

The Affordable Care Act Turns 10

How the ACA has worked for Arkansas



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Policy Brief

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Introduction

On March 23, 2010, President Barack Obama signed the most significant reform to the United States health care system in a half-century. The Patient Protection and Affordable Care Act (“ACA,” or “Obamacare”) aimed to increase access to health care coverage to more individuals across the United States. The law has increased the accessibility of health care for all Americans and improved health outcomes across the country, despite becoming one of the more politicized laws in American history. Since it was passed, there have been numerous efforts to dismantle the ACA, including one currently pending (*Texas v. Azar*), but none have been successful to this point.

The implementation of the ACA started a new era for the United States health care system. It began a discussion about who can access health coverage, as well as the quality and cost of both the coverage and services. The ACA has been especially beneficial for Arkansas, which used the ACA’s guidelines to expand its Medicaid program. Arkansas’s Medicaid expansion program, formerly known as the “Private Option” (now referred to as “Arkansas Works”), led to many more Arkansans being able to access health coverage for the very first time. Having health coverage is especially important during a pandemic, like the United States is currently enduring with COVID-19.

As the ACA reaches its 10th year, the results are clear: Arkansans are better off as a result – through the improvements to the state’s health care system and to the health of Arkansas’s children and families.

In this report, we will explore:

- a brief history of the ACA and Arkansas’s Medicaid Expansion
- ways the ACA continues to improve the health of Arkansans
- how the ACA strengthens Arkansas’s response to a pandemic like COVID-19
- the steps to protect our gains of the past decade and strengthen those for the future

Cover photo citation: <https://www.colorado.edu/today/2020/04/30/affordable-care-act-lived-promise-buffering-bankruptcy-risk-study-shows>



History of the ACA

In 2010, after months of negotiations, the Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama. Generally, a law that is only a decade old has a minimal historic value; however, the ACA is an exception. At its signing, the ACA represented the most significant expansion of health coverage for Americans since Medicare and Medicaid were first passed.¹

Medicare and Medicaid, which President Lyndon B. Johnson signed into law on July 30, 1965, provided the foundation for the ACA. Between 1965 and 2010, small changes were made to the eligibility for and benefits provided by Medicare and Medicaid. In 1972, Medicare became available to individuals with disabilities, people with end-stage renal disease requiring dialysis or kidney transplant, and people 65 or older who selected Medicare coverage.² In 2003, Medicare recipients had their benefits increased to cover prescription drugs, a result of President George W. Bush's signing of the Medicare Prescription Drug, Improvement and Modernization Act. Medicaid, in its earliest form, gave medical insurance to only people already receiving cash assistance from the federal government. This policy was to help states provide medical assistance to residents who otherwise could not afford the costs of necessary health services. Recent versions of Medicaid have expanded coverage to include more low-income families, pregnant women, individuals with disabilities (regardless of age), and those people who need long-term care.³

Otherwise, Medicare and Medicaid were largely untouched, until U.S. Senator Barack Obama was elected President in November 2008. During his campaign, then-Senator Obama proposed expanding eligibility requirements for Medicaid and the State Children's Health Insurance Program (CHIP) and creating a new insurance marketplace to replace the individual market, while maintaining employer-provided health insurance as a significant source of health coverage.⁴ His plan was estimated to reduce the number of uninsured Americans from 67



Photo citation: https://www.upi.com/Top_News/2018/07/30/On-This-Day-Johnson-signs-Medicare-into-law/6501532397364/

million to 33.1 million over its first 10 years – a decrease of 33.9 million Americans. Upon his inauguration, President Obama began to implement what would become the ACA by the time it was signed in March 2010.

How the ACA changed health care in the United States

Medicaid expansion

One of the most revolutionary parts of the ACA was its expansion of Medicaid eligibility to a wider range of low-income adults without health insurance, who were previously ineligible for traditional Medicaid coverage. Medicaid was extended to all United States citizens and legal residents making an income up to 138 percent of the federal poverty level.⁵ This meant more adults could qualify for Medicaid, even those adults without dependent children, and the Medicaid expansion was originally applied to any state participating in the Medicaid program.

Shortly after the ACA was passed, a lawsuit was filed against the federal government that challenged the requirement for states to participate in Medicaid expansion. The United States Supreme Court determined that states did not have to agree to expand Medicaid to continue receiving the previous levels of Medicaid funding (and some states have continued to do so).⁶

Having health coverage is especially important during a pandemic like COVID-19.

