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50 Reasons Medicaid Expansion is Good for Your State

Prepared by: Jane Perkins
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Medicaid Expansion and States:

1. **The Medicaid Expansion is an exceptionally generous deal for the states.** States will receive 100% federal funding for the expansion population for the first three years, to be gradually reduced to 90% thereafter. Between 2014 and 2022, a fully implemented Medicaid Expansion will cover 17 million lower-income people while increasing direct state Medicaid spending by only 2.8% more than if health reform had not been enacted.[1] These figures do not reflect savings that will be produced elsewhere as the ACA is implemented (see below). When these savings are factored in, states are expected to save an estimated $101 billion from 2014-2019.[2]

2. **The Medicaid Expansion will generate savings for some states' Medicaid programs.** Between 2014 and 2019, a few states will save money by making the Expansion: HI, ME, MA, and VT. Other states will experience an increase of less than 1% in their state Medicaid spending, including AZ, DE, DC, NY, ND, SD, WI, and WY.[3]

3. **The Medicaid Expansion will help free up state and local spending that now goes to uncompensated care.** State and local governments help offset the cost of care that is provided to uninsured patients who cannot afford to pay—paying an estimated 30% of the cost of uncompensated care. The ACA will roughly halve state spending on uncompensated care, generating savings of $26-$52 billion.[4]

4. **The Medicaid Expansion will reduce state spending on mental health services for lower-income, uninsured patients.** This includes spending on state mental hospitals, hospital emergency rooms and community health clinics. This spending has been growing over time, with state and local governments covering 42% of the cost of state mental health expenditures by 2009.[5] Full Medicaid Expansion is estimated to save between $11 and $22 billion in funds states will otherwise spend on mental health programs from 2014-2019.[6]

5. **The Medicaid Expansion will enable states to continue using health care provider assessments as part of their state matching funds.** Although federal Medicaid funding to states is open-ended (i.e. a state entitlement), it is limited by a states' ability to raise its matching share. Some states have taken advantage of federal provisions that place assessments on hospitals and other health care providers that are then used to match (and draw down additional) federal dollars.[7] Without the Medicaid Expansion, hospitals and other providers may be unwilling or unable to pay these assessments, resulting in the loss of federal funds and a negative impact on state and local governments.

6. **The Medicaid Expansion will avoid costs associated with transitions and churning.** As individuals change jobs or fall in and out of work, income and eligibility for health insurance coverage fluctuate. Medicaid Expansion will provide stability in coverage; for example, individuals whose income moves them above 100% of the poverty line can remain in Medicaid and thus with the same providers.[8]

Stability in coverage means lower administrative costs. Stability in coverage improves continuity of care and the health care provider's ability to provide good care.[9] The ACA includes numerous options for state Medicaid programs to improve continuity of care; expansion will allow the affected populations to take advantage when a state elects these options.[10]

7. **The Medicaid Expansion will keep residents' federal taxes flowing into the State.** Almost every state resident pays federal taxes, and federal dollars will fund the Medicaid Expansion. Taxpayers residing in states that do not implement the Expansion will be paying out dollars to states that do expand, states like CA, CT, CO, DC, MN, MO, NJ, WA, which have already obtained approval for Medicaid Expansions.[11]

8. **The Medicaid Expansion could help avoid work force flight.** States could lose valuable members of the work force, as some low-income working adults will move to states that are making Medicaid coverage available.

9. **The Medicaid Expansion will attract managed care to the state.** Medicaid managed care companies are experiencing some of the fastest growth among U.S. managed care firms. They are aggressively seeking to move into states that implement the Medicaid Expansion, as states have been actively seeking to move more of their Medicaid populations into managed care.[12] States that do not implement the Medicaid Expansion will lose this population group as part of their business and bargaining strategy.

