ACA Implementation—Monitoring and Tracking

# The Launch of the Affordable Care Act in Selected States:
## Coverage Expansion and Uninsurance

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states can be found at **www.rwjf.org** and **www.healthpolicycenter.org.** The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

# INTRODUCTION

This brief is one in a series examining what selected states are likely to accomplish in terms of implementing the Affordable Care Act (ACA): expanding health insurance coverage; providing outreach, education, and enrollment assistance; increasing competition in individual and small group insurance markets; reforming insurance market rules; and addressing issues related to provider supply constraints. In this series, we compare eight states: five that have chosen to aggressively participate in all aspects of the ACA (Colorado, Maryland, Minnesota, New York, and Oregon) and three that have taken only a limited or no participation approach (Alabama, Michigan, and Virginia). This brief focuses on the number of individuals covered through Health Insurance Marketplaces (HIMs, also known as Exchanges) and Medicaid, and the effect on the number of uninsured.

The study states were chosen from among those participating in a multiyear project funded by the Robert Wood Johnson Foundation (RWJF). The project provides in-kind technical support to states to assist them with implementing the reform components each state has chosen to pursue; the project also provides funds for qualitative and quantitative research to monitor and track ACA implementation at the state and national levels. RWJF selected these states based on their governments' interest in exploring the options related to state involvement in ACA implementation. Some states pursued implementation aggressively, but in others varying degrees of political opposition to the law lessened their full involvement. The result is that the variation in state commitment to health reform among the RWJF states reflects the same variation seen nationally.

The first set of states has been actively pro-reform. These states have adopted several Medicaid expansions in years preceding the ACA and have also adopted important insurance reforms. They were quick to adopt the ACA, including engaging stakeholders and investing in consumer outreach and education. Early in the process, they contracted with information technology vendors to develop eligibility and enrollment systems, though not all of them have seen a smooth rollout of their websites. These states have created State-Based Marketplaces (SBMs) and have adopted the optional Medicaid expansion.

In the second set of states, there has been strong opposition to ACA implementation, at least in some quarters. These states have historically had lower rates of employer-sponsored coverage and higher uninsurance rates. Because of their current circumstances, they have more to gain from health reform than do the leading states. All three rely on the federal government to develop and run their Marketplaces—Federally Facilitated Marketplaces (FFMs)—although Michigan and Virginia have taken on the Marketplace responsibilities associated with plan management. Two of the three—Alabama and Virginia—have not adopted the Medicaid

expansion. All rely on the federal website, but even as the information technology problems are resolved, these states will have fewer resources to devote to outreach, education, and enrollment assistance.

# PATHWAYS TO COVERAGE EXPANSION

The ACA includes many provisions likely to lead to expanded coverage. These include the significant expansion of Medicaid eligibility, the provision of income-related tax subsidies for the purchase of private plans offered in the new insurance Marketplaces, and the individual mandate that provides financial incentives for the currently uninsured to enroll in coverage. The Medicaid expansion allows states the option to expand coverage to individuals with incomes up to 138 percent of the federal poverty level (FPL), regardless of family structure. In many states, the expansion would have the greatest impact on childless adults, as they are most frequently excluded from the Medicaid program.

There are also incentives to increase nongroup coverage both because of the requirement that most individuals obtain health insurance coverage and because of subsidies available for those with incomes between 138 percent (100 percent for states not adopting the Medicaid expansion) and 400 percent of FPL. The premium tax credits are structured as a cap on the share of a household's income that is expected to be contributed for the premium of the second-lowest-cost silver plan; the percentage of income contributed increases as income increases. Nongroup coverage through the Marketplaces is made even more attractive for low-income families (those with incomes below 250 percent of FPL), since they are also eligible for federal subsidies to reduce the cost-sharing (deductibles, co-payments, coinsurance) associated with private Marketplace-based silver plans.

