009 Medicaid enrollment data were unavailable for Pennsylvania, Utah, and Wisconsin, KCMU/UI used 2008 enrollment data.[34]
- For 2010, 2011, and 2012, Census amended the methods used to calculate estimates of the number of uninsured and the number of employer-sponsored insurance, Medicare, and direct purchase non-group insurance enrollees to include Census 2010-based population controls.[35]
- Because 2010 enrollment data were unavailable for Colorado, Idaho, Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 MSIS data.[36]
- Due to data quality issues, Medicaid enrollees with disabilities in Maine who were enrolled only in the fourth quarter of FY 2010 are not included in KCMU/UI data on state or national totals.[37]

Figure 6: Total Medicaid spending per enrollee versus National Health Expenditure Accounts per U.S. resident, inflation adjusted, 2000-10

Pew analyzed CMS-64 data and MSIS data reported by KCMU/UI on Medicaid enrollment to calculate total Medicaid spending per enrollee for FY 2000-10. Pew calculated national health expenditures per U.S. resident for CY 2000-10 based on total national health expenditures and U.S. population from CMS' National Health Expenditure Accounts data. Medicaid spending data and national health expenditures are adjusted for inflation to 2012 dollars using the Bureau of Economic Analysis' 2012 Gross Domestic Product implicit price deflator.[38]

Data notes:

- KCMU/UI rounded Medicaid enrollment estimates for FY 2000 to the nearest 100.[39]
- Because Hawaii did not provide enrollment data for FY 2000, KCMU/UI used data for FY 1999.[40]
- Medicaid enrollment data were not available for Georgia in 2002 and are not included in KCMU/UI data on state or national totals.[41]
- Because of a limitation in the FY 2003 and FY 2004 West Virginia MSIS data, a select number of Medicaid enrollees may have been omitted from the West Virginia enrollment numbers.[42]
- Because 2003 Medicaid enrollment data were unavailable for Maryland, KCMU/UI used 2002 enrollment data.[43]
- Because 2009 Medicaid enrollment data were unavailable for Pennsylvania, Utah, and Wisconsin, KCMU/UI used 2008 enrollment data.[44]
- Because 2010 enrollment data were unavailable for Colorado, Idaho, Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 enrollment data.[45]

- Due to data quality issues, Medicaid enrollees with disabilities in Maine who were enrolled only in the fourth quarter of FY 2010 are not included in KCMU/UI data on state or national totals.[46]

Figure 7: Distribution of Medicaid enrollment and payments for services by enrollment group, 2010

Pew analyzed MSIS data reported by KCMU/UI to show distribution of enrollment and payments by enrollment group. Pew also used data from MSIS reported by KCMU/UI on total enrollment, total Medicaid payments for services, and payments for services per enrollee by enrollment group within this analysis. Payments for services and payments for services per enrollee are not adjusted for inflation, since data are only presented for 2010, the most recent year of data available from this source.

Data notes:

- Because 2010 spending and enrollment data were unavailable for Colorado, Idaho, Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 MSIS data. KCMU/UI then adjusted 2009 spending data to 2010 CMS-64 spending levels.[47]
- Due to data quality issues, Medicaid enrollees with disabilities in Maine who were enrolled only in the fourth quarter of FY 2010 are not included in KCMU/UI payments for services, enrollment counts, or payments per enrollee calculations.[48]
- Because 2010 MSIS data underreports spending for people in New Mexico in the Coordination of Long-Term Services waiver program, KCMU/UI did not report payments for services for the elderly in this state. However, these payments were included in state and national totals.[49]

Figure 8: Elderly and/or disabled enrollees as a percent of total Medicaid enrollment, 2010

Pew analyzed MSIS data reported by KCMU/UI on Medicaid enrollment by enrollment group to calculate the percent of Medicaid enrollees who were elderly and/or disabled in FY 2010 and the percent of Medicaid enrollees who were parents and/or children in FY 2010.

