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Geographic Variation in the Cost of Living: Implications for the Poverty Guidelines and Program Eligibility

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I. Introduction

The poverty guidelines, used to determine income eligibility for many federal program benefits, poverty thresholds, used to determine the official poverty rate, and federal income tax parameters historically have not varied across the country. Notable exceptions include higher poverty guidelines for Alaska and Hawaii where living costs are higher than in the other states, and federal housing assistance that determines eligibility and benefits based on variation in income levels and fair market rents (FMR) across metropolitan and nonmetropolitan county areas. The national poverty guidelines and thresholds are also used to determine income eligibility for some benefit programs and the poverty rates in the U.S. territories (referred to as insular areas in this report).

Despite the use of national poverty guidelines to determine income eligibility for most public benefits across the country, considerable research documents substantial geographic differences in the cost of living across regions, states, and localities within states. For example, recent work by the Census Bureau and others on the Supplemental Poverty Measure (SPM) that adjusts the poverty thresholds for differences in housing costs across metropolitan areas within states has focused new attention on how variation in costs affects economic well-being (Short 2011; Chung et al. 2012; NYC Center for Economic Opportunity 2012; Wheaton et al. 2011). A recent conference sponsored by HHS/ASPE brought scholars from across the country to discuss possible approaches to adjusting the poverty thresholds for geographic variation in prices (Ziliak 2011). While the current SPM adjustment focuses on housing costs, other available indices document variation in the cost of market baskets of goods across the country, food, transportation, and housing plus transportation. Research on medical costs also documents substantial variation in the prices of medical services in different geographic areas.

This accumulated research provides guidance for assessing whether and how the poverty guidelines could be adjusted to accurately reflect differences in the cost of living and the implications of adjusting the guidelines for eligibility and benefit levels in federal programs. This assessment was requested by Congress as part of the Affordable Care Act, passed on March 23, 2010.[1] The specific request to HHS was:

> SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.
>
> a) IN GENERAL. The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by this subtitle) for different geographic areas so as to

[1] Public Law 111-148, Patient Protection and Affordable Care Act of 2010 added by section 1015(f) of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (together referred to as the "Affordable Care Act (ACA)".

> reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.
>
> (b) INCLUSION OF TERRITORIES.
>
> (1) IN GENERAL. The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

This project was designed to provide the Department of Health and Human Services (HHS) with a thorough review of the literature on price variation across geographic areas, an assessment of the available indices to use to adjust the poverty guidelines for geographic price variation, and trial estimates of how geographically adjusted poverty guidelines would affect program eligibility. The review of literature covered a broad range of research on geographic differentials in the cost of living, including a summary of underlying data quality and availability. The review paid particular attention to how well various methods reflect costs faced by low-income populations. The assessment of this literature included the convening of an expert panel review and development of recommendations. The panel's recommendations on the best way to adjust the poverty guidelines for price variation were then used to test the effects on eligibility for Medicaid, the Children's Health Insurance Program (CHIP), Advanced Premium Tax Credits (APTC) under the Affordable Care Act, the Supplemental Nutrition Assistance Program (SNAP), and federally funded child care subsidies through the Child Care and Development Fund (CCDF). The estimates for SNAP and CCDF provide additional backdrop for reviewing how adjustments to the poverty guidelines would affect eligibility for federal benefit programs. If health insurance affordability programs move toward adjusting guidelines for geographic variation in the cost of living, other programs may follow.

This report begins by summarizing how poverty guidelines are currently used to determine benefit eligibility. Subsequently, we synthesize the literature review of geographic variation in prices and highlight the recommendations of the expert panel. The next section presents estimates of how variations in the poverty guidelines would affect program eligibility. This section details the indices tested, methods used to simulate eligibility using the alternative guidelines, and the results for each program. Cost estimates associated with the changes in eligibility for health benefits are also provided. The estimates developed for the insular areas are presented separately, given the substantial limitations in available data

for estimating program eligibility. The final section presents the summary and caveats. Three appendices provide further detail on the adjustments to the poverty guidelines, additional demographic data for the insular areas, and the full literature review.

How Are Poverty Guidelines Currently Used to Determine Program Eligibility?

Most safety net programs compare an individual's or family's income to a percentage multiple of the poverty guidelines to determine income eligibility (table 1). One notable exception is that states cannot set the eligibility limit for CCDF above 85 percent of state median income (SMI), and some states set their eligibility limits as a percentage of SMI.

Table 1. Program Eligibility Rules

Program	Target population	Filing unit	Eligibility limits
Medicaid for persons age 65+ and disabled	Low-income elderly and disabled	Usually individuals	Income under a specified percentage of the poverty guideline; varies by state.
Medicaid (nonelderly, under Affordable Care Act)	Low income individuals	New Medicaid and CHIP family units	States have the option to cover if modified AGI (MAGI)[a] is ≤ 138 percent of poverty guidelines; higher limits in most states for infants and pregnant women and in some states for children and adults. No asset limits. Maintenance of effort requirement applies until 2014 for adults and 2019 for children. In lieu of earned income and other deductions, a 5 percent disregard will be applied to MAGI.
CHIP	Persons ≤ 18 and sometimes parents		Limits are determined by state (> 250 percent of poverty guideline in 25 states). No asset limits.
Affordable Care Act Advanced Premium Tax Credits	Individuals without an affordable ESI plan offer and not eligible for public coverage who purchase insurance through an exchange.	Tax filing unit, including dependents	Eligibility is limited to those with incomes between 100 and 400 percent of poverty guidelines without access to other affordable coverage. Legal immigrants with incomes below this level who are not eligible for Medicaid due to immigration status only are also eligible and are deemed to have income at 100 percent.
SNAP	Low-income households; time-limited for nonworking, non-disabled, childless adults age 18–49.	All persons who purchase and prepare food together; families receiving cash aid may file separately.	Gross income ≤ 130 percent of poverty guidelines and net income ≤ 100 percent; if age 60+ or with a disability, only net income test applies. Some states expand eligibility to as much as 200 percent of poverty guideline through Broad Based Categorical Eligibility option.
CCDF (federally funded child care subsidies)	Families with children ≤ 12 (or disabled teens) with parents employed or in approved activity.	Family; definition varies across states	Eligibility limits set by states; cannot exceed 85 percent of SMI. Many states use poverty guidelines to set limits.

a. Modified adjusted gross income (MAGI) is adjusted gross income (AGI) as defined by federal tax law plus foreign income and tax-exempt interest, calculated for the taxpayer and spouse plus dependents.

The federal poverty guidelines set by HHS each year are a modified version of the official poverty thresholds.[2] The official poverty thresholds, used by the Census Bureau to estimate the number of persons in the country who are poor, vary by family size and by whether there is a child in the family and whether the family head is age 65 or older. The poverty guidelines vary by family size only. The poverty thresholds themselves contain no geographic variation, and the Census Bureau does not issue separate thresholds for the insular areas. For the guidelines, adjustments are made to reflect the higher cost of living in Alaska and Hawaii. The differences for Hawaii and Alaska were developed in 1970 by the Office of Economic Opportunity (OEO) and were based on cost-of-living pay adjustments for federal, white-collar employees living in these two locations compared with Washington, D.C., at that time. Similar to the thresholds, however, HHS does not issue separate poverty guidelines for the insular areas.

Although the federal poverty guidelines vary only by family size, with additional adjustments for Alaska and Hawaii, their usage often varies by program, state, and eligibility group. For example, states vary substantially in the percentage of the poverty guidelines used to determine Medicaid coverage for the elderly, and many states deduct out-of-pocket health spending from income before determining Medicaid eligibility for the elderly. Eligibility for the ATPCs under the Affordable Care Act is based on modified adjusted gross income (MAGI).[3] These refundable tax credits are available to purchase coverage in an exchange for families with MAGI between 100 and 400 percent of the poverty guidelines who are not eligible for Medicaid or CHIP and do not have an affordable offer of employer health insurance coverage or other minimum essential coverage.[4] If individuals living in high health care cost areas face higher premiums in their exchanges, they will receive higher subsidies than those in lower-cost areas. Medicaid and CHIP have minimum eligibility thresholds that differ across a number of dimensions. With this flexibility in eligibility, some states address the issue of variation in prices or the cost of living by having higher eligibility thresholds in the high costs states. The Affordable Care Act does set a maximum eligibility threshold of 400 percent of the federal poverty guidelines for access to premium tax credits.

The SNAP program uses the poverty guidelines for both gross and net income tests, and these income limits are higher in Alaska and Hawaii. While the federal CCDF rules do not link eligibility to the poverty guidelines, many states use the guidelines to set their own eligibility limits.

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[2] See http://aspe.hhs.gov/poverty/index.cfm for the annual poverty guidelines.
[3] MAGI is adjusted gross income (AGI) as defined by federal tax law plus foreign income and tax-exempt interest, calculated for the taxpayer and spouse plus dependents.
[4] Employer-sponsored coverage is considered unaffordable if the employers' contribution to the costs of employer-sponsored coverage is less than 60 percent of the actuarial value of the plan or the premium contribution for individuals exceeds 9.5 percent of income.

What Does the Literature Tell Us about Price Variation across Geographic Areas?

Considerable research has been conducted over many years to understand variation in costs across geographic areas. Some of this research relates directly to poverty measurement, some to broader measures of cost variation, and some to variation in the costs of particular goods. We searched for indices that could be used to adjust the poverty guidelines and reviewed all the indices we identified. The review included measures produced as geographic price or cost of living indices as well as those that could be converted to indices by dividing the dollar amount for particular areas by the national average. We identified a total of 12 indices with potential for adjusting the guidelines for geographic variation (table 2), including some that capture variation in a full market basket of goods and services and others that focus on housing, medical expenses, or wages. Appendix C provides the detailed review of the literature by Wheaton, Dubay, and Zedlewski (2012).

Table 2. Geographic Indices Reviewed (alphabetical order)

Index (source)	Description
ACCRA (CCER)	Cost of consumer goods and services for professional and managerial households in top income quintile for urban areas, extending back to 1968 in some areas.
CEO (Carrillo, Early and Olsen) Index	A composite of costs in 2000 developed from HUD and ACCRA data that is adjusted using BLS price indices to create a panel for 1982–2010 for metro and nonmetro areas in each state.
Fair Market Rents (HUD)	Reflects 40th or 50th percentile of gross rent plus utilities for a standard unit, available annually. (Starting in 2012, based on American Community Survey housing costs.)
Family Budgets (EPI)	Budget representing annual family income required to maintain a safe and comfortable, but modest, standard of living by family type, available for 614 areas, in different time periods.
Geographic Practice Cost Index (CMS)	Includes physician practice and malpractice price differentials used by Medicare, updated every three years (latest in 2012).
H+T Affordability (CNT)	Housing and transportation costs for 337 metropolitan areas, available in 2010.
Medicare Hospital Wage Index (CMS)	Hospital labor costs based on average wages for 444 labor markets, available annually since 2005.
Milliman Medical Index	Costs of health care services for preferred provider plans for a family of four in 14 cities and the nation, available annually since 2004.
Occupational Pay Relatives (BLS)	Relative pay for different occupations in 77 metro areas and the nation, available annually in 2004–10. Terminated with 2011 federal budget.
Regional Price Parities (BEA and BLS)	Reflect all consumption items and produced for MSAs, state and non-MSA areas, starting in 2012.
Self-Sufficiency Standards (WA)	Define amount of income necessary to meet basic needs in 37 states and for different time periods.
Supplemental Poverty Measure Geographic Adjustment (Census)	Index based on median gross rent (rent and utilities) for two-bedroom rental units with complete kitchen and bathroom facilities. Scaled to adjust the housing portion of the SPM threshold.

BEA = Bureau of Economic Analysis; BLS = Bureau of Labor Statistics; CCER = Council for Community and Economic Research; CMS = Center for Medicare and Medicaid Services; EPI = Economic Policy Institute; FMR = Fair Market Rents; WA = University of Washington Center for Women's Welfare.

Three indices capture variation in a full market basket of goods and services purchased by households, and two capture variation in the family budget required to maintain a targeted standard of living. The indices based on goods and services purchased by households include the ACCRA index, developed by the Council for Community and Economic Research; Regional Price Parities (RPPs) published by the Bureau of Economic Analysis (BEA); and the Carillo, Early, and Olsen (CEO) index, developed by researchers at the University of Virginia based in part on ACCRA data. The Economic Policy Institute (EPI) Family Budget represents the annual family income required to maintain a safe and comfortable, but modest standard of living for six family types. The Self-Sufficiency Standard (SSS), developed by the Center for Women's Welfare at the University of Washington and by other state partners, defines the income necessary to meet basic needs without public subsidies or private or informal assistance.

HUD fair market rents have been used in past research to capture variation in housing costs. The Census Bureau has used the American Community Survey (ACS) to develop a rent-based index for adjusting the SPM for geographic variation in housing costs. The SPM geographic adjustment reflects differences in median rents for two-bedroom units with full kitchen and plumbing facilities, and is applied to the housing portion of the SPM poverty threshold. The Center for Neighborhood Technology's Housing and Transportation (H+T) Affordability Index is designed to reflect geographic variation in the combined costs of housing and transportation.

Medical indices include the Geographic Practice Cost Index (GPCI), used by Medicare to adjust physician payments for geographic variation in the costs of practice; the Medicare Hospital Wage Index (MHWI), used by Medicare to adjust for a portion of hospital labor costs across hospitals reimbursed under the Prospective Payment System; and the Milliman Medical Index (MMI), which represents variation in the costs of health care services for a typical family covered by a preferred provider plan. The Occupational Pay Relatives, developed by the Bureau of Labor Statistics, are calculated for nine occupational groups and isolate the geographic effect of differences in wages across areas.

We focused primarily on five factors to assess the potential of the 12 indices for adjusting the poverty guidelines for geographic price variation. These included goods covered, geographic coverage, time frame, applicability to low-income families, and source (private versus public). The assessment of the indices is summarized in table 3.

Table 3. Assessment of Indices along Six Critical Factors

Index	Goods covered	Geography	Time frame	Income group	Private/Public
ACCRA	Broad	Urban	Annual	High	Private (sold)
CEO	Broad	All U.S.	2000 base	All/high	Private (free)
FMR	Housing	All U.S.	Annual	Low	Public
EPI	Broad	Broad	Uneven	Low	Private (free)
GPCI	Medical	Broad	Three years	All	Public
H & T	Housing & transport	Metro	2010	All	Private (sold)
MHWI	Medical	Broad	Annual	All	Public
OPR	Pay	Narrow	Discontinued	Varied	Public
MMI	Medical	14 cities	Annual	All	Private (sold)
RPP	Broad	All U.S.	Annual	All	Public
SSS	Broad	Medium	Uneven	Moderate	Private (free)
SPM	Housing	All U.S.	Annual	Median renter	Public

Coverage of Goods. As noted above, the ACCRA, CEO, and RPP indices reflect a full market basket of goods and services purchased by households. The RPP relies on price data gathered for the Consumer Price Index (CPI) and rental data from the American Community Survey, with prices weighted using data from the Consumer Expenditure Survey. ACCRA obtains price data from reports by chambers of commerce and other local entities. Because the data underlying the CPI are not publicly available, the CEO uses ACCRA price data. CEO's housing estimates are drawn from HUD data. The EPI family budgets and SSS also reflect a full market basket of goods and services, but they are designed to reflect the level of needs for different types of families. The other indices reviewed here reflect geographic variation in housing, housing and transportation, medical costs, or payment levels for various occupations.

Geographic Coverage. Ideally, an index to adjust the poverty guidelines would reflect price variation across the country and could be implemented at the state or a lower geographic level (such as metropolitan and non-metropolitan area within state). For the CEO, FMR, RPP, SPM, GPCI, and MHWI indices, geographic adjustments are available, at least at some level, for all areas of the United States. The EPI family budgets cover much of the United States but are not available for all areas. The ACCRA covers urban areas (metropolitan areas and cities in nonmetropolitan counties meeting certain criteria). The H & T index covers all metropolitan areas, the OPR is available for 77 metropolitan areas, the SSS is available for 37 states, and the MMI is available for 14 cities.

Time Frame. An index for adjusting the poverty guidelines for price variation should be relatively current and should reflect price levels in different areas at the same point in time. Many of the indices pass these criteria at least beginning in 2012, including the ACCRA, FMR, H & T, MHWI, RPP, and SPM. The CEO differs because it builds a panel of costs from original data representative of 2000 adjusted for inflation to capture other years.

The EPI family budget and the SSS are not produced every year for every geographic area, and the GPCI is produced every three years. OPRs were available annually but were terminated with the 2011 federal budget.

A separate question, beyond the scope of this paper, is how and when to update geographic adjustments after initial implementation. Should new adjustments be introduced each year, or should the same index values be applied for consecutive years? An index for a particular area will fall from one year to the next if prices in that area have not risen as quickly as in other areas. If the area's index falls more than the federal poverty guideline increases, this could produce a drop in the area's adjusted poverty guideline. Should some mechanism be put in place to prevent this from happening? The RPPs and Census Bureau SPMs are based on rolling five-year data samples, in which only one-fifth of the underlying data is replaced in each year's estimate, reducing the likelihood of abrupt year-to-year changes. Nonetheless, this issue warrants further consideration.

Relevance to Low-Income Population. Ideally, an adjustment to the poverty guideline would reflect variation in cost of living faced by low-income families. None of the existing indices are specifically designed to measure geographic differences in the prices faced by the lowest income families. RPPs reflect the overall population. FMRs reflect variation in two-bedroom rents at the 40th and sometimes 50th percentile of the rental distribution. Although the SPM threshold reflects family spending on food, clothing, and shelter expenses at the 33rd percentile, the geographic adjustments to the SPM are only applied to the housing portion of the threshold and reflect differences in median two-bedroom rents. The housing portion of the EPI and SSS rely on FMRs; the EPI is intended to reflect costs for the bottom 40 percent of families, while some aspects of the SSS reflect higher standards (for example, child care reflects market cost at the 75th percentile). ACCRA is designed to capture prices for professional workers in the top quintile. Because the CEO draws price data (except for housing) from ACCRA, it is not as representative of the lower-income population. Occupational pay relatives are designed to capture geographic differences in wage levels, controlling for such factors as mix of occupational levels, and so are likely broadly representative of price differences facing workers.

Although none of the current adjustments specifically target geographic variation in prices faced by the lowest-income families, this may be acceptable if prices do not vary much by income level. Renwick (2011) explores this issue in relation to the SPM, finding high correlation (above 0.98) between the SPM geographic adjustment and other measures of rental costs more specifically targeted to the low-income population, including 33rd percentile rents, and median rents calculated for families at less than 200 percent, 150 percent, and 100 percent of the poverty threshold.

Public Availability. Indexes produced by or on behalf of government agencies include the FMR, GPCI, MHWI, OPR, RPP, and SPM. Other indices are produced by private entities, although most are available for free or at minimal cost (CEO, EPI, SSS, and ACCRA). The panel of experts assembled for this project expressed a clear preference for use of government indices in the public domain.

II. Assessment of the Indices

The review of the literature pertaining to geographic variation in prices was presented to an expert panel of researchers chosen for their expertise in this area.[5] The panel included two project consultants and other experts:

- James Ziliak, University of Kentucky, Project Consultant, Poverty Institute
- Steven Zuckerman, the Urban Institute, Project Consultant, Fellow in Health Policy
- Bettina Aten, Bureau of Economic Analysis and lead on the RPP development
- John Greenlees, Bureau of Labor Statistics, Senior Statistician
- Bruce Steinwald, Institute of Medicine, Consultant
- Trudi Renwick, Census Bureau and lead on the SPM development

Additional resource members in attendance included Kathleen Scholl (General Accounting Office), Eric Figueroa (BEA), Troy Martin (BEA), and Thesia Garner (BLS).

There was consensus among the panel members that the available evidence clearly indicates that the cost of living and prices vary across the country. All panel members also agreed that the science of measuring differences in the cost of living across the country was sufficiently developed, although panel members also pointed out data and measurement issues that could be addressed to improve existing indices. Issues such as a lack of ability to capture prices faced by less mobile people (especially the disabled), whether indices fully captured prices faced by low-income families across the country, and the difficulty of capturing price differences in particular cities were all mentioned. Other expert panel members reminded the group that indices for measuring geographic price variation, such as Medicare payment policies, have been in use for years. Panel members also agreed that simplicity is important for gaining acceptance in the use of this type of index, and that the data should be developed by government and in the public domain.

More specific issues were also addressed by the panel. For example, the SPM geographic adjustment reflects geographic variation in housing costs and is only applied to

[5] A full summary of the expert panel meeting held at the Urban Institute on June 6, 2012, is available upon request.

the portion of the SPM threshold representing housing. If applied to the federal poverty guidelines, should the index be applied to the full guideline or to the same share as the SPM? The advantages of the SPM adjustment were noted, including the availability of current data for measuring housing costs (the ACS) and the fact that an adjustment just for housing costs applied to that portion of a family budget results should result in less volatility over time than an adjustment based on the full cost of the market basket. The downside of using housing costs alone is that the price of another core good in the basket may be negatively correlated with housing costs.

Panel members also considered family budget, median income, and wage index approaches for measuring geographic price variation. Family budget approaches were considered to have potential but are expensive to develop, and existing budgets do not provide annually updated estimates covering the full United States. The U.S. Department of Housing and Urban Development uses 80 percent of area median income to define low income. One panel member suggested basing the index on wage differences across areas, but others noted that wage differentials would only be relevant for the working, mobile population, and income is not a measure of prices of the cost of living. There was a general sense that we know that price levels are higher in areas with higher incomes, but we do not know how this varies across the country.