The health insurance marketplace

Another part of the ACA that changed health care in America is the creation of a “health insurance marketplace.” This new marketplace completely changed the way health insurance was purchased in the United States. The ACA required that insurance companies accept all applicants for coverage – regardless of any pre-existing condition or demographic – and required that individuals be charged the same cost for a service, regardless of their health condition. The ACA added a requirement that all insurance plans cover a list of “essential health benefits.” In an effort to allow stakeholders time to implement these changes, many of the ACA’s new provisions, despite being passed in 2009 and signed in 2010, were not effective until January 1, 2014.

The existence of the health insurance marketplace allows consumers to compare plans that provide the right health insurance coverage for their needs. Each year there is a period known as “open enrollment,” during which individuals can change their health insurance plan for the upcoming year. Otherwise, individuals must have a specific event that triggers their ability to enroll in a marketplace health insurance plan, like a divorce, job change, or if the individual is a young adult transitioning from a parent’s health insurance plan.

How the ACA improves the health of Arkansas

Arkansas Works

For many Arkansans, the biggest benefit of the ACA is through its expansion of Medicaid to cover more uninsured, low-income Arkansans who otherwise did not qualify for Medicaid coverage. As the first state in the South to expand its Medicaid program, Arkansas used an innovative approach to the ACA’s Medicaid expansion. Arkansas crafted a “hybrid” model of expansion – coined the “Health Care Independence Act.” This proposal, known first as the “Private Option” and now known as “Arkansas Works,” asked the Centers for Medicare and Medicaid (CMS) for a Section 1115 waiver to use the federal funds allotted for Medicaid expansion to purchase qualified state health plans available through the newly-created health insurance marketplace.⁷ Thanks to the leadership of three Republican state legislators and support from Democrats and Republicans, the proposal was approved by the Arkansas state legislature and submitted to CMS by then-Governor Mike Beebe. After it was approved, Arkansas’s Medicaid expansion took effect on January 1, 2014.

Arkansas’s Medicaid expansion has seen several big changes over the past five years. Examples of these include adding limits to the use of non-emergency transportation and prohibiting advertising and enrollment outreach to eligible populations by state agencies. In 2016, Governor Asa Hutchinson submitted the reauthorization of Arkansas’s Medicaid expansion under its new name – “Arkansas Works.” CMS approved the Arkansas Works program, and it took effect on January 1, 2017.

In 2017, Arkansas’s General Assembly sought to modify Arkansas Works through a Section 1115 waiver amendment that included lowering the program’s income eligibility upper limit from 138 percent of poverty to 100 percent of poverty and implementing a work requirement as a condition for eligibility. One of these modifications, the work-reporting requirement, was approved by CMS and was enacted on June 1, 2018. Shortly after its implementation, the requirement was challenged in federal court (*Gresham v.*

Before the ACA’s **Essential Health Benefits**, millions of people buying coverage on their own couldn’t get critical benefits:

- More than 3 in 5 people didn’t have **maternity coverage**.
- 1 in 3 people didn’t have coverage for **substance use treatment**.
- Close to 1 in 5 people didn’t have coverage for **mental health care**.
- Almost 1 in 10 people didn’t have any coverage for **prescription drugs** (despite 60 percent of people in this country needing at least one medication each year).

FAMILIESUSA
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<https://familiesusa.org/resources/10-essential-health-benefits-insurance-plans-must-cover-under-the-affordable-care-act/>

Azar). In March 2019, a federal judge halted the work-reporting requirement, after more than 18,000 Arkansans lost health insurance coverage. For more information on the work-reporting requirement, check out Arkansas Advocates for Children and Families' three-part series: *An Early Look at the Impact: New Medicaid Work Requirement Hurts Health Coverage in Arkansas*; *Losing Coverage: State Medicaid Work Reporting Requirements Stripped 18,000 Arkansans of Health Insurance in 2018*; and *Final Verdict: Adding Work Requirements to Medicaid Expansion Was a Failed Experiment for the State of Arkansas*.

Impact of Arkansas Works on health coverage

Prior to Medicaid expansion, almost 46 percent of Arkansans with an income below 138 percent of the federal poverty level were uninsured.⁸ Two years after the state expanded Medicaid, only 21 percent of adults in this same income bracket were uninsured: a 25 percent decline. Arkansas's drop in uninsured was the third highest nationally, behind only Kentucky (30 percent) and West Virginia (26 percent).