Data notes:

- Because 2010 enrollment data were unavailable for Colorado, Idaho, Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 data.[50]
- Due to data quality issues, Medicaid enrollees with disabilities in Maine who were enrolled only in the fourth quarter of FY 2010 are not included in KCMU/UI data on state or national totals.[51]

Figure 9: Total Medicaid payments per elderly and/or disabled enrollee, 2010

Pew calculated total Medicaid payments for services per elderly and/or disabled enrollee and per parent and/or child in FY 2010 using MSIS data reported by KCMU/UI on Medicaid enrollment by enrollment group and the distribution of Medicaid payments for services by enrollment group. Payments for services per elderly and/or disabled enrollee and per parent and/or child enrollee are not adjusted for inflation because data are only presented for 2010, the most recent year of data available from this source.

Data notes:

- Because 2010 spending and enrollment data were unavailable for Colorado, Idaho, Missouri, North Carolina, and West Virginia, KCMU/UI used 2009 MSIS data and adjusted them to 2010 CMS-64 spending levels.[52]

- Due to data quality issues, Medicaid enrollees with disabilities in Maine who were enrolled only in the fourth quarter of FY 2010 are not included in KCMU/UI data on state or national totals.[53]
- Because 2010 MSIS data underreports spending for people in New Mexico in the Coordination of Long-Term Services waiver program, KCMU/UI did not report payments for services for the elderly in this state. However, these payments were included in state and national totals.[54]

Figure 10: State-funded Medicaid expenditures as a percent of state own-source revenue, 2012

Pew analyzed FY 2012 CMS-64 data and SFY 2012 Annual Survey of State Government Finances data to calculate total Medicaid spending, state share of Medicaid spending, and state share of Medicaid spending as a percent of state own-source revenue. Pew calculated state own-source revenue as state general revenue data less federal intergovernmental transfers.

Figure 11: State-funded Medicaid expenditure as a percent of state own-source revenue, 2000-12

Pew analyzed FY 2000-12 CMS-64 data and SFY 2000-12 data from the Annual Survey of State Government Finances to calculate state share of Medicaid spending as a percent of state own-source revenue and the percentage point change from 2000 to 2012. Pew calculated state own-source revenue as state general revenue data less federal intergovernmental transfers.

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Appendix B: Data tables

Table B.1

State-Level Data for Figures 2 and 3

Total Medicaid spending and growth, inflation adjusted, 2000–12

State	Total Medicaid spending, 2000 (in billions)	Total Medicaid spending, 2012 (in billions)	Total growth, 2000-12	Compound annual growth rate, 2000-12
United States	$263.7	$429.2	63%	4.1%
Alabama	$3.5	$5.2	47%	3.2%
Alaska	$0.7	$1.4	114%	6.5%
Arizona	$3.0	$8.2	169%	8.6%
Arkansas	$2.1	$4.4	103%	6.1%
California	$29.1	$53.4	83%	5.2%
Colorado	$2.6	$4.9	89%	5.5%
Connecticut	$4.2	$6.7	60%	4.0%
Delaware	$0.7	$1.6	120%	6.8%
District of Columbia	$1.1	$2.2	100%	5.9%
Florida	$10.2	$18.6	82%	5.1%
Georgia	$5.7	$8.8	53%	3.6%
Hawaii	$0.9	$1.5	71%	4.6%
Idaho	$0.8	$1.5	88%	5.4%
Illinois	$10.6	$14.0	32%	2.4%
Indiana	$4.6	$7.9	71%	4.5%
Iowa	$2.2	$3.6	62%	4.1%
Kansas	$1.9	$2.8	48%	3.3%
Kentucky	$4.0	$5.8	43%	3.0%
Louisiana	$4.5	$7.4	62%	4.1%
Maine	$1.6	$2.6	61%	4.0%
Maryland	$4.2	$7.9	89%	5.4%
Massachusetts	$8.5	$13.3	57%	3.8%
Michigan	$9.6	$12.9	35%	2.6%
Minnesota	$4.5	$9.0	98%	5.9%
Mississippi	$2.6	$4.6	76%	4.8%
Missouri	$5.2	$9.0	72%	4.6%
Montana	$0.6	$1.0	67%	4.4%
Nebraska	$1.4	$1.8	26%	1.9%
Nevada	$0.8	$1.8	124%	6.9%
New Hampshire	$1.1	$1.3	16%	1.3%
New Jersey	$8.1	$11.0	36%	2.6%
New Mexico	$1.7	$3.6	117%	6.7%