The panel discussion and the literature review narrowed the indices that could be used to test the effect of geographic variation on program eligibility to the SPM and the RPP. These two indices meet the criteria of being publicly available, produced by the federal government on a regular basis, and not restricted to one segment of the income distribution. The RPPs are comprehensive—reflecting all family spending. The SPM geographic adjustment reflects a narrower concept—geographic variation in median rents—but is simpler to explain. Some noted that future developments in measuring differences in the cost of living, such as adjustments for transportation costs, could offer better alternatives.

How Would the Alternative Indices Affect Program Eligibility across the States?

Based on the panel's recommendations, we use the RPP and SPM indices to adjust the poverty guidelines for geographic variation in the cost of living.[6] We use these alternative guidelines to simulate eligibility for benefit programs, including Medicaid, CHIP, Affordable Care Act subsidies, SNAP, and CCDF subsidies. The results produced using the alternatives are compared with the baseline estimates. All the estimates are based on an average of two years of the Current Population Survey, Annual Social and Economic Supplement (CPS ASEC) data, 2008 and 2009 income years, to improve precision at the state level.

[6] Additional details about the SPM and RPP indices used in this analysis are provided in appendix A.

Adjustments to the Guidelines

For each index, we test the effect of applying a single adjustment at the state level and the effect of applying adjustments at the metropolitan statistical area (MSA) level. Because not all MSAs are identifiable in the public-use CPS ASEC data used for our estimates, the MSA-level adjustments include a single adjustment for all non-identifiable MSAs within each state, as well as an adjustment for the non-MSA areas within each state.

The MSA-level SPM adjustments are obtained from published Census Bureau data (Renwick 2011). The adjustments are based on five years of American Community Survey data, covering 2005 to 2009, and represent each area's median gross rent for a two-bedroom unit with a kitchen and full plumbing divided by the national median. Since the Census Bureau does not produce SPM adjustments at the state level, we calculate state-level adjustments following the Census Bureau's methodology.[7] Because the SPM geographic adjustment reflects variation in rental costs, it is applied to the housing portion of the SPM threshold (49.2 percent of the threshold for renters).[8] Based on this approach, we scale the SPM adjustment used for this analysis so that the resulting adjustment factor is equivalent to applying the original SPM adjustment to 49.2 percent of the poverty guideline.

We use the BEA's 2006–10 RPPs for the second adjustment (Aten, Figueroa, and Martin 2012). The RPPs are available at the state level, the individual MSA level, and the metropolitan and nonmetropolitan portion of each state. Because the RPPs reflect all items, we apply them to the full poverty guideline (rather than to just the housing portion). The state-level RPPs are used directly without further adjustment. For the MSA-level RPP simulations, we used the actual RPPs for MSAs identified in the public-use CPS ASEC, created population-weighted average RPPs for the non-identified MSAs in each state, and used the nonmetropolitan RPP for each state to adjust the guidelines of persons living in nonmetropolitan areas. This produces adjustments at the same geographic levels as for the SPM, although the methods used to create the estimates differ.[9]

Table 4 provides an example of the adjustments used for New York at the state level and for selected areas within the state.[10] The state-level adjustments increase the poverty

[7] We are grateful to Trudi Renwick of the Census Bureau for answering our questions regarding the Census Bureau's methodology. We use 2006–10 ACS data to develop the state adjustments. Although these represent a slightly different period than the MSA-level SPM adjustments (2005–09), the period is consistent with the data years underlying the RPPs used for the analysis.

[8] This represents the average of the housing portion for renters for 2008 (49.0 percent) and 2009 (49.4 percent) (Short and Garner 2012).

[9] Whereas the Census Bureau provides an adjustment for the non-identified MSAs in each state, we must calculate this for the RPP. The Census Bureau's estimate reflects the median rent for the non-identified MSAs in a state, divided by the national median. Our RPP adjustment reflects the population-weighted average RPPs for non-identified MSAs in a state.

[10] A full listing of adjustment factors by area is provided in appendix A.

guideline in New York by 8.4 percent under the SPM and 14.1 percent under the RPP. The MSA-level adjustments increase or decrease the guidelines depending on the area of residence within the state. In Albany, the guidelines increase by 2 percent under the SPM and decreases by 0.2 percent under the RPP. Guidelines increase by as much as 17 percent under the SPM adjustment (for New York City and Long Island) and 21.1 percent under the RPP (for the Poughkeepsie, Newburgh, Middletown metropolitan area). Guidelines fall in Utica and Rome by 12 percent under the SPM and 5.5 percent under the RPP. Nonmetropolitan areas of New York have a 10.3 percent reduction in guidelines under the SPM and a 4.4 percent reduction under the RPP.

Table 4. SPM and RPP Adjustments to Poverty Guidelines: New York (Selected Areas)

	SPM adjustment	**RPP adjustment**
State-level adjustment	8.4%	14.1%
MSA-level adjustment		
Albany-Schenectady-Troy	2.0%	-0.2%
Buffalo-Niagara Falls	-9.0%	-4.5%
New York-Northern New Jersey-Long Island, NY-NJ-PA	17.0%	19.4%
Poughkeepsie-Newburgh-Middletown	15.0%	21.1%
Syracuse	-6.0%	-3.2%
Utica-Rome	-12.0%	-5.5%
Non-metropolitan NY	-10.3%	-4.4%

Source: Authors' calculations based on Aten, Figueroa, and Martin (2012) and Renwick (2011).

Table 5 shows geographic adjustments by state. For the state-level adjustments, the guidelines are increased or decreased by the same percentage for all households in the state. Because the MSA-level adjustments vary across households within the state, we show the average guideline adjustment applied for each state. To allow for the possibility that there may be geographic variation within the state in the distribution of low- and high-income residents, the average MSA adjustments displayed in table 5 reflect the average for households under 200 percent of the official poverty threshold.

Nationally, the SPM geographic adjustment would result in an overall slight increase in average poverty guidelines (1.1 percent for the state index and 0.6 percent for the MSA index). The RPP causes a slight net reduction in average poverty guidelines (a 0.4 percent reduction for the state RPP and a 1.1 percent reduction for the MSA RPP).

Table 5. Mean Geographic Adjustment to the Federal Poverty Guideline, 2008–09

Region	State	State SPM adjustment	MSA SPM adjustment	State RPP adjustment	MSA RPP adjustment
U.S. Total		1.10%	0.60%	-0.40%	-1.10%
Northeast					
	New England				
	Connecticut	12.00%	13.60%	10.50%	11.10%
	Maine	-4.60%	-6.40%	-2.70%	-3.80%
	Massachusetts	14.40%	16.10%	7.40%	7.70%
	New Hampshire	9.70%	11.30%	5.60%	5.70%
	Rhode Island	4.50%	4.60%	-0.20%	0.60%
	Vermont	3.60%	0.30%	-0.30%	-1.10%
	Middle Atlantic				
	New Jersey	18.30%	15.40%	11.50%	16.70%
	New York	8.50%	10.40%	14.10%	12.80%
	Pennsylvania	-4.10%	-4.00%	-1.30%	-1.40%
Midwest					
	East North Central				
	Illinois	0.90%	0.10%	0.40%	-0.10%
	Indiana	-8.30%	-7.40%	-8.00%	-8.50%
	Michigan	-5.50%	-5.10%	-4.70%	-5.20%
	Ohio	-8.20%	-8.40%	-9.10%	-9.70%
	Wisconsin	-6.10%	-6.40%	-7.40%	-8.60%
	West North Central				
	Iowa	-10.60%	-11.80%	-10.70%	-11.10%
	Kansas	-9.20%	-11.30%	-9.60%	-11.40%
	Minnesota	-1.10%	-3.50%	-3.20%	-5.90%
	Missouri	-9.20%	-10.00%	-11.30%	-12.40%
	Nebraska	-9.90%	-10.40%	-9.80%	-10.60%
	North Dakota	-15.00%	-17.70%	-11.80%	-13.30%
	South Dakota	-13.60%	-14.90%	-12.80%	-13.90%
South					
	South Atlantic				
	Delaware	6.10%	3.90%	3.70%	1.70%
	District of Columbia	12.70%	25.70%	15.50%	18.60%
	Florida	6.90%	7.60%	0.00%	0.20%
	Georgia	-3.60%	-4.10%	-5.20%	-5.70%
	Maryland	15.60%	13.30%	10.30%	8.70%
	North Carolina	-8.40%	-8.60%	-7.20%	-8.10%
	South Carolina	-9.90%	-10.30%	-7.80%	-9.00%
	Virginia	3.80%	0.60%	3.10%	-0.40%
	West Virginia	-16.40%	-17.00%	-11.30%	-13.10%
	East South Central				
	Alabama	-12.70%	-13.60%	-9.40%	-10.00%
	Kentucky	-14.00%	-14.70%	-10.30%	-11.40%
	Mississippi	-12.70%	-13.10%	-11.10%	-12.00%
	Tennessee	-10.00%	-10.90%	-8.50%	-9.90%

Table 5. Mean Geographic Adjustment to the Federal Poverty Guideline, 2008–09

Region	State	State SPM adjustment	MSA SPM adjustment	State RPP adjustment	MSA RPP adjustment
South (continued)					
	West South Central				
	Arkansas	-13.60%	-14.60%	-10.70%	-11.90%
	Louisiana	-7.30%	-8.20%	-6.90%	-7.10%
	Oklahoma	-12.20%	-11.80%	-9.10%	-9.10%
	Texas	-2.10%	-3.70%	-2.40%	-3.60%
West					
	Mountain				
	Arizona	-0.20%	-1.40%	-0.10%	-1.20%
	Colorado	0.80%	0.50%	-1.00%	-1.30%
	Idaho	-11.20%	-11.60%	-6.50%	-6.90%
	Montana	-12.20%	-11.90%	-6.10%	-6.70%
	Nevada	7.30%	8.40%	-0.70%	-0.80%
	New Mexico	-9.10%	-10.10%	-5.90%	-6.60%
	Utah	-5.90%	-7.40%	-4.40%	-4.80%
	Wyoming	-11.00%	-11.40%	-4.50%	-4.80%
	Pacific				
	Alaska[a]	8.90%	9.20%	6.10%	6.00%
	California	20.70%	19.90%	10.70%	9.80%
	Hawaii[a]	26.50%	27.00%	16.10%	15.30%
	Oregon	-3.50%	-5.00%	-2.50%	-3.60%
	Washington	2.20%	1.30%	2.00%	1.00%

Source: Authors' calculations based on data provided by the Census Bureau and Bureau of Economic Analysis.
Notes: The mean MSA-level SPM and RPP geographic adjustments are weighted averages of the adjustments applied to the population below 200 percent of the official poverty threshold.
a. The adjustments for Alaska and Hawaii are shown relative to the current federal poverty guideline for the 48 contiguous states and the District of Columbia, not the current guidelines used in Alaska and Hawaii.

Alaska's and Hawaii's adjustments are shown relative to the federal poverty guideline rather than to the higher guidelines currently used in these states. The adjustments for Alaska range from 6 to 9 percent, substantially less than the current 25 percent adjustment to the poverty guideline for Alaska. In contrast, Hawaii's 27 percent SPM adjustment is higher than the current 15 percent increase in the poverty guideline used for Hawaii.

The geographic price adjustments generally move in the same direction for both indices—that is, both the SPM and RPP adjustments tend to result in positive or negative effects for particular states. For example, the geographic adjustments reduce Alabama's average guidelines by between 9.4 and 13.6 percent across the four indices, and New York's guidelines increase by 8.5 to 14.1 percent. The SPM and RPP indices at the MSA level are highly correlated overall, with a correlation coefficient of 0.94 (Wheaton et al. 2012).

The RPP adjustments are smaller than the SPM adjustments in most states. Both indices use the same underlying data source for rents (the ACS) and show similar patterns in

rent differences across states.[11] However, whereas the RPPs capture price variation in other goods and services using data from the CPI and Consumer Expenditure Survey, the SPM treats the prices of other goods and services as uniform across the United States. Incorporating other goods and services into the RPPs reduces the difference between the lowest and highest cost state by two-thirds, compared to the RPPs for rent alone.[12] Treating prices of other goods and services as constant reduces the difference between the lowest and highest cost state by 51 percent for the state-level SPM, compared to the difference in median rent alone. The RPP and SPM differ not only in their treatment of other goods and services, but also with respect to the share of expenditures going to rent. Approximately 20 percent of expenditures are for rents under the RPP, compared to 49.2 percent for the SPM index used here. Assessing the relative merits of the two indices is difficult; whereas the RPP has the advantage of capturing prices of all goods and services, it reflects all consumers. The SPM reflects the fact that lower-income families are likely to spend a higher share of income on rent, an important consideration given that rent varies more across geographic areas than the prices of other goods and services.

Although the price adjustments generally move in the same direction for both indices, this does not hold for all states or MSAs. Sometimes the geographic level of adjustment (state versus MSA) is more important than the use of the SPM housing price adjustment compared to the RPP adjustment. For example, both New Jersey and New York have an MSA RPP adjustment that is similar to its MSA SPM adjustment, but the state-level adjustments differ: the New Jersey adjustment is higher using the SPM state index than the RPP state index (18.3 versus 11.5 percent), and the New York effect is higher using the RPP (14.1 versus 8.5 percent). The complex interactions created by source of adjustment (housing versus all goods and services) and geographic level of adjustment (MSA versus state) create a complex mix of adjustments. The results highlight how the choice of index to adjust for geographic price variation could affect poverty guidelines and program eligibility.

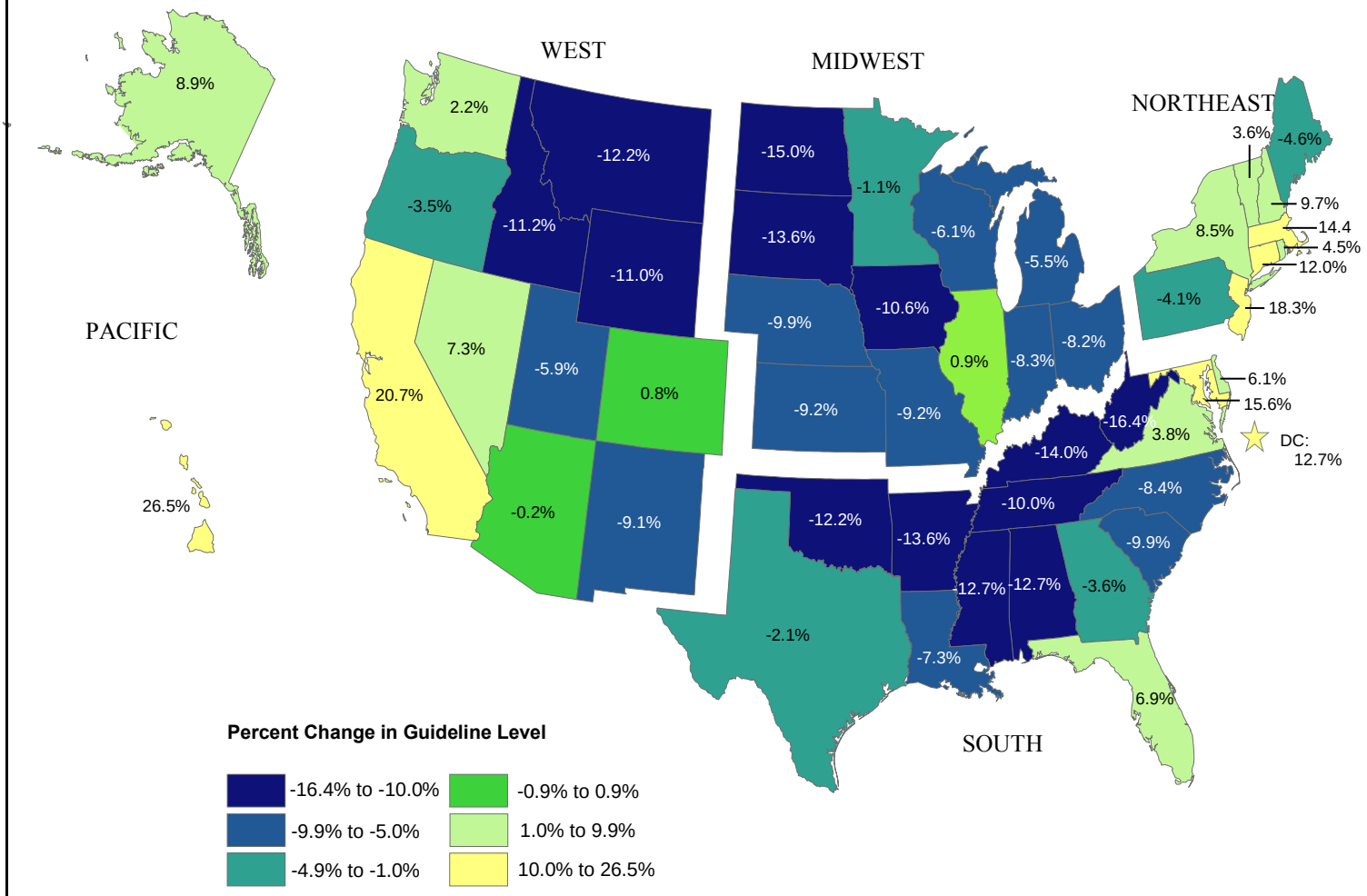
The state average geographic adjustments are illustrated in maps 1 through 4. The adjustments tend to produce lower guidelines in the south and the midwest but higher guidelines in the northeast. The MSA-level adjustments tend to produce larger changes in the guidelines than the state adjustments. There are, of course, exceptions to these generalizations. In the northeast, for example, guidelines for the state of Maine decline for all four indices. Results for states in the western region differ depending on whether they are Pacific division states (such as California) or mountain states (such as Montana or

[11] For example, under both measures Hawaii is the highest rent state, with a rent RPP of 151.3 and median two-bedroom rent (used for the SPM) equal to 154 percent of the national median. West Virginia has the lowest rent, with a rent RPP of 65.9 and median two-bedroom rent equal to 66.5 percent of the national median. Whereas the RPPs reflect all units, the SPM reflects differences in median two-bedroom rents with complete kitchen and plumbing facilities. See appendix A for further detail on state-level median rents and Aten et al. (2012) for state-level rent RPPs.

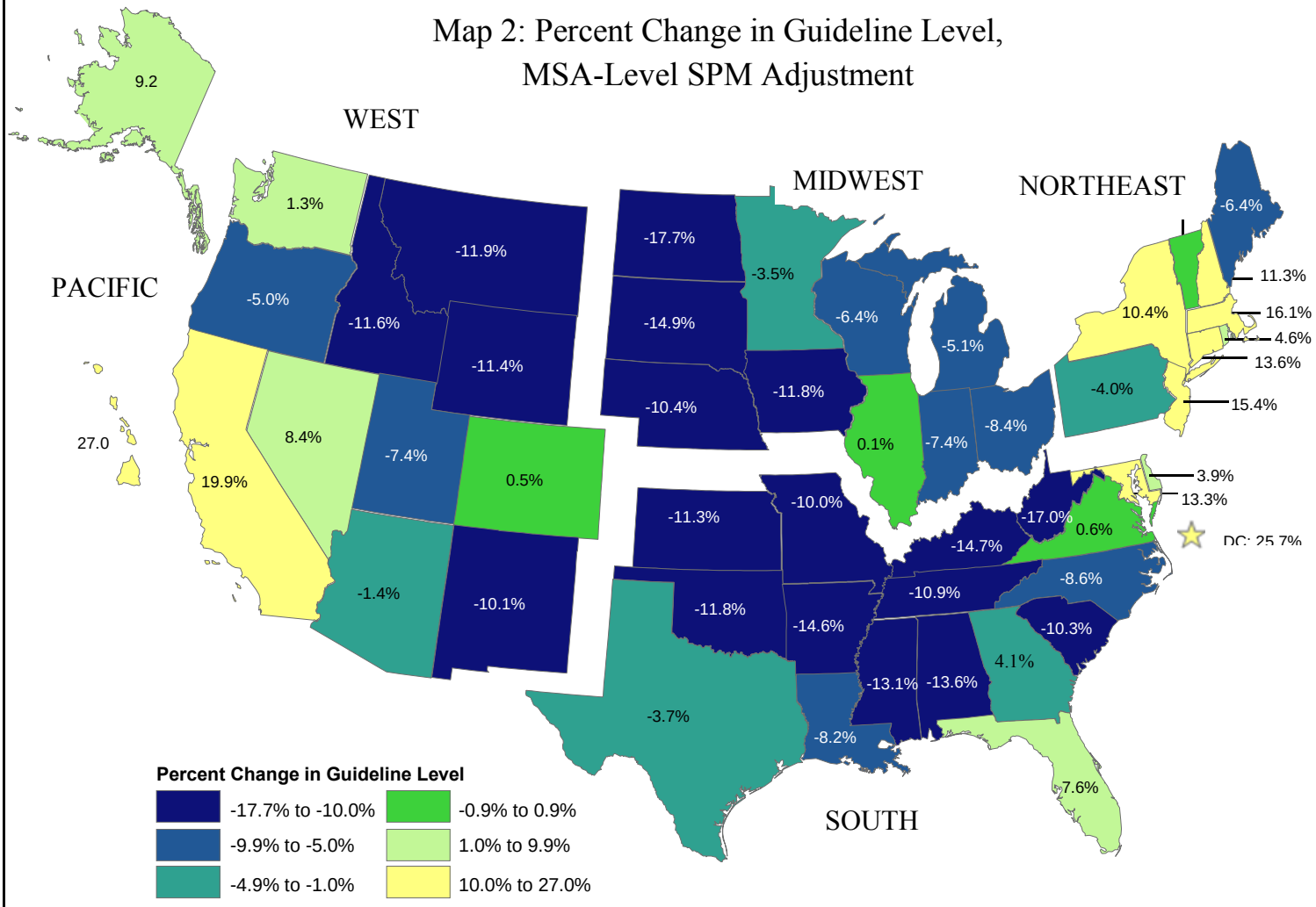
[12] Author's calculations based on table 4 of Aten et al. (2012).