Medicaid expansion has had a huge impact on Arkansas's people of color as well, with the uninsured rate for Black Arkansans dropping from 20.4 percent (2013) to 8 percent (2017). This means that before Medicaid expansion, one out of every five Black Arkansans lacked health insurance, but three years after the state expanded Medicaid, that number was reduced to fewer than one in 10. This dramatic decline was seen across all races and ethnicities in Arkansas after the state expanded Medicaid.⁹ Among Hispanic Arkansans, the rate dropped from 33.7 percent (2013), to 25.2 percent (2017), while Asian Arkansans' uninsured rate declined from 16.5 percent (2013) to 10.9 percent (2017).

Studies on the ACA's impact show that larger gains in coverage rates were experienced among vulnerable populations. On the other hand, research shows that certain modifications to Medicaid expansion, like Arkansas's attempt to implement work-reporting requirements as a prerequisite to Medicaid eligibility, cause coverage losses and present barriers to

enrollment.¹⁰ During the nine months that the work reporting requirement was effective, more than 18,000 Arkansans lost Medicaid coverage – a fact especially concerning given the coverage increases achieved during the first few years of Medicaid expansion.

The Children's Health Insurance Program

Just over a decade before the passage of the ACA, CHIP provided the groundwork for children across the United States to have health insurance coverage.¹¹ This program has had a huge impact on children's health insurance rates in Arkansas and has allowed Arkansas's children to have more consistent access to primary and preventative health care services. It also provides more stability for families who would otherwise not be able to afford the costs associated with their children's medical needs.¹²

The passage of the ACA helped strengthen coverage for children enrolled in CHIP. For children up to age 19, the ACA established a minimum Medicaid eligibility level of 138 percent of the federal poverty level. Before the ACA, the eligibility levels for children varied by age, with the federal eligibility for older children ages 6-18 set at 100 percent of poverty. Despite not being within the population covered by Medicaid expansion, Arkansas's children have benefited from Arkansas Works. The expansion of Medicaid for adults in 2013 led to more than 30,000 previously uninsured children receiving health insurance coverage.¹³ Though not directly impacted by the expanded eligibility, health insurance coverage for children is tied to the health coverage enrollment of the parents of these children, meaning that keeping parents insured is essential to maintaining higher rates of insured children in Arkansas.¹⁴

Separate from Medicaid expansion, children and young adults benefit from the ACA in other ways as well. One of the biggest benefits is that young adults below 26 years old can remain on their parent's insurance coverage, even if the child is married, attending school, or does not live with their parents. Even after the child turns 26, a special enrollment period is triggered, so they can enroll in a plan via the health insurance marketplace outside of the period of open enrollment.

After Medicaid expansion, Arkansas's drop in uninsured was the third highest nationally.

The opioid epidemic

Most Americans are aware that our country suffers from a dangerous opioid epidemic. In 2017, the opioid epidemic claimed the lives of 70,237 Americans, an average of about 192 deaths per day.¹⁵ That figure only includes deaths that were attributed to opioid use, though it is likely that many others went misattributed to other causes of death. Arkansas is one of the hardest-hit states in terms of opioids, with 105 prescriptions for opioids written per 100 Arkansans in 2017. The only state with a higher total was Alabama.¹⁶ There are more opioid prescriptions written in Arkansas each year than people living in Arkansas. This trend has continued for close to a decade – which is why it is imperative that Arkansas has a plan in place for treating opioid overdoses and providing help for individuals who become addicted to opioids.

The ACA and Arkansas's Medicaid expansion have assisted with providing more treatment options for individuals suffering from addiction. By increasing the availability of treatments, more Arkansans can receive treatment, which helps curb this trend. A specific method of intervening in the opioid epidemic is via crisis stabilization units, which are helpful to identify and treat, rather than incarcerate, individuals addicted to drugs. Without the increases in these facilities and access to health insurance under the ACA, many of these treatments would remain

unaffordable for those who need it most. The ACA has saved lives across Arkansas by reducing the cost of and access to treatment.