Continued on next page

State	Total Medicaid spending, 2000 (in billions)	Total Medicaid spending, 2012 (in billions)	Total growth, 2000-12	Compound annual growth rate, 2000-12
New York	$40.0	$53.1	33%	2.4%
North Carolina	$7.3	$12.9	76%	4.8%
North Dakota	$0.6	$0.8	37%	2.6%
Ohio	$10.0	$16.8	69%	4.4%
Oklahoma	$2.2	$4.6	107%	6.3%
Oregon	$3.0	$4.9	66%	4.3%
Pennsylvania	$13.9	$21.2	53%	3.6%
Rhode Island	$1.5	$1.9	26%	2.0%
South Carolina	$3.5	$4.8	36%	2.6%
South Dakota	$0.5	$0.8	50%	3.4%
Tennessee	$6.5	$9.3	41%	2.9%
Texas	$14.4	$28.9	101%	6.0%
Utah	$1.1	$2.0	80%	5.0%
Vermont	$0.7	$1.4	89%	5.4%
Virginia	$3.7	$7.1	92%	5.6%
Washington	$5.6	$8.1	45%	3.1%
West Virginia	$1.8	$2.9	59%	3.9%
Wisconsin	$4.4	$7.5	70%	4.5%
Wyoming	$0.3	$0.6	86%	5.3%

Note: Medicaid spending data are reported by federal fiscal year and are expressed in 2012 dollars.

For data notes, see the methodology in Appendix A.

Source: Pew analysis of data from the Centers for Medicare & Medicaid Services

Table B.2

State-Level Data for Figure 4

Medicaid enrollment and uninsured rates, 2010

State	Medicaid enrollment, 2010	Percent enrolled in Medicaid, 2010	Percent uninsured, 2010	Expanding Medicaid coverage under ACA (as of April 2014)
United States	66,390,642	21%	16%	26 states and DC
Alabama	1,015,576	21%	15%	No
Alaska	127,853	18%	18%	No
Arizona	1,531,122	24%	19%	Yes
Arkansas	720,907	25%	18%	Yes
California	11,428,811	31%	19%	Yes
Colorado	618,334	12%	13%	Yes
Connecticut	712,350	20%	11%	Yes
Delaware	225,426	25%	11%	Yes
District of Columbia	214,290	35%	13%	Yes
Florida	3,703,388	20%	21%	No
Georgia	1,869,622	19%	19%	No
Hawaii	265,588	19%	7%	Yes
Idaho	227,849	14%	19%	No
Illinois	2,822,634	22%	15%	Yes
Indiana	1,209,849	19%	13%	No
Iowa	562,459	18%	12%	Yes
Kansas	394,417	14%	12%	No
Kentucky	919,864	21%	15%	Yes
Louisiana	1,204,829	27%	19%	No
Maine	375,943	28%	9%	No
Maryland	975,437	17%	13%	Yes
Massachusetts	1,690,693	26%	6%	Yes
Michigan	2,261,732	23%	13%	Yes
Minnesota	936,488	18%	10%	Yes
Mississippi	772,141	26%	21%	No
Missouri	1,065,266	18%	14%	No
Montana	128,792	13%	18%	No
Nebraska	265,540	15%	13%	No
Nevada	340,520	13%	21%	Yes
New Hampshire	167,560	13%	10%	Yes
New Jersey	1,055,940	12%	15%	Yes
New Mexico	576,138	28%	21%	Yes
New York	5,570,094	29%	15%	Yes

Continued on next page

State	Medicaid enrollment, 2010	Percent enrolled in Medicaid, 2010	Percent uninsured, 2010	Expanding Medicaid coverage under ACA (as of April 2014)
North Carolina	1,813,298	19%	17%	No
North Dakota	82,762	12%	13%	Yes
Ohio	2,308,999	20%	13%	Yes
Oklahoma	856,835	23%	17%	No
Oregon	643,940	17%	16%	Yes
Pennsylvania	2,417,096	19%	11%	No
Rhode Island	216,302	21%	11%	Yes
South Carolina	922,560	20%	20%	No
South Dakota	133,739	16%	13%	No
Tennessee	1,509,354	24%	14%	No
Texas	4,844,337	19%	25%	No
Utah	349,595	13%	14%	No
Vermont	196,412	31%	9%	Yes
Virginia	1,027,075	13%	14%	No
Washington	1,352,939	20%	14%	Yes
West Virginia	416,858	22%	13%	Yes
Wisconsin	1,253,656	22%	9%	No
Wyoming	87,433	15%	17%	No

Notes: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year, and the number of state residents are midyear point-in-time estimates.

