Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States

Summary

In this brief, we first examine how many of the uninsured in each state would be eligible for health coverage assistance programs—Medicaid, the Children's Health Insurance Program (CHIP) and subsidized private coverage through the new health insurance marketplaces—under the Patient Protection and Affordable Care Act (ACA). The share of the uninsured that is eligible for assistance programs is heavily dependent on a state's decision whether to expand Medicaid eligibility. Among states not currently planning to expand Medicaid eligibility, the share of the uninsured eligible for assistance ranges from 34 to 53 percent. In contrast, the share of the uninsured eligible for assistance ranges from 59 to 81 percent among the states that are currently committed to expanding Medicaid under the ACA.

Second, we estimate the decrease in the uninsured population under the ACA in each state. Among states not currently expanding Medicaid, we predict the number of uninsured would decrease 28 to 38 percent. Eight states committed to expansion would see the number of uninsured decline by more than half. Other states that have already expanded Medicaid eligibility, such as New York and Vermont, would see smaller reductions in uninsured rates.

Third, we examine the share of those remaining uninsured under the ACA in each state who would be eligible for, but not enrolled in, assistance programs. Among states not currently expanding Medicaid, that share would range from 24 to 43 percent of the post-ACA uninsured. The share is projected to be much higher—46 to 77 percent—among states that are expanding Medicaid.

Fourth, we estimate the share who would qualify for assistance and the expected change in the uninsured in each state, with and without the Medicaid expansion. In all states except Massachusetts, the uninsured are more likely to qualify for assistance if their state expands Medicaid, leading to larger reductions in the uninsured.

Introduction

The Patient Protection and Affordable Care Act (ACA) will assist millions of low-income families with making health coverage more affordable. States can choose to expand eligibility for Medicaid to adults and families with incomes up to 138 percent of the federal poverty level (FPL). New health insurance marketplaces will offer subsidized private health coverage to families with incomes up to 400 percent of the FPL who are not eligible for public coverage, do not have access to employer coverage deemed to be affordable under the law,[1] and are lawfully resident. In states that do not expand Medicaid, those with incomes below 100 percent of the FPL are not eligible for subsidized coverage.

In this brief, we examine how many of the uninsured in each state would be eligible for health coverage assistance programs (i.e., Medicaid, the Children's Health Insurance Program (CHIP), and subsidized private coverage through the new health insurance marketplaces) under ACA. In light of the Supreme Court decision that made the Medicaid expansion a state option, our estimates take into account state decisions as of September 30, 2013; included among the states characterized as expanding Medicaid are a handful of states whose proposed Medicaid expansion may require waiver approval by the Center for Medicare and Medicaid Services (CMS).[2] We then show how the ACA is expected to increase insurance coverage in each state. We estimate the share of the remaining uninsured under the ACA who are projected to be eligible for assistance programs but not enrolled. These could be reached by additional outreach programs. Finally, we show the percent of the uninsured eligible for assistance and the change in the uninsured for each state both with and without Medicaid expansion.

These estimates update and expand on our previously published results. Though several of our publications have included estimated enrollment in various forms of coverage under the ACA,[3] we have not previously published 50-state estimates of those eligible for Medicaid/CHIP or subsidized coverage. In August 2013, we released state and local estimates of the change in the insured population under the ACA in a policy brief and an interactive Web site.[4] However, those earlier estimates assumed that all states would expand Medicaid under ACA, whereas

Robert Wood Johnson Foundation

Urban Institute

this brief takes into account current state expansion decisions. For the same reason, we update earlier research focused on the remaining uninsured that was released before the Supreme Court decision.[5] These estimates are based on the American Community Survey (ACS) and may differ from previously released estimates based on the Current Population Survey.

Methods

Sample of households in each state.
To obtain a large, representative sample population for each state, we pool together the observations on the 2008, 2009, and 2010 American Community Surveys (ACS).