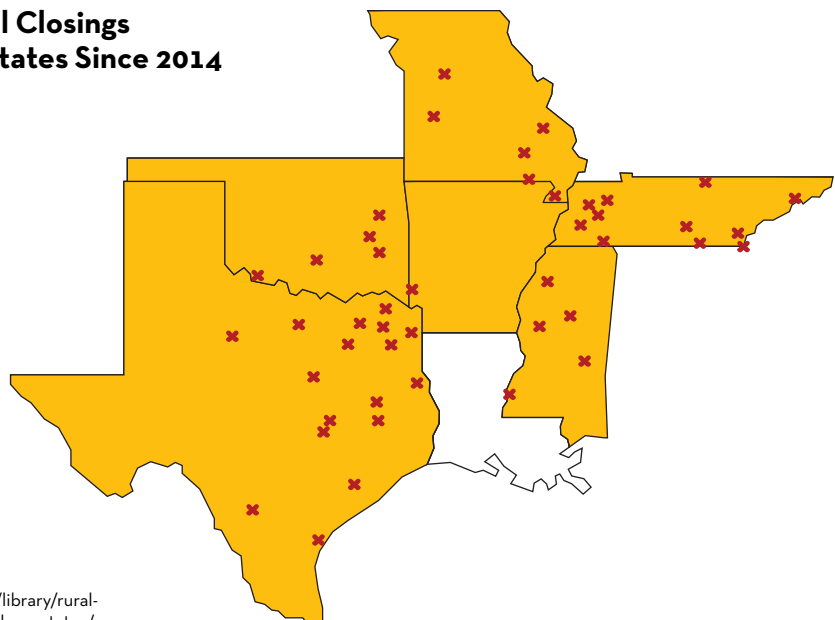
Arkansas is rural, which makes the ACA more important

Since the ACA was passed, studies show that Medicaid expansion has had a particularly significant impact on Medicaid coverage and uninsured rates in rural areas.¹⁷ As Arkansas is a largely rural state, access to health care is often a complicated problem. In rural Arkansas, it is not uncommon for individuals to avoid scheduling a medical appointment because the nearest clinic may be more than an hour away. This problem gets even bigger when you consider whether that appointment will be covered by insurance or not. In 2008/09, before the passage of the ACA and Arkansas's Medicaid expansion, 45 percent of adults in rural Arkansas were uninsured. After the ACA's implementation, in 2015/16, only 22 percent of rural adults lacked health insurance.¹⁸ Making sure that more individuals in rural Arkansas can afford health services when they are necessary is important, as it is often already a burden to drive to one of the more populated regions of the state.

For Arkansas's rural hospitals, the impact of Medicaid expansion is essential.¹⁹ Only one rural hospital in Arkansas has closed since the state expanded its Medicaid program in 2014.²⁰ In comparison, 52 rural hospitals in surrounding non-expansion states were

Before the passage of the ACA and Arkansas's Medicaid expansion, 45 percent of rural Arkansans were uninsured.

Rural Hospital Closings in Southern States Since 2014



Source: <https://achi.net/library/rural-hospital-closings-in-southern-states/>

forced to close during that same span.²¹ Arkansas's only rural hospital to close was in De Queen (in Sevier County) in 2019. According to officials, even that closing was due to the "tremendous debt load and liens that accumulated," and there are "plans for a new hospital to serve that community."²² This demonstrates just how much Medicaid expansion has meant to the rural hospitals around Arkansas. From 2013-2016, uncompensated care dropped from \$216 million to \$84 million – a direct result of more individuals having health insurance across the state.²³ Without Medicaid expansion, the number of uninsured Arkansans would increase again, leading to rural hospitals receiving less money to operate, as fewer people would be able to pay.²⁴

Another example of how hospitals have benefitted from expanded Medicaid coverage is through emergency department usage. Studies have shown that, compared to uninsured individuals in non-expansion states, individuals who gained Medicaid coverage as a result of Medicaid expansion showed decreased reliance on the emergency department as a usual source of care and a shift toward using the emergency department more frequently for conditions that required acute care.²⁵ It has also increased the quality of care for low-income populations.²⁶

The ACA helps Arkansas respond to COVID-19

COVID-19 quickly and dramatically changed daily life in the United States. Cloth face masks became much more than a fashion statement, and Americans became well-versed in "social distancing" from their peers. Fortunately, the ACA and Arkansas's Medicaid expansion enables Arkansas to better respond to public health emergencies like it has faced with COVID-19.