Wyoming). The guidelines for California are higher after an adjustment for the cost of living but lower in many of the mountain states.

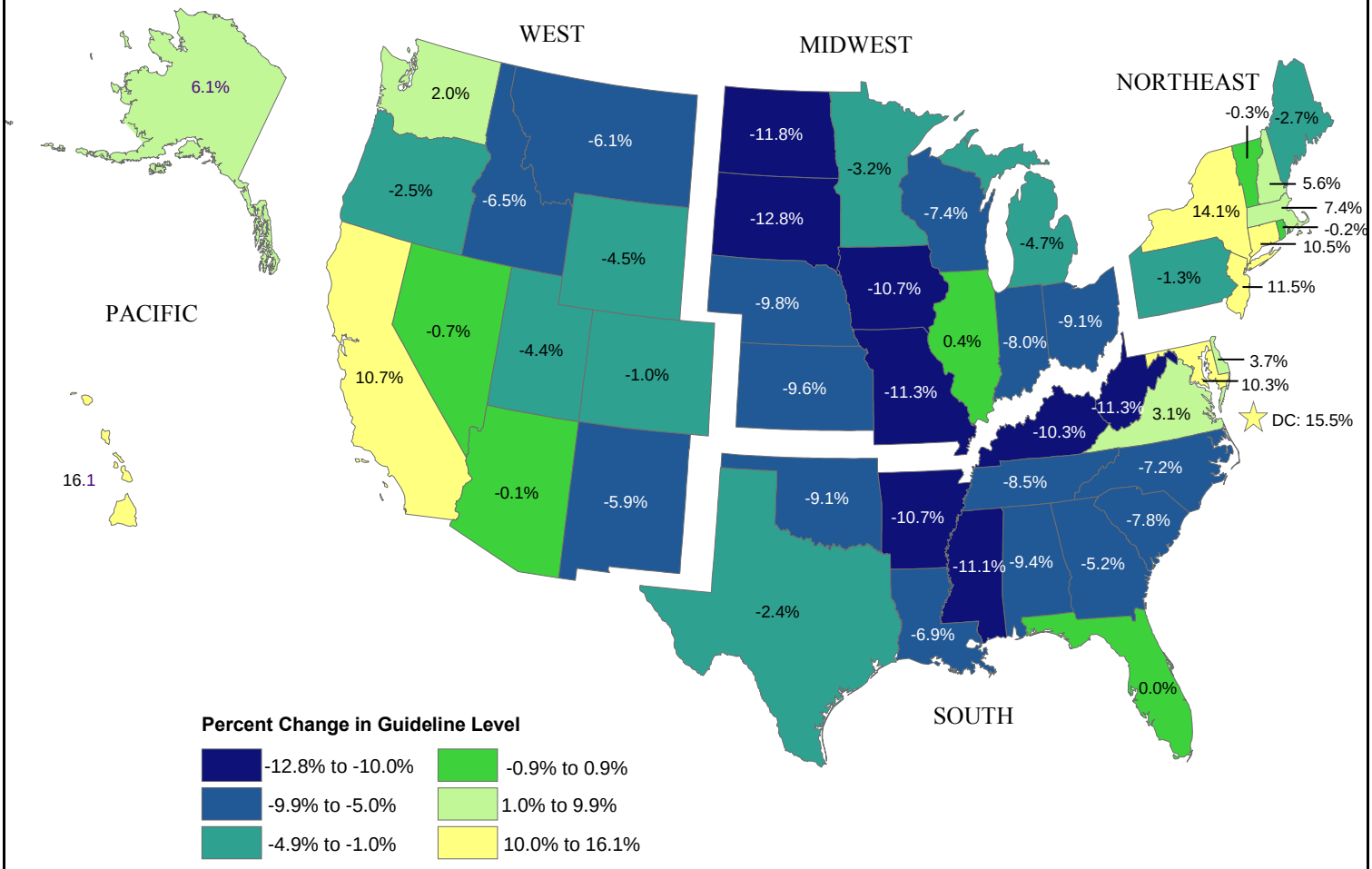
Map 1: Percent Change in Guideline Level, State-Level SPM Adjustment



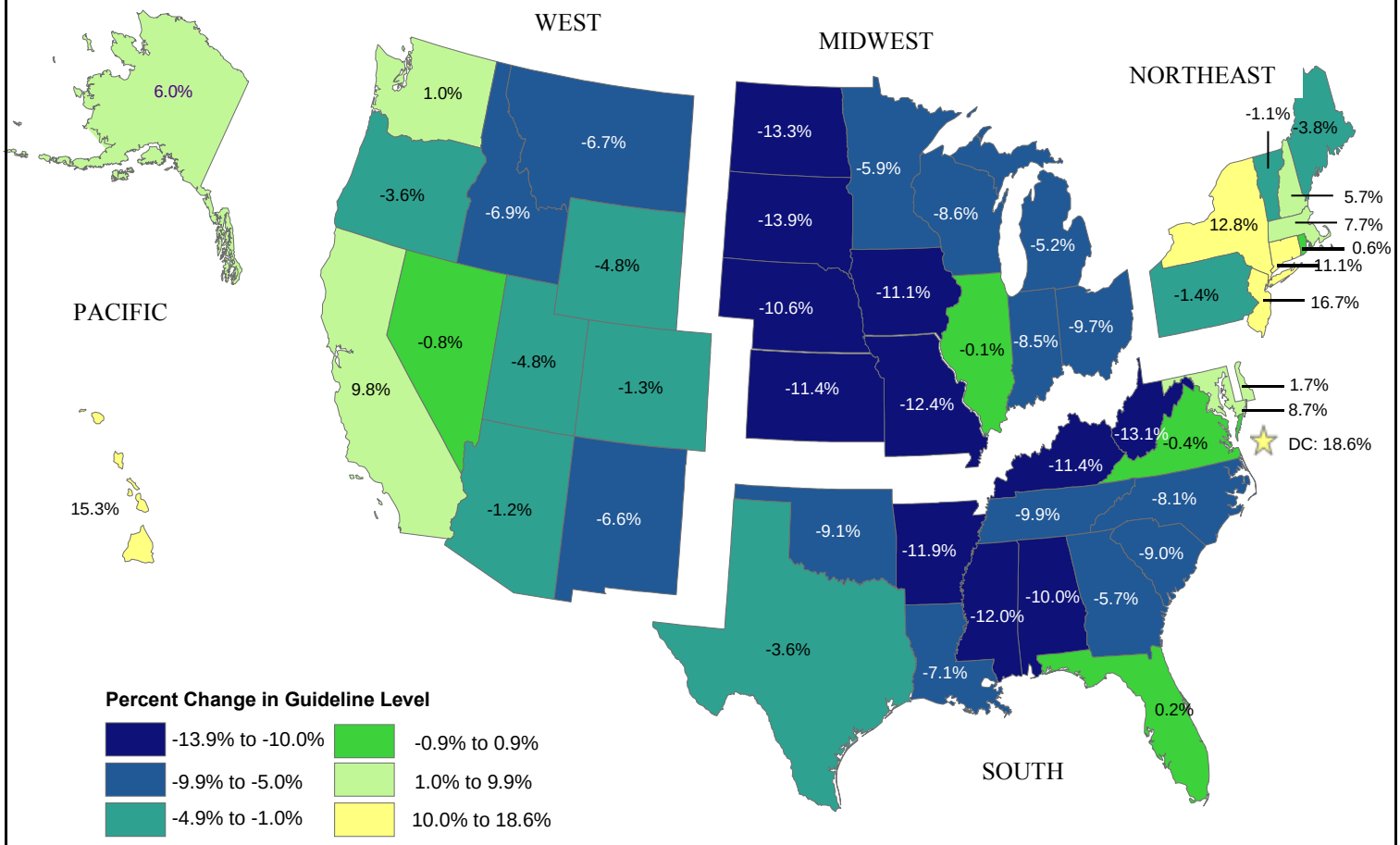
Map 2: Percent Change in Guideline Level, MSA-Level SPM Adjustment



Map 3: Percent Change in Guideline Level, State-Level RPP Adjustment



Map 4: Percent Change in Guideline Level, MSA-Level RPP Adjustment



III. Methods for Simulating Program Eligibility

The SPM and RPP state- and MSA-level adjustments are used to simulate eligibility for the public health programs (Medicaid, CHIP, and Affordable Care Act subsidies), SNAP, and CCDF. While the same input data are used for all estimates, the health estimates for the nonelderly (including the disabled) are produced using the Urban Institute's Health Policy Simulation Model (HIPSM), and the simulations for elderly Medicaid eligibility, SNAP and CCDF are produced using TRIM3 (Transfer Income Model, version 3). We briefly describe the data and the simulations below.

Data

The data underlying the analyses are the 2009 and 2010 CPS-ASEC files, which provide data for calendar years 2008 and 2009. The CPS is a nationally representative survey of the civilian noninstitutionalized population of the United States, conducted monthly by the U.S. Bureau of the Census. The ASEC supplement to the CPS is the source of the official U.S. income and poverty statistics. We use two years of combined ASEC data to build sufficient sample size for state-level estimates.

Baselines

The baseline estimates for Medicaid, CHIP, Affordable Care Act, SNAP, and CCDF are produced by applying program eligibility rules to families and persons represented in the CPS-ASEC. The estimates for Medicaid, CHIP, and APTCs reflect the 2014 rules deflated as if they were in effect in 2011. This allows for baseline eligibility estimates that reflect the expansions under the Affordable Care Act. The Medicaid elderly, SNAP, and CCDF baseline eligibility rules reflect the rules in place in 2009, the year of the data.[13] The baseline simulations include the current poverty guideline adjustments in place in Alaska and Hawaii.

Medicaid and CHIP. As noted above, we use HIPSM to estimate the impact of adjusting the poverty guidelines for the cost of living on Medicaid, CHIP, and APTC eligibility, coverage, and costs. HIPSM is a detailed microsimulation model of the health care system that estimates the cost and coverage effects of proposed health care policy options.[14] To evaluate how the health care system would be affected by policy changes,

[13] The American Recovery and Reinvestment Act (ARRA), also called the Recovery Act, made some changes to SNAP and CCDF for 2009. These changes are not simulated since they do not reflect the longer-run program parameters.

[14] Further information on HIPSM's methodology can be found at http://www.urban.org/publications/412471.html.

HIPSM simulates the decisions of employers, families, and individuals to offer and enroll in health insurance coverage. The model produces/calculates the estimated impact of policy on government and private health care spending, uncompensated care costs, private health insurance premiums, employer offers of coverage, and health insurance coverage. The model incorporates the Health Policy Center's detailed simulation of Medicaid eligibility and enrollment, including eligibility rules for each state and an adjustment for the undercount of Medicaid enrollment on the CPS.[15] Individuals are first tested to determine whether they are eligible for Medicaid or CHIP and then whether they are eligible for the APTC. APTCs are determined based on the second-lowest-cost silver plan in the exchange in which each individual could be enrolled. Within HIPSM, health insurance decisions made by individuals, families, and employers are calibrated to findings in the best empirical economics literature. HIPSM uses a utility-based framework to model choices under alternative scenarios based on choices in the post-reform world.

In order to examine changes that would occur if the poverty guidelines were geographically adjusted, we compare the simulations based on each of the four adjustment factors to a baseline. The baseline estimates what would have occurred if the Affordable Care Act were implemented in 2011.[16] We trend CPS data forward from 2008 and 2009 to 2011 using CBO estimated age targets and apply estimates from Holahan and Garrett (2009) to adjust for the impact of unemployment rates on changes in employer coverage, public coverage, nongroup coverage and the uninsured to reflect the modest differences in unemployment from 2009 to 2011. We use the poverty guidelines adjusted to reflect differences in the cost of living and resimulate Medicaid and CHIP eligibility. These estimates are fed into HIPSM to produce final estimates of eligibility and coverage, and to estimate the APTCs, given Medicaid and employer coverage. HIPSM also produces estimates of the effects on the cost of Medicaid, CHIP, and the APTCs.

We make three simplifying assumptions in the Medicaid and CHIP eligibility simulations. We assume that all states would expand their Medicaid program up to 138 percent of the poverty level and add new eligibility categories for adults (whether or not states will actually expand their program is not currently known for all states). By simulating an expansion for every state, we have the ability to assess the cost implications

[15] Medicaid and CHIP eligibility rules are collected by the Center for Children and Families for the Kaiser Family Foundation. Medicaid and CHIP eligibility rules were obtained for December 2009 from http://www.kff.org/medicaid/upload/7855.pdf. We use the December 2009 rules because they are the closest available rules to the March 23, 2010, enactment date that sets state's maintenance-of-effort rules in place.
[16] Currently HIPSM baseline estimates are calibrated as if the ACA were fully implemented in 2011. While the model can also estimate implementation in the future to match CBO scores, this approach relies on fewer assumptions about economic growth and insurance coverage. This approach incorporates changes due to the Affordable Care Act and has been used in other UI analyses. For example, see Blavin, Buettgens, and Roth (2012).

regardless of what states ultimately choose to do, which will lead to an overestimate of total state and federal costs in the baseline if not all states expand Medicaid.[17] We also assume that states maintain their eligibility for pregnant women and adults after the Affordable Care Act is implemented. This assumption will likely overstate state costs and understate federal costs relative to a scenario where all states reduce eligibility for adults to 138 percent of the poverty guidelines. Finally, we assume that CMS will develop a method to translate current eligibility thresholds and disregard rules into MAGI-based rules that broadly make the same people eligible. This assumption allows us to use the current Medicaid eligibility thresholds and disregard rules in these simulations. We expect that this will likely only marginally affect eligibility and costs and since we do not yet know what states will do this was the only viable approach. We then simulate the expansion in Medicaid under the ACA up to 138 percent of the poverty guidelines based on MAGI with no tests for assets.

Other Programs. As noted above, the Medicaid elderly, SNAP, and CCDF estimates were produced using the TRIM3 model. TRIM3 is a detailed microsimulation model of the key tax and benefit programs affecting low-income families. The model has been developed and used at the Urban Institute for over 30 years, under primary funding from the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (HHS/ASPE).[18] TRIM3 distributes reported annual income across the months of the year, capturing variation in employment status across the year. Eligibility estimates are produced monthly, and results are reported as average monthly estimates.

Medicaid (Elderly). The elderly (persons age 65 and older) can gain eligibility for Medicaid under various conditions. Some are eligible for full-scope Medicaid, insurance that covers all medical costs (hospital and doctor care, drugs, physical therapy, dental care, and other expenses). These individuals either do not qualify for Medicare (usually because they have not worked in covered employment for a sufficient period) or they are termed "medically needy" because their high medical expenses push them below the federal poverty guidelines when they are deducted from their income. Lacking an up-to-date imputation for out-of-pocket medical expenses that includes all obligations, we omitted individuals qualifying under the medically needy provision for full-scope eligibility from these estimates. Although the eligibility estimates underestimate full-scope Medicaid, the results will indicate the relative effects of the four indices for the core group of full-scope Medicaid elderly eligibles.

We also estimate eligibility for Medicaid Restricted benefits for the elderly. This includes those who have Medicare but are eligible for Medicare Savings Programs on the

[17] For a full discussion of the cost and coverage implications of expanding the Medicaid program under the Affordable Care Act nationally and for each state, see http://www.urban.org/publications/412707.html.
[18] Documentation of the TRIM3 model is available at http://trim3.urban.org/T3Technical.php.

basis of asset and income tests. Eligibility for these benefits requires that elderly individuals and couples have financial assets below allowable limits (generally $4,000 for individuals and $6,000 for couples). Those meeting the asset test may qualify for various parts of the Medicare Savings Program depending on their income. Generally, those with incomes below the federal poverty guidelines qualify for premium and co-pay coverage; those with incomes between 100 and 120 percent of the poverty guidelines qualify for part B premium coverage. Those with incomes between 120 and 135 percent of the poverty guidelines may also qualify coverage for part B premium coverage, subject to available funds.[19] Individuals with income below 150 percent of the poverty guidelines qualify for part D subsidies for full or partial drug coverage, and a somewhat higher asset test applies to these individuals.

SNAP. To simulate SNAP eligibility, TRIM3 follows the same steps that would be used by a caseworker: defining the SNAP filing unit, determining whether the members meet categorical eligibility requirements, performing assets tests, calculating income and deductions, determining income eligibility, and calculating the benefit amount. Units consisting entirely of SSI and TANF cash recipients are automatically eligible for SNAP. Under standard program rules, other units must have no more than $2,000 in liquid assets ($3,000 for units with an elderly or disabled member), net income below 100 percent of the poverty guideline, and gross income below 130 percent of the poverty guideline (for units without an elderly or disabled member).[20] TRIM3 simulates SNAP reporting periods and reporting requirements and transitional SNAP for those who leave the TANF program.

The estimates capture state broad-based categorical eligibility (BBCE) rules, which were in effect in 29 states in 2009 (Trippe and Gillooly 2010). BBCE provides automatic SNAP eligibility for households eligible to receive a TANF state maintenance-of-effort (MOE)–funded service (such as an informational brochure) (Food and Nutrition Service 2009). Many states have adopted this type of policy, either for all households or for some types of households. TRIM3 captures state variation in the types of units eligible for BBCE (units with children, units with elderly, units with disabled, and/or units without children, elderly, or disabled members), the gross income limit for each type of unit (typically 130, 185, or 200 percent of the poverty guideline), and whether the state applies the net income test and assets tests for BBCE (most do not).

SNAP includes time limits for nonworking able-bodied adults without dependents (ABAWDs). These time limits are waived in most states due to high rates of unemployment, so we do not impose ABAWD time limits.

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[19] These rules applied in all states before 2010. But beginning in 2010, Connecticut, D.C., and Maine had higher income limits, some states eliminated the assets requirement (AL, AZ, CT, DE, DC, ME, MS, NY, and VT), and Minnesota set the asset limits higher than the national limits.

[20] TRIM3 does not simulate vehicle restrictions (still in effect in some states) because vehicle ownership is not reported on the CPS.

Subsidies through the Child Care and Development Fund (CCDF). The federal CCDF guidelines do not use the poverty guidelines. Instead, federal regulations set a maximum eligibility limit of 85 percent of state median income. States can use that level or a lower set of limits of their choosing. Many states set the limits to a percentage of the poverty guidelines, but others use some percentage of state median income (Giannarelli et al. 2011). States make these choices to stay within their federal grant funds (often augmented with state funds). They may have a high eligibility limit but serve a lower percentage of eligible families, or vice versa.

To demonstrate the effects of adjusting CCDF eligibility for geographic price variation, we simulate a hypothetical baseline with all states' eligibility guidelines set to 185 percent of the poverty guidelines.[21] (We use the higher poverty guidelines for Alaska and Hawaii.) We use other 2009 CCDF rules in the states, such as the age of children eligible for subsidized care (usually age 12) and work requirements for parent eligibility.

Alternatives. The alternative simulations estimate what would happen if adjustments based on one of the four indices reflecting geographic variation in price inflation were used in lieu of the unadjusted federal poverty guidelines. The simulations recalculate eligibility for all the programs for each individual and relevant family unit on the file (whether eligible in the baseline or not) using the federal poverty guideline multiplied by the changes in the index being analyzed. Four separate scenarios are produced reflecting each index shown. The results show the percentage changes from the baselines for each state, grouped by census division.

IV. Effects of Alternative Guidelines on Program Eligibility

Health Programs

Medicaid and CHIP eligibility under the Affordable Care Act and eligibility for APTCs to purchase coverage in the exchange are simulated and then re-estimated using the four alternative geographic adjustments to the federal poverty guidelines for the cost of living.[22] We also estimate enrollment in these post–Affordable Care Act programs, the number of uninsured and changes in federal and state spending for each scenario.

[21] The allowable federal income eligibility maximum is 85 percent of SMI, which ranges from 125 to 250 percent of the federal poverty guidelines. This scenario represents approximately the midpoint of this range.
[22] Estimates of geographic adjustment to pre-ACA Medicaid eligibility rules were also produced. The patterns were essentially identical to those presented for Medicaid eligibility under the ACA.

Eligibility for Medicaid and CHIP for Nonelderly. Table 6 presents the results from our simulations for Medicaid and CHIP eligibility at baseline and with the four alternative geographic adjustments for cost of living. Consistent with adjustments for the price adjustments overall (shown in table 5), the state and MSA SPM indices would slightly increase eligibility (0.6 and 0.3 percent, respectively), and the state and MSA RPP indices would slightly decrease eligibility (0.6 percent and 0.8 percent).

