

State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain

Timely Analysis of Immediate Health Policy Issues

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Introduction

The Affordable Care Act (ACA) calls for an expansion of the Medicaid program, the creation of health insurance exchanges in each state, insurance market regulatory reforms, the provision of subsidies to make private coverage more affordable, and policies such as the individual requirement to obtain coverage or pay a penalty.¹ The law expands Medicaid eligibility to a mandatory minimum of 138 percent of the federal poverty level (FPL) for all nonelderly citizens starting in 2014. The exchanges, to be established by January 1, 2014, will be organized markets where individuals and small businesses can purchase health insurance coverage that is subject to new regulations intended to promote greater transparency and competition in the market for health insurance.² Low- and moderate-income individuals and families with incomes between 138 and 400 percent of FPL will also be eligible for federal subsidies to purchase coverage in the exchanges if they do not have affordable access to employer-based insurance.

States will play a key role in implementing and designing their own exchanges. The establishment of these exchanges is mandatory, but a state can choose to run its own exchange, let the federal government run it or enter into a state/federal partnership. Some states have passed legislation to establish their own exchanges or have begun the process by executive order, while others have decided to leave the task to the federal government. For those states choosing to run their own exchanges, questions that must be considered include the following:

- Should the exchange be run by an existing government agency, a new

agency, a quasi-governmental entity or a not-for-profit private entity?

- What should the composition of the governing board be?
- How should the administrative costs of running an exchange be financed?
- Should the exchange be able to actively negotiate with plans over premiums?
- Can plans be excluded, or must all qualified plans be allowed to participate?
- In computing premiums, should enrollees in the Small Business Health Options Program (SHOP) exchange and nongroup exchange markets be pooled together, or should their premiums be set separately?
- What will be the role of agents and brokers in the exchange?
- Should state insurance regulations be identical inside and outside the exchange?
- How will Medicaid/CHIP eligibility and enrollment be integrated with the exchange?
- Should the Basic Health Plan option be implemented?³

We use the Health Insurance Policy Simulation Model to provide new state-level estimates of the coverage and cost effects of the ACA, updating some of the results of a paper published in March 2011.⁴ We expand upon the prior analysis by exploring if there are correlations between a state's progress toward implementing their exchanges and the anticipated benefits of the ACA for state residents, as measured by expected state gains in insurance coverage and federal subsidies associated with reform. We analyze anticipated changes in each state's share of uninsured residents, the size of its health insurance exchanges, and Medicaid/CHIP enrollment levels. We also analyze

the expected decrease in the amount of uncompensated care provided to the uninsured in each state and provide estimates of federal spending on subsidies in the exchange under the ACA.

In this paper, we combine information from the National Conference of State Legislatures (NCSL)⁵ and the U.S. Department of Health and Human Services (HHS)⁶ to group states based on their progress toward implementing health insurance exchanges. All designations are current as of January 17, 2011. The NCSL provides information on state legislative action, and HHS provides information on states that have received additional funding (federal exchange establishment grants) for the second phase of the state exchange development process. Figure 1 shows how we categorize states into one of three mutually exclusive groups. Group 1 states include those 15 states that have either enacted an exchange establishment law or in which the governor has established one by issuing an executive order.⁷ Massachusetts and Utah passed exchange laws before enactment of the ACA, and all these states (except Colorado, Massachusetts and Utah) have received an exchange establishment grant.

Group 2 states have not yet established exchanges, but have demonstrated significant interest in doing so. Most notably, 17 of the 21 states have received level 1 federal establishment grants, which represent a second round of funding for state exchange development work beyond the initial state planning grants. Obtaining these grants requires states to write proposals to the federal government delineating progress achieved on the exchange work funded under the planning grants and describing their plans-to-date for establishing a



There is considerable variability within the Group 2 states both in the progress made on exchange development and planning and in their political environments, signaling that the likelihood that these states will end up developing their own exchanges varies considerably as well. However,

Finally, 15 Group 3 states do not meet the Group 1 or Group 2 criteria. Nine of these states have made some progress by creating an exchange study or planning entity, while in six of these states (Alaska, Florida, Louisiana, New Hampshire, Ohio and Oklahoma) legislative action was not taken or did not pass in 2011.

We use the Urban Institute's national Health Insurance Policy Simulation Model (HIPSM) to estimate the effects of health reform among the nonelderly population in each state.⁹ The core of the national model is two years of the Current Population Survey's Annual Social and Economic Supplement, matched to several other national datasets, including the Medical Expenditure Panel Survey-Household Component.¹⁰ In order to have comparable methods and estimates across

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2011 and compare results to the HIPSM baseline results for 2011 without implementation of these reforms. This approach differs from that of the Congressional Budget Office (CBO) or the Centers for Medicare and Medicaid Services (CMS) actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of reform with the pre-reform baseline and of various reform

State Grouping

- 1 Group 1
- 2 Group 2
- 3 Group 3

scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief.¹²

The latest version of HIPSM includes methodological updates since prior state-level studies.¹³ These include improvement in the modeling of the affordable employer-sponsored insurance (ESI) offer test for subsidy eligibility, the choice of exchange versus non-exchange plans for families and small businesses, and Medicaid/CHIP eligibility testing and enrollment for those seeking coverage.

We also assume that the nongroup and small group markets would not be pooled together in computing premiums. Previous papers using HIPSM modeled the two markets being pooled together. A few states such as Massachusetts have already pooled these markets and a few more are considering doing so, but the large majority of states are expected to leave them separate, at least in the near term.¹⁴

Finally, for this analysis, we simulated the affordability exemption to the individual mandate that observers expect to be in the forthcoming regulations; this differs from the interpretation of the Joint Committee on Taxation and CBO that we used in earlier modeling. We assume that dependents will not incur mandate penalties if they do not obtain coverage and the lowest available family premium is above 8 percent of family income. A family would still be barred from subsidized exchange coverage if the lowest single premium offered to one member was less than 9.5 percent of family income. These changes result in the number of remaining uninsured being about 4 million higher than in previous estimates.

Other assumptions about state implementation decisions are unchanged from earlier work. Small firms are defined as those with up to 100 full-time-equivalent workers, premiums are rated up to the maximum limits of the law (namely, 3 to 1 rating on age and 1.5 to 1 rating on tobacco use), and the essential health benefits package is assumed to be that of a typical employer-sponsored

plan. The Basic Health Plan option was not modeled.