Eligibility for Medicaid / CHIP and subsidies. We use the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model.[6]

Pre-ACA eligibility. We use 2010 rules, the closest available approximation to the December 2009 rules specified in the ACA, as the basis for distinguishing new versus old eligibles.

Eligibility under the ACA. We compute modified adjusted gross income (MAGI), which includes wages, business income, retirement income, investment income, Social Security, alimony, unemployment compensation, and financial and educational assistance (see Modeling Unemployment Compensation in the appendix). MAGI also includes the income of any dependent children required to file taxes, which for 2009 is wage income greater than $5,700 and investment income greater than $950. Tax unit MAGI is computed as a percentage of the FPL, and this computation is compared with the ACA's 138 percent eligibility threshold for the Medicaid expansion.

Non-citizens. We impute documentation status for non-citizens in each year of survey data separately based on a year-specific model used in the CPS-ASEC. Documentation status is imputed to immigrants in two stages, using individual and family characteristics, based on an imputation methodology that was originally developed by Passel.[7] Undocumented immigrants and legal immigrants resident less than five years are ineligible for Medicaid.

Eligibility for subsidies. We first model the presence of an affordable employer-sponsored insurance (ESI) offer, as defined in the ACA.[8] Those not eligible for any form of public coverage, have family MAGI of up to 400 percent of federal poverty level (FPL), do not have an offer of affordable ESI coverage in the family, and are legally resident are eligible for subsidized private coverage in the health insurance marketplaces.

Health Insurance Policy Simulation Model (HIPSM). Once we have modeled eligibility status for Medicaid/CHIP and subsidized coverage in the exchanges, we use HIPSM to simulate the decisions of employers, families, and individuals to offer and enroll in health insurance coverage and then map those results to the ACS using regression modeling to assign probabilities of take-up. To calculate the impacts of reform options, HIPSM uses a microsimulation approach based on the relative desirability of the health insurance options available to each individual and family under reform.[9] The approach allows new coverage options to be assessed without simply extrapolating from historical data, by taking into account factors such as affordability (premiums and out-of-pocket health care costs for available insurance products), health care risk, whether the individual mandate would apply, and family disposable income.

Our utility model takes into account people's current choices as reported in the survey data. For example, if someone is currently eligible for Medicaid but not enrolled, they or their parents have shown a preference against Medicaid. They will be less likely to enroll in Medicaid under the ACA than a similar person who becomes newly eligible for Medicaid and thus has not had a chance to express a preference. We use such preferences to customize individual utility functions so that people's current choices score the highest among their current coverage choices, and these preferences affect their behavior under the ACA. The resulting health insurance decisions made by individuals, families,

and employers are calibrated to findings in the empirical economics literature, such as price elasticities for employer-sponsored and non-group coverage.

Changes in health insurance coverage under the ACA are computed in six main steps:

Changes in Medicaid and CHIP enrollment. We begin by estimating additional enrollment in Medicaid and CHIP, both by those gaining eligibility under the ACA and among those who are eligible under current Medicaid and CHIP eligibility rules, but not enrolled. Many characteristics are used to determine take-up, but the two most important are newly gaining eligibility and current insurance coverage, if any. For purposes of modeling new enrollment, those with incomes below the 138 of percent FPL threshold who are currently eligible for Medicaid waiver programs are not considered newly Medicaid-eligible unless their state's program is closed to enrollment.

Changes in enrollment in the non-group exchange. We estimate enrollment in single and family policies in the non-group exchange, both by those eligible for subsidies and those ineligible. Undocumented immigrants are barred from the exchange. First, we estimate those who would be family policyholders based on the characteristics of their family and estimate enrollment for them and their family members who would be eligible for the same insurance plan. Then, for those not covered by family policies, we estimate enrollment in single plans.