For data notes, see the methodology in Appendix A.

Source: Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, and the U.S. Census Bureau

Table B.3

State-Level Data for Figure 5

Health insurance coverage by source as a percent of the population, 2000–12

State	Change (in percentage points)				Expanding Medicaid coverage under ACA (as of April 2014)
	Medicaid enrollment, 2000-10	Employer-sponsored insurance enrollment, 2000-12	Medicare enrollment, 2000-12	Uninsured rate, 2000-12	
United States	5.8	-10.0	2.2	2.3	26 states and DC
Alabama	6.3	-9.7	5.4	2.5	No
Alaska	0.5	-7.0	2.2	1.0	No
Arizona	10.6	-11.5	3.1	1.8	Yes
Arkansas	5.8	-12.7	1.2	4.2	Yes
California	6.9	-8.3	2.2	0.3	Yes
Colorado	3.5	-10.0	2.7	0.7	Yes
Connecticut	7.7	-8.0	-0.7	-0.9	Yes
Delaware	9.2	-15.3	4.4	2.2	Yes
District of Columbia	9.1	-2.3	-0.8	-4.5	Yes
Florida	5.7	-12.4	1.3	5.2	No
Georgia	4.2	-14.1	2.1	5.0	No
Hawaii	2.8	-8.5	3.8	-0.3	Yes
Idaho	2.9	-8.9	4.7	0.6	No
Illinois	8.0	-9.5	2.7	1.6	Yes
Indiana	6.2	-13.8	2.6	3.0	No
Iowa	7.6	-11.6	0.5	2.0	Yes
Kansas	4.0	-11.3	1.0	2.9	No
Kentucky	3.3	-10.8	2.9	3.0	Yes
Louisiana	8.0	-5.3	0.8	1.4	No
Maine	12.0	-5.9	1.2	-0.8	No
Maryland	3.3	-10.5	0.4	3.5	Yes
Massachusetts	8.4	-4.8	2.4	-3.0	Yes
Michigan	9.2	-11.5	4.8	3.0	Yes
Minnesota	5.5	-9.8	4.9	0.3	Yes
Mississippi	5.1	-12.6	2.9	1.9	No
Missouri	0.1	-12.2	4.7	4.7	No
Montana	2.3	-6.0	4.8	2.1	No
Nebraska	0.6	-6.8	3.8	5.4	No
Nevada	4.7	-14.0	1.9	7.4	Yes
New Hampshire	3.8	-7.6	1.4	4.1	Yes
New Jersey	1.8	-11.1	0.7	3.6	Yes

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State	Change (in percentage points)				Expanding Medicaid coverage under ACA (as of April 2014)
	Medicaid enrollment, 2000-10	Employer-sponsored insurance enrollment, 2000-12	Medicare enrollment, 2000-12	Uninsured rate, 2000-12	
New Mexico	6.0	-6.6	3.6	-1.0	Yes
New York	10.8	-6.3	1.9	-3.2	Yes
North Carolina	3.8	-13.8	3.4	5.1	No
North Dakota	2.6	1.3	-1.9	1.9	Yes
Ohio	7.5	-13.6	3.7	2.5	Yes
Oklahoma	5.9	-4.2	0.5	-0.2	No
Oregon	0.4	-11.8	3.0	3.7	Yes
Pennsylvania	4.6	-10.6	1.9	4.5	No
Rhode Island	3.2	-10.1	0.1	5.4	Yes
South Carolina	0.6	-10.3	1.8	3.5	No
South Dakota	3.3	-5.1	-0.8	3.7	No
Tennessee	-3.2	-10.9	4.2	3.3	No
Texas	6.3	-8.1	0.8	2.9	No
Utah	3.5	-11.1	1.8	3.6	No
Vermont	7.1	-7.9	4.9	-0.4	Yes
Virginia	3.2	-8.1	1.7	2.8	No
Washington	4.5	-5.3	1.6	0.5	Yes
West Virginia	2.9	-8.2	1.5	1.0	Yes
Wisconsin	10.5	-14.2	0.6	2.6	No
Wyoming	4.9	-1.6	3.2	1.0	No

Notes: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year.