The ACA benefits Arkansas's pandemic response because it allows Arkansas to receive more money from the federal government to cover the costs of operating Medicaid. The amount of money that Arkansas receives from the federal government is determined by its Federal Medical Assistance Percentage (FMAP). FMAP allows states with lower per capita income to afford to expand Medicaid

coverage and provide Medicaid services to individuals who qualify. The statutory maximum FMAP is 83 percent, while the statutory minimum is 50 percent. For its traditional Medicaid population, Arkansas, a low per capita income state, has an FMAP of 71.42 percent in 2020. The current pandemic has meant that more Arkansans are now unemployed than before COVID-19. As a result, more Arkansans are enrolling in Medicaid coverage in order to keep health insurance. As of May 2020, Arkansas had its highest number of enrollees for traditional Medicaid, Arkansas Works, and for children in at least a year.²⁷ The Medicaid FMAP offsets the cost that Arkansas pays for the medical services for these new Medicaid beneficiaries.

In the spring of 2020, in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), passed in response to the damage COVID-19 caused in the United States, Congress increased the FMAP for the traditional Medicaid population by 6.2 percent. This meant that, on top of a higher than average FMAP, Arkansas will receive even more federal funding to cover the costs of administering Medicaid during this pandemic. By increasing the amount of money that Arkansas gets for administering its Medicaid program, this reduces the costs the state has to pay for the services and allows more flexibility in the state budget. Both health advocates and state officials are hopeful that subsequent COVID-19 relief bills will include an additional increase to the Medicaid FMAP. This benefit also applies to ARKids B (Arkansas's version of CHIP). Since the reimbursement rate for CHIP is an enhanced version of the Medicaid FMAP, an increase to the Medicaid FMAP results in Arkansas getting more money from the federal government to cover the costs of children who are enrolled in ARKids B.

Even though the CARES Act increase to FMAP does not apply to the Medicaid expansion population, the ACA's passage allows Arkansas to receive more money for this population as well. In fact, after the ACA was passed, the Medicaid FMAP was set at 100 percent for the expansion population for its first three years to allow a state to receive maximum federal funding if it expanded

As of May, Arkansas had its highest number of enrollees for traditional Medicaid, Arkansas Works, and for children.

Medicaid to more individuals. In January 2020, the FMAP rate was reduced to 90 percent for the expansion population, under the original provisions of the ACA. With more Arkansans being eligible for Medicaid expansion, whether because they lost employer-sponsored health insurance or some other qualifying event, having the FMAP rate at 90 percent for these Arkansans brings in more money for Arkansas to provide coverage and provides more flexibility for the state to address other needs that relate to COVID-19.

The ACA has helped budgets - both for families and the State

Often overlooked is the impact of the ACA's Medicaid expansion on the budget of expansion states. Despite being a concern for some people after the passage of the ACA, expanding health coverage to more Americans has led to state budgets seeing economic growth as a result of the ACA's passage. From 2018 to 2021, Medicaid expansion will have generated \$444 million in savings for Arkansas, as the state pays less for uncompensated care to hospitals (as discussed above) and collects more premium tax revenue.²⁸ In addition, Medicaid expansion brings back billions of tax dollars to Arkansas. This money flows through the state's economy and creates more jobs for Arkansans. If Arkansas chooses to end its Medicaid expansion, the state could lose nearly \$2 billion in federal funds, in addition to the increased costs associated with fewer Arkansans having health insurance.²⁹ Many states have reported reduced costs related to behavioral health, crime, and the criminal justice system as a result of Medicaid expansion providing coverage for more individuals.³⁰

Another often overlooked benefit of the ACA is the flexibility it provides for families' household budgets. With lower health care costs and less risk of unexpected medical bills breaking the bank, families can better afford necessities. By providing low-income Americans with health insurance, the ACA and its expansion help those eligible avoid having to make the decision between going to see a doctor when they are sick or putting food on the table for their family. In addition to reducing the cost of health care, the ACA also provides peace of mind to the individuals on Medicaid that they will be covered in an emergency.