Table 6. Medicaid and CHIP Eligibility under the Affordable Care Act, 2011

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		97,884	0.6%	0.3%	-0.6%	-0.8%
Northeast						
	New England					
	Connecticut	1,219	8.1%	9.0%	7.1%	7.0%
	Maine	536	-3.2%	-6.0%	-2.2%	-3.0%
	Massachusetts	2,224	11.3%	12.6%	4.1%	6.0%
	New Hampshire	268	7.9%	10.7%	5.9%	3.9%
	Rhode Island	312	2.3%	2.3%	-0.2%	0.5%
	Vermont	262	2.5%	1.4%	-0.5%	-0.9%
	Middle Atlantic					
	New Jersey	2,473	10.4%	8.5%	6.3%	8.9%
	New York	7,323	3.9%	4.1%	6.3%	4.6%
	Pennsylvania	3,615	-2.4%	-1.9%	-1.2%	-0.4%
Midwest						
	East North Central					
	Illinois	4,294	2.1%	1.4%	1.5%	1.4%
	Indiana	2,423	-6.0%	-5.5%	-6.0%	-6.1%
	Michigan	2,927	-3.3%	-3.3%	-2.8%	-3.7%
	Ohio	3,325	-5.5%	-5.3%	-6.2%	-6.0%
	Wisconsin	1,710	-4.3%	-4.9%	-5.5%	-6.6%
	West North Central					
	Iowa	1,207	-8.9%	-10.2%	-9.0%	-9.2%
	Kansas	760	-6.2%	-8.5%	-6.9%	-8.5%
	Minnesota	1,815	-1.1%	-2.3%	-3.0%	-5.3%
	Missouri	1,903	-7.4%	-6.6%	-9.5%	-9.2%
	Nebraska	439	-8.2%	-8.9%	-8.2%	-9.2%
	North Dakota	126	-10.5%	-13.8%	-7.7%	-10.2%
	South Dakota	208	-12.6%	-12.4%	-11.3%	-11.4%
South						
	South Atlantic					
	Delaware	238	3.1%	2.3%	2.2%	1.1%
	District of Columbia	228	6.0%	12.1%	6.9%	8.2%
	Florida	5,081	4.6%	4.8%	0.0%	0.1%
	Georgia	3,208	-2.7%	-3.0%	-4.0%	-4.0%
	Maryland	1,514	10.2%	8.7%	5.5%	6.3%
	North Carolina	2,892	-5.0%	-5.3%	-3.9%	-5.2%
	South Carolina	1,373	-9.0%	-8.0%	-6.5%	-6.8%
	Virginia	1,750	3.6%	0.8%	3.4%	-0.4%
	West Virginia	619	-8.7%	-9.2%	-5.4%	-6.7%

Table 6. Medicaid and CHIP Eligibility under the Affordable Care Act, 2011

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	1,586	-14.1%	-14.3%	-12.1%	-11.6%
	Kentucky	1,403	-9.6%	-9.4%	-6.8%	-7.9%
	Mississippi	1,196	-8.1%	-7.7%	-8.0%	-6.4%
	Tennessee	2,177	-5.8%	-6.5%	-5.0%	-5.1%
	West South Central					
	Arkansas	1,024	-11.8%	-12.9%	-9.7%	-10.6%
	Louisiana	1,532	-4.3%	-3.1%	-4.3%	-3.5%
	Oklahoma	1,032	-6.9%	-6.9%	-5.9%	-4.2%
	Texas	8,310	-1.3%	-1.6%	-1.4%	-1.5%
West						
	Mountain					
	Arizona	2,430	0.0%	-1.0%	0.0%	-0.7%
	Colorado	1,148	2.0%	0.9%	-1.5%	-0.4%
	Idaho	419	-10.3%	-11.7%	-5.6%	-6.2%
	Montana	283	-17.5%	-17.9%	-12.3%	-13.8%
	Nevada	714	5.5%	5.5%	-0.3%	-0.8%
	New Mexico	840	-4.5%	-5.1%	-4.1%	-3.5%
	Utah	705	-8.0%	-8.9%	-7.4%	-7.8%
	Wyoming	120	-8.2%	-8.2%	-3.4%	-4.2%
	Pacific					
	Alaska	180	-7.1%	-6.7%	-8.5%	-8.8%
	California	13,004	12.0%	11.3%	6.2%	6.1%
	Hawaii	514	6.0%	6.6%	1.4%	1.1%
	Oregon	1,096	-3.5%	-3.6%	-2.6%	-3.0%
	Washington	1,898	1.4%	1.1%	1.4%	0.5%

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).
Notes: Simulations assume that provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply. This table includes persons currently eligible, ineligible reporters, and those that will be eligible under the Affordable Care Act.

These relatively small changes in eligibility overall mask larger changes in eligibility across regions, divisions, and states. The New England and middle Atlantic states, for example, would generally experience higher than average increases in eligibility regardless of the index used (increases range from less than 2 percent to almost 13 percent), although two states in this region, Maine and Pennsylvania, would experience eligibility declines. Nearly all states in the midwest (except Illinois) would experience declines in Medicaid eligibility. In the south, the east south central and west south central divisions would experience declines in eligibility. Eligibility would increase in the more urban states in the south Atlantic (Delaware, D.C., Florida, Maryland, and Virginia) but decrease in the more rural states (Georgia, North and South Carolina, and West Virginia). Most mountain states would experience declines ineligibility (except Colorado and Nevada), and the results are

mixed for states in Pacific division (with California having a large increase in eligibility and Alaska having a decrease). These results are consistent with general patterns of housing costs and prices in these states as reflected in the SPM and RPP indices.[23] The higher poverty guidelines in the higher-cost states would increase Medicaid eligibility, and lower poverty guidelines would decrease Medicaid eligibility.

Regardless of the adjustment index used, Montana, Alabama, South Dakota, Arkansas, and North Dakota show the greatest reductions in eligibility. For example, Montana has eligibility reductions of almost 18 percent for the state SPM estimate and between 12 and 14 percent for both RPP estimates. There is less consistency across the indices regarding which five states have the greatest increases in eligibility for Medicaid and CHIP. Connecticut and California are among the states with the greatest increases in eligibility across all four indices; New Jersey and the District of Columbia fall in this group based on three of the four indices; and Massachusetts is in this group for both SPM measures. California has the greatest estimated eligibility increase (12.0 percent) using the state SPM, reflecting the state's high housing costs. The MSA SPM predicts the largest increase in Medicaid eligibility in Massachusetts (12.6 percent). In general, changes in eligibility are somewhat smaller for the RPP indices than for the SPM indices. The range of RPP adjustments to the guidelines is narrower than the range using the SPM.

Eligibility for Premium Tax Credits (APTCs). Table 7 presents data on baseline eligibility for premium tax credits to purchase coverage in an exchange and changes based on the four alternative geographic adjustments for cost of living. We exclude estimates for Connecticut, Maine, Rhode Island, Vermont, North Dakota, South Dakota, Delaware, the District of Columbia, and Wyoming because sample sizes are not adequate to produce precise estimates. Unlike estimates of Medicaid and CHIP eligibility, which include all individuals who meet the eligibility criteria regardless of their insurance coverage, estimates of eligibility for APTCs include only individuals who are uninsured, have private nongroup coverage, or have no affordable offer of employer-sponsored coverage in the post-reform world. This means that geographic adjustments to eligibility for APTCs are affected by the distribution of the population across the adjusted income range, and how those who lack access to affordable coverage are distributed across the adjusted income range.

In states with geographic adjustments less than 1, fewer people would be income-eligible for APTCs, but a greater share of the income-eligible group does not already have access to affordable coverage. In states with geographic adjustments greater than 1, more people would become income-eligible for APTCs, but a greater share of the eligible population already has access to affordable coverage. As a result, the changes in eligibility for APTCs move in the opposite direction from the geographic indices. Individuals without

[23] Alaska's decrease occurs because the RPP and SPM adjustments range from 6 to 9 percent, less than the current 25 percent adjustment in the guidelines for Alaska.

current access to affordable coverage tend to be more concentrated near the lower income limit for APTC eligibility (100 percent of the poverty guidelines) than the upper income limit (400 percent of the poverty guidelines). When the poverty limit is adjusted upward in a high-cost state, more people lose APTC eligibility due to the increase in the lower income limit than gain eligibility due to the increase in the upper income limit. Similarly, when the poverty limit is adjusted downward in a low-cost state, more people gain eligibility due to the reduction in the lower income limit than lose it due to the reduction in the upper income limit. In a later section, we explore the impact of the geographic adjustment on the combined effects of enrollment and costs for Medicaid, CHIP and APTCs, which provides a clearer picture of overall changes and of the shifting between programs and payers.

In contrast to the results shown for Medicaid and CHIP eligibility, the SPM-based adjustments produce about a 1 percent decrease in eligibility for APTCs, and the RPP-based adjustments produce about a 1 percent increase in eligibility. Massachusetts has the greatest decrease in APTC eligibility with the adjustments based on the state and MSA SPM, falling by 26.8 and 40.8 percent, respectively. The large decrease for the MSA SPM adjustment may be due to the relatively small sample of individuals eligible for the APTCs in the exchange in Massachusetts. The SPM adjustments also produce substantial declines in APTC eligibility in California (roughly 22 percent for both SPM indices), and the state RPP index produces the largest eligibility decline in California (11.3 percent). The range of effects across the indices for California is consistent with the underlying geographic price adjustments. The greatest decline in eligibility based on the MSA RPP is for New Jersey (16.2 percent). Across all four geographic adjustments, Kentucky would experience the greatest increase in eligibility for APTCs with estimates based on the SPM of about 26 percent and based on the RPP of about 20 percent. As shown above (table 6), Medicaid eligibility would decline in Kentucky with the price-adjusted poverty guidelines, one of the factors increasing eligibility for APTCs.

Table 7. Eligibility for Premium Tax Credits for the Exchange, 2011

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		16,525	-1.3%	-0.9%	1.1%	1.0%
Northeast						
	New England					
	Connecticut	34	*	*	*	*
	Maine	34	*	*	*	*
	Massachusetts	56	-26.8%	-40.8%	-4.1%	-13.7%
	New Hampshire	68	-9.7%	-10.6%	-7.0%	-4.3%
	Rhode Island	49	*	*	*	*
	Vermont	11	*	*	*	*
	Middle Atlantic					
	New Jersey	307	-16.2%	-15.2%	-10.6%	-16.2%
	New York	958	-7.3%	-5.2%	-11.2%	-7.3%
	Pennsylvania	579	3.4%	-0.4%	0.7%	-0.4%
Midwest						
	East North Central					
	Illinois	633	-4.4%	-4.9%	-3.9%	-4.5%
	Indiana	232	9.2%	11.7%	9.8%	13.2%
	Michigan	520	8.3%	6.2%	7.6%	6.8%
	Ohio	659	6.3%	5.6%	8.2%	7.3%
	Wisconsin	269	6.9%	4.1%	6.9%	8.3%
	West North Central					
	Iowa	59	19.4%	22.2%	19.4%	19.5%
	Kansas	171	11.4%	14.9%	11.4%	14.9%
	Minnesota	109	1.4%	9.4%	5.7%	10.7%
	Missouri	283	9.8%	8.1%	15.3%	14.0%
	Nebraska	106	8.1%	9.3%	8.1%	9.3%
	North Dakota	42	*	*	*	*
	South Dakota	45	*	*	*	*
South						
	South Atlantic					
	Delaware	43	*	*	*	*
	District of Columbia	19	*	*	*	*
	Florida	1,346	-7.7%	-8.2%	0.2%	-1.2%
	Georgia	494	7.7%	9.3%	9.0%	10.2%
	Maryland	248	-16.9%	-11.7%	-9.0%	-10.5%
	North Carolina	541	8.3%	8.7%	7.9%	8.0%
	South Carolina	267	9.8%	10.3%	7.8%	6.7%
	Virginia	417	-5.1%	-4.5%	-5.1%	-3.3%
	West Virginia	82	22.5%	26.7%	11.0%	18.5%

Table 7. Eligibility for Premium Tax Credits for the Exchange, 2011

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	217	18.6%	18.6%	13.3%	16.1%
	Kentucky	222	25.9%	26.8%	20.1%	20.6%
	Mississippi	195	14.5%	10.2%	15.0%	10.2%
	Tennessee	376	10.2%	9.6%	9.6%	8.3%
	West South Central					
	Arkansas	170	18.8%	23.5%	15.9%	15.8%
	Louisiana	204	11.8%	7.9%	11.8%	11.7%
	Oklahoma	222	6.3%	8.2%	5.7%	5.1%
	Texas	1,681	3.1%	2.6%	3.2%	2.0%
West						
	Mountain					
	Arizona	379	1.0%	2.9%	0.5%	1.4%
	Colorado	355	-2.6%	-1.3%	2.6%	-0.1%
	Idaho	115	10.3%	12.5%	3.8%	4.8%
	Montana	73	17.8%	18.0%	12.6%	14.5%
	Nevada	170	-5.0%	-6.5%	0.7%	2.0%
	New Mexico	152	5.3%	6.7%	5.3%	4.4%
	Utah	174	13.3%	15.5%	13.3%	13.3%
	Wyoming	46	*	*	*	*
	Pacific					
	Alaska	66	8.7%	8.4%	9.5%	10.4%
	California	2,327	-23.3%	-21.9%	-11.3%	-11.2%
	Hawaii	51	-10.6%	-12.6%	-4.3%	-4.1%
	Oregon	222	6.4%	6.5%	5.1%	5.8%
	Washington	432	-3.1%	-2.5%	-3.1%	-2.6%

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).
Notes: Simulations assume that the provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.
* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

Enrollment in Medicaid, CHIP, and Subsidized Coverage in the Exchange. Table 8 presents data on total enrollment in any type of subsidized coverage, including Medicaid, CHIP, and exchange enrollment with an APTC, under the baseline simulation and the simulations with the four geographic price adjustments to the poverty guidelines. The overall changes in enrollment are negligible for the SPM adjustments, and there are small decreases in total enrollment of 0.4 and 0.6 percent, respectively, for the state and MSA RPP adjustments. Enrollment changes vary considerably across divisions and states.

In general, the four geographic price adjustments move together across the divisions and mirror the patterns for Medicaid eligibility. With few exceptions, states with lower costs of living in the east and west north central, mountain, and east and west south central divisions show moderate declines in subsidized enrollment. The SPM adjustments would reduce enrollment in subsidized coverage in Idaho and Montana by over 7 percent. The RPP adjustments would produce greatest declines in enrollment in the west north central division. North Dakota would have the greatest declines in enrollment across the four indices. States in the middle Atlantic and New England divisions, except Pennsylvania and Maine, would experience increases of less than 4 percent in subsidized enrollment regardless of geographic adjustment. States in the Pacific and south Atlantic regions show mixed results. More rural states where prices and housing costs are lower have predicted declines in enrollment of less than 3 percent, and more urban states have predicted increases in enrollment of a similar magnitude.

Tables 9, 10, and 11 present simulation results for the baseline and the four geographic price adjustments for enrollment in Medicaid, CHIP, and exchanges with an APTC, and the number of uninsured persons. In general, the enrollment estimates mirror the patterns observed for estimated program eligibility and are therefore not described in detail. However, the Medicaid enrollment estimates drive the overall enrollment results since many more individuals would be eligible for and enroll in Medicaid than would gain subsidized coverage in the exchange under the Affordable Care Act rules. The changes in the number of uninsured are inversely related to the geographic price adjustments. As estimated eligibility and enrollment increase with increases in the poverty guidelines, the predicted number of uninsured individuals falls.

Table 8. Total Enrollment in Subsidized Coverage under the Affordable Care Act (Medicaid, CHIP, and Exchange Enrollment with an Advanced Premium Tax Credit)

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		70,730	0.0	-0.2	-0.4	-0.6
Northeast						
	New England					
	Connecticut	664	2.2	2.6	2.2	2.4
	Maine	349	-1.7	-3.9	-1.5	-1.7
	Massachusetts	1,174	3.9	5.1	2.3	2.2
	New Hampshire	176	3.3	3.8	2.2	2.2
	Rhode Island	242	-0.4	0.0	-0.4	-0.4
	Vermont	150	0.7	-0.7	0.0	0.0
	Middle Atlantic					
	New Jersey	1,462	4.1	3.8	3.8	3.9
	New York	4,923	1.3	2.1	2.4	2.1
	Pennsylvania	2,593	-0.7	-1.1	-0.5	-0.4
Midwest						
	East North Central					
	Illinois	2,880	0.9	0.5	0.7	0.8
	Indiana	1,557	-4.1	-4.3	-4.1	-4.0
	Michigan	2,169	-0.4	-1.0	-0.6	-1.3
	Ohio	2,578	-2.7	-2.8	-2.6	-3.4
	Wisconsin	1,220	-1.8	-2.6	-3.1	-3.3
	West North Central					
	Iowa	535	-4.5	-5.5	-4.3	-4.9
	Kansas	574	-2.5	-4.2	-2.9	-3.6
	Minnesota	968	-0.9	-3.6	-1.8	-5.2
	Missouri	1,357	-3.6	-2.6	-4.6	-4.1
	Nebraska	342	-3.3	-3.3	-3.3	-3.6
	North Dakota	106	-8.2	-12.8	-7.1	-9.3
	South Dakota	167	-6.4	-7.1	-5.0	-6.4
South						
	South Atlantic					
	Delaware	161	0.6	1.8	0.6	0.0
	District of Columbia	170	4.5	5.6	4.5	4.5
	Florida	4,097	2.1	2.1	0.0	0.0
	Georgia	2,206	-1.3	-1.9	-1.4	-2.0
	Maryland	923	3.4	3.2	1.4	1.5
	North Carolina	2,272	-1.7	-1.9	-1.7	-1.7
	South Carolina	1,017	-3.7	-4.1	-2.4	-2.6
	Virginia	1,290	2.2	0.5	1.5	-0.2
	West Virginia	434	-3.8	-3.3	-2.6	-3.1

Table 8. Total Enrollment in Subsidized Coverage under the Affordable Care Act (Medicaid, CHIP, and Exchange Enrollment with an Advanced Premium Tax Credit)

Region State	Baseline (1,000s)	Percent Change from Baseline			
		State SPM	MSA SPM	State RPP	MSA RPP
South (continued)					
East South Central					
Alabama	1,123	-5.7	-6.3	-5.1	-4.6
Kentucky	1,113	-3.7	-3.7	-1.9	-3.2
Mississippi	948	-4.1	-4.2	-4.3	-3.4
Tennessee	1,613	-2.3	-1.3	-1.4	-1.0
West South Central					
Arkansas	820	-6.6	-6.9	-4.7	-5.8
Louisiana	1,138	-1.4	-0.4	-1.5	-0.5
Oklahoma	800	-5.5	-5.0	-4.3	-3.0
Texas	6,696	-0.5	-1.3	-0.6	-1.0
West					
Mountain					
Arizona	1,740	0.2	-0.6	0.2	-0.5
Colorado	944	0.4	-0.1	-0.6	-0.2
Idaho	353	-7.6	-7.6	-4.1	-4.1
Montana	212	-7.6	-7.1	-3.9	-3.9
Nevada	510	2.5	3.2	0.0	0.2
New Mexico	633	-1.8	-3.1	-1.6	-1.6
Utah	509	-2.4	-3.7	-1.8	-2.6
Wyoming	109	-2.8	-2.8	-0.9	-2.8
Pacific					
Alaska	137	-4.6	-3.8	-5.4	-6.2
California	10,167	3.6	3.5	1.7	1.8
Hawaii	263	3.7	3.3	1.1	1.1
Oregon	903	-0.9	-1.8	-0.4	-1.0
Washington	1,247	0.2	0.7	0.2	0.3

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).
Notes: Simulations assume that provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.

Table 9. Medicaid and CHIP Enrollment under the Affordable Care Act

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		62,130	0.0	-0.3	-0.6	-0.8
Northeast						
	New England					
	Connecticut	641	2.7	3.4	2.4	2.7
	Maine	336	-1.6	-4.1	-1.2	-1.9
	Massachusetts	1,100	5.2	6.7	2.7	3.2
	New Hampshire	149	3.7	4.0	2.0	2.1
	Rhode Island	216	0.7	0.9	-0.4	0.2
	Vermont	139	2.0	-0.3	0.0	-0.2
	Middle Atlantic					
	New Jersey	1,300	5.5	4.7	3.9	5.0
	New York	4,505	2.3	2.3	3.5	2.3
	Pennsylvania	2,276	-1.2	-0.6	-0.5	-0.4
Midwest						
	East North Central					
	Illinois	2,598	1.7	1.6	1.4	1.8
	Indiana	1,467	-4.4	-4.6	-4.4	-4.6
	Michigan	1,900	-1.8	-1.2	-1.5	-1.6
	Ohio	2,219	-3.2	-3.3	-3.9	-3.9
	Wisconsin	1,056	-2.3	-2.8	-3.5	-3.9
	West North Central					
	Iowa	487	-6.6	-8.0	-6.5	-6.9
	Kansas	487	-3.4	-5.6	-3.8	-5.9
	Minnesota	870	-0.8	-5.1	-1.9	-6.4
	Missouri	1,218	-4.4	-3.5	-5.6	-5.2
	Nebraska	293	-4.8	-5.6	-4.8	-5.6
	North Dakota	83	-9.0	-10.6	-7.0	-8.6
	South Dakota	140	-6.4	-6.7	-5.3	-6.3
South						
	South Atlantic					
	Delaware	142	1.7	1.1	1.2	0.0
	District of Columbia	162	4.1	6.5	4.7	4.7
	Florida	3,388	3.2	3.2	0.1	-0.1
	Georgia	1,972	-2.3	-2.6	-2.4	-2.7
	Maryland	809	5.0	3.3	2.2	1.4
	North Carolina	2,013	-3.0	-3.5	-2.9	-3.1
	South Carolina	891	-4.9	-5.4	-3.6	-4.0
	Virginia	1,109	2.3	-0.4	2.1	-0.2
	West Virginia	397	-5.5	-5.7	-3.4	-4.2

Table 9. Medicaid and CHIP Enrollment under the Affordable Care Act

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	1,008	-6.20	-7.03	-5.39	-4.56
	Kentucky	990	-7.77	-7.84	-5.40	-6.33
	Mississippi	850	-4.14	-3.99	-4.42	-2.76
	Tennessee	1,426	-3.77	-2.98	-2.92	-2.32
	West South Central					
	Arkansas	721	-8.39	-9.56	-6.11	-6.99
	Louisiana	1,047	-2.22	-0.96	-2.22	-1.56
	Oklahoma	691	-5.06	-4.98	-3.94	-2.37
	Texas	5,760	-1.06	-1.57	-1.06	-1.24
West						
	Mountain					
	Arizona	1,538	0.00	-1.30	0.00	-0.58
	Colorado	749	1.12	0.77	-1.17	0.33
	Idaho	287	-8.53	-9.04	-5.01	-5.44
	Montana	177	-8.07	-8.60	-4.59	-5.59
	Nevada	428	3.04	3.06	-0.37	-0.72
	New Mexico	564	-4.06	-4.10	-2.62	-2.39
	Utah	405	-5.65	-7.78	-4.88	-6.23
	Wyoming	85	-4.97	-4.97	-2.28	-3.15
	Pacific					
	Alaska	117	-6.44	-6.24	-7.43	-8.51
	California	8,852	6.09	5.72	2.78	2.64
	Hawaii	253	1.82	1.61	0.28	0.36
	Oregon	769	-1.66	-3.04	-1.11	-1.89
	Washington	1,053	0.78	0.15	0.61	-0.03

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).
Notes: Simulations assume that the provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.

