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Realizing Health Reform's Potential

The Affordable Care Act's New Tools and Resources to Improve Health and Care for Low-Income Families Across the Country

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Abstract: The Commonwealth Fund *Scorecard on State Health System Performance for Low-Income Populations, 2013,* finds wide gaps by income in access to care, quality of care received, and health outcomes in all states, and major differences between states in health system performance for people with below-average incomes. The Affordable Care Act provides state and local leaders with unprecedented opportunity along with new tools and resources to raise the standard for everyone and to begin to close the geographic and income divide. This issue brief reviews provisions of the law that have the potential to benefit low- and modest-income individuals, including those that expand health insurance coverage; strengthen primary care and improve care coordination; bolster the capacity of providers serving low-income communities; move toward greater accountability for the quality and cost of care; and invest in public health. It concludes by highlighting some of the challenges that lie ahead.

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OVERVIEW

The Affordable Care Act aims to improve the health and health care experiences of all Americans, but it has the potential especially to benefit those with low or modest incomes. As the Commonwealth Fund's *Scorecard on State Health System Performance for Low-Income Populations, 2013,* illustrates, people who live in households with below-average annual incomes are disproportionately at risk for experiencing the shortcomings of the U.S. health care system.[1] The health reform law offers state and local community leaders a historic opportunity to improve the health and welfare their populations, thereby lowering these risks.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Key provisions in the health reform law with particular benefits for communities and families with low- and modest-incomes include:

- expanding and improving health insurance coverage;
- strengthening primary care and improving care coordination;
- bolstering the capacity of providers serving low-income populations;
- moving toward greater accountability for the quality and cost of care; and
- investing in prevention and public health.

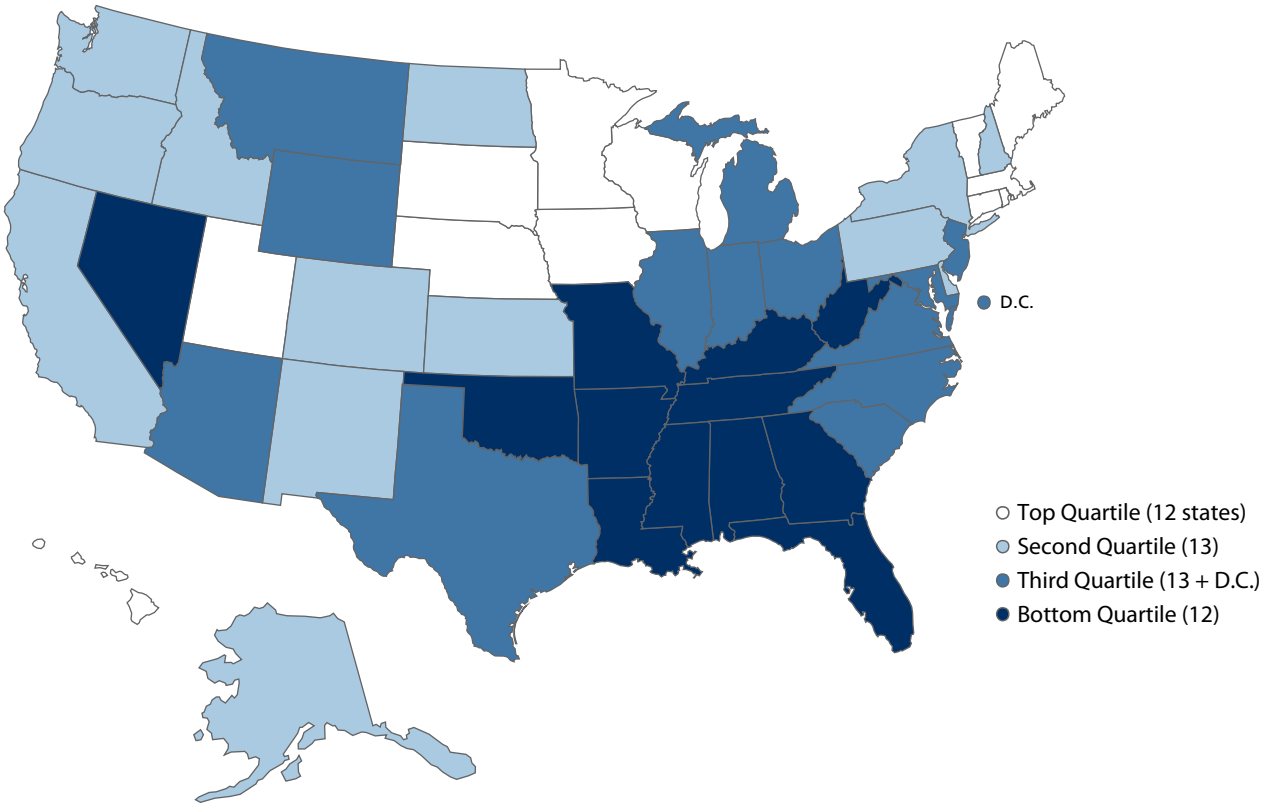
This issue brief looks at each of these areas and explores the need for creative action at the state and local level to ensure the new tools and policies are used effectively. The new tools provided by the Affordable Care Act will add to the states' already powerful roles as purchasers of coverage for public programs and state employees, regulators of providers and insurers, and advocates of public health.[2] Local communities and care system leaders can participate in innovations designed to improve health and health care and make care more affordable. Exhibit 1 from the low-income populations Scorecard indicates that the most acute needs for improvement are in states in the South and South Central United States; however, all states have ample room to improve.