Beginning in 2014, states do not have to maintain Medicaid eligibility for adults above 138 percent of FPL. We assume that states would discontinue eligibility for adults eligible under Section 1115 waivers or Section 1931 who are above that income threshold. Other categories of adults could be affected, notably the medically needy and pregnant women, but we did not model any change in their eligibility due to the difficulty in identifying them in our underlying survey data.

Results

The Uninsured

Overall, the ACA could decrease the number of nonelderly uninsured by 24 million, from 50.3 to 26.2 million, representing a decrease of 9 percentage points (or 48 percent). However, Table 1 shows that the effect of the ACA on the uninsured will vary considerably across state groups. Among all the categories, Group 1 states—those that have already enacted establishment legislation or where the governor has issued an executive order—are expected to experience the smallest decline (42 percent or 7 percentage points) in the number of uninsured under the ACA. Group 2 states, on average, are likely to face comparable but slightly higher percentage point declines (47 percent) in the number of uninsured. In contrast, Group 3 states, on average, have a higher baseline uninsurance rate and are likely to experience larger percentage decreases (exceeding 50 percent) in the number of uninsured under reform relative to Group 1 and Group 2 states. In other words, states that have made the least progress toward establishing their exchanges are likely to benefit the most from the ACA in terms of covering their uninsured population.

Table 1 also shows significant variation in the number of baseline and expected post-reform uninsured within state group categories. For example, among the Group 1 states, the decline in the

number of uninsured ranges from 17 percent (1 percentage point) in Massachusetts¹⁵ and 24 percent (3 percentage points) in Washington, to 58 percent (9 percentage points) in Indiana and 67 percent in West Virginia (12 percentage points). Likewise, some Group 2 states, such as Alabama and Missouri, are estimated to have the ACA reduce their number of uninsured by more than 60 percent, whereas the number of uninsured in Arizona and Iowa are expected to fall by approximately one-third. Similarly, among the Group 3 states, only 12 percent of the nonelderly in New Hampshire are currently uninsured compared with 26 percent in Florida and 29 percent in Texas. Interestingly, the three states with the highest baseline uninsurance rates—Texas (29 percent), New Mexico (28 percent) and Nevada (24 percent)—each fall in a different group category.

In Table 2, we present the expected change in uncompensated care spending on the uninsured. Currently, total uncompensated care is paid for by the federal government (45 percent), state and local governments (30 percent) and health care providers (25 percent).¹⁶ We anticipate that the ACA will decrease the national costs of providing uncompensated care by 51 percent, from \$78.5 billion to \$38.7 billion. Further, we estimate that every state will decrease its uncompensated care spending under the ACA. More populous states and those with high pre-reform numbers of uninsured are expected to see the largest decrease in spending on uncompensated care. In absolute terms, uncompensated care declines will be largest in Texas (\$3.7 billion), followed by Florida (\$3.4 billion), California (\$3.3 billion) and New York (\$2.6 billion). Although these four states belong to separate groups, the differences we report between state groupings are striking.

The between-group differences in Table 2 are consistent with the observation that states making the least progress toward establishing exchanges will benefit the most from the ACA in reducing the number of uninsured. Group 3 will

experience the largest percentage drop in uncompensated spending in aggregate under the ACA (-59 percent), from \$24.5 billion to \$10.1 billion. Within this group, the estimated percentage change ranges from -40 percent in Montana to -71 percent in Ohio and South Carolina. There will be an overall decrease of 49 percent for Group 2 states, ranging from 14 percent in Delaware to 87 percent in Kentucky, the largest percentage drop in the nation. The states in Group 1 will see their uncompensated costs drop by 44 percent, the lowest amount among the three groups. The smallest decrease within Group 1 belongs to Massachusetts (-7 percent), which has already enacted comprehensive health reform and has the lowest baseline uninsurance rate of any state, but a number of states in this group will experience large relative declines in uncompensated care, including West Virginia (66 percent), Oregon (71 percent) and Hawaii (84 percent).

Medicaid/CHIP

Changes in the number of uninsured are primarily driven by the Medicaid expansion, change in employer coverage and increases in nongroup coverage in exchanges. Below we decompose the reduction in the number of uninsured in each state into the three contributors.¹⁷ Table 3 highlights the impact of the ACA on Medicaid and CHIP enrollment. The ACA expands Medicaid eligibility to most individuals with family income below 138 percent of FPL. This is of particular importance for adults as Children's Health Insurance Program (CHIP) eligibility thresholds for children are already well above 138 percent of FPL in all states.¹⁸ State variation in current eligibility rules will have a large impact on how many new individuals will enroll in each state's Medicaid and CHIP programs post-reform. Current Medicaid and CHIP eligibility rules are complex and vary greatly for children, parents and adult nonparents. The states with the smallest shares of the nonelderly population newly eligible for public coverage are nearly all among the states with the highest pre-reform eligibility thresholds for parents.¹⁹ A few states have fairly generous Medicaid thresholds for adult nonparents as well,

namely Massachusetts, Arizona, Delaware, New York, Vermont and Hawaii. In Massachusetts, most adults with family income up to 300 percent of FPL can receive subsidized coverage through MassHealth or Commonwealth Care.

Overall, we estimate that 12.4 million people made newly eligible through the Medicaid expansion will enroll in Medicaid coverage. In addition to expanding Medicaid eligibility, the ACA will increase enrollment among those currently eligible.²⁰ We estimate that the ACA will increase enrollment among those currently eligible from 45.1 million to 49.2 million. Total Medicaid and CHIP enrollment among the nonelderly would thus rise from 45.1 million to 61.1 million, an increase of 16.6 million (37 percent).