Enrollment of the uninsured in ESI. Demand for ESI would increase because of the individual mandate, small-group market reforms, and small firm tax credits. We estimate additional ESI enrollment for those currently uninsured with an ESI offer in their family and who would not enroll in coverage in steps 1 and 2 above. As with step 2, we treat single and family policies separately. In a full HIPSM simulation, employers change their ESI offer decisions, and there is movement both into and out of ESI. We do not currently model employer behavior on the ACS, but our results are

similar to results from the full simulation with the CPS for overall level of ESI after reform as well as the characteristics of the uninsured who gain ESI coverage.

Enrollment of the uninsured in nongroup coverage. We complete the simulation by estimating additional enrollment in non-group coverage outside the exchange by those currently uninsured with no ESI offer in the family who would not enroll in steps 1 or 2. This would result largely from the effect of the mandate. There would be some additional coverage for the undocumented here as well, since nongroup coverage would be their only option without an ESI offer.
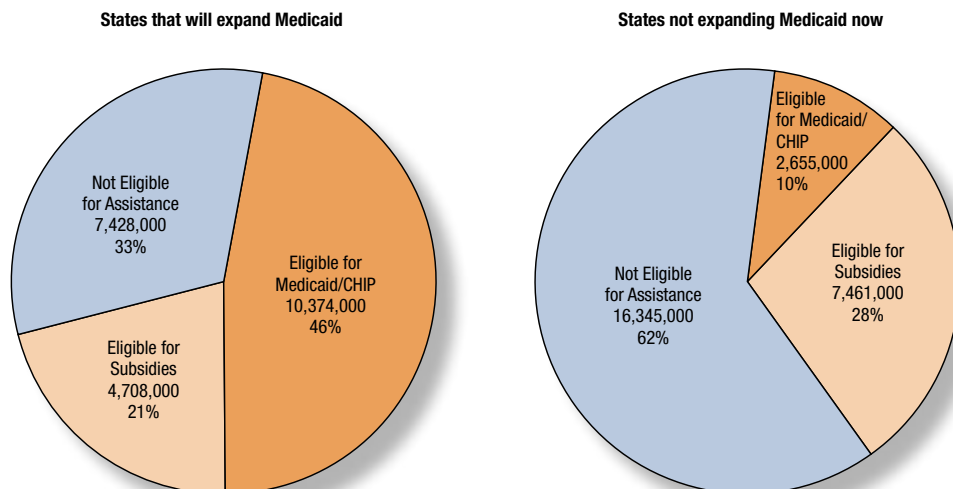
Transition from single to family ESI. The individual mandate will provide incentives for families to obtain coverage for all members. In particular, the expected utility model in HIPSM predicts that a certain number of single ESI policyholders in families where other members are uninsured or taking non-group coverage would purchase family ESI to cover the entire family. We model such transitions on the ACS based on the behavior of single ESI policyholders in HIPSM with mixed coverage in other members. Such families are not common, but this transition captures a behavioral response to the individual mandate.

Transition from non-group to ESI. In addition to the transition from ESI to the non-group exchange, HIPSM predicts changes from nongroup coverage to ESI. These cannot be fully modeled on the ACS because we do not model changes in ESI offers, but we can model such transitions in cases where an ESI offer was present both with and without the ACA. Single and family ESI policies are considered separately. The number of people changed by this step is much lower than the number affected by most of the earlier steps, but this movement into ESI is a notable result from HIPSM.

Results

In Table 1, we show the estimated number uninsured in each state before the ACA, using data from 2008 and 2010. We then estimate the number who would be eligible

Figure 1: Eligibility for Assistance Among Those Currently Uninsured.

States that will expand Medicaid

Not Eligible for Assistance
7,428,000
33%

Eligible for Medicaid/CHIP
10,374,000
46%

Eligible for Subsidies
4,708,000
21%

States not expanding Medicaid now

Eligible for Medicaid/CHIP
2,655,000
10%

Not Eligible for Assistance
16,345,000
62%

Eligible for Subsidies
7,461,000
28%

for Medicaid or CHIP under the ACA and the number who would be eligible for subsidized coverage in the ACA's new health insurance marketplaces. As indicated above, our estimates take into account each state's current decision on expanding Medicaid. As of September 2013, 24 states and the District of Columbia are committed to expanding Medicaid under the ACA. Of the 26 remaining states, legislative debate about the Medicaid expansion is ongoing in four states.