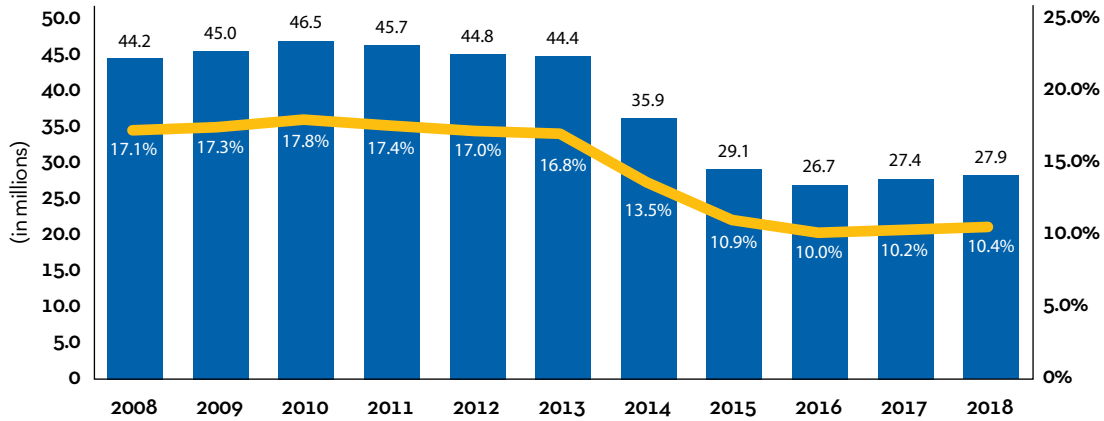
Texas v. Azar (2019)

Despite all the benefits the ACA has provided to Arkansas, it has been a target of political challenges since it was passed. The latest example is *Texas v. Azar*, a 2019 case that challenges a key part of the ACA. The lawsuit is split largely down political party lines, with 18 states with a Republican Attorney General (including Arkansas's Attorney General) as the plaintiffs (who are challenging the law) and 21 states with a Democratic Attorney General as the defendants (who want the ACA upheld).

In *Texas v. Azar*, the plaintiffs are challenging the individual mandate of the ACA. About a year after the law was passed, the United States Supreme Court ruled that the ACA's individual mandate was a valid tax and upheld it. Multiple efforts to repeal the individual mandate have failed since the Supreme Court's decision. In 2017, the Republican-controlled Congress passed the Tax Cuts and Jobs Act, which contained a provision that reduced the individual mandate to \$0 for individuals who do not have health insurance. Plaintiffs in *Texas v. Azar* argue that, now that the individual mandate "produces no revenue for the federal government," it should be struck down. Both a U.S. District Court and the U.S. Court of Appeals for the Fifth Circuit agreed. In its decision, the Fifth Circuit declined to comment on whether the entire ACA should be struck down and returned the case to the District Court to assess whether the ACA could remain without the individual mandate. In early 2020, the United States Supreme Court agreed to hear *Texas v. Azar* in the fall of 2020.

Expanding health coverage has led to state budgets seeing economic growth.

Number of Uninsured and Uninsured Rate among the Nonelderly Population, 2008-2018



Note: Includes nonelderly individuals ages 0 to 64.

Source: Kaiser Family Foundation analysis of 2008-2018 American Community Survey, 1-Year Estimates.

If the ACA were struck down, the results would be catastrophic for low-income families. A recent Urban Institute study found that elimination of the ACA would cause nearly 20 million people to lose their health insurance coverage (reversing the trends displayed in the graph above) and dramatically decrease the amount of federal money that states receive.³¹ The study estimates that more than 50 million Americans would be uninsured, representing more than 18.3 percent of the population under age 65.³² Hospital finances, which rely largely on the number of patients who are insured, would suffer tremendously from the absence of the ACA through incurring the costs of uncompensated care. To offset the burden, the costs would increase for services. Since rural hospitals benefitted substantially from the ACA being passed, they would see a detrimental impact of it being removed.

Strengthening the ACA's impact

As the courts decide the future of *Texas v. Azar*, it is important to not lose sight of the impact the ACA has had on Arkansas. Despite being increasingly politicized, it has saved the lives of millions since it was implemented just 10 years ago. Landmark legislation like this is never perfect, but it is far better than the previous situation prior to its existence, especially for low-income people and people of color. By continuing to fund and improve upon the ACA, the state will ensure that the gains made in Arkansas's health care system are maintained and expanded.

In Arkansas, the Medicaid budget must be approved each year by three quarters of the state legislature. Whether thousands of Arkansans continue to have health insurance is determined by this vote. It is imperative that Arkansas continues to receive federal money for Medicaid and make health care treatment available for those who could not afford it otherwise. One's ability to receive health care should not be determined by how much they can pay – it should be determined by what health care they need to maintain or return to full health. Arkansas, especially as one of the poorest states per-capita, should work toward the goal of improving the health of all of its residents – a goal that can only be reached by continuing to support and build upon the foundation laid by the ACA.

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