Medicaid/CHIP enrollment is expected to increase by over 50 percent (approximately 8 percentage points) in Group 3 states and by approximately 30 percent (5 percentage points) in Group 1 and Group 2 states. However, there is also substantial variation among states within a given group. For instance, among Group 1 states, Medicaid/CHIP enrollment is expected to increase by over 60 percent in Nevada, Oregon and Utah, whereas only minor changes are expected in Massachusetts and Vermont. Similarly, among the Group 3 states, Medicaid/CHIP enrollment could increase by over 75 percent in Montana compared with 40 percent in Oklahoma. Enrollment among current eligibles increased by a fairly steady 1 to 2 percentage points across all states; the biggest differences are in the number of new eligible enrollees. No state in Group 3 currently has income-based Medicaid eligibility for adult nonparents, and eligibility thresholds for adult parents are all below 100 percent of FPL. As a result, newly eligible Medicaid enrollees would make up 6 percent of the total nonelderly population in this group. About half the states in Groups 1 and 2 have some form of income-based eligibility for adult non-parents, though many of these programs have more limited benefits or closed enrollment. Newly eligible Medicaid enrollees would

make up 4 percent of the total non-elderly in these groups.

Private Coverage

Table 4 shows that slightly more people would have employer-sponsored coverage under the ACA than without it. Fifty-eight percent of the nonelderly population will be covered by an employer plan inside or outside the exchange post-reform, 2 percentage points higher than the baseline estimate. In all states, overall rates of employer coverage remain relatively constant or modestly increase from baseline to post-reform.

Nearly 10 million individuals or 4 percent of the national nonelderly population will receive coverage through the SHOP exchanges. The share of the nonelderly population expected to obtain coverage through SHOP exchanges varies slightly by state, ranging from under 2 percent in Mississippi and New Mexico, to over 5 percent in Massachusetts and Hawaii. This variation is likely attributable to baseline differences in the share of workers employed by small firms and the share of workers employed by small firms with an ESI offer. However, the average SHOP exchange size, as a percent of the nonelderly population, is comparable (between 3 and 4 percent) across the three state groupings. Many small businesses currently offering coverage would do so through the exchange, so the number with employer-based coverage outside the exchange would be lower than without reform.

The rest of the reduction in the number of uninsured comes from net new coverage in the nongroup exchanges. Nationally, 15.3 million individuals or 6 percent of the nonelderly population will receive coverage through nongroup health insurance exchanges, while less than 1 percent will purchase nongroup coverage outside the exchange (Table 5). State by state, the percent estimated to be covered in the nongroup exchanges varies from 3 percent in Massachusetts to 9 percent in Idaho. This variation is like attributable to baseline differences in ESI coverage rates, uninsurance rates, and the share of the nonelderly

population in the exchange premium subsidy income range. In contrast, the average percentages across state groupings are comparable, ranging from 5 percent in Group 2 states to 6 percent in Group 3 states.

In Table 6, we report the value of premium and cost-sharing subsidies given to nonelderly exchange enrollees, along with the number of individuals receiving subsidies in the exchange. Overall, states stand to receive approximately \$37.6 billion in premium and cost-sharing subsidies from the federal government, with \$10.6 billion, \$15.0 billion, and \$12.0 billion allocated to Group 1, Group 2 and Group 3 states, respectively. Table 6 also shows that, on average, Group 3 states have a higher share of their population receiving any subsidy and have higher subsidies per capita relative to Group 1 and Group 2 states. This is attributable to the fact that Group 3 states have a larger share of their population in the exchange premium subsidy income range. Generally, states with the largest nongroup exchanges will also have the most individuals receiving subsidies and the largest amounts of subsidies. California, Texas and Florida, for instance, have the largest nongroup exchanges, the most individuals receiving subsidies and the largest total amount of subsidies.

Conclusion

One key element of the ACA is the creation of state-based health insurance exchanges by 2014. Currently, only 15 states (Group 1) have either enacted an

exchange establishment law through the legislature or executive order, and 21 states (Group 2) have made some substantive progress by passing an intent bill, having legislation pending, or receiving an establishment grant for the exchange development process. Some of the remaining 15 states (Group 3) have created an exchange study or planning entity, while others have not taken any legislative action or did not pass any legislative action in 2011.

Under the ACA, uninsurance rates would decrease in all 50 states and in Washington, D.C., contributing to a national decline of 24 million nonelderly uninsured individuals. On average, states that have made the least progress toward ACA implementation are likely to see the largest percent and percentage point declines in their uninsurance rates. The considerable state variation from the national average shows that factors, such as current insurance markets and demographic makeup, play an important role in shaping the effects of the ACA.

The reductions in the number of uninsured are primarily driven by enrollment in the exchanges and the Medicaid/CHIP expansion. Nationally, 25 million individuals could receive coverage through the SHOP or nongroup exchanges, and Medicaid/CHIP enrollment could increase by approximately 17 million. Enrollment in the nongroup exchanges depends on current ESI eligibility as well as state income distributions, but on average, exchange sizes are unlikely to significantly vary across state groups.

However, residents in Group 3 states are expected to receive higher federal exchange subsidies per capita relative to residents in Group 1 and Group 2 states. Medicaid/CHIP enrollment could increase by over 50 percent among Group 3 states, compared with approximately 30 percent in Group 1 and Group 2 states.

This brief has shown that the states that have made the least progress in adopting provisions of health reform, including the state-run exchanges, are in general those that have the largest potential coverage gains. The Group 3 states will gain the most from the Medicaid expansion and will receive the most federal subsidy dollars per capita. The fact that Group 3 states have not yet made substantial progress in developing exchanges does not mean that individuals and families living in the Group 3 states will not benefit from health reform. The Medicaid expansion will occur as a matter of national policy. The Group 3 states will tend to see the largest expansion of their Medicaid programs and will thus benefit even without taking action on exchange development, although state enrollment processes could affect actual outcomes (i.e., states that do not simplify Medicaid or otherwise facilitate eligibility determination and enrollment under the new rules will tend to enroll fewer people). In addition, under the ACA, the federal government will establish exchanges if states fail to do so. However, this assumes that sufficient federal financial resources and political support are available to effectively operate federally operated exchanges.