Not surprisingly, the share of the uninsured who would be eligible for some form of financial assistance with health coverage (in either Medicaid/CHIP coverage or subsidies to help with the purchase of nongroup coverage) in January 2014 is notably smaller in states not expanding Medicaid. Among states not planning to expand Medicaid at this time, the share of the uninsured eligible for some type of financial assistance ranges from 34 percent in Texas to 53 percent in Maine. Among the states that are planning to expand Medicaid, the share eligible for assistance ranges from 59 percent in New Jersey to 81 percent in Kentucky, Michigan and West Virginia.

Among all states expanding Medicaid, 67 percent of the uninsured would be eligible for assistance (Figure 1). About 10.4 million would be eligible

for Medicaid or CHIP, and 4.7 million eligible for subsidized private coverage in the marketplaces. Among all states not currently expanding Medicaid, 38 percent of the uninsured would be eligible for assistance: 2.7 million eligible for Medicaid/CHIP, and 7.5 million eligible for subsidized private coverage. The number eligible for subsidized coverage includes some with incomes between 100 and 138 percent of the FPL which would become eligible for Medicaid if their state chooses to expand eligibility.

Among states not committed to expanding Medicaid at this time, the ACA is expected to decrease the number uninsured by between 28 percent (Alabama and Wyoming) and 38 percent (New Hampshire and Montana). For all estimates of insurance coverage, we model the ACA as if fully implemented; the impact on coverage in the first two years of the ACA is likely to be somewhat less. The projected percentage decrease in the uninsured varies more widely among Medicaid expansion states. Not surprisingly, states that have already expanded Medicaid eligibility for adults see smaller percent decreases than those that have not. At one extreme, Massachusetts has already implemented its health reform law; thus, it is not expected that the ACA will noticeably affect the state's already low uninsured

rate. Vermont and New York are other examples of states that have already reduced the number of their uninsured residents by expanding Medicaid eligibility. They are expected to see reductions in the number of uninsured by 25 and 32 percent respectively. At the other extreme, eight states are expected to see their number of uninsured reduced by more than 50 percent, with the largest reduction (57 percent) expected in West Virginia.

While the large majority of those gaining coverage under the ACA are eligible for assistance, some will newly enroll in employer-sponsored or unsubsidized private coverage as well. This new enrollment will mainly be due to the individual coverage requirement, though other provisions of the law, such as tax credits for some small businesses offering coverage, contribute as well. In an earlier report, for example, we considered the impact of the law on employer-sponsored coverage.[10]

In Table 2, we look closely at those we project will remain uninsured under the ACA, particularly those who are eligible for Medicaid, CHIP, or subsidized coverage, but have not enrolled. The remaining uninsured people not eligible for any assistance program include undocumented

immigrants (who would make up about a quarter of the remaining uninsured nationwide) and those who choose not to purchase private insurance and potentially face a penalty under the ACA's individual coverage requirement.

Among states not expanding Medicaid, the share of the remaining uninsured under the ACA eligible for Medicaid, CHIP, or subsidized coverage is projected to range from 24 percent in Georgia and Texas to 43 percent in Maine. More effective outreach efforts in these states could reduce the share expected to remain uninsured despite being eligible for Medicaid, CHIP or exchange subsidies under the ACA .

Among the states expanding Medicaid, the share of the remaining uninsured projected to be eligible for assistance is much larger, ranging from 46 percent in New Jersey to 77 percent in West Virginia. Thus, to the extent that outreach efforts lead to higher participation in these programs than our model predicts, these states could further reduce the uninsured beyond the declines reflected in these tables.