The number of residents who are uninsured or enrolled in employer-sponsored insurance and Medicare are reported by calendar year. Population data are midyear point-in-time estimates.

Due to lags in reporting, comparable data are not available on the number of state residents enrolled in Medicaid in 2011 and 2012.

Not all insurance sources, such as non-group insurance and military coverage, are listed in this table.

For data notes, see the methodology in Appendix A.

Source: Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, and the U.S. Census Bureau

Table B.4

State-Level Data for Figure 6

Total Medicaid spending per enrollee and growth in per-enrollee spending, inflation adjusted, 2000–10

State	Medicaid spending per enrollee, 2000	Medicaid spending per enrollee, 2010	Total growth, 2000-10
United States	$5,956	$6,254	5.0%
Alabama	$5,332	$5,102	-4.3%
Alaska	$6,165	$10,575	71.5%
Arizona	$4,452	$6,458	45.1%
Arkansas	$4,259	$5,859	37.6%
California	$3,609	$4,134	14.5%
Colorado	$6,879	$7,036	2.3%
Connecticut	$10,020	$8,264	-17.5%
Delaware	$5,745	$6,187	7.7%
District of Columbia	$7,391	$9,200	24.5%
Florida	$4,575	$5,008	9.5%
Georgia	$4,637	$4,479	-3.4%
Hawaii	$4,364	$5,577	27.8%
Idaho	$5,350	$6,511	21.7%
Illinois	$6,095	$5,841	-4.2%
Indiana	$6,125	$5,345	-12.7%
Iowa	$6,989	$5,816	-16.8%
Kansas	$7,262	$6,677	-8.1%
Kentucky	$5,550	$6,395	15.2%
Louisiana	$5,494	$5,958	8.4%
Maine	$7,657	$6,638	-13.3%
Maryland	$5,806	$7,728	33.1%
Massachusetts	$7,690	$7,501	-2.5%
Michigan	$7,023	$5,520	-21.4%
Minnesota	$7,623	$8,702	14.2%
Mississippi	$4,400	$5,666	28.8%
Missouri	$5,288	$8,095	53.1%
Montana	$6,365	$7,930	24.6%
Nebraska	$5,985	$6,680	11.6%
Nevada	$5,170	$4,838	-6.4%
New Hampshire	$9,743	$8,613	-11.6%
New Jersey	$9,433	$10,490	11.2%
New Mexico	$4,174	$6,449	54.5%
New York	$11,749	$9,647	-17.9%

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State	Medicaid spending per enrollee, 2000	Medicaid spending per enrollee, 2010	Total growth, 2000-10
North Carolina	$5,950	$6,232	4.7%
North Dakota	$9,277	$9,018	-2.8%
Ohio	$7,027	$7,003	-0.3%
Oklahoma	$3,835	$4,951	29.1%
Oregon	$5,277	$6,878	30.3%
Pennsylvania	$7,843	$8,370	6.7%
Rhode Island	$8,466	$9,569	13.0%
South Carolina	$4,578	$5,784	26.4%
South Dakota	$5,314	$6,520	22.7%
Tennessee	$4,264	$6,045	41.8%
Texas	$5,330	$5,875	10.2%
Utah	$5,469	$5,358	-2.0%
Vermont	$4,881	$6,623	35.7%
Virginia	$5,414	$6,729	24.3%
Washington	$6,121	$5,742	-6.2%
West Virginia	$5,214	$6,596	26.5%
Wisconsin	$7,111	$5,561	-21.8%
Wyoming	$5,784	$6,760	16.9%

Notes: Expenditures are expressed in 2012 dollars.

Medicaid spending data are reported by federal fiscal year.

For data notes, see the methodology in Appendix A.