Table 1: Change in the Nonelderly Uninsured Due to Reform

	Total Nonelderly Population	Baseline Uninsured		Post-Reform Uninsured		Change		
		N	% of Nonelderly	N	% of Nonelderly	N	%	% Pts
Group 1 States	76,354	13,569	18%	7,879	10%	-5,690	-42%	-7%
California	34,179	7,471	22%	4,563	13%	-2,908	-39%	-9%
Colorado	4,505	817	18%	432	10%	-385	-47%	-9%
Connecticut	3,034	391	13%	215	7%	-176	-45%	-6%
District of Columbia	545	65	12%	39	7%	-26	-40%	-5%
Hawaii	1,098	102	9%	54	5%	-49	-48%	-4%
Indiana	5,456	856	16%	362	7%	-493	-58%	-9%
Maryland	5,071	734	14%	421	8%	-313	-43%	-6%
Massachusetts	5,450	215	4%	179	3%	-36	-17%	-1%
Nevada	2,354	555	24%	290	12%	-265	-48%	-11%
Oregon	3,353	678	20%	318	9%	-359	-53%	-11%
Rhode Island	915	122	13%	65	7%	-57	-47%	-6%
Utah	2,494	424	17%	199	8%	-225	-53%	-9%
Vermont	531	61	12%	36	7%	-25	-41%	-5%
Washington	5,887	812	14%	615	10%	-197	-24%	-3%
West Virginia	1,482	266	18%	89	6%	-177	-67%	-12%
Group 2 States	115,624	18,730	16%	9,869	9%	-8,861	-47%	-8%
Alabama	4,031	696	17%	256	6%	-440	-63%	-11%
Arizona	5,949	1,306	22%	894	15%	-412	-32%	-7%
Delaware	755	115	15%	71	9%	-44	-38%	-6%
Idaho	1,338	239	18%	113	8%	-126	-53%	-9%
Illinois	11,439	1,795	16%	886	8%	-908	-51%	-8%
Iowa	2,612	292	11%	197	8%	-95	-33%	-4%
Kentucky	3,681	727	20%	296	8%	-431	-59%	-12%
Maine	1,112	146	13%	70	6%	-76	-52%	-7%
Michigan	8,643	1,336	15%	703	8%	-633	-47%	-7%
Minnesota	4,493	453	10%	288	6%	-165	-36%	-4%
Mississippi	2,540	530	21%	225	9%	-304	-57%	-12%
Missouri	5,139	780	15%	278	5%	-502	-64%	-10%
Nebraska	1,564	226	14%	111	7%	-115	-51%	-7%
New Jersey	7,683	1,334	17%	783	10%	-550	-41%	-7%
New Mexico	1,833	506	28%	254	14%	-252	-50%	-14%
New York	17,081	2,780	16%	1,833	11%	-947	-34%	-6%
North Carolina	8,248	1,583	19%	817	10%	-766	-48%	-9%
Pennsylvania	10,351	1,319	13%	606	6%	-713	-54%	-7%
Tennessee	5,402	982	18%	458	8%	-524	-53%	-10%
Virginia	6,909	1,023	15%	477	7%	-546	-53%	-8%
Wisconsin	4,823	562	12%	253	5%	-309	-55%	-6%
Group 3 States	76,785	17,953	23%	8,472	11%	-9,481	-53%	-12%
Arkansas	2,455	545	22%	217	9%	-328	-60%	-13%
Georgia	8,825	1,992	23%	959	11%	-1,033	-52%	-12%
Kansas	2,366	361	15%	191	8%	-171	-47%	-7%
Montana	845	179	21%	82	10%	-97	-54%	-11%
North Dakota	547	74	14%	43	8%	-31	-42%	-6%
South Carolina	3,833	754	20%	318	8%	-436	-58%	-11%
South Dakota	692	108	16%	52	7%	-57	-52%	-8%
Texas	22,757	6,654	29%	3,266	14%	-3,389	-51%	-15%
Wyoming	472	84	18%	42	9%	-42	-50%	-9%
Alaska	617	128	21%	61	10%	-67	-52%	-11%
Florida	15,318	3,952	26%	1,949	13%	-2,003	-51%	-13%
Louisiana	3,858	811	21%	321	8%	-490	-60%	-13%
New Hampshire	1,145	136	12%	69	6%	-67	-50%	-6%
Ohio	9,937	1,578	16%	644	6%	-934	-59%	-9%
Oklahoma	3,117	597	19%	259	8%	-338	-57%	-11%
Total	268,763	50,252	19%	26,220	10%	-24,032	-48%	-9%

Source: Urban Institute analysis, HPSM 2011.

Notes: We simulate the provisions of the Affordable Care Act fully implemented in 2011. Group 1 states have enacted establishment legislation or had executive order issued; Group 2 states have intent legislation, legislation pending, or have received a federal establishment grant; Group 3 states have uncertain outlooks. Some have created a study entity/planning committee only and others have not taken or did not pass legislation in 2011 (AK, FL, LA, NH, OH, OK). All sample size numbers are in thousands.