10. **The Medicaid Expansion will have a deep and broad impact on the state economy.** New federal Medicaid dollars will travel through the state economy, improving employment, labor income, and capital income. New federal dollars will turn over multiple times in the state economy (for example, from physician to employee to grocer).[13]

11. **The Medicaid Expansion will generate revenue.** State and local revenues will increase when state residents pay income, sales, and other taxes generated by the federal funding for the Medicaid Expansion, which in some states will offset much, perhaps all, of the additional costs.[14] These increased state income taxes are a major factor in the Arkansas Department of Human Services' estimate that the Expansion will save the state $372 million in the first several years.[15]

Medicaid Expansion and Health Care Providers:

12. **The Medicaid Expansion will help hospitals caring for a disproportionate share of low-income and uninsured people.** Many community and public hospitals have been receiving enhanced federal funding, called Medicare and Medicaid disproportionate share hospital (DSH) funding, to compensate them for some of the costs associated with treating large numbers of the uninsured. On the assumption that the number of uninsured people will fall dramatically beginning in 2014 when the individual mandate and Medicaid Expansion take effect, the ACA decreases DSH payments.[16] In states that do not expand Medicaid, the need for uncompensated care may remain relatively stable, while the amount of DSH funds that can be used to subsidize some of that care will fall substantially. This may result in severe financial hardship for hospitals, meaning that they will increase costs to paying patients or provide less uncompensated care.

13. **The Medicaid Expansion will reduce use of costly hospital departments.** Uninsured people often cannot find a regular source of care and depend on hospital emergency departments for emergency and non-emergency care. Emergency room care is expensive. By contrast, once people get Medicaid, they use the hospital emergency department at the same rate as people who have private insurance for both emergency and non-urgent care. As with the privately insured, most of the Medicaid visits to the

emergency room are for urgent or serious issues.[17] Fewer people in ERs means less waiting time for people with real emergencies, which includes everyone regardless of income.

14. **The Medicaid Expansion could help safety net and low-profit margin hospitals keep their emergency departments open.** From 1990 to 2009, the number of hospital emergency departments in non-rural areas declined by 27%.[18] Medicaid funding for uninsured patient care could help emergency departments open.

15. **The Medicaid Expansion will be a source of revenue for hospitals, regardless of what the Independent Payment Advisory Board decides.** The ACA establishes the Independent Payment Advisory Board, which must propose measures to reduce Medicare spending in years when spending growth will outpace target growth rates. The proposals cannot ration care, raise revenue by increasing beneficiary cost-sharing or reducing services, and until 2019 cannot reduce some provider (e.g. hospital) payment rates.[19] In years when the targets are not met, the IPAB's proposals to reduce Medicaid spending could mean that hospitals will face even deeper cuts in states that do not implement the Medicaid Expansion.

16. **The Medicaid Expansion will benefit community health centers.** Federally funded health centers are the main source of primary care for medically underserved populations. The Expansion will enable these centers to expand capacity to serve the uninsured as well as those newly covered by Medicaid. Fully implemented by the states, the Medicaid Expansion will allow health centers to reach approximately 19.8 million new patients. Without the Expansion, health centers' new patient care capacity will be reduced by nearly 27%, a 5.3 million drop in new patients.[20]

Medicaid Expansion and the Residents of the State:

17. **The Medicaid Expansion will significantly reduce the number of uninsured adult residents**, particularly in southern states, where, on average, a 50% reduction will occur.[21]

18. **The Medicaid Expansion will help stop the deterioration in health access that nonelderly adults have been experiencing over the last decade.** Their likelihood of having a usual source of care and having an office visit have all declined while the likelihood of having an emergency room visit has increased. Nonelderly adults were 66% more likely to report having unmet medical needs in 2010 compared to 2000. Uninsured adults experienced the most dramatic declines. By comparison, children experienced increased coverage through Medicaid and CHIP over the decade and by the end of the decade were more likely to have a usual source of care and office visits.[22]