REFORMS OF SPECIAL BENEFIT TO LOW-INCOME POPULATIONS

Expanding and Improving Health Insurance Coverage

Medicaid expansion. Under the Affordable Care Act, states have the option to extend Medicaid eligibility beginning in January 2014 to all citizens and eligible legal residents under age 65 with incomes up to 133

Exhibit 1. Overall Health System Performance for Low-Income Populations



Source: Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013.

percent of the federal poverty level ($15,282 for a single person and $31,322 for a family of four in 2013). The federal government will cover 100 percent of the costs of all newly eligible beneficiaries from 2014 through 2016, with its share gradually decreasing to 90 percent in 2020 and thereafter.

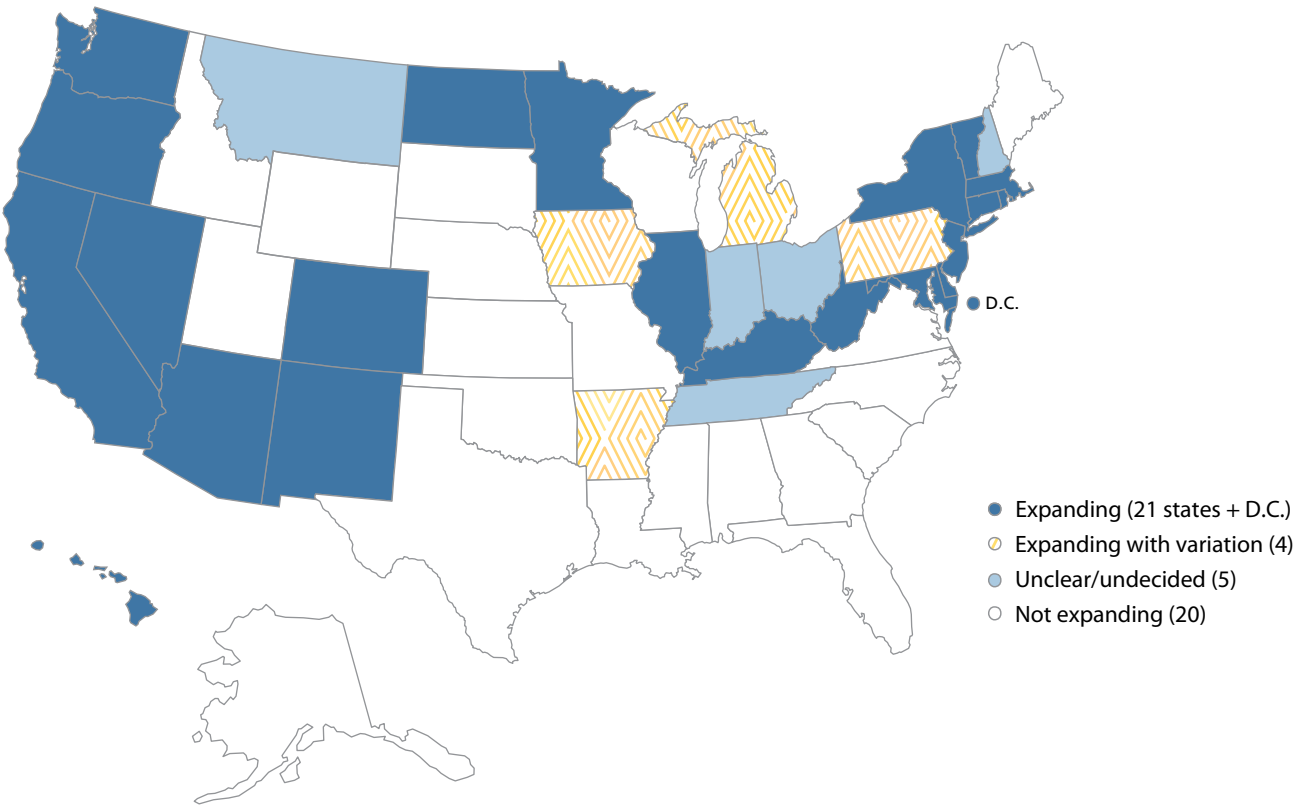
As of September 2013, 21 states plus the District of Columbia indicated they would expand Medicaid. Four additional states have also agreed to use a different approach—expanding Medicaid eligibility with waivers from the Department of Health and Human Services (Exhibit 2).[3] Currently five states have not decided whether to expand, and the remaining 20 states have said they are not expanding the program.