Employer coverage, in general, should increase because of the presence of the Small Business Health Options Program (SHOP) Marketplace, which is expected to make it easier for small employers to search for available plans and compare premiums, leading to increased competition and lower premiums over time. There are also tax credits available for small employers. In addition, the individual mandate should increase employer coverage, as it did in Massachusetts, since individuals faced with a coverage requirement frequently prefer to obtain their coverage through their employers. Some employers, largely those with a predominantly low-wage workforce, may find new incentives to discontinue existing coverage under the ACA, but the overall net effect of the ACA on employer coverage should be neutral or positive.[1]

In this brief we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM)[2] to estimate the changes in coverage, the size of Health Insurance Marketplaces, the impact of the Medicaid expansion, and the effect on the uninsured in each of the eight study states where the law is fully implemented. (In a companion paper,[3] we provide early enrollment data.) The HIPSM model merges data from several national data sets to reflect demographic, economic, and health status characteristics of the US nonelderly population. It then models the behavior of employers and individuals, allowing the model to predict responses to changes in insurance market rules, tax benefits, mandates, subsidies, and the Medicaid expansion. The model is described elsewhere.[4] These results reflect the effect of the ACA in 2016, assuming all current rollout problems are resolved and the law is fully implemented. If rollout issues are not fully resolved in some states, we may overestimate enrollment in Medicaid and Marketplaces.

# RESULTS

We project a small net increase in employer coverage in all of our study states, with the exception of New York (Table 1). Retention of employer-based insurance is expected to be high due to the substantial tax advantages that coverage provides for many workers, antidiscrimination rules, and lower administrative costs associated with large firms providing their own coverage, among other factors.[5] We estimate that New York will experience a small net decline in employer coverage due to the disproportionate benefits the ACA brings to the state's generally dysfunctional pre-reform nongroup market. Subsidies and the individual mandate have already brought significantly lower premiums and greater stability to the state's community-rated nongroup market,

## Table 1: Change in Employer-Sponsored Insurance (ESI), 2016 Estimates (Marketplace and Non-marketplace)

| | Pre-ACA | | Post-ACA | | |
|---|---|---|---|---|---|
| State | N (thousands) | Percent of Population with ESI | N (thousands) | Percent of Population with ESI | Percentage Point Change |
| **SBM States** | | | | | |
| Colorado | 2,746 | 59.0% | 2,856 | 61.4% | 2.4% |
| Maryland | 3,401 | 65.2% | 3,407 | 65.3% | 0.1% |
| Minnesota | 2,910 | 64.5% | 3,032 | 67.3% | 2.8% |
| New York | 9,968 | 56.4% | 9,940 | 55.0% | -1.4% |
| Oregon | 1,846 | 55.2% | 1,865 | 55.7% | 0.5% |
| **FFM States** | | | | | |
| Alabama | 2,336 | 57.6% | 2,362 | 58.5% | 0.9% |
| Michigan | 5,018 | 58.1% | 5,094 | 59.0% | 0.9% |
| Virginia | 4,518 | 63.9% | 4,614 | 65.3% | 1.4% |

*Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.*

and these substantial improvements will tend to attract some with prior employer coverage into that market.

Table 2 shows the estimated enrollment in SHOP and nongroup Marketplaces for each of the states. There are no important differences between SBM and FFM states, though enrollment in Table 2 may be overstated in FFM and some SBM states if website issues persist (these issues were not assumed in the HIPSM results). FFM states will also have fewer public resources devoted to outreach and enrollment assistance, and these may have important effects on enrollment. In the SBM states, the size of the SHOP Marketplace is estimated to range from 77,000 in Oregon to 453,000 in New York. Estimated SHOP enrollment ranges from 1.6 percent of the state's population in Maryland to 2.9 percent in Minnesota. In the three FFM states, the percentage of each state's nonelderly populations estimated to enroll in the SHOP Marketplaces ranges from 2.0 percent in Virginia to 3.0 percent in Michigan. Much of the employer Marketplace population is expected to come from employers who previously provided coverage on their own. Some also comes from individuals previously enrolled in nongroup coverage or previously uninsured.