Table 10. Exchange Enrollment with an Advanced Premium Tax Credit under the Affordable Care Act

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		8,600	-0.2	0.5	1.1	1.1
Northeast						
	New England					
	Connecticut	23	*	*	*	*
	Maine	13	*	*	*	*
	Massachusetts	74	-11.2	-14.7	-1.6	-10.9
	New Hampshire	27	*	*	*	*
	Rhode Island	26	*	*	*	*
	Vermont	11	*	*	*	*
	Middle Atlantic					
	New Jersey	162	-5.2	-1.4	4.6	-3.6
	New York	418	-8.7	0.7	-8.4	0.6
	Pennsylvania	317	3.7	-3.9	-0.9	0.1
Midwest						
	East North Central					
	Illinois	282	-6.1	-9.2	-5.8	-8.1
	Indiana	90	3.7	3.9	3.7	8.3
	Michigan	269	9.3	0.7	5.6	0.6
	Ohio	359	1.4	0.7	5.6	0.4
	Wisconsin	164	1.9	-1.3	-0.3	1.4
	West North Central					
	Iowa	48	*	*	*	*
	Kansas	87	2.4	4.6	3.7	10.6
	Minnesota	98	-1.2	11.4	0.0	8.6
	Missouri	139	4.4	5.8	6.6	6.8
	Nebraska	49	*	*	*	*
	North Dakota	23	*	*	*	*
	South Dakota	27	*	*	*	*
South						
	South Atlantic					
	Delaware	19	*	*	*	*
	District of Columbia	8	*	*	*	*
	Florida	709	-2.7	-2.8	-0.3	0.4
	Georgia	234	6.8	4.1	6.8	3.3
	Maryland	114	-6.8	3.4	-4.2	3.0
	North Carolina	259	8.2	10.7	8.0	9.4
	South Carolina	126	6.3	6.9	6.5	7.4
	Virginia	181	2.0	6.7	-1.6	-0.3
	West Virginia	37	*	*	*	*

Table 10. Exchange Enrollment with an Advanced Premium Tax Credit under the Affordable Care Act

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	115	1.2	4.0	-0.4	-1.9
	Kentucky	123	29.6	29.8	25.4	21.6
	Mississippi	98	-1.9	-4.6	-1.9	-8.9
	Tennessee	187	8.8	12.3	9.7	8.9
	West South Central					
	Arkansas	99	10.1	16.2	7.8	5.3
	Louisiana	91	7.4	6.4	7.0	11.2
	Oklahoma	109	-5.9	-3.5	-5.7	-6.1
	Texas	936	3.2	0.7	2.5	0.3
West						
	Mountain					
	Arizona	202	1.9	4.7	1.9	0.2
	Colorado	195	-2.5	-3.7	1.7	-2.6
	Idaho	66	-1.0	1.0	0.5	3.3
	Montana	35	*	*	*	*
	Nevada	82	-0.4	4.7	1.6	4.4
	New Mexico	69	17.6	7.7	7.8	6.4
	Utah	104	10.8	12.7	10.5	11.6
	Wyoming	24	*	*	*	*
	Pacific					
	Alaska	20	*	*	*	*
	California	1,315	-11.7	-10.2	-4.9	-3.7
	Hawaii	10	*	*	*	*
	Oregon	134	4.0	6.0	3.5	4.4
	Washington	194	-2.2	4.4	-1.6	2.0

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).
Notes: Simulations assume that provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.
* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

Table 11. Total Uninsured under the Affordable Care Act

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		26,749	0.4	1.0	0.5	0.5
Northeast						
	New England					
	Connecticut	175	-2.6	-1.4	-1.6	-1.4
	Maine	56	2.8	10.5	2.5	4.1
	Massachusetts	188	-1.3	-1.1	0.7	-1.7
	New Hampshire	72	-3.4	-1.9	-1.3	-3.0
	Rhode Island	70	2.8	1.7	0.3	-0.1
	Vermont	34	2.4	4.8	0.7	1.7
	Middle Atlantic					
	New Jersey	777	1.5	1.5	1.0	1.0
	New York	1,880	-1.2	-1.2	-1.7	-1.5
	Pennsylvania	661	-2.5	1.2	0.6	0.1
Midwest						
	East North Central					
	Illinois	912	-0.7	1.9	-0.6	0.6
	Indiana	365	4.2	4.2	5.3	3.8
	Michigan	729	-0.9	1.5	-0.7	1.3
	Ohio	695	2.4	2.0	2.0	3.0
	Wisconsin	249	2.5	6.4	7.0	6.4
	West North Central					
	Iowa	198	-0.5	0.2	-0.3	-0.9
	Kansas	191	-0.2	2.8	-0.5	1.2
	Minnesota	283	-0.3	0.6	-0.5	2.0
	Missouri	300	5.1	3.8	8.1	5.5
	Nebraska	124	2.0	1.5	1.4	2.6
	North Dakota	44	11.6	12.9	9.6	11.6
	South Dakota	53	2.9	1.9	1.8	4.3
South						
	South Atlantic					
	Delaware	70	-0.4	-0.7	0.6	-0.6
	District of Columbia	36	-7.3	-7.4	-7.6	-7.7
	Florida	2,004	-0.6	-0.2	0.0	-0.2
	Georgia	970	1.0	2.8	1.4	2.0
	Maryland	404	0.7	0.4	0.6	0.2
	North Carolina	859	0.6	0.5	0.6	1.0
	South Carolina	333	3.4	2.1	2.1	0.8
	Virginia	515	-0.2	0.4	-0.4	1.4
	West Virginia	94	3.7	1.5	1.5	1.4

Table 11. Total Uninsured under the Affordable Care Act

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	284	7.6	9.2	7.1	3.2
	Kentucky	316	1.8	3.7	0.6	0.7
	Mississippi	226	4.2	4.5	4.2	3.3
	Tennessee	461	7.1	0.5	5.7	1.5
	West South Central					
	Arkansas	224	6.8	7.2	5.7	5.4
	Louisiana	349	-1.6	-2.1	-2.2	0.5
	Oklahoma	285	7.7	5.8	5.5	1.9
	Texas	3,405	0.5	2.4	0.6	0.9
West						
	Mountain					
	Arizona	817	-0.6	1.7	-0.2	0.1
	Colorado	450	-0.5	0.4	0.2	-0.9
	Idaho	119	8.3	8.8	3.7	3.3
	Montana	88	5.6	6.5	3.3	2.7
	Nevada	282	0.4	-1.0	0.1	0.5
	New Mexico	262	-1.7	1.2	0.5	1.3
	Utah	199	0.8	3.6	3.3	3.1
	Wyoming	43	1.4	1.4	1.0	2.0
	Pacific					
	Alaska	65	5.0	5.1	5.2	4.8
	California	4,499	-1.6	-1.6	-1.3	-1.5
	Hawaii	56	-1.4	-1.1	0.3	-2.4
	Oregon	336	2.0	3.4	1.4	1.6
	Washington	641	0.2	0.2	-0.2	0.1

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).

Notes: Simulations assume that the provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.

* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

Federal and State Spending on Medicaid, CHIP and APTC. Table 12 presents estimates of state and federal spending on subsidized health insurance programs in the baseline and the simulations of the four geographic price adjustments to the poverty guidelines. The SPM adjustments would increase total state and federal spending very slightly, and the RPP adjustments would either not change or only slightly reduce total spending.

The spending patterns across regions and states, of course, mirror the eligibility and enrollment patterns presented above. Across all the measures, both state and federal spending increase when geographic adjustments increase the poverty guidelines and decrease when they reduce the guidelines. State spending declines by more than 7 percent in Alaska regardless of the geographic adjustment used, due to the fact that the SPM and RPP adjustments are not as high as Alaska's current poverty guideline adjustment. State spending would decrease in Arkansas, Iowa, North Dakota, and Maine by more than 3 percent for one or more of the geographic adjustments. California, Connecticut, Massachusetts, and the District of Columbia would experience the greatest increases in costs across at least two geographic adjustment alternatives.

Federal spending changes would be somewhat larger than those estimated for states. In high-cost states this occurs because there is an increase in individuals eligible for Medicaid and CHIP and a reduction in those eligible for APTCs. The greater federal contribution for Medicaid and CHIP, especially under the Medicaid expansion, means that the federal government has a greater increase in costs relative to the states. The reverse is true in low-costs states. For example, in contrast to the state spending declines of 1 percent for the MSA indices to 6 percent for the state indices, the state SPM and RPP adjustments would reduce federal spending in Iowa by almost 12 percent, and the MSA adjustments would reduce spending in Arkansas by 8 to 9 percent. New Jersey shows the greatest increase in federal spending at about 11 percent across all four geographic adjustments. Federal spending would also increase in California, the District of Columbia, Connecticut, Massachusetts, and New York (for the RPP) by 4 to 9 percent.

Table 13 shows the distribution of federal spending between Medicaid and CHIP and APTC in exchanges, but these results are not described in detail. The results mirror the patterns found for eligibility these programs after geographic adjustment: federal spending on Medicaid and CHIP would increase, and spending on APTCs in exchanges would decrease in states when the poverty guidelines increase.

Table 12. State and Federal Spending under the Affordable Care Act, 2011

Region	State	State Medicaid spending under baseline (millions)	Federal Medicaid, CHIP, & exchange spending under baseline (millions)	Percent Change from Baseline							
				State SPM		MSA SPM		State RPP		MSA RPP	
				State spending	Federal spending	State spending	Federal spending	State spending	Federal spending	State spending	Federal spending
U.S. Total		$102,742	$206,464	0.2	0.1	0.1	0.2	-0.1	-0.2	0.0	-0.4
Northeast											
	New England										
	Connecticut	$918	$1,959	2.6	8.0	1.6	8.6	1.7	7.6	2.2	4.8
	Maine	$584	$1,611	-2.9	-3.7	-3.6	-4.7	-2.8	-3.6	-2.7	-3.7
	Massachusetts	$3,046	$4,231	3.7	4.8	5.5	6.6	1.0	2.3	1.1	2.7
	New Hampshire	$329	$504	0.2	1.2	0.2	1.6	0.0	0.6	0.1	1.2
	Rhode Island	$621	$871	-0.2	0.2	-0.2	0.2	-0.1	0.0	0.0	0.2
	Vermont	$215	$509	0.7	1.2	-1.5	-0.2	-0.8	-0.6	-1.5	-0.6
	Middle Atlantic										
	New Jersey	$2,376	$3,687	1.0	11.4	0.9	11.0	0.5	10.6	2.5	12.7
	New York	$12,667	$17,483	0.2	1.4	0.0	3.7	0.0	4.1	0.1	3.7
	Pennsylvania	$5,588	$9,766	-0.5	-0.7	-0.7	-0.6	0.0	-0.2	-0.6	-0.5
Midwest											
	East North Central										
	Illinois	$5,115	$7,030	0.1	0.5	-0.4	1.0	0.0	0.4	-0.3	1.1
	Indiana	$2,295	$6,053	-0.5	-4.5	-0.5	-4.8	-0.5	-4.5	-0.5	-4.8
	Michigan	$3,365	$6,601	-0.2	-0.4	-0.3	-0.5	-0.1	-0.3	-0.3	-1.0
	Ohio	$3,694	$8,593	-1.0	-1.5	-0.5	-1.8	-1.2	-2.1	-0.6	-2.1
	Wisconsin	$1,295	$3,257	-0.7	-1.0	-1.4	-0.9	-0.8	-2.8	-1.4	-1.9
	West North Central										
	Iowa	$554	$1,508	-5.7	-11.7	-1.6	-5.2	-5.7	-11.6	-1.0	-4.9
	Kansas	$802	$1,596	-0.5	-0.6	-0.6	-2.5	-0.5	-0.8	-0.6	-2.6
	Minnesota	$2,074	$2,422	-0.1	-0.5	-0.5	-2.5	-0.7	-0.9	-0.8	-2.9
	Missouri	$2,082	$4,634	-0.4	-1.7	-0.2	-1.7	-0.5	-2.0	-0.4	-1.9
	Nebraska	$467	$955	-0.5	-1.0	-1.4	-1.9	-0.5	-1.0	-1.4	-1.9
	North Dakota	$109	$335	-4.5	-7.5	-1.3	-4.5	-1.2	-3.3	-1.2	-3.9
	South Dakota	$311	$648	-0.6	-2.3	-0.6	-2.3	-0.6	-2.2	-0.5	-2.2

Table 12. State and Federal Spending under the Affordable Care Act, 2011

Region	State	State Medicaid spending under baseline (millions)	Federal Medicaid, CHIP, & exchange spending under baseline (millions)	Percent Change from Baseline							
				State SPM		MSA SPM		State RPP		MSA RPP	
				State spending	Federal spending	State spending	Federal spending	State spending	Federal spending	State spending	Federal spending
South											
	South Atlantic										
	Delaware	$378	$608	0.0	1.3	-0.2	0.7	0.0	0.2	-0.3	0.3
	District of Columbia	$327	$926	1.5	7.2	1.5	8.7	1.5	7.3	1.3	7.6
	Florida	$5,012	$11,954	0.5	2.1	0.5	3.5	0.0	0.0	0.3	-0.1
	Georgia	$2,027	$6,619	-0.6	-2.5	-0.3	-2.2	-0.6	-2.5	-0.3	-3.3
	Maryland	$1,406	$2,415	0.1	3.4	0.0	2.7	-0.1	2.2	-0.1	1.9
	North Carolina	$2,590	$8,059	-0.4	-2.6	-0.5	-2.8	-0.4	-2.6	-0.4	-2.6
	South Carolina	$741	$2,877	0.9	-2.0	0.8	-1.8	1.0	-1.2	1.0	-1.7
	Virginia	$2,054	$3,282	0.0	1.6	-0.1	-4.7	0.0	1.6	0.0	-2.2
	West Virginia	$486	$2,125	-0.6	-3.0	-0.4	-3.8	-0.4	-1.4	-0.4	-1.8
	East South Central										
	Alabama	$1,307	$3,917	-0.8	-5.8	-1.0	-6.6	-0.8	-5.1	-0.9	-5.3
	Kentucky	$1,611	$5,219	-0.3	-2.4	-0.4	-2.4	-0.2	-1.3	-0.3	-2.3
	Mississippi	$750	$3,451	-1.3	-2.9	-1.0	-2.5	-1.3	-3.2	-0.7	-1.9
	Tennessee	$2,583	$6,478	-1.6	-2.4	-1.3	-1.5	-1.4	-1.8	-1.3	-1.3
	West South Central										
	Arkansas	$555	$2,337	-4.0	-9.0	-4.6	-9.4	-3.6	-7.9	-4.0	-7.8
	Louisiana	$856	$3,422	0.1	-2.5	0.3	-1.5	0.1	-2.8	0.1	-2.1
	Oklahoma	$1,196	$2,872	-0.8	-2.1	-0.8	-2.3	-0.8	-1.9	-0.5	-1.6
	Texas	$6,558	$14,893	-0.2	-0.4	-0.4	-0.8	-0.2	-0.5	-0.3	-0.5
West											
	Mountain										
	Arizona	$1,277	$4,137	0.0	0.0	-1.7	-1.7	0.0	0.0	-1.0	-1.3
	Colorado	$1,189	$1,928	0.0	0.5	-0.1	0.2	0.0	-0.4	0.0	0.1
	Idaho	$302	$952	-2.0	-4.4	-1.9	-4.9	-1.3	-2.3	-1.3	-2.8
	Montana	$161	$492	-2.1	-5.5	-2.1	-5.7	-1.5	-4.3	-1.5	-4.3
	Nevada	$607	$1,087	0.2	1.0	-0.1	0.2	0.0	-1.1	0.1	-1.1
	New Mexico	$390	$1,491	-0.9	-2.1	-0.9	-3.5	-0.7	-1.8	-0.7	-1.9
	Utah	$376	$1,244	-1.4	-3.1	-1.5	-3.4	-1.4	-2.9	-1.4	-3.2
	Wyoming	$165	$265	-0.4	-1.5	-0.4	-1.5	-0.1	-1.1	-0.1	-3.8

Table 12. State and Federal Spending under the Affordable Care Act, 2011

Region State	State Medicaid spending under baseline (millions)	Federal Medicaid, CHIP, & exchange spending under baseline (millions)	Percent Change from Baseline							
			State SPM		MSA SPM		State RPP		MSA RPP	
			State spending	Federal spending	State spending	Federal spending	State spending	Federal spending	State spending	Federal spending
West (continued)										
Pacific										
Alaska	$239	$418	-7.8	-16.7	-7.3	-16.5	-8.5	-17.2	-9.2	-17.7
California	$16,089	$23,376	2.1	5.3	1.7	4.9	0.8	2.0	1.1	2.1
Hawaii	$371	$757	0.1	3.4	0.0	3.3	0.0	3.0	-0.5	1.7
Oregon	$657	$2,209	-0.6	-1.2	-0.9	-1.5	-0.6	-0.6	-0.9	-1.4
Washington	$1,975	$2,399	0.8	0.8	-0.2	0.3	0.7	0.8	-0.3	-0.1

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).
Notes: Simulations assume that the provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.

Table 13. Federal Spending on Medicaid and CHIP and on Advanced Premium Tax Credits

Region State	Federal Medicaid and CHIP spending under baseline (millions)	Federal exchange spending under baseline (millions)	Percent Change from Baseline							
			State SPM		MSA SPM		State RPP		MSA RPP	
			Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies
U.S. Total	$203,180	$3,284	0.1	0.7	0.1	3.1	-0.3	6.1	-0.5	7.3
Northeast										
New England										
Connecticut	$1,943	$16	8.2	*	8.8	*	7.7	*	5.0	*
Maine	$1,609	$2	-3.8	*	-4.8	*	-3.7	*	-3.7	*
Massachusetts	$4,176	$55	5.5	-44.5	7.3	-47.3	2.8	-37.7	3.2	-33.6
New Hampshire	$499	$5	1.7	*	2.0	*	0.8	*	1.5	*
Rhode Island	$853	$18	0.7	*	0.7	*	-0.1	*	0.2	*
Vermont	$502	$7	1.2	*	-0.6	*	-0.5	*	-1.1	*
Middle Atlantic										
New Jersey	$3,599	$88	12.4	-27.8	12.0	-32.4	11.4	-22.2	13.8	-33.6
New York	$17,346	$137	1.7	-35.5	3.9	-21.1	4.4	-40.3	3.9	-21.6
Pennsylvania	$9,591	$175	-0.7	0.3	-0.6	-2.6	-0.2	-0.8	-0.5	-2.5
Midwest										
East North Central										
Illinois	$6,871	$159	0.5	-2.6	1.3	-11.9	0.5	-1.8	1.4	-10.4
Indiana	$6,013	$40	-5.1	78.7	-5.4	78.7	-5.1	78.7	-5.4	82.2
Michigan	$6,515	$86	-0.6	11.1	-0.6	6.1	-0.4	8.6	-1.1	7.0
Ohio	$8,441	$152	-2.0	21.6	-2.1	13.3	-2.4	17.7	-2.5	20.4
Wisconsin	$3,191	$66	-1.3	11.9	-1.0	2.1	-3.6	32.0	-2.4	20.7
West North Central										
Iowa	$1,486	$22	-12.4	33.5	-5.8	38.9	-12.3	36.7	-5.4	29.0
Kansas	$1,574	$22	-1.0	33.1	-3.3	49.7	-1.3	40.3	-3.3	49.7
Minnesota	$2,361	$61	-0.4	-1.1	-3.0	17.8	-0.9	0.7	-3.4	19.0
Missouri	$4,584	$50	-1.9	14.5	-2.0	24.4	-2.3	27.6	-2.3	29.3
Nebraska	$930	$25	-1.4	*	-2.4	*	-1.4	*	-2.4	*
North Dakota	$330	$5	-9.5	*	-6.7	*	-5.3	*	-5.7	*
South Dakota	$640	$8	-2.6	*	-2.5	*	-2.4	*	-2.4	*

Table 13. Federal Spending on Medicaid and CHIP and on Advanced Premium Tax Credits