Of the estimated 25.4 million uninsured adults whose incomes would make them eligible for expanded Medicaid, nearly half live in these 20 states.[4] Many of these individuals—those earning more than the poverty level ($11,170 for an individual and $23,050 for a family of four)—will be eligible for subsidized private coverage through the new marketplaces. However, there are no new subsidized insurance options for the more than 8 million uninsured residents of the 20 states who have incomes *below* the poverty level.[5] That's because Congress assumed, prior to the Supreme Court's decision on the Affordable Care Act, that these families would be eligible for expanded Medicaid.[6] (See the Appendix for states' current eligibility thresholds for Medicaid.)

The option to expand Medicaid will remain open, although full federal support is available only through 2016. Notably, many of the states that are currently not expanding lag national averages for premature death, gaps in preventive care, and other indicators of access to timely and affordable care.

New insurance marketplaces offering subsidized coverage. The other major source of coverage expansion—available in every state—is health insurance

Exhibit 2. Status of State Participation in Medicaid Expansion as of September 2013



Note: Indiana and Tennessee have considered expanding with variation.
Source: Avalere, *State Reform Insights*; Center on Budget and Policy Priorities; Politico.com; Commonwealth Fund analysis.

marketplaces, sometimes called exchanges. Starting in October 2013, consumers can purchase private health insurance plans from the marketplaces, with coverage effective January 2014. The plans must provide an essential benefits package that is similar to a typical employer plan. Individuals and families earning between 100 percent and 400 percent of the poverty level who do not have access to public insurance or affordable employer-based insurance will be eligible for tax credits to help offset the expense of premiums. For those with incomes below 200 percent of poverty—the population most at risk for having out-of-pocket medical expenses that could be ruinous—the law significantly reduces cost-sharing (i.e., copayments, coinsurance, and deductibles) for qualified plans (Exhibit 3). In addition, the Affordable Care Act established, for the first time, a limit on how much people can be asked to pay out-of-pocket for medical and prescription drug expenses, with substantially lower limits for people with incomes below 200 percent of poverty (Exhibit 3). The new industrywide cost-sharing standard for those with low-incomes will take effect in January 2014 for health coverage purchased in the insurance marketplaces.[7]

The new subsidized private health plans combined with Medicaid expansion have the potential to reduce the number of uninsured substantially if all states eventually expand Medicaid. In addition, new insurance market rules will apply in all states, improving coverage for millions of insured people who have gaps in benefits or skimpy coverage that puts them at risk for high out-of-pocket costs.

In addition to providing better access and financial protections for the uninsured and inadequately insured, Medicaid and insurance expansions have the potential to yield positive benefits for the state's economy. Virtually every study on the statewide economic impact of Medicaid expansion under the Affordable Care Act is positive—state outlays are more than offset by the direct, indirect, and induced effect of billions of federal dollars stimulating job creation and generating state tax revenue. A forthcoming synthesis covering at least 31 states—13 of which are not

Exhibit 3. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

FPL	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: Silver plan
<133%	Single (S): <$15,282 Family (F): <$31,322	2% (or Medicaid)		94%
133%–149%	S: $15,282 – <$17,235 F: $31,322 – <$35,325	3.0%–4.0%	S: $2,083 F: $4,167	94%
150%–199%	S: $17,235 – <$22,980 F: $35,325 – <$47,100	4.0%–6.3%		87%
200%–249%	S: $22,980 – <$28,725 F: $47,100 – <$58,875	6.3%–8.05%	S: $3,125 F: $6,250	73%
250%–299%	S: $28,725 – <$34,470 F: $58,875 – <$70,650	8.05%–9.5%		70%
300%–399%	S: $34,470 – <$45,960 F: $70,650 – <$94,200	9.5%	S: $4,167 F: $8,333	70%
400%+	S: $45,960+ F: $94,200+	—	S: $6,250 F: $12,500	—

Note: FPL refers to federal poverty level. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan.
Source: Federal poverty levels are for 2013; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

yet participating in Medicaid expansion—finds that relatively small investments stand to return billions of dollars in increased economic activity over the coming decade.[8]