Table 2: Changes in Uncompensated Care Among the Nonelderly

	Baseline Uncompensated Care (Millions)	Post-Reform Uncompensated Care (Millions)*	Total Change	
			\$ (Millions)	%
Group 1 States	\$19,342	\$10,897	-\$8,445	-44%
California	\$9,119	\$5,792	-\$3,327	-36%
Colorado	\$1,371	\$844	-\$527	-38%
Connecticut	\$946	\$501	-\$445	-47%
District of Columbia	\$56	\$29	-\$28	-49%
Hawaii	\$249	\$40	-\$209	-84%
Indiana	\$1,612	\$751	-\$861	-53%
Maryland	\$874	\$339	-\$535	-61%
Massachusetts	\$310	\$288	-\$22	-7%
Nevada	\$883	\$449	-\$434	-49%
Oregon	\$836	\$243	-\$593	-71%
Rhode Island	\$273	\$110	-\$163	-60%
Utah	\$655	\$236	-\$419	-64%
Vermont	\$124	\$78	-\$45	-37%
Washington	\$1,466	\$1,004	-\$463	-32%
West Virginia	\$568	\$194	-\$375	-66%
Group 2 States	\$34,586	\$17,739	-\$16,846	-49%
Alabama	\$1,240	\$571	-\$669	-54%
Arizona	\$1,297	\$1,013	-\$284	-22%
Delaware	\$318	\$273	-\$45	-14%
Idaho	\$369	\$206	-\$163	-44%
Illinois	\$4,153	\$2,639	-\$1,514	-36%
Iowa	\$196	\$97	-\$99	-51%
Kentucky	\$1,615	\$204	-\$1,411	-87%
Maine	\$518	\$134	-\$384	-74%
Michigan	\$2,063	\$1,151	-\$912	-44%
Minnesota	\$736	\$477	-\$258	-35%
Mississippi	\$1,086	\$439	-\$646	-60%
Missouri	\$978	\$311	-\$667	-68%
Nebraska	\$431	\$193	-\$238	-55%
New Jersey	\$1,555	\$918	-\$637	-41%
New Mexico	\$510	\$198	-\$312	-61%
New York	\$5,755	\$3,121	-\$2,634	-46%
North Carolina	\$4,120	\$2,284	-\$1,836	-45%
Pennsylvania	\$3,017	\$1,513	-\$1,503	-50%
Tennessee	\$1,935	\$634	-\$1,301	-67%
Virginia	\$1,654	\$742	-\$912	-55%
Wisconsin	\$1,041	\$620	-\$421	-40%
Group 3 States	\$24,547	\$10,091	-\$14,456	-59%
Arkansas	\$905	\$290	-\$615	-68%
Georgia	\$2,830	\$1,025	-\$1,805	-64%
Kansas	\$601	\$250	-\$351	-58%
Montana	\$202	\$121	-\$80	-40%
North Dakota	\$176	\$81	-\$95	-54%
South Carolina	\$1,434	\$420	-\$1,014	-71%
South Dakota	\$242	\$114	-\$128	-53%
Texas	\$8,320	\$4,636	-\$3,684	-44%
Wyoming	\$132	\$69	-\$63	-47%
Alaska	\$147	\$72	-\$75	-51%
Florida	\$4,927	\$1,559	-\$3,369	-68%
Louisiana	\$833	\$268	-\$565	-68%
New Hampshire	\$258	\$130	-\$128	-50%
Ohio	\$2,655	\$777	-\$1,878	-71%
Oklahoma	\$886	\$277	-\$609	-69%
Total	\$78,475	\$38,727	-\$39,748	-51%

Source: Urban Institute analysis, HIPS 2011.

* We simulate the provisions of the Affordable Care Act fully implemented in 2011. Group 1 states have enacted establishment legislation or had executive order issued; Group 2 states have intent legislation, legislation pending, or have received a federal establishment grant; Group 3 states have uncertain outlooks. Some have created a study entity/planning committee only and others have not taken or did not pass legislation in 2011 (AK, FL, LA, NH, OH, OK).

Table 3: Change in Medicaid/CHIP Enrollment for the Nonelderly

	Baseline		Post-Reform				Change		
	N	% of Nonelderly	Current Eligibles		New Eligibles		N	%	% Pts
			N	% of Nonelderly	N	% of Nonelderly			
Group 1 States	13,040	17%	13,959	18%	2,972	4%	3,891	30%	5%
California	6,704	20%	7,184	21%	1,442	4%	1,922	29%	6%
Colorado	509	11%	577	13%	176	4%	243	48%	5%
Connecticut	375	12%	379	12%	118	4%	122	33%	4%
District of Columbia	128	24%	130	24%	22	4%	23	18%	4%
Hawaii	179	16%	193	18%	45	4%	59	33%	5%
Indiana	971	18%	1,013	19%	352	6%	394	41%	7%
Maryland	557	11%	614	12%	155	3%	212	38%	4%
Massachusetts	1,116	20%	1,092	20%	5	0%	-19	-2%	0%
Nevada	250	11%	298	13%	112	5%	160	64%	7%
Oregon	475	14%	524	16%	268	8%	316	67%	9%
Rhode Island	181	20%	186	20%	33	4%	38	21%	4%
Utah	247	10%	297	12%	111	4%	160	65%	6%
Vermont	120	23%	122	23%	2	0%	3	3%	1%
Washington	950	16%	1,060	18%	28	0%	138	15%	2%
West Virginia	276	19%	291	20%	104	7%	118	43%	8%
Group 2 States	20,193	17%	21,954	19%	4,557	4%	6,318	31%	5%
Alabama	707	18%	767	19%	259	6%	319	45%	8%
Arizona	1,242	21%	1,366	23%	63	1%	186	15%	3%
Delaware	117	16%	131	17%	10	1%	24	20%	3%
Idaho	188	14%	210	16%	73	5%	96	51%	7%
Illinois	1,954	17%	2,138	19%	488	4%	672	34%	6%
Iowa	379	15%	380	15%	71	3%	72	19%	3%
Kentucky	700	19%	740	20%	254	7%	295	42%	8%
Maine	239	22%	243	22%	42	4%	46	19%	4%
Michigan	1,472	17%	1,613	19%	301	3%	442	30%	5%
Minnesota	712	16%	793	18%	16	0%	97	14%	2%
Mississippi	595	23%	654	26%	191	8%	250	42%	10%
Missouri	778	15%	894	17%	334	6%	450	58%	9%
Nebraska	212	14%	231	15%	75	5%	94	44%	6%
New Jersey	932	12%	1,047	14%	218	3%	333	36%	4%
New Mexico	410	22%	421	23%	141	8%	152	37%	8%
New York	3,871	23%	4,235	25%	198	1%	561	15%	3%
North Carolina	1,372	17%	1,517	18%	486	6%	631	46%	8%
Pennsylvania	1,677	16%	1,797	17%	514	5%	635	38%	6%
Tennessee	1,051	19%	1,124	21%	310	6%	383	36%	7%
Virginia	756	11%	839	12%	281	4%	364	48%	5%
Wisconsin	829	17%	814	17%	233	5%	218	26%	5%
Group 3 States	11,820	15%	13,299	17%	4,873	6%	6,352	54%	8%
Arkansas	483	20%	510	21%	200	8%	227	47%	9%
Georgia	1,209	14%	1,365	15%	577	7%	732	61%	8%
Kansas	303	13%	349	15%	138	6%	183	61%	8%
Montana	104	12%	132	16%	51	6%	79	76%	9%
North Dakota	53	10%	60	11%	25	5%	32	61%	6%
South Carolina	561	15%	623	16%	280	7%	342	61%	9%
South Dakota	96	14%	103	15%	38	6%	46	48%	7%
Texas	3,959	17%	4,497	20%	1,358	6%	1,896	48%	8%
Wyoming	59	12%	64	14%	22	5%	27	46%	6%
Alaska	81	13%	92	15%	28	5%	39	48%	6%
Florida	2,030	13%	2,355	15%	1,031	7%	1,355	67%	9%
Louisiana	688	18%	748	19%	329	9%	388	56%	10%
New Hampshire	107	9%	117	10%	38	3%	48	45%	4%
Ohio	1,577	16%	1,740	18%	592	6%	755	48%	8%
Oklahoma	509	16%	545	17%	166	5%	202	40%	6%
Total	45,054	17%	49,211	18%	12,403	5%	16,561	37%	6%

Source: Urban Institute analysis, HIPS 2011.