Region	State	Federal Medicaid and CHIP spending under baseline (millions)	Federal Exchange spending under baseline (millions)	Percent Change from Baseline							
				State SPM		MSA SPM		State RPP		MSA RPP	
				Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies
South											
	South Atlantic										
	Delaware	$601	$7	1.8	*	0.6	*	0.3	*	0.3	*
	District of Columbia	$921	$5	7.4	*	9.2	*	7.5	*	7.9	*
	Florida	$11,728	$226	2.3	-10.2	3.8	-11.5	0.0	0.0	-0.2	3.0
	Georgia	$6,526	$93	-2.9	26.5	-2.4	15.8	-3.0	29.1	-3.6	20.0
	Maryland	$2,372	$43	4.1	-36.9	3.4	-34.6	2.5	-20.2	2.3	-21.7
	North Carolina	$7,904	$155	-3.0	20.9	-3.1	11.2	-3.0	19.5	-3.1	21.3
	South Carolina	$2,809	$68	-2.5	18.3	-2.3	17.1	-1.6	16.3	-2.1	15.8
	Virginia	$3,210	$72	1.8	-7.9	-5.4	26.6	1.8	-8.0	-2.4	7.8
	West Virginia	$2,115	$10	-3.7	*	-4.6	*	-1.8	*	-2.6	*
	East South Central										
	Alabama	$3,874	$43	-5.8	-4.2	-7.0	21.8	-5.3	14.3	-5.3	-3.1
	Kentucky	$5,199	$20	-2.9	102.7	-2.8	99.1	-1.5	62.5	-2.6	91.4
	Mississippi	$3,423	$28	-3.2	37.9	-2.7	25.6	-3.5	37.9	-2.1	25.6
	Tennessee	$6,378	$100	-3.1	41.1	-2.3	48.9	-2.4	34.8	-2.1	47.2
	West South Central										
	Arkansas	$2,289	$48	-10.8	72.3	-11.6	96.5	-9.7	81.2	-9.6	76.9
	Louisiana	$3,397	$25	-3.7	158.6	-2.8	174.1	-3.7	117.3	-3.0	126.4
	Oklahoma	$2,827	$45	-2.2	6.3	-2.6	17.2	-2.1	9.6	-1.8	9.5
	Texas	$14,591	$302	-0.7	11.0	-0.9	1.4	-0.7	10.3	-0.6	2.5
West											
	Mountain										
	Arizona	$4,105	$32	0.0	0.0	-2.1	60.4	0.0	0.0	-1.6	46.1
	Colorado	$1,894	$34	0.6	-3.8	0.6	-18.4	-0.4	2.8	0.2	-2.8
	Idaho	$934	$18	-5.3	39.9	-5.8	42.5	-2.7	16.5	-3.3	24.1
	Montana	$484	$8	-6.8	*	-7.3	*	-5.4	*	-5.5	*
	Nevada	$1,057	$30	1.1	0.0	0.3	-1.8	-1.2	3.2	-1.2	3.3
	New Mexico	$1,468	$23	-2.6	24.1	-3.9	24.3	-2.1	9.8	-2.2	13.8
	Utah	$1,219	$25	-3.8	32.9	-4.2	32.2	-3.7	32.9	-3.9	30.9
	Wyoming	$258	$7	-1.5	*	-1.5	*	-1.0	*	-3.7	*

Table 13. Federal Spending on Medicaid and CHIP and on Advanced Premium Tax Credits

Region	State	Federal Medicaid and CHIP spending under baseline (millions)	Federal Exchange spending under baseline (millions)	Percent Change from Baseline							
				State SPM		MSA SPM		State RPP		MSA RPP	
				Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies	Medicaid and CHIP	Exchange subsidies
West (continued)											
	Pacific										
	Alaska	$410	$8	-19.7	*	-19.5	*	-20.3	*	-20.7	*
	California	$22,922	$454	6.5	-53.9	5.9	-42.1	2.4	-19.9	2.5	-18.8
	Hawaii	$753	$4	3.5	*	3.3	*	3.1	*	1.7	*
	Oregon	$2,138	$71	-1.8	14.4	-2.1	14.2	-0.9	8.4	-2.0	14.4
	Washington	$2,320	$79	0.9	-0.2	0.0	10.3	0.8	-0.2	-0.1	0.2

Source: Urban Institute Health Insurance Policy Simulation Model (HIPSM).

Notes: Simulations assume that the provisions of the Affordable Care Act were fully implemented in 2011 and that states maintain eligibility levels per their current Medicaid maintenance-of-effort requirements after those requirements cease to apply.

* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

Changes in Elderly Medicaid Eligibility. All four adjustments in the poverty guidelines would increase full-scope Medicaid eligibility for the elderly (table 14). In many states the eligibility changes resulting from the adjustments for geographic price variation are close to zero. These small changes are likely due to the very low incomes of elderly individuals who are eligible for full-scope Medicaid. That is, they remain eligible in states where the indices produce large negative effects on the poverty guidelines (such as Georgia, Kentucky, Tennessee, and Louisiana) because their incomes are still below the reduced poverty guidelines.

A few states stand out as examples with substantial increases in full-scope eligibility for Medicaid among the elderly after adjusting for geographic price variation. For example, the SPM adjustments to the poverty guidelines increase the number of elderly eligible for full-scope Medicaid by 16 to 17 percent in Massachusetts, 21 to 25 percent in New Jersey, and 17 to 19 percent in California. These are relatively high housing cost states, and large shares of the elderly have incomes that cluster near the current poverty guidelines.[24] A large increase in the guidelines would result in a considerable increase in Medicaid eligibility.

Similarly, a few states would experience relatively large declines in full-scope Medicaid eligibility for the elderly. For example, the SPM adjustments would reduce the number of elderly eligible for full-scope Medicaid in Missouri by 24 to 27 percent and in South Carolina by 16 to 24 percent, and the RPP adjustments would result in eligibility reductions of about 33 percent in Missouri and 12 to 19 percent in South Carolina. The results suggest that the incomes of many elderly individuals who are eligible for full-scope Medicaid in these areas fall just below the current poverty guidelines, and they would lose eligibility with geographic adjustment of the guidelines because they live in relatively low-cost states. The substantial declines occur regardless of whether the SPM or the RPP indices are used.

[24] While the elderly are less likely to be poor than the overall population, they are more likely to be low income (income between 100 and 200 percent of the federal poverty level) (O'Brien, Wu, and Beer 2010).

Table 14. Average Monthly Elderly People Eligible for Full-Scope Medicaid Benefits, 2008–09

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		4,317	2.8	2.4	1.0	1.1
Northeast						
	New England					
	Connecticut	27	*	*	*	*
	Maine	40	*	*	*	*
	Massachusetts	120	15.7	16.8	5.2	5.4
	New Hampshire	9	*	*	*	*
	Rhode Island	20	*	*	*	*
	Vermont	14	*	*	*	*
	Middle Atlantic					
	New Jersey	151	25.0	21.2	16.9	21.1
	New York	429	0.0	0.3	0.3	0.3
	Pennsylvania	240	-4.8	-7.1	-0.9	-2.8
Midwest						
	East North Central					
	Illinois	157	0.4	2.4	0.0	2.4
	Indiana	35	*	*	*	*
	Michigan	117	-15.2	-4.5	-12.6	-5.7
	Ohio	36	*	*	*	*
	Wisconsin	59	0.0	0.0	0.0	0.0
	West North Central					
	Iowa	24	*	*	*	*
	Kansas	17	*	*	*	*
	Minnesota	67	-1.1	-2.7	-2.9	-6.3
	Missouri	50	-26.5	-23.5	-32.7	-33.5
	Nebraska	15	*	*	*	*
	North Dakota	7	*	*	*	*
	South Dakota	2	*	*	*	*
South						
	South Atlantic					
	Delaware	4	*	*	*	*
	District of Columbia	15	*	*	*	*
	Florida	309	0.0	0.0	0.0	0.0
	Georgia	91	0.0	0.0	0.0	0.0
	Maryland	77	0.0	0.0	0.0	0.0
	North Carolina	187	-11.0	-15.2	-9.4	-13.9
	South Carolina	94	-24.2	-16.8	-19.3	-12.0
	Virginia	113	2.5	-5.0	2.2	-5.2
	West Virginia	20	*	*	*	*

Table 14. Average Monthly Elderly People Eligible for Full-Scope Medicaid Benefits, 2008–09

Region State	Baseline (1,000s)	Percent Change from Baseline			
		State SPM	MSA SPM	State RPP	MSA RPP
South (continued)					
East South Central					
Alabama	28	*	*	*	*
Kentucky	54	0.0	0.0	0.0	0.0
Mississippi	22	*	*	*	*
Tennessee	111	0.0	0.0	0.0	0.0
West South Central					
Arkansas	48	*	*	*	*
Louisiana	87	0.0	0.0	0.0	0.0
Oklahoma	47	*	*	*	*
Texas	156	0.0	0.0	0.0	0.0
West					
Mountain					
Arizona	113	0.0	-1.7	0.0	-0.6
Colorado	54	0.0	0.0	0.0	0.0
Idaho	12	*	*	*	*
Montana	8	*	*	*	*
Nevada	30	*	*	*	*
New Mexico	16	*	*	*	*
Utah	22	*	*	*	*
Wyoming	1	*	*	*	*
Pacific					
Alaska	6	*	*	*	*
California	825	19.3	17.3	10.8	11.6
Hawaii	40	*	*	*	*
Oregon	34	*	*	*	*
Washington	59	0.0	0.0	0.0	0.0

Source: TRIM3 microsimulation model.
Notes: For people not reporting Medicaid on the CPS, no spend-down was assumed when determining their eligibility for the Medically Needy program. People assigned Medicaid on the CPS (true reports and Census allocated coverage) are not included in this table if simulated by TRIM3 to be ineligible for Medicaid.
* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

Eligibility for restricted Medicaid benefits among the elderly would decrease using both the SPM and RPP adjustments to the guidelines (table 15). Some states would experience very large declines in eligibility, including most states in the east north central, east south central, and west south central divisions. West Virginia stands out with the largest declines in

eligibility (55–57 percent using the SPM indices and 40–43 percent using the RPP indices).[25] As noted earlier, elderly people with incomes that are approximately 100–150 percent of the federal poverty guidelines may qualify for these benefits under the current poverty guidelines. With lower poverty guidelines in areas with relatively low costs of living, fewer elderly individuals would be eligible for these benefits. Conversely, a few states have relatively large predicted increases in eligibility. Examples include Massachusetts, New Jersey, New York, and California. In these states, more elderly individuals qualify for restricted benefits because poverty guidelines in their states would be substantially higher than the current guidelines.

[25] Readers should be cautious in interpreting this result since the sample size for West Virginia is relatively small (roughly 100 average monthly eligible people in the baseline).

Table 15. Average Monthly Elderly Persons Eligible for Restricted Medicaid Benefits, 2008–09

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		5,264	-3.1	-5.1	-3.4	-7.2
Northeast						
	New England					
	Connecticut	212	15.1	16.5	13.8	12.6
	Maine	67	-9.0	-12.9	-7.1	-7.0
	Massachusetts	79	23.4	33.8	10.4	18.2
	New Hampshire	18	*	*	*	*
	Rhode Island	13	*	*	*	*
	Vermont	13	*	*	*	*
	Middle Atlantic					
	New Jersey	84	53.2	47.0	26.3	53.2
	New York	415	18.8	22.8	35.6	27.5
	Pennsylvania	162	-8.7	-4.4	-4.7	-3.2
Midwest						
	East North Central					
	Illinois	111	7.8	-10.0	0.7	-11.8
	Indiana	129	-22.0	-21.7	-22.0	-24.4
	Michigan	110	-6.7	-17.1	-4.1	-16.3
	Ohio	283	-21.2	-22.8	-21.9	-25.7
	Wisconsin	70	-21.1	-30.1	-23.8	-37.9
	West North Central					
	Iowa	43	*	*	*	*
	Kansas	45	*	*	*	*
	Minnesota	45	*	*	*	*
	Missouri	116	-15.7	-23.1	-19.4	-27.1
	Nebraska	15	*	*	*	*
	North Dakota	7	*	*	*	*
	South Dakota	16	*	*	*	*
South						
	South Atlantic					
	Delaware	29	*	*	*	*
	District of Columbia	27	*	*	*	*
	Florida	430	15.6	13.4	-0.7	2.0
	Georgia	175	-7.0	-13.7	-9.5	-16.5
	Maryland	82	30.2	20.4	21.6	14.1
	North Carolina	119	-22.8	-21.4	-15.9	-22.6
	South Carolina	95	-7.6	-24.8	-8.4	-22.4
	Virginia	91	5.1	-8.0	3.1	-8.7
	West Virginia	52	-54.8	-56.9	-39.8	-43.1

Table 15. Average Monthly Elderly Persons Eligible for Restricted Medicaid Benefits, 2008–09

Region	State	Baseline (1,000s)	Percent Change from Baseline: State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	190	-28.2	-27.3	-21.6	-23.3
	Kentucky	90	-39.2	-43.8	-25.3	-31.2
	Mississippi	122	-20.8	-22.1	-17.1	-19.1
	Tennessee	147	-23.2	-26.8	-17.1	-23.9
	West South Central					
	Arkansas	81	-36.9	-31.2	-24.4	-27.1
	Louisiana	94	-15.7	-13.9	-12.4	-11.1
	Oklahoma	47	*	*	*	*
	Texas	572	-3.4	-6.6	-3.9	-6.4
West						
	Mountain					
	Arizona	117	-1.7	-1.4	-0.1	-0.7
	Colorado	52	5.9	-2.2	-5.5	-7.2
	Idaho	22	*	*	*	*
	Montana	21	*	*	*	*
	Nevada	37	*	*	*	*
	New Mexico	50	-16.1	-22.8	-7.5	-11.4
	Utah	17	*	*	*	*
	Wyoming	14	*	*	*	*
	Pacific					
	Alaska	6	*	*	*	*
	California	276	15.5	32.6	9.6	0.7
	Hawaii	19	*	*	*	*
	Oregon	64	-6.6	-19.1	-1.3	-10.0
	Washington	73	9.8	-5.0	8.1	-0.3

Source: TRIM3 microsimulation model.

* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

SNAP

On average, SNAP eligibility for all persons would decline slightly using both the SPM and RPP indices (table 16). Slightly larger eligibility declines occur using the MSA indices to adjust the guidelines compared with the state indices. The greater declines in eligibility using the MSA adjustments for both indices compared with the state adjustments suggest that, in general, fewer people would gain eligibility in higher-cost areas within a state when moving from a statewide to a MSA-level guideline adjustment than would lose eligibility in lower-cost MSA and nonmetropolitan areas of the state. These outcomes are affected by the extent of the difference between the state-level and MSA-level adjustments in the different parts of a state and the number of potentially eligible persons with incomes in the affected range.

The range of changes in eligibility across states is relatively large for all four indices. For example, the MSA SPM would reduce eligibility by 19.5 percent in West Virginia and increase eligibility in California by 16 percent. The state SPM also produces a wide range of SNAP eligibility effects (-17.5 percent in West Virginia and +17.9 percent in California). The states with the largest adjustments in eligibility based on the RPP indices sometimes differ from the results for the SPM. For example, the MSA RPP effects on eligibility range from -17.6 percent in Mississippi to +14.8 percent in New Jersey.

States that tend to experience relatively large (10 percent or more) declines in eligibility across all indices tend to be in the west north central (except Minnesota), the east south central, and the west south central (except Texas). Relatively fewer states experience such large increases in eligibility across all indices. Exceptions are New Jersey (with 14 to 17 percent increases in SNAP eligibility) and California (with 9 to 18 percent increases in eligibility). While the increases in eligibility are more modest, most states in the northeast region would experience eligibility increases (except Maine and Pennsylvania).

In a few states, the SPM and RPP indices produce quite different results. For example, the SPM adjustments to the guidelines would increase eligibility in Florida, Hawaii, and Nevada, but the RPP would produce little change or declines in SNAP eligibility. Any serious consideration of adjustments to program eligibility on the basis of geographic differences in costs will need to grapple with these differences. The results indicate that in some states housing costs reflected in the SPM paint a very different picture of the geographic variation in costs than general price differences reflected in the RPP.

Table 16. Average Monthly Persons Eligible for SNAP, 2008–09

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		55,510	-0.4	-1.3	-1.1	-2.1
Northeast						
	New England					
	Connecticut	512	8.6	11.3	8.3	8.5
	Maine	241	-1.7	-3.8	-0.7	-1.6
	Massachusetts	1,072	9.3	8.3	4.7	5.2
	New Hampshire	142	5.6	6.6	3.6	3.3
	Rhode Island	231	1.9	1.9	0.0	0.2
	Vermont	104	3.7	0.4	-0.1	-0.5
	Middle Atlantic					
	New Jersey	896	17.1	14.2	14.0	14.8
	New York	4,099	7.0	7.8	11.7	9.1
	Pennsylvania	2,253	-5.6	-6.8	-2.0	-3.8
Midwest						
	East North Central					
	Illinois	1,837	1.2	-0.9	0.6	-1.6
	Indiana	1,145	-5.6	-5.9	-5.5	-6.3
	Michigan	2,446	-3.7	-4.7	-2.9	-4.5
	Ohio	2,445	-8.9	-9.2	-9.8	-10.4
	Wisconsin	1,140	-4.9	-5.2	-6.3	-7.6
	West North Central					
	Iowa	367	-14.4	-13.8	-14.7	-12.7
	Kansas	418	-13.1	-15.8	-13.2	-14.6
	Minnesota	668	-1.0	-5.7	-3.9	-6.9
	Missouri	941	-9.9	-11.9	-13.4	-15.0
	Nebraska	202	-11.1	-12.3	-11.1	-12.7
	North Dakota	119	-9.5	-12.8	-7.6	-7.8
	South Dakota	121	-10.9	-12.3	-9.6	-11.3

Table 16. Average Monthly Persons Eligible for SNAP, 2008–09

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
South						
	South Atlantic					
	Delaware	185	3.7	2.0	1.8	-1.0
	District of Columbia	111	5.3	11.0	7.1	7.9
	Florida	2,980	6.9	7.4	0.0	0.6
	Georgia	2,179	-2.7	-4.5	-4.3	-5.0
	Maryland	735	6.7	5.1	4.7	4.0
	North Carolina	1,651	-8.9	-9.0	-6.6	-8.2
	South Carolina	1,059	-9.8	-9.7	-7.9	-8.3
	Virginia	928	4.3	1.0	2.6	-0.2
	West Virginia	479	-17.5	-19.5	-11.9	-15.2
	East South Central					
	Alabama	923	-12.9	-13.7	-8.3	-9.3
	Kentucky	841	-10.9	-12.5	-8.4	-10.0
	Mississippi	766	-17.3	-17.8	-15.4	-17.6
	Tennessee	1,337	-9.5	-11.0	-7.9	-10.7
	West South Central					
	Arkansas	604	-15.6	-17.7	-14.1	-13.9
	Louisiana	947	-7.8	-12.0	-7.4	-8.6
	Oklahoma	650	-17.0	-16.0	-12.5	-13.5
	Texas	5,793	-0.9	-2.1	-1.0	-1.6
West						
	Mountain					
	Arizona	1,703	0.0	-0.3	0.0	-0.6
	Colorado	619	1.1	0.9	-0.8	-0.3
	Idaho	274	-14.3	-15.6	-9.3	-10.1
	Montana	190	-10.3	-10.5	-6.1	-6.4
	Nevada	517	5.6	7.3	-0.4	-0.7
	New Mexico	409	-9.3	-9.3	-4.6	-6.0
	Utah	282	-9.0	-13.9	-6.1	-9.1
	Wyoming	59	-17.0	-17.6	-8.9	-9.2
	Pacific					
	Alaska	98	-12.3	-12.4	-15.4	-15.2
	California	5,445	17.9	16.1	9.9	8.9
	Hawaii	189	10.2	12.6	0.4	-0.7
	Oregon	824	-2.5	-3.5	-2.0	-2.9
	Washington	1,329	1.0	0.2	0.8	-0.2

Source: TRIM3 microsimulation model.

CCDF

As mentioned previously, states do not necessarily use poverty guidelines when setting CCDF eligibility estimates. These results show the effects of the guideline adjustments under a hypothetical scenario where all states have CCDF eligibility limits in the baseline equal to 185 percent of the federal poverty guidelines. The RPP adjustments to these guidelines would produce a small decline in eligibility, while the SPM adjustments would produce a small increase in eligibility (table 17). As described earlier, eligibility is available to working parents with qualifying children and family income below 185 percent of the alternative poverty guidelines. The eligible population represents a higher income group than the results for SNAP where the gross income limit is typically 130 percent of the poverty guidelines.

With geographic price adjustments to the poverty guidelines, CCDF eligibility would tend to increase in New England and the middle Atlantic states (except Pennsylvania) and decline in the midwest (both east and west north central divisions except Illinois). Estimates for the southern region indicate that eligibility would decline in all states for all indices in the east and west south central division, but the south Atlantic division includes states with large increases (Maryland) and large declines (South Carolina) in eligibility. The results reflect the varied demographic and economic profiles in the south Atlantic region states. The mountain division includes states with little change in eligibility (Arizona and Colorado) and large declines (especially Idaho). Again the SPM and RPP can produce quite different results. The decline in eligibility in Idaho would be twice as high using the SPM than it is using the RPP, reflecting the state's relatively low housing costs.