Strengthening Primary Care

Primary care is the foundation of a high-performance health system, offering an entry point, a source of preventive care, and ongoing care when sick. The Affordable Care Act aims to strengthen the nation's primary care system by expanding medical homes, enhancing payment for primary care practices, and targeting extra help for historically underserved communities. Low-income populations and communities in particular stand to benefit because they are less likely to have access to primary care physicians, placing them at risk for complications that could be avoided with timely, effective care.[9]

Enhancing payments to primary care providers. The reform law enhances Medicare and Medicaid's payment rates for primary care to reward and encourage primary care providers to participate in the programs and to provide quality care. Under the law, during 2013 and 2014, Medicaid payments for primary care physicians will be increased to at least the Medicare rates for equivalent services. This will raise payment in an estimated 48 states. (In 2012, Medicaid's primary care fees were at or above Medicare's only in Alaska and North Dakota.[10]) The two-year increase, fully funded by the federal government, will provide an estimated $8.3 billion in additional revenue for participating primary care providers.[11]

Since 2011, Medicare has provided physician practices that focus on primary care (defined in the law as practices with primary care billings of at least 60%) with a 10 percent bonus for primary care services, on top of the program's usual reimbursement rates.[12] The bonus payments, which continue until January 1, 2016, are projected to total $3.5 billion.[13] In the program's first year, the new Medicare payments totaled more than $560 million: California, Florida, and New York/Connecticut each received nearly $50 million in enhanced payments, while Texas received nearly $40 million.[14]

Making down payments on medical homes and health homes. The Affordable Care Act also encourages the adoption and spread of patient-centered medical homes—primary care practices that provide patients with enhanced access to care, recommended preventive services, care management, and coordination.

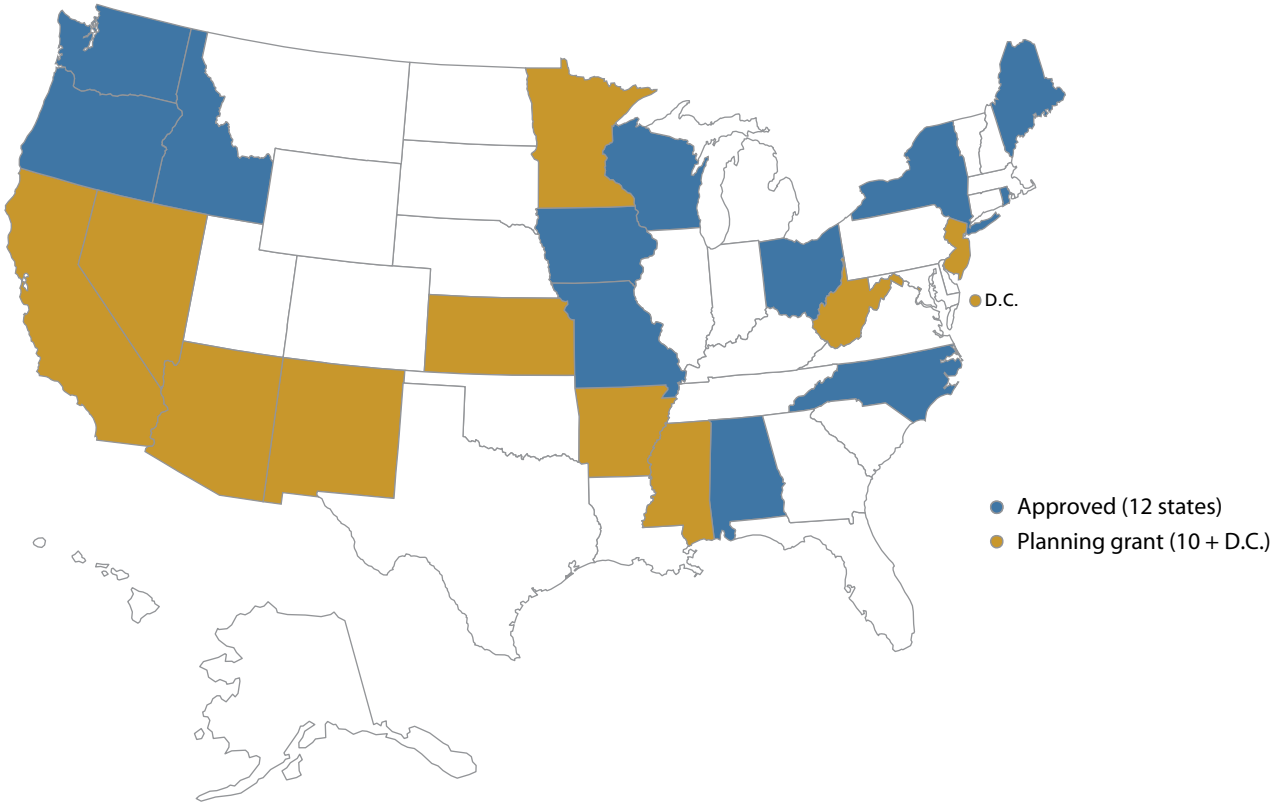
To cover the costs of expanding services and to encourage innovation, Medicare and Medicaid have launched initiatives—often in partnership with private insurance payers—to offer primary care practices enhanced payments to enable them to provide "team-based care," including additional nurses, care availability at any time of day, and improved care management. These initiatives include:

- The Multi-Payer Advanced Primary Care Practice Demonstration. Medicare joined Medicaid and private insurers already participating in eight state-led programs to make medical homes more widely available to enrollees. Participating practices are paid monthly fees for managing their patients' care (per-member per-month fees).
- The Comprehensive Primary Care Initiative. Multiple payers pay participating practices per-member per-month fees; and the practices—about 500 across four states and three regions—are also eligible to share in any savings achieved after two years.
- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration. Approximately 500 FQHCs transitioning into medical homes receive a per-member per-month fee for their fee-for-service Medicare patient populations.

In addition, states that expand or implement "health homes" for Medicaid beneficiaries with chronic conditions can receive federal funding matched at a

Exhibit 4. Medicaid Health Home Activity as of July 2013

Funded through the Affordable Care Act, Medicaid Health Homes involve teams or networks to care for patients with multiple chronic conditions. Health home services include: care management, coordination, transitional and follow-up care after a hospital stay, referral to community/social services, and health information technology to link services.



Sources: Centers for Medicare and Medicaid Services; National Academy for State Health Policy.

rate of 90 percent. Similar to medical homes, health homes designate a case manager for patients with multiple chronic conditions and offer enhanced payment for care management and coordination and for transitional and follow-up care after a hospital stay. As of July 2013, health home plans in 12 states had been approved by the Centers for Medicare and Medicaid Services (Exhibit 4).

Improving the Way Medicare and Medicaid Coordinate Care for Dual-Eligibles

The 9.2 million low-income seniors and people with disabilities who qualify for both Medicare and Medicaid—known as dual-eligibles—are at risk for poorly coordinated care and services between the two programs as well as among providers. The Medicare–Medicaid Coordination Office established under the law awarded grants of up to $1 million each to 15 states seeking to better integrate care for dual-eligibles. The office is reviewing proposals from 24 states to test models to improve care and financial alignment between the two programs.[15]

Bolstering the Capacity of Providers Serving Low-Income Populations

Several provisions in the law bolster the capacity of providers serving low-income populations. The law authorizes $11 billion over five years for the operation and expansion of community health centers (also known as federally qualified health centers, or FQHCs) and for integrating them more fully with other providers. In addition, the health reform law offers expanded scholarships and loan repayment for primary care providers working in underserved areas.

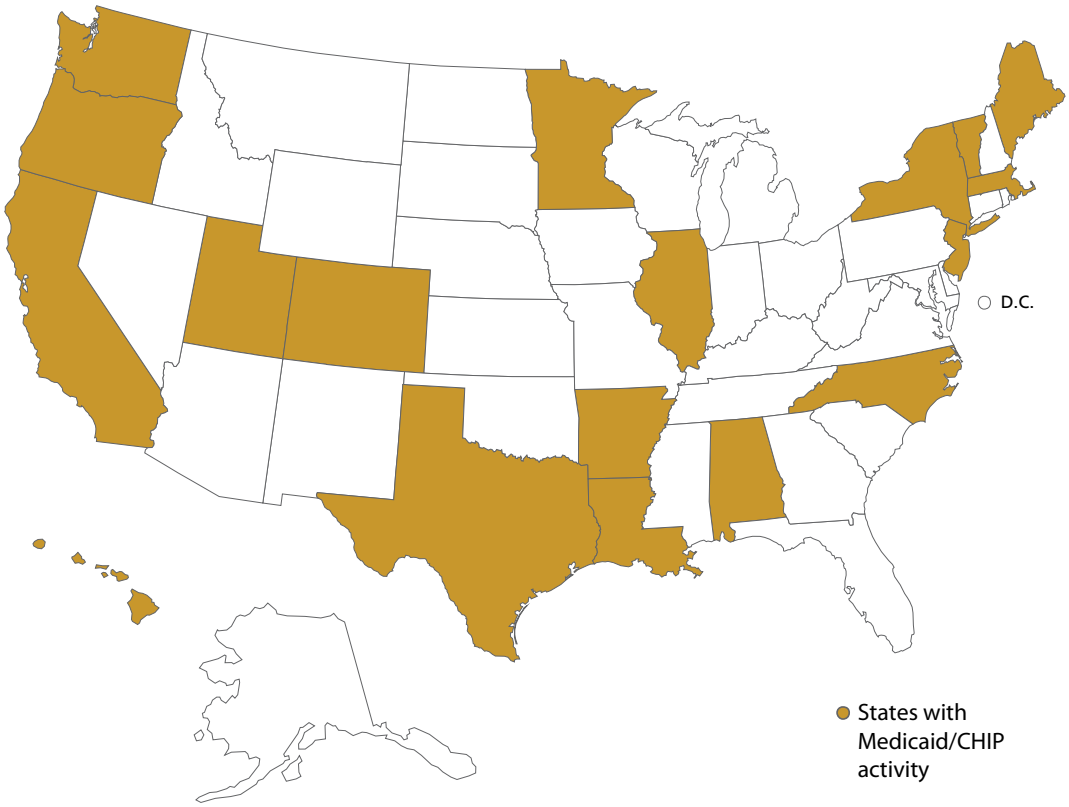
Moving Toward Greater Accountability for Costs and Outcomes