19. **The Medicaid Expansion will reduce adult death rates.** In states that have already expanded Medicaid, mortality rates have been reduced significantly. Death rates were the greatest among adults between the ages of 35 and 64 years, people of color, and residents of low-income counties. Adults also experienced significant reductions in delays getting health care due to cost. Comparable states that did not expand Medicaid did not have similar results.[23] A report in Tennessee concludes that expanding Medicaid coverage to 225,000 people would save 9 lives in the state every week for the next 10 years.[24]

20. **The Medicaid Expansion will improve the financial security of the state's residents.** Tracking of Oregon's Medicaid expansion to uninsured adults found the coverage reduces by 40% the probability that people report having to borrow money or skip payments on other bills because of Medicaid expenses. It decreases by 25% the probability that they will have unpaid medical bills sent to a collection agency.[25]

21. **The Medicaid Expansion could reduce the growing role of health debt as a cause of personal bankruptcy.** The financial security brought about by the Medicaid Expansion can lead to reductions in bankruptcies. Medical debt factors into fully 62% of all bankruptcies-up from contributing to 46% of bankruptcies in 2001.[26]

22. **The Medicaid Expansion will allow access to health services for the state's residents working in low pay jobs.** Medicaid Expansion will provide access to health care for these workers. If these individuals remain uninsured, the costs of their illnesses and injuries will continue to be shifted onto privately insured state residents. As Congress noted when it enacted the ACA, this "cost shift" is now raising family health insurance premiums, on average, by over $1,000 per year.[27]

23. **The Medicaid Expansion will help ensure a healthier workforce for employers of low-wage workers**, including states that are employing large numbers of low wage state employees. Improved health decreases absenteeism, which in turn increases productivity.[28]

24. **The Medicaid Expansion will provide coverage for working persons who lose their jobs** through no fault of their own and cannot afford to continue with their employer-based insurance coverage because the COBRA premiums are unaffordable.[29]

25. **The Medicaid Expansion is critical for women.** Compared with other countries (e.g. Germany, Australia, France, Canada, UK), more women in the U.S. report that they cannot get care because of cost. Fully 77% of uninsured women aged 19-64 experienced cost-related access problems.[30] In 2010, 55 percent of the 19 million currently uninsured women in the U.S. had incomes low enough to qualify for coverage under the Medicaid Expansion.[31] The Expansion will produce a significant reduction in the number of uninsured women aged 16-64 in each of the 50 states.[32] Expansion will offer a strong benefit package to women because it will include *at least* all of the benefits offered in the exchanges, including maternity and preventive services and family planning benefits.[33]

26. **The Medicaid Expansion will avoid discrimination against people with mental health disabilities.** When it enacted the Expansion, Congress included a provision that requires newly eligible individuals to receive mental health and substance use services at parity with other benefits.[34]

27. **The Medicaid Expansion will help individuals with mental illness.** Approximately one in six currently uninsured adults with income below 133% of poverty has a severe mental illness. Many others have less serious mental health conditions.[35]

28. **The Medicaid Expansion will help homeless individuals.** Half of the newly eligible individuals have incomes at 50% or less of the poverty line. Many of these very-low income people are homeless, and approximately ¼ of them have a serious mental illness.[36] Medicaid Expansion will mean more comprehensive care for these individuals, allowing them to obtain chronic care management and preventive services. Medicaid will allow the state to leverage numerous service options, such as health homes, to provide these new beneficiaries with care management services linked to supportive housing.[37]

29. **The Medicaid Expansion will help the LGBT community.** Unemployment and poverty are higher for LGBT individuals than for the general U.S. population (an estimated 14% of LGBT individuals earn less than $10,000 per year, compared to 6% of the general population).[38] As a result, a significant proportion of LGBT adults will be likely benefit from the Medicaid Expansion.