Source: Pew analysis of data from the Centers for Medicare & Medicaid Services, Pew analysis of Medicaid Statistical Information System data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, and the U.S. Census Bureau

Table B.5

State-Level Data for Figures 7 and 8

Distribution of Medicaid enrollment and payments for services by enrollment group, 2010

State	Enrollment rates, 2010			Payments for services, 2010		
	Total	Elderly and disabled individuals	Parents and children	Total (in billions)	Elderly and disabled individuals	Parents and children
United States	66,390,642	24%	76%	$369.3	64%	36%
Alabama	1,015,576	33%	67%	$4.2	60%	40%
Alaska	127,853	20%	80%	$1.2	55%	45%
Arizona	1,531,122	16%	84%	$9.2	42%	58%
Arkansas	720,907	30%	70%	$3.7	72%	28%
California	11,428,811	18%	82%	$39.3	68%	32%
Colorado	618,334	21%	79%	$3.9	65%	35%
Connecticut	712,350	24%	76%	$5.4	66%	34%
Delaware	225,426	18%	82%	$1.3	49%	51%
District of Columbia	214,290	26%	74%	$1.7	76%	24%
Florida	3,703,388	28%	72%	$16.4	67%	33%
Georgia	1,869,622	25%	75%	$7.3	59%	41%
Hawaii	265,588	20%	80%	$1.4	58%	42%
Idaho	227,849	25%	75%	$1.4	67%	33%
Illinois	2,822,634	19%	81%	$14.9	54%	46%
Indiana	1,209,849	22%	78%	$5.8	70%	30%
Iowa	562,459	22%	78%	$3.1	70%	30%
Kansas	394,417	29%	71%	$2.4	70%	30%
Kentucky	919,864	36%	64%	$5.5	63%	37%
Louisiana	1,204,829	28%	72%	$6.3	66%	34%
Maine	375,943	38%	62%	$2.2	75%	25%
Maryland	975,437	23%	77%	$6.9	64%	36%
Massachusetts	1,690,693	26%	74%	$11.6	66%	34%
Michigan	2,261,732	22%	78%	$11.1	65%	35%
Minnesota	936,488	25%	75%	$7.4	69%	31%
Mississippi	772,141	33%	67%	$3.9	66%	34%
Missouri	1,065,266	28%	72%	$7.3	64%	36%
Montana	128,792	25%	75%	$0.9	65%	35%
Nebraska	265,540	23%	77%	$1.6	66%	34%
Nevada	340,520	21%	79%	$1.4	56%	44%
New Hampshire	167,560	27%	73%	$1.1	69%	31%
New Jersey	1,055,940	31%	69%	$8.8	75%	25%
New Mexico	576,138	19%	81%	$3.3	N/A*	N/A*

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State	Enrollment rates, 2010			Payments for services, 2010		
	Total	Elderly and disabled individuals	Parents and children	Total (in billions)	Elderly and disabled individuals	Parents and children
New York	5,570,094	24%	76%	$49.6	70%	30%
North Carolina	1,813,298	27%	73%	$10.5	62%	38%
North Dakota	82,762	26%	74%	$0.7	74%	26%
Ohio	2,308,999	25%	75%	$14.5	72%	28%
Oklahoma	856,835	22%	78%	$4.1	58%	42%
Oregon	643,940	24%	76%	$3.9	64%	36%
Pennsylvania	2,417,096	35%	65%	$17.6	73%	27%
Rhode Island	216,302	33%	67%	$1.8	64%	36%
South Carolina	922,560	26%	74%	$4.7	63%	37%
South Dakota	133,739	23%	77%	$0.8	61%	39%
Tennessee	1,509,354	28%	72%	$8.4	53%	47%
Texas	4,844,337	22%	78%	$25.6	55%	45%
Utah	349,595	16%	84%	$1.7	58%	42%
Vermont	196,412	24%	76%	$1.2	56%	44%
Virginia	1,027,075	28%	72%	$6.1	64%	36%
Washington	1,352,939	22%	78%	$6.6	61%	39%
West Virginia	416,858	38%	62%	$2.5	72%	28%
Wisconsin	1,253,656	25%	75%	$6.6	70%	30%
Wyoming	87,433	20%	80%	$0.5	66%	34%

* Because Medicaid Statistical Information System data for 2010 underreports spending for people in the Coordination of Long-Term Services waiver program in New Mexico, payments for services for the elderly in this state were not reported. However, these payments were included in the state and national totals.