Table 17. Children Eligible for CCDF Subsidies if Eligibility Were Set at 185 Percent of Poverty Guidelines, 2008–09

Region	State	Baseline (1,000s)	Percent Change from Baseline			
			State SPM	MSA SPM	State RPP	MSA RPP
U.S. Total		8,800	0.4	0.4	-1.2	-1.7
Northeast						
	New England					
	Connecticut	82	13.1	17.9	11.4	14.1
	Maine	29	*	*	*	*
	Massachusetts	104	20.8	25.1	15.9	13.5
	New Hampshire	22	*	*	*	*
	Rhode Island	22	*	*	*	*
	Vermont	15	*	*	*	*
	Middle Atlantic					
	New Jersey	168	20.6	17.0	11.1	17.4
	New York	476	6.9	9.3	15.0	13.5
	Pennsylvania	258	-7.3	-7.1	-2.4	-4.3
Midwest						
	East North Central					
	Illinois	354	2.2	1.3	0.6	2.0
	Indiana	245	-13.4	-12.1	-13.2	-14.8
	Michigan	269	-7.6	-6.7	-6.2	-6.4
	Ohio	327	-10.3	-10.5	-11.2	-13.1
	Wisconsin	152	-6.9	-6.3	-8.2	-12.0
	West North Central					
	Iowa	73	-9.9	-8.8	-9.9	-8.4
	Kansas	105	-11.2	-10.9	-12.1	-11.0
	Minnesota	114	-0.9	-4.8	-3.9	-11.5
	Missouri	184	-9.5	-11.6	-10.5	-12.1
	Nebraska	60	-12.1	-11.1	-12.1	-10.1
	North Dakota	19	*	*	*	*
	South Dakota	31	*	*	*	*
South						
	South Atlantic					
	Delaware	28	*	*	*	*
	District of Columbia	17	*	*	*	*
	Florida	496	8.5	10.5	0.0	0.0
	Georgia	329	-4.2	-6.0	-6.3	-6.8
	Maryland	135	19.2	17.1	11.7	9.3
	North Carolina	313	-5.4	-5.2	-3.2	-4.5
	South Carolina	138	-15.4	-12.2	-13.7	-11.1
	Virginia	195	4.8	4.0	3.5	-0.1
	West Virginia	32	*	*	*	*

Table 17. Children Eligible for CCDF Subsidies if Eligibility Were Set at 185 Percent of Poverty Guidelines, 2008–09

Region	State	Baseline (1000s)	Percent Change from Baseline: State SPM	MSA SPM	State RPP	MSA RPP
South (continued)						
	East South Central					
	Alabama	169	-9.3	-9.9	-8.4	-6.9
	Kentucky	116	-13.7	-15.0	-10.6	-12.8
	Mississippi	134	-8.6	-7.4	-6.1	-6.9
	Tennessee	195	-13.3	-12.7	-11.2	-11.7
	West South Central					
	Arkansas	98	-15.1	-14.8	-11.3	-12.7
	Louisiana	187	-10.8	-7.3	-10.3	-5.8
	Oklahoma	140	-7.6	-7.5	-5.3	-5.8
	Texas	894	-2.6	-3.7	-2.8	-3.9
West						
	Mountain					
	Arizona	182	0.0	1.9	0.0	2.0
	Colorado	129	0.4	0.0	-0.3	-1.7
	Idaho	52	-13.9	-21.0	-9.5	-9.6
	Montana	24	*	*	*	*
	Nevada	74	8.2	9.9	-1.1	0.0
	New Mexico	93	-9.2	-8.7	-7.3	-5.9
	Utah	72	-3.8	-6.0	-3.2	-3.0
	Wyoming	16	*	*	*	*
	Pacific					
	Alaska	20	*	*	*	*
	California	1,094	20.7	19.1	10.0	9.0
	Hawaii	46	*	*	*	*
	Oregon	102	-7.0	-6.1	-5.9	-4.9
	Washington	172	2.8	6.6	2.8	2.7

Source: TRIM3 microsimulation model.

* Due to small sample size, results for these states are not shown separately, although they are included in the U.S. total.

V. Effects of Cost of Living Variation in Insular Areas on Program Eligibility

The U.S. insular areas include the Commonwealth of Puerto Rico, Guam, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, and American Samoa. In 2010, 4,100,954 individuals lived in the insular areas, and Puerto Rico accounted for 90.1 percent

of these individuals.[26] With the exception of Guam, median household income in the insular areas is substantially less than income in the mainland, ranging from 36 percent of the U.S. median in Puerto Rico to 74 percent in the Virgin Islands.[27]

Most social welfare programs available in the 50 states and the District of Columbia are also available in the insular areas, and any changes to take into account variation in the cost of living could affect program eligibility in the insular areas. However, income eligibility determination for benefits in insular areas often differs substantially from the standards used for the states and the District of Columbia, depending on the program and the insular area. SNAP operates in the Virgin Islands and Guam, but special grant programs operate in Puerto Rico, the Northern Marianas, and America Samoa. Medicaid and the CCDF are grant-in-aid programs by which the federal government helps finance benefits and services in the insular areas, if the insular area chooses to participate in the grant program. All insular areas have Medicaid and CHIP programs and are included in the Affordable Care Act. The special grant programs and allocations for other programs already reflect some extent differences in incomes and prices in the insular areas, and this must be taken into account when estimating the potential effects of more directly adjusting eligibility for such price variation.

Poverty Thresholds and Guidelines in the Insular Areas

The Census Bureau uses the same poverty thresholds for insular areas as for states and the District of Columbia in measuring poverty. Since the ACS has been fielded in Puerto Rico since 2005, annual poverty estimates are available for this insular area. The poverty rate in Puerto Rico was 45 percent in 2010, compared with 15 percent in the United States (Census Bureau 2011). Comparable 2010 rates are not available for the other insular areas; however, family poverty rates can be approximated using published data from the Census Bureau's 2010 Demographic Profile Summary Files (DPSFs). These data suggest family poverty rates of 18 percent in the U.S. Virgin Islands, 19 percent in Guam, 44 percent in the Northern Mariana Islands, and 54 percent in American Samoa.

HHS does not issue poverty guidelines for the insular areas. Instead, the federal office that administers any program in the insular areas is generally responsible for deciding whether to use the contiguous states and D.C. guidelines or follow some other procedure. A 2009 GAO report (GAO 2009a) investigated the potential for adjusting poverty guidelines for use in the insular areas. The report noted that the U.S. Office of Personnel Management's nonforeign area cost-of-living adjustments (COLAs) could be used for each insular area

[26] U.S. Census Bureau, data from the 2010 Census. Specifically, the population in Puerto Rico was 3,725,789, American Samoa 55,519, Guam 159,358, Northern Marianas 53,883, and Virgin Islands 106,405.
[27] Authors' calculations based on data from the 2009 ACS, 2009 PRCS, and the 2010 DPSF for the insular areas.

except American Samoa (where nonforeign area COLAs are not available).[28] In a response to this report, HHS/ASPE argued that the nonforeign area COLAs were of "insufficient statistical quality" to adjust the poverty guidelines. Also, this project's expert panel members concluded that these COLAs would not be appropriate for adjusting insular area poverty guidelines since they reflect costs for federal employees rather than the low-income population.

In their response to the GAO report, HHS/ASPE outlined two possible alternative methods: (1) setting the guideline as a percentage of median family income, or (2) setting the guideline based on the "responsiveness of the poverty threshold to changes in inflation-adjusted income over time." The Census Bureau suggested that GAO consider comparing the nonforeign COLAs for insular areas to the housing-cost differentials from the ACS, Census, and HUD FMRs.

Variation in Cost of Living in the Insular Areas

We know relatively little about the cost of living in the insular areas, especially for low-income families. Collins, Bosworth, and Soto-Class (2006) summarize the results of a 2002 survey comparing living costs in Puerto Rico to Washington, D.C. The survey found that overall living costs in Puerto Rico were 96.6 percent of those in D.C. Some costs in Puerto Rico, including housing were lower than in D.C., while others such as transportation were higher. However, the authors note that the comparisons are not precise due to consumption differences between Puerto Rico and Washington, D.C. Also, the price differences apply to the entire income distribution rather than low-income families.

The SPM and RPP geographic cost of living indices applied in this study to the U.S. mainland do not currently cover the insular areas. Some research uses fair market rents to capture housing costs, and there are some data on wage differentials in insular areas. The 2000 Decennial Census serves as the base for HUD FMRs for Puerto Rico, Guam, the Northern Marianas, American Samoa, and the U.S. Virgin Islands. The 2010 Decennial Census records more up-to-date information about housing costs in the insular areas outside Puerto Rico, but microdata for the insular areas have not yet been released or incorporated into the HUD FMRs. Also, published tables do not allow comparison of median rent for same-sized units. The Puerto Rican Community Survey (PRCS) does record information about housing costs in Puerto Rico.[29,30] Although the quality of the PRCS is not as high as for

[28] The nonforeign area COLAs reflect prices for over 300 items, including goods and services, housing, transportation and miscellaneous expenses. The COLAs are paid to white-collar civilian federal employees working in Alaska, Hawaii, and the covered insular areas to reflect higher prices in these areas. See http://www.opm.gov/oca/cola/index.asp.

[29] With the introduction of the ACS, the long form of the Decennial Census was eliminated in the United States and Puerto Rico. The long form includes questions about income and housing characteristics that are not included in the short form.

the ACS, it does provide the best and most recent indication of housing costs in Puerto Rico, and so we use it to calculate an SPM type index and to estimate the effects on eligibility.[31]

The project reviewed other economic benchmarks for assessing prices in the insular areas. The OES provides occupational wage data for Guam, Puerto Rico, and the Virgin Islands. However, American Samoa and the Northern Marianas are not included. Wage data for Puerto Rico and the Virgin Islands are available through the Quarterly Census of Employment and Wages (QCEW). The QCEW was used to develop a geographic index in GAO's analysis of changes to the funding formula for Vocational Rehabilitation Services (GAO 2009b). The Purchasing Power Parities (PPPs) developed for international comparisons of GDP may also be of some use. PPPs are available for American Samoa, Guam, Puerto Rico, and the Virgin Islands.[32] However, neither the wage data nor the PPPs provide a measure of differences in the cost of living faced by low-income families.

Benefit Eligibility in Safety Net Programs

Benefit eligibility differs across programs and sometimes across insular areas within a program area. In most cases, benefit eligibility formulae differ from those in the United States, and any adjustments to the guidelines or attempts to adjust eligibility for differences in prices relative to the U.S. states and District of Columbia must take that into account.

Federal Health Programs. Medicaid and CHIP programs operate differently in insular areas along a number of dimensions. Medicaid is not an entitlement as it is for those residing in the states, and federal expenditures are capped for each insular area. The insular areas have broader authority than states to determine Medicaid eligibility. American Samoa and Guam use the federal poverty guidelines to determine eligibility for Medicaid and CHIP, Puerto Rico uses a percentage of the commonwealth poverty level (CPL),[33] the U.S. Virgin Islands use local income levels, and the Mariana Islands use a percentage of the SSI income threshold.

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[30] Although the 2005–09 PRCS data are available, they were not used to develop FMRs because the data are insufficient to eliminate units that do not meet HUD standards. HUD used data on the change in all rents for all of Puerto Rico to update the prior FMRs (HUD 2012).

[31] One study found that Puerto Rico has a high rate of inaccurate addresses, and the mail response rates lagged about 25 percentage points behind the United States. The low rate of response by mail and phone results in a low rate of completed interviews and "impacts the reliability of survey estimates for Puerto Rico (Census 2012)." A few items (yearly mobile home costs, property value, year built, and year last married) have particularly high levels of item nonresponse, but these items are not required for our estimates.

[32] PPPs are available at http://www.pdwb.de/archiv/cia/ciabip00.htm.

[33] The commonwealth poverty level used in Puerto Rico to determine Medicaid eligibility is an administrative tool, and its origin is not documented. The CPL is approximately half the federal poverty threshold (U.S. House of Representatives, Ways and Means Committee, 2008).

The federal government has historically paid 50 percent of the cost of Medicaid in the insular areas, up to a total cap on costs. In 2010, for example, the federal government paid only 35 percent of Puerto Rico's Medicaid costs (including the temporary increase in the funding cap under ARRA). The Affordable Care Act raised the federal funding caps for Puerto Rico and the insular areas by $6.3 billion between July 1, 2011, and September 30, 2019. (Each insular area will receive a share of the additional funding.) The Affordable Care Act also increased the federal Medicaid matching rate for the insular areas to 55 percent. Puerto Rico's current Medicaid income eligibility limit for parents in a family of four is effectively 36 percent of FPL. Puerto Rico covers children in families of four up to 71 percent of FPL using federal matching funds under a CHIP-funded Medicaid expansion, and it covers some individuals above these income limits through a separate program funded with nonfederal dollars.

Insular areas have made broadly different choices for Medicaid eligibility. Only 6 percent of the population is covered by Medicaid and CHIP in the Virgin Islands, compared with 17 percent in Guam and 23 percent in Puerto Rico. Residents of American Samoa are not required to enroll in Medicaid, but 88 percent of the population is presumed covered because they have income below 200 percent of the federal poverty guidelines (GAO 2009c).

In addition to increased caps in the insular areas for Medicaid, the Affordable Care Act allocated $925 million to Puerto Rico and $75 million to the other territories to either provide premium assistance and cost-sharing subsidies to help individuals purchase coverage through an exchange or to increase the limit on their federal allocation for their Medicaid program.

SNAP. In 2009, Puerto Rico's Nutrition Assistance Program (NAP) provided nutrition assistance to about 30 percent of its population. Puerto Rico sets income eligibility limits and benefits to bring the program costs in line with the federal funding levels. In 2009, for example, the net income screen for NAP was $193 a month for an individual and $389 for a two-person household compared with $867 and $1,167 in the continental United States (Peterson et al. 2010). NAP uses more generous income exemptions and deductions than those in SNAP. Benefit amounts are not established relative to the Thrifty Food Plan, rather the benefit is calculated based on the number of participants and the size of the block grant. (A minimum NAP benefit was $55 per month in 2009.)

As noted earlier, the Virgin Islands and Guam operate the standard SNAP benefit program using the same eligibility and benefit rules as are used in the states and the District of Columbia. The program in the Northern Marianas differs from SNAP primarily in that its maximum grant is renegotiated periodically, a portion (30 percent) of each household's benefit must be used to purchase locally produced food or other food-related items such as fishing equipment, maximum allotments are about 5 percent higher than in the states, and

income eligibility limits are about half those in the regular program (Committee on Ways and Means 2008). In fiscal year 2007, the Northern Marianas program assisted 8,100 people with a monthly benefit averaging $81 per person; total spending was $9.8 million for FY 2008. American Samoa receives an annually indexed grant to operate a nutrition assistance program limited to low-income elderly and disabled persons. In 2007, 3,000 people a month were aided, and $6.5 million was spent in fiscal year 2008. Income eligibility limits are about 25 percent lower than the regular SNAP program and benefits are similar (Public Law 107-171).

CCDF. As in the states and the District of Columbia, the CCDF program is a grant in aid and not an entitlement program. The insular areas receive monies from the discretionary fund based on the same factors used for the states. These include the ratio of the number of children under age 5 in the insular area to the number in the country, a school lunch factor, and a weighting factor based on per capita income. The insular areas do not receive mandatory CCDF funds.[34]

The eligibility rules for CCDF subsidies in the insular areas follow rules similar to those used in the states (Minton et al. 2011). For example, eligible three-person families must have monthly countable income less than $3,900, $2,300, $2,000, $1,423, and $2,752 in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands, respectively. The insular areas have minimum hours of work requirements for eligibility (which vary somewhat across them). Similar to state rules, the insular areas generally allow a child up to age 12 to be eligible, except in the Virgin Islands, where the age is 13.

CCDF caseloads are relatively small with 400 families in an average month in fiscal year 2010 in American Samoa, 500 in Guam, 200 in the Northern Marianas, 9,300 in Puerto Rico, and 400 in the Virgin Islands.[35] Associated fiscal year 2010 CCDF allocations were $2.8 million in American Samoa, $4.0 million in Guam, $1.9 million in the Northern Marianas, $33.9 million in Puerto Rico, and $1.9 million in the Virgin Islands.

Estimating the Effects of Alternative Poverty Guidelines on Eligibility

The PRCS allows us to estimate the effect of adjusting poverty guidelines for differences in the cost of living in Puerto Rico. However, similar data are not available for the other insular areas. As noted earlier, the 2010 Census data for these insular areas are not available in a

[34] Mandatory funds derive from the IV-A child care programs originally established for AFDC, JOBS in 1994 or 1995.

[35] 2010 CCDF Data Tables (Preliminary Estimates, December 2011). http://www.acf.hhs.gov/programs/occ/resource/ccdf-data-10acf800-preliminary. HHS/ACF, Office of Child Care, CCDF statistics. table 1, Average Monthly Adjusted Number of Families and Children Served (FFY 2010).

form that would allow estimation of program eligibility.[36] There are 2000 Census data for some insular areas, but indications from published tables from the 2010 Census indicate that demographics and incomes have changed substantially over the decade.[37] Also, data are not available for American Samoa or the Northern Mariana Islands. Lacking data for estimating program eligibility outside Puerto Rico, we provide the available published data from the 2010 Census and generally discuss the implications of adjusting current eligibility for differences in the cost of living.

Geographic-Adjusted Guidelines for Puerto Rico. As noted earlier, neither the SPM nor the RPP index is produced for the insular areas. (BEA statistical experts say that it would be possible to develop RPPs for Puerto Rico, but this would be a long-term development.) The PRCS allows us to compute a housing cost factor for Puerto Rico using the same method used by the Census Bureau to create the SPM. We calculated the 50th percentile rent in Puerto Rico from the 2006–10 PRCS and applied the difference between Puerto Rico and the United States to the share of income spent on housing in the continental United States (using the same factor as in the states). The median rent for a two-bedroom unit with full plumbing and kitchen in Puerto Rico was $360 or 43 percent of the median national rent of $838 used for the SPM index.[38] Applying this adjustment only to the housing portion of the guideline defined earlier produces an adjustment in the guidelines of 0.72 to capture relative housing costs in Puerto Rico. The results reflect all of Puerto Rico.[39]

Estimation. The 2009 PRCS provides an up-to-date demographic and income profile for Puerto Rico. The survey provides housing costs, cash income (by source), and health insurance coverage. We use these data to roughly estimate the number eligible for Medicaid, CHIP, and subsidies under Affordable Care Act, SNAP, and CCDF.

Simulations of the effect of price-adjusted Medicaid, CHIP, and Affordable Care Act income eligibility guidelines in Puerto Rico are derived through a simple model of eligibility. Household members are grouped into health insurance units, and Medicaid, CHIP, and Affordable Care Act subsidy eligibility rules are applied to complete a baseline. Reports of current enrollment are used to identify current enrollees, and additional eligibles under Affordable Care Act rules are added by applying simple rules of income relative to the

[36] Public-use microdata will be available in summer 2013, according to the Release Schedule from the Census Bureau dated February 14, 2012.
[37] For example, Census reports show that the population count declined over 2000–10 by 22 percent in the Northern Marianas. The population increased by 3 percent in Guam, but the number of Guam residents age 65 and older increased by 30 percent while the population of residents age 14 or younger declined by 8 percent (Pacific Islands Report, www.pidp.eastwestcenter.org/pirereport/2010/September/09-04-07).
[38] Calculations by the authors based on the five-year version of the PRCS.
[39] The PRCS does not provide MSAs for Puerto Rico, but the IPUMS assigns an MSA (based on PUMAs) for approximately 60 percent of the area in Puerto Rico. Given the imprecision of these data and the fact that the vast majority of the Puerto Rican population lives in urban areas, we use a single geographic unit for Puerto Rico.

national poverty guidelines (in the baseline) and relative to the price-adjusted poverty guidelines (in the alternative).

In addition to Medicaid, Puerto Rico provides health insurance coverage to low-income populations with incomes up to 200 percent of CPL, financed without federal dollars. Coverage under this program cannot be distinguished from coverage under Medicaid and CHIP on the PRCS. Moreover, it is not clear whether this program will exist after the Affordable Care Act is implemented or whether these individuals would purchase coverage in the exchange. To address this issue, we present data for three groups: those eligible for Medicaid or CHIP, those not eligible for Medicaid or CHIP but reporting public coverage, and those eligible for APTCs to purchase coverage in the exchange.

We simulate eligibility in two ways. We first model Puerto Rico's current eligibility based on the CPL. Children in families with income up to 200 percent of CPL are eligible, and categorically eligible groups (parents, elderly, and disabled) are eligible in families with income up to 100 percent of CPL. In 2011, Puerto Rico expanded Medicaid coverage to childless adults up to 100 percent of CPL with authority under the Affordable Care Act. These individuals had previously been eligible for Puerto Rico's self-funded health insurance program. We did not model this expansion since it was implemented after the 2010 Puerto Rico Community Survey data were collected.

We assume a Medicaid expansion up to 138 percent of CPL under Affordable Care Act rules, and those who are uninsured or have private nongroup coverage with incomes below 400 percent of CPL are eligible for subsidized premiums in an exchange. We chose to model Puerto Rico's implementation of the Affordable Care Act in this manner to be consistent with what is required of states. Puerto Rico has more flexibility, subject to CMS approval, regarding eligibility thresholds and whether they create an exchange or simply expand the Medicaid program. Puerto Rico had initially decided not to implement an exchange. However, the November 2012 election resulted in a change in governors, and the Commonwealth is currently revisiting this decision. Given this uncertainly and to facilitate comparisons, we modeled implementation that would be consistent with that occurring in the states.

These baseline simulations produce eligibility estimates for Medicaid, CHIP, and APTCs. The second set of simulations estimate eligibility in Puerto Rico using the Affordable Care Act rules with the federal poverty guidelines to show eligibility in Puerto Rico using the same standards as states. We apply the adjustment to the federal poverty guidelines for the second set of estimates to estimate the effect of an adjustment for prices in Puerto Rico.