The health reform law also authorizes financial incentives for Medicare providers to work together to improve health care quality and efficiency in networks called accountable care organizations (ACOs). These networks are held accountable for improving care while controlling costs, and are eligible to share in savings achieved through reducing costs as long they also meet certain performance standards. As of September 2013, there were 243 Medicare ACOs, with varying levels of shared savings and risk, operating in most states and serving 4 million beneficiaries nationwide.[16] In addition, 18 states have taken steps to develop accountable care models for their Medicaid and Children's Health Insurance Program populations (Exhibit 5).[17] Minnesota, New Jersey, and Oregon are at the forefront of this effort, having launched ACOs for their Medicaid populations.[18] Private insurers also have developed ACO contracts, often in tandem with public and other payers.

Investing in Prevention and Public Health

Low-income populations are disproportionately affected by health problems—including obesity, asthma, diabetes, smoking, and substance abuse-related conditions—that potentially can be mitigated by preventive and public health interventions.[19] The Affordable Care Act established the Prevention and Public Health Fund, which distributed approximately $2.25 billion to health and human services agencies to support public health activities in states and local communities from 2010 through 2012.[20] The law also provides for support of community health teams, although funds have not yet been appropriated.

Exhibit 5. Medicaid/CHIP Accountable Care Model Activity, September 2013



Source: National Academy for State Health Policy, State "Accountable Care" Activity Map, http://www.nashp.org/state-accountable-care-activity-map.

CHALLENGES AHEAD

Projections estimate that as a result of the insurance coverage expansions, 25 million to 33 million people who would have otherwise been uninsured will gain insurance by 2022. However, estimates also suggest that as many as 27 million to 31 million will remain uninsured at that time.[21]

As many as one-quarter of the uninsured are expected to be unauthorized immigrants.[22] Under the law, these individuals are ineligible for Medicaid and are barred from purchasing coverage in the new exchanges. In states that choose not to expand Medicaid eligibility, the uninsured will also include adult citizens with incomes below the poverty level who will not be eligible for the new premium tax credits because their income is too low.[23] In these states, the poorest residents will be left out while those with higher incomes will receive financial help in buying insurance.

Providers caring for low-income patients will continue to bear the financial burden of providing charity care. The new law authorizes reductions in current federal payments (known as disproportionate share hospital, or DSH, payments) for uncompensated care provided by hospitals with a high share of Medicaid or uninsured patients. The scheduled cuts in subsidies could put safety-net hospitals at risk.

CONCLUSION

States have considerable power to shape their health care systems, yet that power has historically been limited by local resources. Local health care leaders, including hospital leaders, physician practices, and clinics, have also lacked the resources to invest and innovate. The Affordable Care Act provides new opportunities to improve health care access, quality, and outcomes for low-income populations while reducing longer-term costs. It is up to state and local leaders to act effectively and creatively to translate the potential into concrete gains to begin to close the geographic and income divide.

Notes

1 C. Schoen, D. C. Radley, P. Riley, J. A. Lippa, J. Berenson, C. Dermody, and A. Shih, *Health Care in the Two Americas: Findings from the Scorecard on State Health System Performance for Low-Income Populations* (New York: The Commonwealth Fund, Sept. 2013); D. McCarthy, S. K. H. How, C. Schoen, J. C. Cantor, and D. Belloff, *Aiming Higher: Results from a State Scorecard on Health System Performance, 2009* (New York: The Commonwealth Fund, Oct. 2009).

2 McCarthy, How, Schoen et al., *Aiming Higher*, 2009; J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).

3 Avalere, *State Reform Insights*; Center on Budget and Policy Priorities; Politico.com; Commonwealth Fund analysis.

4 R. Rudowitz and J. Stephens, *Analyzing the Impact of State Medicaid Expansion Decisions* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, July 2013).