Notes: Medicaid enrollment data are reported as the number of individuals enrolled in Medicaid over the course of the federal fiscal year, and payments for services data are reported by federal fiscal year.

For additional data notes, see the methodology in Appendix A.

Source: Pew analysis of Medicaid Statistical Information System and CMS-64 data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute

Table B.6

State-Level Data for Figure 9

Total Medicaid payments per enrollee by enrollment group, 2010

State	Per-enrollee payments for services	
	Elderly and disabled individuals, 2010	Parents and children, 2010
United States	$14,946	$2,596
Alabama	$7,622	$2,469
Alaska	$25,975	$5,227
Arizona	$15,945	$4,108
Arkansas	$12,462	$2,054
California	$12,906	$1,354
Colorado	$19,297	$2,759
Connecticut	$20,800	$3,420
Delaware	$15,840	$3,651
District of Columbia	$23,667	$2,620
Florida	$10,510	$2,049
Georgia	$9,472	$2,109
Hawaii	$15,063	$2,709
Idaho	$16,330	$2,647
Illinois	$15,065	$2,988
Indiana	$15,208	$1,861
Iowa	$17,219	$2,131
Kansas	$14,441	$2,514
Kentucky	$10,408	$3,433
Louisiana	$12,230	$2,469
Maine	$11,822	$2,371
Maryland	$19,472	$3,304
Massachusetts	$17,357	$3,121
Michigan	$14,465	$2,217
Minnesota	$22,063	$3,311
Mississippi	$9,850	$2,588
Missouri	$15,872	$3,393
Montana	$18,357	$3,330
Nebraska	$17,473	$2,707
Nevada	$10,815	$2,210
New Hampshire	$17,087	$2,871
New Jersey	$20,055	$3,023
New Mexico	N/A*	$4,803
New York	$26,347	$3,538
North Carolina	$13,366	$2,989

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State	Per-enrollee payments for services	
	Elderly and disabled individuals, 2010	Parents and children, 2010
North Dakota	$24,046	$2,891
Ohio	$18,080	$2,352
Oklahoma	$12,507	$2,598
Oregon	$15,866	$2,900
Pennsylvania	$15,411	$2,979
Rhode Island	$15,747	$4,473
South Carolina	$12,439	$2,547
South Dakota	$15,103	$2,922
Tennessee	$10,724	$3,602
Texas	$12,985	$3,058
Utah	$17,470	$2,450
Vermont	$14,448	$3,543
Virginia	$13,625	$3,015
Washington	$13,077	$2,464
West Virginia	$11,716	$2,698
Wisconsin	$14,528	$2,127
Wyoming	$20,950	$2,619

* Because Medicaid Statistical Information System data for 2010 underreports spending for people in the Coordination of Long-Term Services waiver program in New Mexico, payments for services for the elderly in this state were not reported. However, these payments were included in the state and national totals.

Notes: Medicaid spending data are reported by federal fiscal year.

For additional data notes, see the methodology in Appendix A.

Source: Pew analysis of Medicaid Statistical Information System and CMS-64 data reported by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute

Table B.7

State-Level Data for Figures 10 and 11

State-funded Medicaid expenditures as a percentage of state own-source revenue, 2000–12