30. **The Medicaid Expansion will link adults with chronic and disabling conditions to health care**, including individuals who do not qualify for Medicare because of that program's two-year disability waiting period.[39]

31. **Medicaid Expansion will allow access to health services for low-income Veterans**, covering about 650,000 of the 1.3 million currently uninsured Vets. Texas, Florida and California have the most uninsured veterans, with the highest number in Texas.[40]

32. **The Medicaid Expansion, while targeted to adults, will actually help children.** In the typical state, parents lose eligibility for Medicaid when their incomes reach just 63% of the federal poverty line (approximately $12,000 for a family of three in 2012). Medicaid Expansion will increase coverage for parents; thus, their health status is expected to improve. When parents and caretakers are insured, their children are more likely to be insured and to make more effective use of their coverage. Coverage of parents also improves continuity of children's coverage and reduces the likelihood of breaks in coverage.[41] Children coming onto Medicaid will be eligible for the program's tailored child health benefit package, Early and Periodic Screening, Diagnosis and Treatment.[42]

33. **The Medicaid Expansion will ensure that low-income parents are not punished when they move more fully into the workforce.** By contrast, in states that do not expand, low-income parents may avoid increasing their work time because they need to maintain Medicaid coverage for their children.

34. **The Medicaid Expansion will increase access to and use of health care by people of color.** If implemented as written, the ACA is expected to cover 32 million Americans. Half of the 32 million will come into the health care system through Medicaid, and three out of four of those individuals are people of color.[43]

35. **The Medicaid Expansion will reduce healthcare costs by reducing health disparities.** Between 2003 and 2006, more than $200 billion could have been saved in direct medical care expenditures if racial and ethnic health disparities did not exist. Since the lack of insurance is a contributing factor causing health care disparities, expanding Medicaid to provide insurance can save money.

36. **The Medicaid Expansion will help slow the spread of HIV/AIDS** by allowing individuals to obtain testing and initiate treatment sooner, which can help prevent the transmission of HIV. Currently, nearly 30% of people with HIV are uninsured, and up to 59% are not in regular care.[44] Existing programs for low-income people with HIV/AIDS, while effective, have been increasingly strained as their budgets decrease while demand grows. For example, nine states currently have waiting lists for joining an AIDS Drug Assistance Program (ADAPs). Most low-income people living with HIV have to wait until the onset of a life-threatening opportunistic infection to qualify for Medicaid on the basis of disability. Expanding Medicaid to individuals living with HIV, but who have not yet progressed to AIDS, will not only keep those individuals healthier longer, but will help reduce the number of new infections in the future.

37. **The Medicaid Expansion will ensure that 11.5 million people—the poorest of the poor—are not left out in the cold.** Under the ACA, individuals with incomes below 100% of the federal poverty line will not be able to obtain premium tax support for insurance products available through the exchange.[45] These individuals are likely to remain uninsured if states do not expand Medicaid.[46]

38. **The Medicaid Expansion will provide tailored coverage for lower-income people**, including coverage that is particularly relevant to adults and couple, such as family planning services and supplies, and to individuals with chronic conditions, such as prescriptions and home health care.[47]
39. **The Medicaid Expansion will ensure that enrollees help pay for their health care while maintaining affordability**, by allowing nominal copayments for individuals with incomes below the poverty line while capping cost-sharing at five percent of monthly income.[48]

40. **The Medicaid Expansion means jobs.** The Expansion would bring over 7500 jobs to Tennessee in 2014 alone;[49] in Maryland, 9,122 jobs in FY 2014 alone (and nearly 27,000 jobs in FY 2020).[50] Following the increase in the federal Medicaid matching rate in the American Recovery and Reinvestment Act, one estimate from Illinois found the Medicaid program supported as many as 385,742 jobs and generated wages as high as $15.8 billion during FY 2009 alone.[51]

Medicaid Expansion and Efficiency and Fairness:

41. **The Medicaid Expansion is an efficient way to cover this group of low-income individuals.** The Expansion merely requires addition of a new coverage group to Medicaid's existing market-based benchmark coverage options. It does not require a new insurance program to be designed and a new bureaucracy to be created. Addition of this population group will increase the bargaining power of the state with health plans and providers.