Table 2 also shows the size of the nongroup Marketplaces. Individuals enroll in nongroup coverage through Marketplaces because of competitive premiums and because of the federal financial assistance to help pay for premiums and lower cost-sharing requirements.

The size of the nongroup Marketplaces in the SBM states will range from 223,000 in Oregon to 615,000 in New York. As a percentage of state's population, the size of the nongroup Marketplaces is estimated to range from 3.6 percent in New York to 7.3 percent in Colorado. Table 2 also shows the number of individuals expected to receive subsidies in each state. This number ranges from 113,000 in Minnesota to 454,000 in New York. Between 44.1 percent (Maryland) and 73.8 percent (New York) of residents purchasing coverage in the Marketplaces are projected to receive subsidies.

In the FFM states, 4.3 percent of the nonelderly population are expected to enroll in Alabama, 5.8 percent in Virginia, and 5.2 percent in Michigan, assuming website issues are resolved and outreach and education funding problems are overcome. The largest nongroup Marketplace in these three states is expected in Michigan with 446,000 enrollees. Individuals enroll in nongroup Marketplaces because of the availability of subsidies but also because of lower cost premiums resulting from greater plan transparency and, in many areas, increased competition. As will be discussed in a companion brief (on insurance market competition), there are a number of plans available in the FFM states, and even unsubsidized individuals will benefit from the lower premiums that have resulted. The share of Marketplace enrollees estimated to receive subsidies ranges from 54.7 percent in Virginia to 71.5 percent in Alabama.

## Table 2: Marketplace Enrollment of the Nonelderly With Reform, 2016 Estimates

| | Number in Marketplace | Percent of State Population in Marketplace | Persons Receiving Subsidies (With Reform, Expansion) | Percent of Nongroup Marketplace Population Receiving Subsidies (With Reform, Expansion) |
|---|---|---|---|---|
| **SBM States** | | | | |
| **Colorado** | | | | |
| SHOP | 79,000 | 1.7% | n/a | n/a |
| Nongroup | 342,000 | 7.3% | 218,000 | 63.9% |
| **Maryland** | | | | |
| SHOP | 84,000 | 1.6% | n/a | n/a |
| Nongroup | 277,000 | 5.3% | 122,000 | 44.1% |
| **Minnesota** | | | | |
| SHOP | 129,000 | 2.9% | n/a | n/a |
| Nongroup | 227,000 | 5.0% | 113,000 | 49.7% |
| **New York** | | | | |
| SHOP | 453,000 | 2.6% | n/a | n/a |
| Nongroup | 615,000 | 3.6% | 454,000 | 73.8% |
| **Oregon** | | | | |
| SHOP | 77,000 | 2.3% | n/a | n/a |
| Nongroup | 223,000 | 6.7% | 125,000 | 55.9% |
| **FFM States** | | | | |
| **Alabama*** | | | | |
| SHOP | 92,000 | 2.3% | n/a | n/a |
| Nongroup | 175,000 | 4.3% | 125,000 | 71.5% |
| **Michigan** | | | | |
| SHOP | 257,000 | 3.0% | n/a | n/a |
| Nongroup | 446,000 | 5.2% | 297,000 | 66.5% |
| **Virginia*** | | | | |
| SHOP | 139,000 | 2.0% | n/a | n/a |
| Nongroup | 407,000 | 5.8% | 223,000 | 54.7% |

*Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.*
*Notes: *Alabama and Virginia reflect the adoption of the Medicaid expansion. ACA was simulated as if fully implemented in 2016.*

Table 3 shows the impact of adopting the Medicaid expansion, which occurred in each of our SBM states and in Michigan. The estimated increase in Medicaid enrollment ranges from 120,000 in Minnesota to 527,000 in Michigan. The Minnesota expansion will be relatively small because its pre-ACA Medicaid eligibility and coverage levels are quite high. New York is also expected to have a relatively small increase in Medicaid coverage because of its extensive current coverage; the new enrollment will come from increased participation of current eligibles in addition to a small expansion to new eligibles. Minnesota and New York will see coverage expansion of 16.5 percent and 12.0 percent, respectively, compared with their current enrollment.