5 Kaiser Family Foundation, "Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL)," *State Health Facts* (Washington, D.C.: Henry J. Kaiser Family Foundation), http://kff.org/uninsured/state-indicator/distribution-by-fpl-2/.

6 P. W. Rasmussen, S. R. Collins, M. M. Doty, and T. Garber, *In States' Hands: How the Decision to Expand Medicaid Will Affect the Most Financially Vulnerable Americans* (New York: The Commonwealth Fund, Sept. 2013).

7 As of 2013, some employer health plans outside the exchanges that currently have separate out-of-pocket limits for medical coverage and prescription drugs have been granted a one-year extension to comply.

8 We have identified 37 studies, covering 31 states, that examine the potential economic impact of new federal resources flowing to states as a result of Medicaid expansion. Information and links to the studies are available from the authors of this brief. A forthcoming synthesis will be available from The Commonwealth Fund.

9 M. K. Abrams, R. Nuzum, S. Mika, and G. Lawlor, *How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers* (New York: The Commonwealth Fund, Jan. 4, 2011); and K. Davis, M. K. Abrams, and K. Stremikis, "How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation," *Journal of General Internal Medicine*, published online April 27, 2011.

10 S. Zuckerman and D. Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Dec. 2012).

11 Abrams, Nuzum, Mika et al., *How the Affordable Care Act Will Strengthen*, 2011; Davis, Abrams, and Stremikis, "How the Affordable Care Act," 2011.

12 Ibid.

13 Ibid.

14 Centers for Medicare and Medicaid Services, "Primary Care Incentive Payment Program (PCIP): Medicare PCIP Payments for 2011 Exceed Will $560 Million," http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2011-Payments.pdf.

15 Centers for Medicare and Medicaid Services, State Demonstrations to Integrate Care for Dual Eligibles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html; and Centers for Medicare and Medicaid Services, Financial Alignment Initiative, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Meidcare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

16 The Medicare ACOs include 220 that are participating in the Medicare Shared Savings Program (MSSP) and 23 in the Pioneer program that has higher levels of shared risk and potential savings. See D. Glass, J. Stensland, and K. Smalley, "Medicare Accountable Care Organizations (ACOs): Recent Developments and Future

Directions," Presentation at Medicare Payment Advisory Commission Public Meeting, Sept. 12, 2013; and Centers for Medicare and Medicaid Services, "Pioneer Accountable Care Organizations Succeed in Improving Care, Lowering Costs," News release, July 16, 2013.

17 National Academy for State Health Policy, State "Accountable Care" Activity Map, http://www.nashp.org/state-accountable-care-activity-map.

18 V. A. Lewis, C. H. Colla, K. L. Carluzzo et al., "Accountable Care Organizations in the United States: Market and Demographic Factors Associated with Formation," *Health Services Research,* published online Oct. 1, 2013; and D. Bachrach, W. Bernstein, and A. Karl, *High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid* (New York: The Commonwealth Fund, Nov. 2012).

19 E. L. Schor, J. Berenson, A. Shih, S. R. Collins, C. Schoen, P. Riley, and C. Dermody, *Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations* (New York: The Commonwealth Fund, Oct. 2011).

20 The Affordable Care Act and the Prevention and Public Health Fund Report to Congress for FY2012.

21 Congressional Budget Office, May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage (Washington, D.C.: CBO, 2013); and S. R. Collins, S. Guterman, R. Nuzum, M. A. Zezza, T. Garber, and J. Smith, *Health Care in the 2012 Presidential Election: How the Obama and Romney Plans Stack Up* (New York: The Commonwealth Fund, Oct. 2012).

22 B. D. Sommers, "Stuck Between Health and Immigration Reform—Care for Undocumented Immigrants," *New England Journal of Medicine,* Aug. 15, 2013 369(7):593–95; and M. Buettgens and M. A. Hall, *Who Will Be Uninsured After Health Insurance Reform?* (Princeton, N.J.: Robert Wood Johnson Foundation, March 2011).

23 Rasmussen, Collins, Doty et al., *In States' Hands*, 2013; and S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013).