Notes: We simulate the provisions of the Affordable Care Act fully implemented in 2011. Group 1 states have enacted establishment legislation or had executive order issued; Group 2 states have intent legislation, legislation pending, or have received a federal establishment grant; Group 3 states have uncertain outlooks. Some have created a study entity/planning committee only and others have not taken or did not pass legislation in 2011 (AK, FL, LA, NH, OH, OK). All sample size numbers are in thousands. The total change is the difference between the sum of the current and new eligible enrollees and the baseline enrollees.

Table 4: Change in Employer Sponsored Insurance Coverage for the Nonelderly

	Baseline Enrollment		Post-Reform					
			Exchange		Non-Exchange		Total	
	N	% of Nonelderly	N	% of Nonelderly	N	% of Nonelderly	N	% of Nonelderly
Group 1 States	43,310	57%	2,856	4%	41,417	54%	44,272	58%
California	17,062	50%	1,180	3%	16,463	48%	17,643	52%
Colorado	2,653	59%	145	3%	2,584	57%	2,729	61%
Connecticut	2,041	67%	111	4%	1,953	64%	2,064	68%
District of Columbia	305	56%	17	3%	289	53%	305	56%
Hawaii	706	64%	62	6%	632	58%	694	63%
Indiana	3,297	60%	197	4%	3,143	58%	3,340	61%
Maryland	3,400	67%	204	4%	3,210	63%	3,415	67%
Massachusetts	3,815	70%	313	6%	3,557	65%	3,870	71%
Nevada	1,380	59%	81	3%	1,335	57%	1,416	60%
Oregon	1,891	56%	126	4%	1,787	53%	1,913	57%
Rhode Island	547	60%	41	4%	507	55%	548	60%
Utah	1,596	64%	97	4%	1,549	62%	1,645	66%
Vermont	314	59%	25	5%	294	55%	319	60%
Washington	3,486	59%	217	4%	3,306	56%	3,523	60%
West Virginia	816	55%	41	3%	807	54%	848	57%
Group 2 States	67,043	58%	4,545	4%	63,951	55%	68,496	59%
Alabama	2,359	59%	146	4%	2,261	56%	2,406	60%
Arizona	2,923	49%	189	3%	2,869	48%	3,058	51%
Delaware	469	62%	27	4%	454	60%	481	64%
Idaho	759	57%	49	4%	723	54%	772	58%
Illinois	6,795	59%	508	4%	6,491	57%	6,999	61%
Iowa	1,679	64%	85	3%	1,649	63%	1,734	66%
Kentucky	1,968	53%	119	3%	1,907	52%	2,026	55%
Maine	636	57%	44	4%	598	54%	641	58%
Michigan	5,194	60%	392	5%	4,912	57%	5,304	61%
Minnesota	2,933	65%	194	4%	2,840	63%	3,034	68%
Mississippi	1,175	46%	53	2%	1,150	45%	1,204	47%
Missouri	3,082	60%	231	4%	2,891	56%	3,121	61%
Nebraska	951	61%	52	3%	914	58%	966	62%
New Jersey	4,970	65%	307	4%	4,756	62%	5,063	66%
New Mexico	762	42%	45	2%	762	42%	806	44%
New York	9,298	54%	710	4%	8,804	52%	9,514	56%
North Carolina	4,399	53%	323	4%	4,157	50%	4,480	54%
Pennsylvania	6,490	63%	463	4%	6,016	58%	6,479	63%
Tennessee	2,807	52%	176	3%	2,711	50%	2,888	53%
Virginia	4,346	63%	245	4%	4,148	60%	4,393	64%
Wisconsin	3,049	63%	187	4%	2,937	61%	3,125	65%
Group 3 States	40,090	52%	2,526	3%	39,302	51%	41,828	54%
Arkansas	1,178	48%	70	3%	1,163	47%	1,233	50%
Georgia	4,830	55%	289	3%	4,733	54%	5,022	57%
Kansas	1,418	60%	78	3%	1,343	57%	1,422	60%
Montana	454	54%	43	5%	431	51%	474	56%
North Dakota	341	62%	25	5%	324	59%	350	64%
South Carolina	2,187	57%	114	3%	2,108	55%	2,222	58%
South Dakota	402	58%	33	5%	375	54%	409	59%
Texas	10,513	46%	618	3%	10,694	47%	11,312	50%
Wyoming	277	59%	21	4%	262	55%	282	60%
Alaska	331	54%	23	4%	313	51%	336	55%
Florida	7,714	50%	553	4%	7,495	49%	8,048	53%
Louisiana	2,002	52%	144	4%	1,930	50%	2,074	54%
New Hampshire	805	70%	59	5%	759	66%	818	71%
Ohio	5,929	60%	355	4%	5,686	57%	6,040	61%
Oklahoma	1,708	55%	101	3%	1,685	54%	1,785	57%
Total	150,443	56%	9,927	4%	144,669	54%	154,596	58%

Source: Urban Institute analysis, HIPS 2011.

Notes: We simulate the provisions of the Affordable Care Act fully implemented in 2011. Group 1 states have enacted establishment legislation or had executive order issued; Group 2 states have intent legislation, legislation pending, or have received a federal establishment grant; Group 3 states have uncertain outlooks. Some have created a study entity/planning committee only and others have not taken or did not pass legislation in 2011 (AK, FL, LA, NH, OH, OK). All sample size numbers are in thousands.