The percentage increase in Medicaid enrollment will be far higher in Colorado, Maryland, Michigan, and Oregon, particularly the latter. Prior to the ACA, Maryland had a primary adult care benefit program that provided a limited package of benefits to eligible adults. All those previously receiving those limited benefits are considered new eligibles under the law since the ACA provides them with a comprehensive set of benefits; thus, the state will receive a higher federal matching rate for this population beginning in 2014. Colorado and Oregon have more restrictive Medicaid eligibility standards prior to 2014, so their relative increases in the Medicaid program under the ACA will be large (49.7 percent and 63.8 percent, respectively). Michigan will see

## Table 3: Change in Medicaid/CHIP Coverage Among the Nonelderly With Reform, 2016 Estimates

| | Without Reform | | With Reform | | | |
|---|---|---|---|---|---|---|
| | Number of People | % of Nonelderly Population | Number of People | % of Nonelderly Population | Change | Percent Increase in Medicaid Enrollment |
| **States Expanding Medicaid** | | | | | | |
| **Colorado** Medicaid/CHIP | 498,000 | 10.7% | 746,000 | 16.0% | 248,000 | 49.7% |
| **Maryland** Medicaid/CHIP | 643,000 | 12.3% | 914,000 | 17.5% | 271,000 | 42.2% |
| **Michigan** Medicaid/CHIP | 1,612,000 | 18.7% | 2,139,000 | 24.8% | 527,000 | 32.7% |
| **Minnesota** Medicaid/CHIP | 724,000 | 16.1% | 844,000 | 18.7% | 120,000 | 16.5% |
| **New York** Medicaid/CHIP | 4,265,000 | 24.9% | 4,777,000 | 27.9% | 512,000 | 12.0% |
| **Oregon** Medicaid/CHIP | 509,000 | 15.2% | 834,000 | 24.9% | 325,000 | 63.8% |
| **States Not Expanding Medicaid** | | | | | | |
| **Alabama** Medicaid/CHIP | 743,000 | 18.3% | 835,000 | 20.6% | 92,000 | 12.4% |
| **Virginia** Medicaid/CHIP | 681,000 | 9.6% | 815,000 | 11.5% | 134,000 | 19.7% |

*Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.*
*ACA was simulated as if fully implemented in 2016.*

an increase in Medicaid enrollment of 32.7 percent. Table 3 also shows the changes in Medicaid coverage in Alabama and Virginia; at present, neither has adopted the expansion and both will see much smaller increases in Medicaid enrollment than in the expansion states. Coverage will increase even without the Medicaid expansion because there will be increases in coverage among those currently eligible due to increased outreach efforts and various strategies to simplify eligibility determination and enrollment under the ACA. Alabama will see an increase in Medicaid of 12.4 percent (92,000) and Virginia 19.7 percent (134,000). The share of the states' nonelderly populations in Medicaid under the ACA but without adopting the Medicaid expansion will be 20.6 percent in Alabama and 11.5 percent in Virginia. If Alabama and Virginia had adopted the expansion, they would have Medicaid enrollment increases of 353,000 and 338,000, respectively (not shown); these equate to increases relative to baseline enrollment projections of 47.5 percent and 49.7 percent, respectively. These states, along with others that have not expanded Medicaid, will see significant gaps in coverage between current Medicaid eligibility levels and 100 percent of the federal poverty level, where subsidy eligibility levels begin.