Appendix. Medicaid Policies by State

	Income Eligibility for Medicaid/CHIP as a Percent of Federal Poverty Level (FPL), 2013*			State Participation in Affordable Care Act Medicaid Expansion**	Medicaid Medical Home Payments and Multipayer Initiatives Currently Under Way***
	Children (Ages 6–18)	Parents—Working (Ages 18–64) Medicaid/Limited^	Childless Adults—Working (nondisabled) (Ages 18–64) Medicaid/Limited^	138% FPL Income Eligibility for Medicaid Expansion	
Alabama	100	23 / NA	NA	No	
Alaska	175	78 / NA	NA	No	
Arizona	100	106 / NA	100^^ / NA	Yes	
Arkansas	200	16 / 200	NA / 200	Yes, with variation	X
California	100	106 / 206	NA / 210	Yes	
Colorado	133	106 / NA	20 / NA	Yes	X
Connecticut	185	191 / NA	70 / NA	Yes	
Delaware	100	120 / NA	110 / NA	Yes	
District of Columbia	300	206 / NA	211 / NA	Yes	
Florida	100	56 / NA	NA	No	
Georgia	100	48 / NA	NA	No	
Hawaii	300	133 / NA	133 / NA	Yes	
Idaho	133	37/ 185	NA / 185	No	X
Illinois	133	139 / NA	NA	Yes	
Indiana	150	24 / 206	NA / 210^^	Unclear/Undecided	
Iowa	133	80 / 250	NA / 250	Yes, with variation	
Kansas	100	31 / NA	NA	No	
Kentucky	150	57 / NA	NA	Yes	
Louisiana	200	24 / NA	NA	No	
Maine	150	200 / NA	NA / 100^^	No	X
Maryland	300	122 / NA	NA / 128^^	Yes	X
Massachusetts	150	133 / 300	NA / 300^^	Yes	X
Michigan	150	64 / NA	NA / 45^^	Yes, with variation	X
Minnesota	275	215 / 275	75 / 200	Yes	X
Mississippi	100	29 / NA	NA	No	
Missouri	150	35 / NA	NA	No	
Montana	133	54 / NA	NA	Unclear/Undecided	
Nebraska	200	58 / NA	NA	No	
Nevada	100	84 / NA	NA	Yes	
New Hampshire	300	47 / NA	NA	Unclear/Undecided	
New Jersey	133	200^^ / NA	NA / 23	Yes	X
New Mexico	285	85 / 408^^	NA / 414^^	Yes	
New York	133	150 / NA	100 / NA	Yes	X
North Carolina	100	47 / NA	NA	No	X
North Dakota	100	57 / NA	NA	Yes	
Ohio	200	96 / NA	NA	Unclear/Undecided	X
Oklahoma	185	51 / 200	NA / 200	No	X
Oregon	100	39 / 201^^	NA / 201^^	Yes	X
Pennsylvania	100	58 / NA	NA	Yes, with variation	X
Rhode Island	250	181 / NA	NA	Yes	X
South Carolina	200	89 / NA	NA	No	
South Dakota	140	50 / NA	NA	No	
Tennessee	100	122 / NA	NA	Unclear/Undecided	
Texas	100	25 / NA	NA	No	
Utah	100	42 / 200	NA / 200	No	
Vermont	225	191 / 331	160 / 353	Yes	X
Virginia	133	30 / NA	NA	No	
Washington	200	71 / 200^^	NA / 200^^	Yes	X
West Virginia	100	31 / NA	NA	Yes	
Wisconsin	150	200 / NA	NA / 200^^	No	
Wyoming	100	50 / NA	NA	No	

Notes: FPL denotes federal poverty level. The Medicaid/CHIP-funded Medicaid expansion program income eligibility listed here is restricted to children ages 6–18, the child is age six or older, but has not yet reached his or her 19th birthday. States provide coverage for children ages 0–5 as well, with income eligibility ranging across states up to 300% FPL. Income eligibility levels for children combine "regular" Medicaid (where states receive Medicaid matching payments) and any CHIP-funded Medicaid expansion programs (where the state receives the enhanced CHIP matching payments for these children).

NA = not applicable.

* Source: Kaiser Family Foundation, State Health Facts, Income Eligibility Limits for Children's Regular Medicaid and Children's CHIP-funded Medicaid Expansions as a Percent of Federal Poverty Level (FPL), Jan. 2013, http://kff.org/medicaid/state-indicator/income-eligibility-fpl-medicaid/; Kaiser Family Foundation, State Health Facts, Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL), Jan. 2013, http://kff.org/medicaid/state-indicator/income-eligibility-low-income-adults/.

^ Denotes more limited coverage, where a state has a waiver or state-funded program with more limited benefits and/or higher cost-sharing than Medicaid to provide coverage to adults at higher income levels.

^^ Denotes enrollment is closed to new applicants at any point between January 1, 2012, and January 1, 2013.

** Source: P. W. Rasmussen, S. R. Collins, M. M. Doty, and T. Garber, *In States' Hands: How the Decision to Expand Medicaid Will Affect the Most Financially Vulnerable Americans* (New York: The Commonwealth Fund, Sept. 2013).

Data: Avalere State Reform Insights; Center of Budget and Policy Priorities; Politico.com; Commonwealth Fund analysis.

*** Source: National Academy for State Health Policy State Scan, updated April 2013, http://www.nashp.org/med-home-map.

About the Authors

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