42. **The Medicaid Expansion will extend a highly successful health insurance program** that every state has aggressively implemented over the years. Every state has extended eligibility and/or services beyond the minimum coverage requirements of the federal law. At this point, more than 60% of current Medicaid funding covers optional population groups and services that no state is required to cover. In some states, the uptake of optional spending has been particularly dramatic, for example: 76.5% of expenditures in North Dakota are attributable to optional spending; 74.7%, in Ohio; 74% in Wisconsin; 69.4% in Iowa.[52]

43. **Medicaid is efficient.** The per enrollee cost growth in Medicaid (6.1%) is lower than the per enrollee cost growth in comparable coverage under Medicare (6.9%), private health insurance (10.6%), and monthly premiums for employer-sponsored coverage (12.6%).[53]

44. **The Medicaid Expansion and ACA will produce cost savings to states even as individuals who are currently eligible but not enrolled in Medicaid come forward to enroll.** Some states are concerned that the federal government will not really be paying the entire bill in the first three years because individuals who are already eligible for Medicaid will take advantage of the coverage "welcome mat" and "come out of the woodwork" to enroll. The states will receive their regular federal matching funding for these already-eligible individuals. The estimates of state costs (see #1 above) already include the costs associated with these potential new enrollees who are currently eligible. Equally important, the welcome mat effect will occur whether or not the state implements the Expansion. Beginning in 2014, the opportunity for uninsured people to purchase health insurance with federal subsidies will drive adults to insurance exchanges to obtain the health insurance, and upon arrival, their eligibility for Medicaid will automatically be determined—whether or not the state has expanded Medicaid.

45. **The Medicaid Expansion represents fiscal responsibility and shared responsibility between state and federal government.** It will be more efficient for all of the federal taxpayers who live in the state if individuals between 100-133% of the poverty line are covered through Medicaid rather than the exchange. The Congressional Budget Office has determined that the per capita cost of covering this population in the exchange will be $5,926 in 2019, as compared with $1,826 through Medicaid Expansion.[54] Using these numbers, a state leaving the 100-133% group to exchange coverage instead of a Medicaid Expansion would effectively be arguing that the Federal government should pay $5,926 per person, to save the state from paying $182.60 – the state's 10% share of the $1,826 Medicaid cost. That leaves the government paying $5,926 instead of $1,643.40 – the Federal government's 90% share of the Medicaid cost.

46. **The Medicaid Expansion will mean that states' spending of state and federal dollars for state program upgrades will not have been wasted.** Beginning in April 2011, states could receive significantly enhanced federal matching funds (90% instead of the usual 50% administrative matching rate) to upgrade their eligibility systems and make them ready for the 2014 expansions. The majority of states have approved (19 states) or submitted plans (10 states) to overhaul or build their systems.[55] If a recipient state refusing now to implement the Expansion, it will have made an inefficient use of taxpayer funds.

47. **The Medicaid Expansion merely echoes what a number of states had already obtained Medicaid funding to do.** States have already obtained approval from the federal government to expand their Medicaid programs to uninsured adults—at the current, rather than Expansion, federal matching rates. By 2008, 18 states had already received federal permission to extend this coverage, including Arizona, Idaho, Indiana, Maine, Michigan, Tennessee and Utah.[56]

48. **Successes in the states illustrate the value of the Medicaid Expansion.** The success of health reform in Massachusetts demonstrates that making health care coverage available for most everyone, as would be accomplished by full implementation of the ACA—i.e. with the Medicaid Expansion—is the key to successful reform. The Commonwealth Care program provides health care insurance without premiums to all adults up to 150% of the poverty level. Combined with other aspects of health reform in Massachusetts, this has resulted in 439,000 more Massachusetts residents having health care coverage compared to before reform, with 98.1 % of residents now having coverage, the highest rate in the country.[57]