Table 5: Change in Nongroup Coverage for the Nonelderly

	Baseline Enrollment		Post-Reform					
			Exchange		Non-Exchange		Total	
	N	% of Nonelderly	N	% of Nonelderly	N	% of Nonelderly	N	% of Nonelderly
Group 1 States	4,521	6%	4,575	6%	784	1%	5,359	7%
California	2,296	7%	2,296	7%	405	1%	2,701	8%
Colorado	334	7%	336	7%	64	1%	400	9%
Connecticut	157	5%	154	5%	34	1%	188	6%
District of Columbia	37	7%	32	6%	8	2%	41	7%
Hawaii	43	4%	39	4%	6	1%	44	4%
Indiana	192	4%	227	4%	22	0%	249	5%
Maryland	252	5%	280	6%	58	1%	338	7%
Massachusetts	219	4%	170	3%	49	1%	219	4%
Nevada	98	4%	139	6%	27	1%	166	7%
Oregon	234	7%	226	7%	29	1%	255	8%
Rhode Island	46	5%	53	6%	9	1%	63	7%
Utah	175	7%	173	7%	17	1%	191	8%
Vermont	21	4%	33	6%	4	1%	37	7%
Washington	383	6%	361	6%	44	1%	405	7%
West Virginia	35	2%	56	4%	6	0%	62	4%
Group 2 States	6,023	5%	6,078	5%	1,035	1%	7,113	6%
Alabama	116	3%	161	4%	29	1%	190	5%
Arizona	304	5%	341	6%	53	1%	394	7%
Delaware	32	4%	35	5%	5	1%	40	5%
Idaho	116	9%	122	9%	11	1%	133	10%
Illinois	586	5%	499	4%	119	1%	618	5%
Iowa	210	8%	150	6%	28	1%	178	7%
Kentucky	156	4%	207	6%	27	1%	234	6%
Maine	50	4%	65	6%	9	1%	75	7%
Michigan	437	5%	453	5%	65	1%	518	6%
Minnesota	297	7%	227	5%	38	1%	265	6%
Mississippi	128	5%	132	5%	21	1%	154	6%
Missouri	317	6%	298	6%	33	1%	330	6%
Nebraska	126	8%	116	7%	16	1%	132	8%
New Jersey	300	4%	353	5%	72	1%	425	6%
New Mexico	76	4%	117	6%	14	1%	132	7%
New York	765	4%	817	5%	118	1%	935	5%
North Carolina	460	6%	438	5%	77	1%	515	6%
Pennsylvania	657	6%	615	6%	130	1%	745	7%
Tennessee	284	5%	298	6%	46	1%	344	6%
Virginia	318	5%	373	5%	81	1%	453	7%
Wisconsin	288	6%	260	5%	43	1%	303	6%
Group 3 States	3,938	5%	4,654	6%	675	1%	5,329	7%
Arkansas	109	4%	145	6%	10	0%	155	6%
Georgia	371	4%	426	5%	53	1%	480	5%
Kansas	177	7%	130	5%	31	1%	161	7%
Montana	71	8%	61	7%	7	1%	69	8%
North Dakota	61	11%	46	8%	5	1%	51	9%
South Carolina	171	4%	204	5%	26	1%	230	6%
South Dakota	56	8%	50	7%	10	1%	60	9%
Texas	930	4%	1,404	6%	219	1%	1,623	7%
Wyoming	34	7%	38	8%	5	1%	44	9%
Alaska	23	4%	41	7%	4	1%	45	7%
Florida	973	6%	1,121	7%	167	1%	1,288	8%
Louisiana	216	6%	205	5%	40	1%	245	6%
New Hampshire	64	6%	59	5%	11	1%	70	6%
Ohio	531	5%	546	5%	52	1%	598	6%
Oklahoma	150	5%	175	6%	33	1%	208	7%
Total	14,482	5%	15,307	6%	2,494	1%	17,801	7%

Source: Urban Institute analysis, HIPS 2011.

Notes: We simulate the provisions of the Affordable Care Act fully implemented in 2011. Group 1 states have enacted establishment legislation or had executive order issued; Group 2 states have intent legislation, legislation pending, or have received a federal establishment grant; Group 3 states have uncertain outlooks. Some have created a study entity/planning committee only and others have not taken or did not pass legislation in 2011 (AK, FL, LA, NH, OH, OK). All sample size numbers are in thousands.

Table 6: Nongroup Exchange Subsidies Among the Nonelderly Under the ACA

	Total Nonelderly Population	Premium and Cost-Sharing Subsidies			
		Number Receiving Any Subsidy	% of Population Receiving Any Subsidy	Total (Millions)	Total Subsidy per Capita
Group 1 States	76,354	2,340	3%	\$10,608	\$139
California	34,179	1,192	3%	\$5,458	\$160
Colorado	4,505	188	4%	\$674	\$150
Connecticut	3,034	65	2%	\$327	\$108
District of Columbia	545	12	2%	\$56	\$102
Hawaii	1,098	17	2%	\$77	\$70
Indiana	5,456	120	2%	\$649	\$119
Maryland	5,071	112	2%	\$466	\$92
Massachusetts	5,450	79	1%	\$440	\$81
Nevada	2,354	83	4%	\$353	\$150
Oregon	3,353	119	4%	\$635	\$189
Rhode Island	915	22	2%	\$115	\$126
Utah	2,494	101	4%	\$365	\$146
Vermont	531	17	3%	\$83	\$156
Washington	5,887	178	3%	\$752	\$128
West Virginia	1,482	35	2%	\$158	\$106
Group 2 States	115,624	3,233	3%	\$15,034	\$130
Alabama	4,031	106	3%	\$488	\$121
Arizona	5,949	184	3%	\$709	\$119
Delaware	755	17	2%	\$80	\$106
Idaho	1,338	67	5%	\$258	\$193
Illinois	11,439	255	2%	\$1,372	\$120
Iowa	2,612	62	2%	\$268	\$103
Kentucky	3,681	132	4%	\$496	\$135
Maine	1,112	36	3%	\$154	\$138
Michigan	8,643	269	3%	\$1,200	\$139
Minnesota	4,493	100	2%	\$481	\$107
Mississippi	2,540	93	4%	\$408	\$161
Missouri	5,139	139	3%	\$641	\$125
Nebraska	1,564	47	3%	\$207	\$133
New Jersey	7,683	151	2%	\$746	\$97
New Mexico	1,833	73	4%	\$352	\$192
New York	17,081	412	2%	\$1,996	\$117
North Carolina	8,248	254	3%	\$1,332	\$161
Pennsylvania	10,351	308	3%	\$1,388	\$134
Tennessee	5,402	188	3%	\$900	\$167
Virginia	6,909	176	3%	\$787	\$114
Wisconsin	4,823	162	3%	\$772	\$160
Group 3 States	76,785	2,696	4%	\$12,005	\$156
Arkansas	2,455	101	4%	\$478	\$195
Georgia	8,825	232	3%	\$1,097	\$124
Kansas	2,366	72	3%	\$281	\$119
Montana	845	33	4%	\$147	\$174
North Dakota	547	22	4%	\$87	\$159
South Carolina	3,833	114	3%	\$527	\$137
South Dakota	692	27	4%	\$108	\$156
Texas	22,757	854	4%	\$3,764	\$165
Wyoming	472	23	5%	\$110	\$233
Alaska	617	22	3%	\$75	\$121
Florida	15,318	653	4%	\$2,988	\$195
Louisiana	3,858	93	2%	\$384	\$100
New Hampshire	1,145	24	2%	\$105	\$92
Ohio	9,937	327	3%	\$1,425	\$143
Oklahoma	3,117	100	3%	\$430	\$138
Total	268,763	8,269	3%	\$37,647	\$140