There may be changes in state decisions about the Medicaid expansion for some time to come. In most of the states not currently

expanding, Medicaid expansion will likely be an issue again in 2014 as state legislatures convene and governor's budgets are issued. Also, several states currently planning to expand Medicaid are exploring an approach that is likely to require a waiver from HHS. Arkansas' waiver was approved at the end of September 2013, but waiver applications are pending for Iowa and Michigan.

Given the ongoing debate and uncertainty, we show the share of the uninsured eligible for assistance and the projected reduction in the uninsured due to the ACA in every state both with and without Medicaid expansion (Table 3). In every state, except for Massachusetts, Medicaid expansion would result in more uninsured people becoming eligible for assistance and a greater reduction in the number of uninsured. For example, we saw in Table 1 that without expansion, 36 percent of the uninsured in Mississippi would be eligible for assistance and the ACA would reduce the number of uninsured by 29 percent. Table 3 repeats this for the columns without expansion, but also shows that under the Medicaid expansion, 80 percent of Mississippi's uninsured would be eligible for assistance, and the projected number of uninsured would decrease by 54 percent.

Table 1: The Uninsured and Eligibility for Assistance Under the ACA, Estimates by State

| State | Medicaid Expansion | Currently Uninsured | | | | | | Uninsured Under the ACA | |
		Total	Eligible for Medicaid/ CHIP	Eligible for Exchange Subsidies	In a Family with a Small Firm Worker**	Other Current Uninsured	% Eligible for Assistance	Total	% Decrease in Uninsured
Alabama	No	708,000	85,000	181,000	284,000	157,000	38%	508,000	28%
Alaska	No	139,000	12,000	47,000	56,000	24,000	43%	90,000	35%
Arizona	Yes	1,190,000	511,000	224,000	341,000	113,000	62%	642,000	46%
Arkansas	Yes	515,000	276,000	110,000	97,000	31,000	75%	241,000	53%
California	Yes	7,177,000	3,144,000	1,421,000	2,116,000	496,000	64%	4,039,000	44%
Colorado	Yes	853,000	380,000	187,000	224,000	61,000	66%	464,000	46%
Connecticut	Yes	338,000	145,000	74,000	93,000	26,000	65%	191,000	43%
Delaware	Yes	96,000	43,000	23,000	23,000	7,000	69%	61,000	37%
District of Columbia	Yes	49,000	23,000	9,000	11,000	5,000	66%	27,000	46%
Florida	No	4,092,000	347,000	1,184,000	1,784,000	777,000	37%	2,818,000	31%
Georgia	No	1,931,000	181,000	492,000	910,000	349,000	35%	1,366,000	29%
Hawaii	Yes	98,000	54,000	21,000	17,000	6,000	77%	48,000	51%
Idaho	No	284,000	27,000	93,000	122,000	41,000	42%	185,000	35%
Illinois	Yes	1,794,000	867,000	323,000	468,000	136,000	66%	980,000	45%
Indiana	No*	944,000	113,000	290,000	377,000	164,000	43%	609,000	35%