Medicaid Expansion and the Law:

49. **State law may require the State to implement the Medicaid Expansion.** For example, an Arizona law requires the Director of the State Medicaid program to ensure that sufficient funds are available to provide Medicaid benefits to "all persons" whose incomes are at or below the federal poverty, to be supplemented "as necessary, by any other available sources including … federal monies."[58] An Alaska law says that "[a]ll residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance" under Title XIX of the Social Security Act.[59]

50. **It is the law.** While the Supreme Court found that a state could not be "coerced" into implementing the Expansion, its full remedy was to "limit[] the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid Expansion."[60] Thus, the Expansion population is still listed in the Medicaid Act as a group that the state "must" cover.[61]

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[1] January Angeles, Center on Budget and Policy Priorities, *How Health Reform's Medicaid Expansion will Impact State Budgets* (July 12, 2012) (discussing CBO estimates).

[2] The Lewin Group, a frequent consultant to state Medicaid programs, estimates savings of $101 billion. *See* The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* (June 8, 2010) (Working Paper #11); *see also* Matthew Buettgens et al., Robert Wood Johnson Found. & Urban Institute, *Consider Savings as well as Costs: State Governments Would Spend at Least $90 Billion Less with the ACA than Without It from 2014 to 2019* (July 2011) (estimating total state savings from the ACA at $92-$129 billion).

[3] Annie Lowrey, N.Y. Times, *How Much Would the Medicaid Expansion Cost Your State?* (July 2, 2012) (expressed as a percentage of 2011 GDP).

[4] Matthew Buettgens et al., Robert Wood Johnson Found. & Urban Institute, *Consider Savings as Well as Costs* (July 2011) (citing the work of Hadley and colleagues for state and local spending on uncompensated care).

[5] National Ass'n of State Mental Health Program Directors Research Inst., Inc., *State Mental Health Agency Revenues and Expenditures for Mental Health Services* (Aug. 22, 2011).
[6] Matthew Buettgens et al., The Robert Wood Johnson Found & Urban Inst., *Consider Savings as Well as Costs* (July 2011).
[7] For conditions and limits on this funding, *see* 42 U.S.C. § 1396b(w); 42 C.F.R. § 433.68.
[8] Matthew Buettgens et al., The Robert Wood Johnson Found. & Urban Inst., *Churning Under the ACA and State Policy Options for Mitigation* (June 2012).
[9] The Commonwealth Fund, Laura Summer & Cindy Mann, Georgetown Univ. Health Policy Instit., *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (2006).
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[14] Andrea Kovach, Sargent Shriver National Center on Poverty Law, *Expanding Medicaid: The Choice is Clear* (Shriver Brief July 10, 2012).
[15] John Lyon, Ark. News Bureau, *Update DHHS: Savings to state would exceed Medicaid expansion costs* (July 17, 2012) (also attributing saving to the increased federal funding and reduction in the amount the state spends on uncompensated care).
[16] Corey Davis, National Health Law Program, *Q&A Disproportionate Share Hospitals and the ACA* (June 2012).
[17] Anna Somers et al., Center for Studying Health System Change, *Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms* (Brief No. 23 July 2012).
[18] Renee Y. Hsia, MD*, Factors Associated With Closures of Emergency Departments in the United States* 305 J. Am. Med. Ass'n 1978 (May 18, 2011).
[19] 42 U.S.C. § 1395kkk.
[20] Katherine J. Hayes, JD. et al., George Washington Univ. School of Public Health & Health Servs., *How the Supreme Court's Medicaid Decision May Affect Health Centers: An Early Estimate* (July 19, 2012).
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[27] See 42 U.S.C. § 18091(2)(F).
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[58] Ariz. Rev. Stat. § 2901.01(B) (enacted after the people passed Proposition 204).
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[61] *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).