State	State-funded Medicaid spending, 2000 (in billions)	State-funded Medicaid spending, 2012 (in billions)	State spending as a share of state own-source revenue, 2000	State spending as a share of state own-source revenue, 2012	Percentage-point change, 2000-12
United States	$113.8	$181.4	12.2%	16.2%	4.0
Alabama	$1.1	$1.6	9.0%	11.4%	2.4
Alaska	$0.2	$0.6	2.9%	5.2%	2.3
Arizona	$1.0	$2.5	7.3%	14.9%	7.7
Arkansas	$0.6	$1.3	7.2%	11.5%	4.3
California	$13.9	$25.8	10.6%	17.8%	7.2
Colorado	$1.3	$2.4	10.4%	15.6%	5.2
Connecticut	$2.1	$3.3	12.6%	17.8%	5.2
Delaware	$0.4	$0.7	7.7%	12.6%	4.9
District of Columbia	$0.3	$0.7	N/A*	N/A*	N/A*
Florida	$4.5	$8.1	10.9%	16.8%	5.8
Georgia	$2.3	$3.0	10.6%	13.3%	2.7
Hawaii	$0.4	$0.7	7.2%	9.8%	2.6
Idaho	$0.2	$0.5	6.2%	10.1%	3.9
Illinois	$5.2	$6.9	13.8%	15.2%	1.4
Indiana	$1.8	$2.6	9.8%	12.4%	2.5
Iowa	$0.8	$1.4	8.8%	11.4%	2.5
Kansas	$0.8	$1.2	9.6%	10.9%	1.3
Kentucky	$1.2	$1.7	9.0%	11.5%	2.5
Louisiana	$1.4	$2.3	10.5%	16.0%	5.5
Maine	$0.5	$0.9	11.4%	18.2%	6.8
Maryland	$2.1	$3.9	11.6%	16.9%	5.3
Massachusetts	$4.2	$6.6	15.0%	20.7%	5.7
Michigan	$4.3	$4.4	11.0%	12.5%	1.5
Minnesota	$2.2	$4.5	10.3%	18.2%	7.9
Mississippi	$0.6	$1.2	7.7%	12.7%	5.0
Missouri	$2.1	$3.3	14.4%	20.3%	5.9
Montana	$0.2	$0.3	5.5%	9.5%	4.0
Nebraska	$0.6	$0.8	10.5%	12.8%	2.3
Nevada	$0.4	$0.8	7.1%	9.6%	2.6
New Hampshire	$0.5	$0.6	14.4%	14.8%	0.4
New Jersey	$4.0	$5.4	12.6%	14.3%	1.8

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State	State-funded Medicaid spending, 2000 (in billions)	State-funded Medicaid spending, 2012 (in billions)	State spending as a share of state own-source revenue, 2000	State spending as a share of state own-source revenue, 2012	Percentage-point change, 2000-12
New Mexico	$0.4	$1.1	6.0%	11.9%	5.8
New York	$19.9	$26.3	26.5%	26.3%	-0.1
North Carolina	$2.8	$4.5	10.9%	14.6%	3.7
North Dakota	$0.2	$0.3	7.3%	5.0%	-2.2
Ohio	$4.1	$6.1	12.3%	15.7%	3.4
Oklahoma	$0.7	$1.6	6.6%	12.3%	5.7
Oregon	$1.2	$1.8	9.7%	13.1%	3.4
Pennsylvania	$6.4	$9.5	16.0%	20.4%	4.4
Rhode Island	$0.7	$0.9	18.4%	20.3%	1.9
South Carolina	$1.1	$1.4	9.1%	10.0%	0.9
South Dakota	$0.2	$0.3	8.0%	12.4%	4.4
Tennessee	$2.4	$3.1	18.9%	19.3%	0.4
Texas	$5.6	$12.0	11.3%	16.9%	5.7
Utah	$0.3	$0.6	4.4%	6.1%	1.7
Vermont	$0.3	$0.6	10.3%	16.0%	5.7
Virginia	$1.8	$3.5	7.5%	11.6%	4.1
Washington	$2.7	$3.9	12.9%	16.2%	3.3
West Virginia	$0.5	$0.8	8.0%	10.1%	2.0
Wisconsin	$1.8	$2.9	8.6%	12.8%	4.3
Wyoming	$0.1	$0.3	5.6%	6.9%	1.3

* Data on state own-source revenues were not available for the District of Columbia.

Notes: Expenditures are expressed in 2012 dollars.

Medicaid spending data are reported by federal fiscal year, while state revenue data reflect each state's fiscal year.

For additional data notes, see the methodology in Appendix A.

Source: Pew analysis of data from the Centers for Medicare & Medicaid Services, and the U.S. Census Bureau

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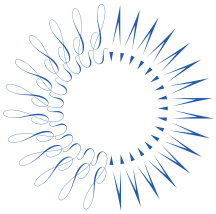

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