Source: Urban Institute analysis, HIPS 2011.

Notes: We simulate the provisions of the Affordable Care Act fully implemented in 2011. Group 1 states have enacted establishment legislation or had executive order issued; Group 2 states have intent legislation, legislation pending, or have received a federal establishment grant; Group 3 states have uncertain outlooks. Some have created a study entity/planning committee only and others have not taken or did not pass legislation in 2011 (AK, FL, LA, NH, OH, OK). All sample size numbers are in thousands.

Endnotes

- 1 Exemptions will be granted for those that do not have an affordable insurance policy available to them, the incarcerated, American Indians, financial hardship, religious objections, those without coverage for less than three months, undocumented immigrants and those with incomes below the tax filing threshold.
- 2 The non-exchange nongroup and small group markets are also subject to these new regulations.
- 3 Dorn S, Buettgens M, and Carroll C. "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States." Washington, DC: The Urban Institute, 2011, www.urban.org/url.cfm?ID=412412.
- 4 Buettgens M, Holahan J, and Carroll C. "Health Reform across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid." Washington, DC: The Urban Institute, 2011, www.urban.org/url.cfm?ID=412310.
- 5 National Conference of State Legislatures, NCSL's Federal Health Reform: 2011 State Legislative Tracking Database, www.ncsl.org/?tabid=22123 (accessed December 2011).
- 6 U.S. Department of Health and Human Services, www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html (accessed December 2011).
- 7 States that enacted the law through the legislature include California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Nevada, Oregon, Utah, Vermont, Washington D.C., and West Virginia. Executive order states include Indiana and Rhode Island. It is important to note, however, that Indiana's executive order agrees to cooperate in conditionally establishing and operating an exchange, assuming there is no forthcoming federal guidance that changes the state's decision (www.in.gov/gov/files/EO_11-01.pdf).
- 8 See information on the Pennsylvania decision at www.pahealthoptions.com. Illinois and North Carolina have also passed intent laws, and the District of Columbia, Michigan, New Jersey, New York and Wisconsin have legislation pending.
- 9 For more about HIPSM and a list of recent research using it, see www.urban.org/url.cfm?ID=412154. A more technical description of the construction of the model can be found in Garrett B, Holahan J, Headen I, et al., "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), www.urban.org/url.cfm?ID=411905.
- 10 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.
- 11 The state-specific HIPSM models involve a more detailed construction of each state's baseline. These models borrow observations from the region where the target state is located to increase sample size and smooth out behavior. The data is reweighted to achieve state-specific population targets and enrollment targets in a set of categories for which the state might have particular data of interest. Observations in the target states are more heavily weighted relative to observations in the region outside the state.
- 12 Buettgens M, Garrett B, and Holahan J. "America under the Affordable Care Act." Washington, DC: The Urban Institute, 2010, www.urban.org/url.cfm?ID=412267.
- 13 Buettgens et al., "Health Reform across the States"; Buettgens M, Dorn S, and Carroll C. "ACA and State Governments: Consider Savings as Well as Costs." Washington, DC: The Urban Institute, 2011, www.urban.org/url.cfm?ID=412361.
- 14 Also, small firms were defined as those of up to 100 (full-time-equivalent) workers. All states must use this definition beginning in 2016, though most currently use a threshold of 50 workers. This is not a change from earlier HIPSM modeling.
- 15 Massachusetts would see little change because of the ACA largely due to the health reforms already operating within the state.
- 16 Hadley J, Holahan J, Coughlin TA, et al. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." Washington, DC: The Urban Institute, 2008, www.urban.org/url.cfm?ID=1001210.
- 17 Not all individuals who enroll in Medicaid/CHIP or in the exchanges post-reform were uninsured in the baseline. For example, some individuals can drop their baseline coverage (e.g., employer coverage or unsubsidized non-group coverage) and enroll in Medicaid/CHIP or in the exchanges post-reform. This explains why the sum of the Medicaid/CHIP increase and exchange enrollment levels adds up to more than the total reduction in the number of uninsured.
- 18 For an analysis of children's coverage and the ACA, see Kenney GM, Buettgens M, Guyer J, et al. "Improving Coverage for Children Under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP." *Health Affairs*, 30(12): 2371-2381, 2011, <http://content.healthaffairs.org/content/30/12/2371.full.html>.
- 19 State Health Facts. "Medicaid and State Funded Coverage Income Eligibility Limits for Low-Income Adults, 2009," Menlo Park, CA: Kaiser Family Foundation, www.statehealthfacts.org.
- 20 There would be a "no-wrong-door" Web interface that would automatically determine eligibility for Medicaid, CHIP and exchange subsidies and automatically enroll those found eligible for Medicaid or CHIP. Some of those eligible would be bound by the individual mandate. This is a particularly true for CHIP, for which eligibility extends in some states up to 400 percent of FPL. Also, as was seen in Massachusetts, an individual mandate establishes a new social norm to obtain coverage that leads to a modest increase in enrollment even among those exempt from the coverage requirement.

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