Iowa	Yes	279,000	148,000	64,000	53,000	15,000	76%	132,000	53%
Kansas	No	380,000	41,000	114,000	163,000	62,000	41%	252,000	34%
Kentucky	Yes	646,000	390,000	132,000	89,000	34,000	81%	296,000	54%
Louisiana	No	805,000	74,000	239,000	336,000	156,000	39%	549,000	32%
Maine	No	143,000	16,000	60,000	46,000	21,000	53%	90,000	37%
Maryland	Yes	666,000	308,000	120,000	196,000	42,000	64%	382,000	43%
Massachusetts	Yes	307,000	122,000	76,000	82,000	26,000	65%	307,000	0%
Michigan	Yes	1,250,000	722,000	290,000	172,000	66,000	81%	557,000	55%
Minnesota	Yes	485,000	236,000	114,000	103,000	32,000	72%	254,000	48%
Mississippi	No	544,000	60,000	133,000	233,000	117,000	36%	385,000	29%
Missouri	No	808,000	98,000	243,000	318,000	150,000	42%	545,000	33%
Montana	No	184,000	24,000	62,000	69,000	29,000	47%	115,000	38%
Nebraska	No	219,000	25,000	64,000	93,000	37,000	41%	151,000	31%
Nevada	Yes	614,000	265,000	126,000	172,000	51,000	64%	348,000	43%
New Hampshire	No*	146,000	13,000	59,000	55,000	19,000	49%	90,000	38%
New Jersey	Yes	1,172,000	459,000	237,000	390,000	85,000	59%	681,000	42%
New Mexico	Yes	448,000	219,000	88,000	110,000	31,000	69%	228,000	49%
New York	Yes	2,373,000	1,004,000	563,000	634,000	173,000	66%	1,613,000	32%
North Carolina	No	1,610,000	158,000	452,000	715,000	286,000	38%	1,139,000	29%
North Dakota	Yes	68,000	35,000	18,000	10,000	4,000	79%	31,000	55%
Ohio	No*	1,436,000	155,000	452,000	562,000	266,000	42%	969,000	33%
Oklahoma	No	719,000	90,000	203,000	306,000	119,000	41%	483,000	33%
Oregon	Yes	684,000	345,000	152,000	146,000	40,000	73%	335,000	51%
Pennsylvania	No*	1,300,000	138,000	420,000	525,000	216,000	43%	879,000	32%
Rhode Island	Yes	124,000	54,000	30,000	30,000	10,000	67%	68,000	45%
South Carolina	No	816,000	87,000	227,000	338,000	164,000	39%	574,000	30%
South Dakota	No	106,000	9,000	33,000	42,000	22,000	40%	70,000	34%
Tennessee	No*	931,000	107,000	272,000	375,000	177,000	41%	649,000	30%
Texas	No	6,150,000	581,000	1,534,000	2,979,000	1,056,000	34%	4,241,000	31%
Utah	No	434,000	47,000	128,000	196,000	63,000	40%	273,000	37%
Vermont	Yes	54,000	21,000	20,000	9,000	5,000	75%	41,000	25%
Virginia	No	993,000	90,000	276,000	472,000	156,000	37%	698,000	30%
Washington	Yes	959,000	444,000	223,000	229,000	63,000	70%	500,000	48%
West Virginia	Yes	272,000	159,000	60,000	39,000	14,000	81%	117,000	57%
Wisconsin	No	555,000	68,000	174,000	198,000	115,000	43%	369,000	34%
Wyoming	No	82,000	8,000	28,000	28,000	17,000	44%	51,000	38%

SOURCE: ACS-HIPSM 2013, ACA modeled as fully implemented.

* Currently Undecided, Treated as Not Expanding

** Excludes those eligible for Medicaid, CHIP or subsidized coverage.

Table 2: The Projected Uninsured Under the ACA and their Eligibility for Assistance, Estimates by State