To estimate SNAP eligibility, we make the simplifying assumption that the entire household files for SNAP as a single unit. We sum up the household's income, subtract

deductions to calculate net income, and apply the SNAP gross and net income tests to estimate eligibility. SNAP units without an elderly or disabled member must have gross income less than 130 percent of the poverty guideline, and all units must have net income less than 100 percent of the guideline. Households consisting entirely of people receiving SSI or public assistance are automatically eligible for SNAP. We assume that Puerto Rico would obtain permission to waive time limits for ABAWDs. Due to data limitations, we do not model assets tests or the dependent care or child support deductions, and we assign a flat $65 per month in medical expenses to units with an elderly or disabled member for use in simulating the medical expense deduction. Other deductions are captured, including the standard deduction, the earned income deduction, and the excess shelter expense deduction (using reported information on shelter costs in the PRCS). We use the federal poverty guideline in the baseline simulation and multiply the guideline by 0.72 to adjust for the housing cost differential in Puerto Rico in the alternative simulation.

Eligibility for CCDF subsidies is estimated similarly. We use the health insurance unit as the family unit for determining eligibility. To be eligible, the unit must have earned income and at least one child under the age of 13. Eligibility is determined by comparing income, less a 15 percent earned income deduction, to the eligibility limit. As with the U.S. estimates, we simulate a hypothetical eligibility limit of 185 percent of the federal poverty guideline. In the alternative simulation, we multiply the federal poverty guideline by 0.72 to reflect the lower cost of housing in Puerto Rico.

Results

As table 18 indicates, 761,000 nonelderly individuals and 96,000 thousand elderly individuals are eligible for Medicaid or CHIP under rules in place in 2010 based on the CPL (858,000 combined). There are also an additional 917,000 individuals who report public health insurance but whom we do not find to be eligible for Medicaid or CHIP. We believe that the vast majority of these individuals are enrolled in the health program financed by the Commonwealth of Puerto Rico and that covers individuals up to 200 percent of CPL.[40] Under the Affordable Care Act, Puerto Rico has 1.5 million individuals eligible for Medicaid and CHIP, 382,000 reporting public coverage but not eligible for Medicaid, and 232,000 eligible for APTCs based on the CPL. Medicaid eligibility remains the same for the elderly since the Affordable Care Act does not apply to elderly individuals.

Modeling eligibility under the Affordable Care Act using eligibility thresholds based on the federal poverty guidelines produces a very different picture. The federal guidelines substantially increase the number of individuals eligible for Medicaid compared to the CPL.

[40] Some of these individuals may also be disabled persons that our disability measure does not identify. The PRCS does not directly report disability. Our disability measure uses reports of receipt of disability benefits and reports of not working due to disability to identify the disabled. In addition, others may be eligible for and enrolled in Medicaid, but measurement error in our model does not identify them as eligible.

Almost 2.5 million nonelderly individuals are eligible for Medicaid or CHIP, 62,000 report public health insurance coverage but are not eligible for Medicaid or CHIP, and 157,000 would be eligible for premium tax credits. In addition, 306,000 elderly persons would be eligible for Medicaid, and 34,000 more report public health insurance.

After adjusting the poverty guidelines for housing costs in Puerto Rico, just over 2 million nonelderly persons would be eligible for Medicaid, 145,000 more report public health insurance who are not eligible for Medicaid, and 213,000 would become eligible for APTCs. In addition, 207,000 elderly would be eligible for Medicaid, and 71,000 report public coverage who are not eligible for Medicaid. Overall, adjusting the poverty guidelines would decrease eligibility for Medicaid or CHIP by an estimated 17 percent relative to under the Affordable Care Act based on the federal poverty guidelines, and eligibility for advanced premium tax credits would increase by 11 percent.

Table 18. Eligibility for Subsidized Coverage in Puerto Rico under Federal Guidelines and Federal Guidelines Adjusted for Housing Costs

Current Eligibility Using Commonwealth Poverty Level

	Nonelderly	Elderly	Total
Medicaid eligible	761,169	96,332	857,501
Public reporters	796,461	120,434	916,895
Eligible for Advanced Premium Tax Credit	NA	NA	NA
Total	1,557,630	216,766	1,774,396

Affordable Care Act Eligibility Using Commonwealth Poverty Level

	Nonelderly	Elderly	Total
Medicaid eligible	1,490,966	96,332	1,587,298
Public reporters	381,706	120,434	502,140
Eligible for Advanced Premium Tax Credit	231,884	NA	231,884
Total	2,104,556	216,766	2,321,322

Affordable Care Act Eligibility Using Federal Poverty Guidelines

	Nonelderly	Elderly	Total
Medicaid eligible	2,405,751	305,727	2,711,478
Public reporters	61,639	33,808	95,447
Eligible for Advanced Premium Tax Credit	156,952	NA	156,952
Total	2,624,342	339,535	2,963,877

Affordable Care Act Eligibility Using Alternative Poverty Guidelines[a]

	Nonelderly	Elderly	Total
Medicaid eligible	2,034,716	207,446	2,242,162
Public reporters	145,008	71,471	216,479
Eligible for Advanced Premium Tax Credit	212,651	NA	212,651
Total	2,392,375	278,917	2,671,292

Source: Urban Institute analysis of Puerto Rico Community Survey data.
a. Under the alternative scenario, the federal poverty guidelines are multiplied by 0.72 to reflect lower housing costs in Puerto Rico.

We estimate that 2.1 million people in Puerto Rico would be eligible for SNAP (table 19) if Puerto Rico provided benefits under the standard federal rules of the program.[41] Multiplying the federal guideline by 0.72 to reflect lower housing costs in Puerto Rico would reduce the number of eligible persons by 447,000 (21 percent). By comparison, NAP covered approximately 1.18 million people in an average month during 2009 (Peterson et al. 2010).

An estimated 322,000 children would be eligible for CCDF in Puerto Rico, with eligibility set at 185 percent of the federal guideline. Adjusting the poverty guidelines for lower housing costs in Puerto Rico would reduce the number of eligible individuals by 53,000 (17 percent).

Table 19. CCDF and SNAP Eligibility in Puerto Rico, under Hypothetical Baseline and Alternative with Federal Guideline Adjusted for Housing Costs

	Baseline (1,000s)	Federal Guideline Adjusted for Housing Costs[a]	
		Change from baseline	Percent change from baseline
CCDF (if eligibility set at <185 percent of poverty guidelines)			
Eligible children	322	-53	-17
SNAP[b]			
Eligible people	2,112	-447	-21

Source: Urban Institute Analysis of Puerto Rico Community Survey.
a. Under the alternative scenario, the federal poverty guidelines are multiplied by 0.72 to reflect lower housing costs in Puerto Rico.
b. SNAP does not operate in Puerto Rico. Instead the federal government provides a block grant to Puerto Rico for nutrition assistance. However, the baseline estimate reflects eligibility assuming that Puerto Rico provides SNAP under the standard federal rules of the program.

Other Insular Areas. The Census 2010 advance report presents income distributions and basic demographics for each insular area. These data are useful for drawing some inferences about the possible effect of changes reflecting the cost of living on program eligibility. In general, the population in the insular areas outside Puerto Rico differs from the United States and Puerto Rico, and the differences vary across the insular areas. Although poverty rates are higher than in the U.S. mainland in all these territories, rates are especially high in American Samoa and the Northern Marina Islands and resemble the rates in Puerto Rico.

[41] Peterson et al. (2010) provide detailed microsimulation estimates of the number of people eligible and enrolled in SNAP had the program been in place in Puerto Rico in 2009. They estimate that 1.4 million individuals would participate in SNAP. Although they do not report the estimated number of eligible individuals, their estimated number of eligible households—721,000—is within 11 percent of our estimate of 650,000.

The population in American Samoa, Guam, and the Northern Mariana Islands is somewhat younger than in the United States and Puerto Rico (table 20).[42] From 9 to 12 percent of the population in these territories, for example, is under age 5 compared with 7 and 6 percent of the populations in the U.S. and Puerto Rico, respectively. The population is somewhat more educated in American Samoa, Guam and Northern Mariana Islands than in Puerto Rico or the U.S. Virgin Islands.

All the insular areas outside Puerto Rico have higher employment rates than Puerto Rico, approximating rates for the continental United States. Although Guam and the U.S. Virgin Islands have lower poverty rates and higher employment rates than Puerto Rico, a larger share of the population lacks health insurance (21 and 31 percent respectively, compared with 8 percent in Puerto Rico). Over a third of the population in the Northern Mariana Islands lacks health insurance. As mentioned previously, American Samoans are not required to enroll in Medicaid to receive covered services. Although Census data indicate that most American Samoans lack health insurance coverage, 88 percent are presumed covered by Medicaid due to having income below 200 percent of the federal poverty guideline (GAO 2009c).

[42] Additional demographic data for the insular areas is presented in appendix B.

Table 20. Population Characteristics: United States and Insular Areas

	United States	Insular Areas				
		Puerto Rico	American Samoa	Guam	Northern Mariana Islands	U.S. Virgin Islands
Total population in Census 2010 (1,000s)	308,746	3,726	56	159	54	106
Survey-estimated 2009 population (1,000s)[a]	307,007	3,967	N/A	N/A	N/A	N/A
Age						
< 5	7%	6%	12%	9%	9%	7%
5–19	20%	22%	34%	27%	26%	21%
20–64	60%	58%	50%	57%	63%	59%
65+	13%	14%	4%	7%	3%	14%
Percent of population foreign born	13%	3%	35%	31%	45%	33%
Percent of population not a U.S. citizen (or national)[b]	7%	2%	35%	18%	43%	12%
Educational attainment (percent of population 25+)						
with high school degree or higher	85%	69%	82%	79%	82%	69%
with bachelor's degree or higher	28%	21%	10%	20%	20%	19%
Civilian employment-population ratio (age 16+)	58.3%	38.5%	47.8%	56.3%	64.2%	60.0%
Percent of families in poverty	11%	41%	54%	19%	44%	18%
Among families with related children < 18	17%	51%	78%	30%	59%	31%
Civilian noninstitutionalized population (1,000s)[c]	301,472	3,939	55	154	54	105
Percent with private health insurance coverage	67%	44%	17%	56%	34%	54%
Percent with public health insurance coverage	29%	54%	30%	30%	35%	23%
Uninsured	15%	8%	59%	21%	34%	31%
Median gross rent	$842	$419	$463	$879	$324	$767

Sources: United States: 2010 United States Census Summary File 1 and 2009 American Community Survey (ACS). Puerto Rico: 2009 Puerto Rico Community Survey (PRCS) and 2010 Census Demographic Profile Summary File (DPSF). Other insular areas: 2010 Census DPSFs.

a. This row presents the population figures in the 2009 ACS and PRCS, which serve as the universe for the United States and Puerto Rico percentage figures in this table (unless otherwise specified). These populations are estimated based on samples and do not include institutionalized individuals.

b. Includes only individuals who were both not U.S. citizens and not U.S. nationals in American Samoa, Guam, and the Northern Mariana Islands; includes all those who are not U.S. citizens in other areas.

c. Some individuals may report both private and public coverage, so totals may not sum to 100 percent.

The median gross monthly rents in Guam ($879) and the U.S. Virgin Islands ($767) are similar to the United States ($842), but median gross rents in the other insular areas are substantially lower ($324 to $463). Because median gross rent in Guam and the U.S Virgin Islands is fairly similar to the United States, guidelines adjusted using a rent-based index

would likely be similar to the unadjusted federal guideline in those two areas. However, this is an imprecise comparison because it reflects the overall median gross rent, without controlling for number of bedrooms and whether the unit has a complete kitchen and plumbing (lacking in roughly 10 percent of Guam and U.S. Virgin Islands households—see appendix B). Given the somewhat higher poverty rates in Guam and the U.S. Virgin Islands (relative to the United States), a somewhat higher share of the population would likely be eligible for assistance than in the United States regardless of whether an unadjusted or adjusted federal guideline was used to determine eligibility.

The substantially lower median rents in American Samoa and the Northern Marianas indicate that using a rent-based index to capture price differentials would reduce federal poverty guidelines and program eligibility. However, the reported rents in these areas probably do not provide a good benchmark for adjusting the poverty guidelines. At least a quarter of households in these areas lack complete kitchen or plumbing facilities; if these units were excluded from the calculation of the median rent, the rents would likely be higher. Nonetheless, a rent-based index excluding substandard units would still likely lower the guidelines in these areas relative to the unadjusted federal guideline, and fewer families would be eligible for assistance than when using unadjusted federal guideline. The high poverty rates in American Samoa and the Northern Marianas (44 and 54 percent of families, respectively) also indicate that substantial shares of these populations would be eligible for assistance regardless of the guideline adjustment used.

VI. Summary

Considerable research documents substantial geographic variation in the cost of living between regions, states, and localities within states. Recent work on a new Supplemental Poverty Measure that incorporates price variation across MSAs into the poverty thresholds has focused more attention on this variation. Today, many federal benefit programs use the same income guidelines for determining eligibility across most states. Exceptions are that poverty guidelines are higher in Alaska and Hawaii because of their historically high living costs. Given the documented geographic variation in prices across the country, it is useful to understand how adjustments for price variation would affect eligibility for benefit programs.

This study uses the best-available indices that capture geographic variation in prices to estimate how adjustments to the poverty guidelines would affect eligibility and costs for post–Affordable Care Act health benefits (including Medicaid, CHIP, and tax credits to subsidize the purchase of coverage on exchanges). Estimates of eligibility effects are also provided for SNAP and CCDF. With the exception of CCDF, these programs use national federal poverty guidelines to determine income eligibility. (Many states use poverty

guidelines to determine eligibility for CCDF, but federal maximum eligibility guidelines are expressed in terms of median income.)

We selected the best-available indices after a full review of the recent literature and consultation with the expert panel assembled for this project. The ideal indices for adjusting the poverty guidelines would cover price variation across the entire United States, be produced regularly, and focus on prices faced by low-income families. Members of the expert panel that provided advice to the project expressed a clear preference for government indices available in the public domain. Although none of the indices specifically targets the lowest income families, the two indices that come closest to meeting these criteria are the measures developed by the Census Bureau to adjust the SPM poverty thresholds and the RPPs developed by the Bureau of Economic Analysis to track differences in the cost of a full market basket of goods across the country. This study uses these indices to adjust the poverty guidelines for price variation. We use versions of the indices at both the state and the MSA level. The MSA-level adjustments obviously capture important in-state price variation, but the state-level adjustments are simpler.

We use two well-documented microsimulation models available at the Urban Institute to test out the effect of price adjustments to poverty thresholds on program eligibility and costs. HIPSM is used to estimate health program eligibility, enrollment and costs for the nonelderly population, and TRIM3 is used to estimate Medicaid eligibility for the elderly population, and eligibility for SNAP and CCDF benefits. Both models use the same input data, the March 2009 and 2010 Annual Social and Economic Supplement to the Current Population Survey, representing income in years 2008 and 2009. Two years of data are combined to provide greater precision at the state level.

These models are used to estimate eligibility for each program using baseline rules and in four alternatives that apply the state and MSA-level SPM and RPP adjustments to the federal poverty guidelines. Baseline rules for the health programs reflect the new rules established by the Affordable Care Act for Medicaid and advanced premium tax credits (APTCs) for purchasing insurance in exchanges. While these rules will not take effect until 2014, the simulations show effects on eligibility assuming full implementation in 2011. Simplifying assumptions are used that simulate eligibility for Medicaid for all adults up to 138 percent of the poverty guidelines and APTCs for families without affordable employer insurance offers with income between 138 and 400 percent of poverty guidelines. Program rules in place in 2009 are used to develop baselines for SNAP. While states do not necessarily use poverty guidelines when setting CCDF eligibility estimates, we simulate the same program rules across all states to demonstrate the effects of adjustments for price variation on program eligibility. We simulate a hypothetical scenario assuming all states have CCDF eligibility limits equal to 185 percent of the poverty guidelines.

While the alternative indices would not make a large difference for program eligibility at the national level, they would have substantial effects at the region and state levels. The average national adjustments to the poverty guidelines are 1.1 and 0.6 percent for the SPM at the state and MSA level, respectively, and -0.4 and -1.1 percent for the RPP at the state and MSA level, respectively. The adjustments across the states range broadly with increases in the guidelines in most northeast states (except Maine and Pennsylvania) and decreases in guidelines in the midwest (except Illinois) and south. The adjusted poverty guidelines would be lower in most of the mountain states and higher in most of the Pacific states.

The effects of the adjustments to the guidelines in a few states would be relatively large (greater than 15 percent). For example, the SPM adjustments would increase the poverty guidelines by 15 to 18 percent in New Jersey, 14 to 16 percent in Massachusetts, 13 to 17 percent in Maryland, and 20 to 21 percent in California. States with large declines in guidelines include the Dakotas and West Virginia. In general, the RPP indices produce a somewhat narrower range of adjustments to the poverty guidelines than the SPM. With the exception of Hawaii and the District of Columbia, the RPP adjustments do not exceed 15 percent. The effect of the housing cost adjustment (used in the SPM) produces wider variation across the states.

The effects on specific programs generally follow these patterns, although results are also affected by variation in program rules and the distribution of income among those currently eligible. That is, concentrations of eligible populations at very low incomes are less likely to change as a result of adjustments to the poverty guidelines. They will remain eligible given the relatively modest changes in guidelines in most states. Some specific results are the following:

- The SPM adjustments to the poverty guidelines would slightly increase Medicaid and CHIP eligibility (0.6 percent and 0.3 percent for the state and MSA indices, respectively), and the RPP indices would slightly decrease eligibility (0.6 percent and 0.8 percent for the state and MSA indices, respectively). Changes in total enrollment in any type of subsidized coverage—Medicaid, CHIP, and exchange enrollment with an APTC—would be negligible with the SPM adjustments to the poverty guidelines and very slight for the RPP measures.

    - Medicaid eligibility would generally increase in the New England and middle Atlantic states regardless of the index used and decline in most southern and midwestern states (except Illinois). Generally, eligibility would increase in the more urban states and decrease in the more rural states. Eligibility would decrease in most of the mountain states (except Colorado and Nevada), and the results are

very mixed for states in Pacific division (with California having a large increase in the predicted number of eligible individuals and Alaska having a decrease).

- Similar to overall changes in eligibility, state and federal spending would increase slightly with the SPM adjustments and decrease slightly with the RPP adjustments to the guidelines. The spending patterns mirror eligibility and enrollment patterns across divisions and states.

- All four adjustments in the poverty guidelines would increase full-scope Medicaid eligibility for the elderly across the nation. In many states, the eligibility changes resulting from the adjustments for geographic price variation are close to zero. These small changes are likely due to the very low incomes among elderly persons eligible for full-scope Medicaid. That is, they remain eligible in states where the indices produce large negative effects on the poverty guidelines (such as Georgia, Kentucky, Tennessee, and Louisiana) because their incomes fall below even the reduced poverty guidelines.

- On average, SNAP eligibility for all persons would decline by 0.4 to 1.1 percent using the SPM and RPP state indices to adjust the federal poverty guidelines. Slightly larger negative adjustments (1.3 and 2.1 percent) occur when the MSA indices are used compared with the state indices, reflecting the concentration of the SNAP eligible population within the states.

  - The range of changes in SNAP eligibility across states is relatively large for all four indices. For example, the SPM indices would produce an estimated eligibility decline of 18 to 20 percent in West Virginia, but increases of 16 to 18 percent in California. SNAP eligibility would decline by 17.6 percent in Mississippi and increase by 14.8 percent in New Jersey.

- The alternative indices would produce relatively little difference in the hypothetical CCDF program eligibility simulations overall. Consistent with other results, the SPM adjustments to the poverty guidelines would produce a small increase in eligibility and the RPP adjustments would produce a small decline in eligibility.

  - CCDF eligibility would increase in New England and the middle Atlantic states (except Pennsylvania) and decline in the midwest (both east and west north central divisions except Illinois). Eligibility would decline in all states in the east and west south central divisons, but the south Atlantic division includes states with large eligibility increases (Maryland) and large eligibility declines (South Carolina and West Virginia). The mountain division includes states with little

change in eligibility (Arizona and Colorado) and large declines in eligibility (especially Idaho). The results reflect the varied economic profiles across the states.

The adoption of adjustments to poverty guidelines for geographic price variation also could affect program eligibility in the insular areas. While the benefit programs examined in this study operate in insular areas, the rules vary from those in the states. The federal government caps total spending for some programs (such as Medicaid and SNAP in Puerto Rico), and insular areas generally have individual flexibility in setting eligibility limits.

This study provides estimates of the effect of adjustments for geographic price variation in Puerto Rico. Puerto Rico accounts for 90 percent of the population living in insular areas, and the PRCS provides data appropriate for simulating program eligibility. The PRCS data on rental costs show that an adjustment to the housing portion of the federal poverty guideline would produce guidelines 28 percent lower than the average in the United States. The simulations show eligibility under the Affordable Care Act for Medicaid, CHIP, and APTCs using both the commonwealth poverty level used in Puerto Rico and the federal poverty guidelines. Moving from eligibility under the Affordable Care Act based on the FPL to eligibility based on 72 percent of FPL would decrease Medicaid/CHIP eligibility by 17 percent and increase APTC eligibility by 11 percent. SNAP and CCDF eligibility would fall by 21 and 17 percent, respectively, relative to a hypothetical baseline simulations.

The study provides rough approximations to the effects of adjusting program eligibility for price variation across the country. Four indices show the importance of adjustments at the MSA and state levels and adjustments that account only for housing costs compared to those that account for a full market basket of goods. Ideally, adjustments to the poverty guidelines for price variation would use an index reflecting all prices faced by low-income populations. Also, adjustments to particular programs for price differentials would need to consider all aspects of benefit programs. Current eligibility for benefit programs reflects careful choices, such as disregards for household expenses (used in SNAP), that already reflect some differences in costs faced by individual low-income families. Also, national standards for benefit eligibility tend to distribute more federal dollars to lower-income states that are likely to have lower prices and fewer funds to higher-income states that tend to have higher prices. This balance would need to be weighed carefully in any move towards geographic price adjustments in the poverty guidelines.

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