The net effect of all the ACA-related changes in coverage in the Medicaid expansion states will be a substantial reduction in the number of people uninsured in each state (Table 4). The reductions in Minnesota and New York are not quite as large because of their current high levels of coverage, but even these states can expect roughly 38 percent reductions in the uninsured. The reductions in the uninsured are more than 40 percent in Colorado, Maryland, and Michigan and more than 50 percent in Oregon. The number of uninsured falls by more than 600,000 people in Michigan; more than 300,000 people in Colorado, Maryland, and Oregon; and by 1.0 million in New York. However, uninsurance rates remain significant even in these states. For example, New York's uninsured rate is estimated to be 9.9 percent and Colorado's 9.8 percent under the ACA. Some of this reflects the presence of undocumented immigrants who are prohibited from enrolling in Marketplace-based coverage with or without subsidies and who are excluded

## Table 4: Change in the Uninsured Nonelderly With Reform, 2016 Estimates

| | Without Reform | | With Reform | | | |
|---|---|---|---|---|---|---|
| | Number of People | % of Nonelderly Population | Number of People | % of Nonelderly Population | Change | Percent Reduction in Uninsured |
| **States Expanding Medicaid** | | | | | | |
| **Colorado** Uninsured | 848,000 | 18.2% | 456,000 | 9.8% | -392,000 | -46.2% |
| **Maryland** Uninsured | 762,000 | 14.6% | 442,000 | 8.5% | -320,000 | -42.0% |
| **Michigan** Uninsured | 1,339,000 | 15.5% | 722,000 | 8.4% | -617,000 | -46.1% |
| **Minnesota** Uninsured | 456,000 | 10.1% | 283,000 | 6.3% | -173,000 | -37.9% |
| **New York** Uninsured | 2,724,000 | 15.9% | 1,700,000 | 9.9% | -1,024,000 | -37.6% |
| **Oregon** Uninsured | 674,000 | 20.1% | 329,000 | 9.8% | -345,000 | -51.2% |
| **States Not Expanding Medicaid** | | | | | | |
| **Alabama** Uninsured | 694,000 | 17.1% | 486,000 | 12.0% | -208,000 | -29.9% |
| **Virginia** Uninsured | 1,045,000 | 14.8% | 714,000 | 10.1% | -331,000 | -31.7% |

*Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.*
*ACA was simulated as if fully implemented in 2016.*

from the Medicaid expansions. But some of the remaining uninsured are exempt from the mandate (e.g., due to low income or still not having access to affordable coverage), while others are bound by it but choose to pay the penalty instead of complying.

As shown in Table 4, Alabama and Virginia will see reductions in the uninsured of 29.9 percent and 31.7 percent, respectively, or 208,000 in Alabama and 331,000 in Virginia. However, if Alabama and Virginia had adopted the Medicaid expansion, the number of uninsured would have fallen by 64.2 percent and 51.8 percent, respectively.[6] With the expansion, Alabama would reduce the number of uninsured by an additional 238,000, and Virginia would reduce the number of uninsured by an additional 210,000. Alabama would lower its uninsured rate from 12.0 percent to 7.1 percent and Virginia from 10.1 percent to 6.1 percent.

# CONCLUSION

This brief has examined the increases in coverage and reductions in the number of uninsured that we estimate for 2016. We assume all early problems in the rollout of health reform are resolved and present estimates assuming full implementation in 2016. The SBM states will have substantially larger increases in coverage, primarily because they have all adopted the Medicaid expansion. Michigan would have similar results. All of the states, with exception of New York, will have small increases in employer coverage, and all will benefit from the expansion of subsidized coverage in the Marketplaces. There will be substantial reductions in the uninsured in the order of about 40 to 50 percent in the states that are expanding Medicaid. The reductions in the uninsured in Alabama and Virginia, states without the Medicaid expansion, will be more like 30 percent, primarily because of the impact of subsidies and exchange coverage.

# ENDNOTES


1. Blumberg L, Buettgens M, Feder J, and Holahan J. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." Washington, DC: The Urban Institute. 2011.
2. A full description of HIPSM can be found at: http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf
3. Courtot B, Coughlin T, and Upadhyay D. "Building ACA-Compliant Eligibility and Enrollment Systems in Selected States." Washington, DC: The Urban Institute, 2014.
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## About the Authors and Acknowledgements


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