State	Medicaid Expansion	Remaining Uninsured under the ACA				
		Total	Eligible for Medicaid/ CHIP	Eligible for Subsidies	Other Uninsured Under the ACA	% Eligible for Assistance
Alabama	No	508,000	56,000	76,000	376,000	26%
Alaska	No	90,000	6,000	22,000	62,000	31%
Arizona	Yes	642,000	186,000	114,000	341,000	47%
Arkansas	Yes	241,000	105,000	51,000	85,000	65%
California	Yes	4,039,000	1,330,000	719,000	1,990,000	51%
Colorado	Yes	464,000	160,000	98,000	205,000	56%
Connecticut	Yes	191,000	60,000	43,000	88,000	54%
Delaware	Yes	61,000	28,000	12,000	21,000	66%
District of Columbia	Yes	27,000	9,000	6,000	11,000	57%
Florida	No	2,818,000	204,000	531,000	2,083,000	26%
Georgia	No	1,366,000	112,000	214,000	1,040,000	24%
Hawaii	Yes	48,000	20,000	12,000	16,000	67%
Idaho	No	185,000	16,000	36,000	133,000	28%
Illinois	Yes	980,000	373,000	171,000	436,000	56%
Indiana	No*	609,000	61,000	117,000	431,000	29%
Iowa	Yes	132,000	59,000	33,000	40,000	69%
Kansas	No	252,000	22,000	48,000	182,000	28%
Kentucky	Yes	296,000	160,000	62,000	75,000	75%
Louisiana	No	549,000	48,000	107,000	394,000	28%
Maine	No	90,000	9,000	29,000	52,000	43%
Maryland	Yes	382,000	138,000	68,000	176,000	54%
Massachusetts	Yes	307,000	122,000	76,000	108,000	65%
Michigan	Yes	557,000	272,000	140,000	144,000	74%
Minnesota	Yes	254,000	91,000	64,000	90,000	61%
Mississippi	No	385,000	41,000	56,000	288,000	25%
Missouri	No	545,000	57,000	106,000	382,000	30%
Montana	No	115,000	13,000	26,000	76,000	34%
Nebraska	No	151,000	16,000	30,000	105,000	30%
Nevada	Yes	348,000	111,000	67,000	170,000	51%
New Hampshire	No*	90,000	6,000	28,000	56,000	38%
New Jersey	Yes	681,000	186,000	130,000	354,000	46%
New Mexico	Yes	228,000	89,000	44,000	95,000	58%
New York	Yes	1,613,000	695,000	311,000	582,000	62%
North Carolina	No	1,139,000	105,000	198,000	836,000	27%
North Dakota	Yes	31,000	13,000	9,000	8,000	73%
Ohio	No*	969,000	101,000	191,000	676,000	30%
Oklahoma	No	483,000	58,000	87,000	337,000	30%
Oregon	Yes	335,000	126,000	75,000	134,000	60%
Pennsylvania	No*	879,000	79,000	196,000	182,000	31%
Rhode Island	Yes	68,000	22,000	16,000	29,000	56%
South Carolina	No	574,000	55,000	101,000	418,000	27%
South Dakota	No	70,000	6,000	14,000	50,000	29%
Tennessee	No*	649,000	71,000	121,000	458,000	29%
Texas	No	4,241,000	331,000	668,000	3,242,000	24%
Utah	No	273,000	24,000	48,000	201,000	26%
Vermont	Yes	41,000	15,000	12,000	10,000	65%
Virginia	No	698,000	58,000	126,000	513,000	26%
Washington	Yes	500,000	174,000	115,000	211,000	58%
West Virginia	Yes	117,000	62,000	29,000	27,000	77%
Wisconsin	No	369,000	35,000	85,000	249,000	32%
Wyoming	No	51,000	5,000	13,000	33,000	35%

SOURCE: ACS-HIPSM 2013, ACA modeled as fully implemented.

* Currently Undecided, Treated as Not Expanding

Table 3: The Uninsured Eligible for Assistance and Reduction in the Uninsured, With and Without Medicaid Expansion

State	% of the Uninsured Eligible for Asisstance		% Reduction in the Uninsured	
	With Expansion	Without Expansion	With Expansion	Without Expansion
Alabama	80%	38%	53%	28%
Alaska	75%	43%	54%	35%
Arizona	62%	34%	46%	31%
Arkansas	75%	40%	53%	31%
California	64%	35%	44%	29%
Colorado	66%	38%	46%	32%
Connecticut	65%	38%	43%	29%
Delaware	69%	42%	37%	34%
District of Columbia	66%	31%	46%	25%
Florida	68%	37%	48%	31%
Georgia	70%	35%	49%	29%
Hawaii	77%	35%	51%	25%
Idaho	75%	42%	53%	35%
Illinois	66%	34%	45%	28%
Indiana	78%	43%	55%	35%
Iowa	76%	42%	53%	35%
Kansas	72%	41%	51%	34%
Kentucky	81%	41%	54%	30%
Louisiana	76%	39%	55%	32%
Maine	79%	53%	52%	37%
Maryland	64%	35%	43%	29%
Massachusetts	65%	38%	0%	0%
Michigan	81%	41%	55%	31%
Minnesota	72%	43%	48%	31%
Mississippi	79%	36%	54%	29%
Missouri	79%	42%	56%	33%
Montana	81%	47%	57%	38%
Nebraska	72%	41%	51%	31%
Nevada	64%	35%	43%	30%
New Hampshire	76%	49%	52%	38%
New Jersey	59%	35%	42%	28%
New Mexico	69%	35%	49%	31%
New York	66%	38%	32%	30%
North Carolina	69%	38%	48%	29%
North Dakota	79%	48%	55%	37%
Ohio	81%	42%	55%	33%
Oklahoma	72%	41%	51%	33%
Oregon	73%	42%	51%	32%
Pennsylvania	77%	43%	54%	32%
Rhode Island	67%	40%	45%	27%
South Carolina	76%	39%	50%	30%
South Dakota	80%	40%	55%	34%
Tennessee	76%	41%	52%	30%
Texas	63%	34%	47%	31%
Utah	68%	40%	49%	37%
Vermont	75%	51%	25%	28%
Virginia	69%	37%	49%	30%
Washington	70%	40%	48%	31%
West Virginia	81%	42%	57%	34%
Wisconsin	76%	43%	50%	34%
Wyoming	71%	44%	54%	38%

SOURCE: ACS-HIPSM 2013, ACA modeled as fully implemented.

Endnotes

1   Specifically, if one family member is offered employer coverage for which the worker contribution of the single premium is less than 9.5 percent of family income, then the entire family is ineligible for subsidies.

2   Centers for Medicaid and Medicare Services (CMS). 2013. "State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014." http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

3   Blavin F, Buettgens M and Roth J. "State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain." Washington, DC: The Urban Institute, 2012, http://www.urban.org/health_policy/url.cfm?ID=412485

4   Kenney GM, Huntress M, Buettgens M, Lynch V and Resnick D. "State and Local Coverage Changes Under Full Implementation of the Affordable Care Act." Washington, DC: The Urban Institute, 2013, http://www.urban.org/health_policy/url.cfm?ID=1001692 Uninsured estimates for Arizona given here differ from those in that paper due to a difference in how baseline Medicaid eligibility is modeled.

5   Buettgens M and Hall M. "Who Will Be Uninsured After Health Insurance Reform?" Washington, DC: The Urban Institute, 2011, http://www.urban.org/health_policy/url.cfm?ID=1001520

6   Buettgens M, Resnick D, Lynch V and Carroll C. "Documentation on the Urban Institute's American Community Survey-Health Insurance Policy Simulation Model (ACS-HIPSM)." Washington, DC: The Urban Institute, 2013, http://www.urban.org/health_policy/url.cfm?ID=412841

7   Resnick, D. "Imputing Undocumented Immigration Status in the American Community Survey." Washington, DC: The Urban Institute, 2013.

8   Details in Buettgens et al. 2013.

9   Buettgens M. "HIPSM Methodology: National Version." Washington, DC: The Urban Institute, 2011.

10 Blumberg LJ, Buettgens M, Feder J and Holahan J. "Implications of the Affordable Care Act for American Business." Washington, DC: The Urban Institute, 2012, http://www.urban.org/health_policy/url.cfm?ID=412675

About the Authors and Acknowledgments

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. For more information, visit http://www.urban.org. Follow the Urban Institute on Twitter www.urban.org/twitter or Facebook www.urban.org/facebook. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter www.rwjf.org/twitter or Facebook www.rwjf.org/facebook.