Implications of Partial Repeal of the ACA through Reconciliation

Linda J. Blumberg, Matthew Buettgens, and John Holahan
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In Brief

Congress is now considering partial repeal of the Affordable Care Act (ACA) through the budget reconciliation process. Since only components of the law with federal budget implications can be changed through reconciliation, this approach would permit elimination of the Medicaid expansion, the federal financial assistance for Marketplace coverage (premium tax credits and cost-sharing reductions), and the individual and employer mandates; it would leave the insurance market reforms (including the nongroup market’s guaranteed issue, prohibition on preexisting condition exclusions, modified community rating, essential health benefit requirements, and actuarial value standards) in place. There is currently no consensus around alternative health policies to enact as the ACA is repealed; consequently, partial repeal via reconciliation without replacement is possible and merits analysis.

In this brief, we compare future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.
Federal government spending on health care for the nonelderly would be reduced by $109 billion in 2019 and by $1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.

State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.

The 2016 reconciliation bill did not increase funding for uncompensated care beyond current levels. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.

If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.

Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the House v. Burwell case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.
Introduction

Congress passed a reconciliation bill repealing substantial portions of the Affordable Care Act (ACA) in January 2016; however, the bill was vetoed by President Obama. Congress is now poised to pass a similar bill in early 2017. The bill Congress passed did not contain policies intended to replace the ACA, presumably because a consensus did not exist on what form such an alternative should take. It is unlikely that supporters of ACA repeal will have agreed on an alternative before voting on repeal. In the absence of agreement on an alternative to the ACA, Congress is likely to delay the repeal of most, if not all, provisions in the bill for two or three years, giving members time to try developing an alternative set of policies. This was the approach taken by Congress last year.

Under Senate rules, reconciliation bills can only make legislative changes that affect the federal budget. In the context of the ACA, rules permit repeal of the Medicaid expansion; the premium tax credits and cost-sharing assistance provided to people with modest income through the Marketplaces; the tax on some people who do not carry minimum creditable health insurance (a.k.a. the individual mandate); and the employer responsibility requirement (a.k.a. the employer mandate), which assesses a penalty on some employers whose workers obtain subsidized coverage through the Marketplaces. Because provisions that do not directly affect spending or revenues cannot be included in reconciliation bills, the 2016 bill did not eliminate the insurance market reforms, which include the extension of family coverage for adult children up to age 26, prohibitions on preexisting condition exclusions, and requirements for modified community rating, essential health benefits, and actuarial value standards. An attempt to repeal these provisions through normal legislative channels would be subject to a filibuster. For that reason, we assume that these provisions would remain in effect, at least in the near term.

This brief considers the effect of partial repeal of the ACA in the context of reconciliation. Since the 2016 reconciliation bill delayed its repeal of most budget-related components of the ACA for two years, we simulate the cost and coverage implications of a similar 2017 reconciliation bill in 2019. We also provide 10-year estimates for 2019 to 2028. However, even with most components delayed two years, such a reconciliation bill would substantially alter the nation’s private nongroup insurance markets during 2017, with even larger effects on the 2018 plan year. Insurers could decide to stop offering insurance through the ACA-compliant nongroup insurance markets for 2018, knowing that enrollment will drop and the markets will soon be disassembled. A substantial drop in insurer participation is even more likely if Marketplace cost-sharing assistance is discontinued in 2017 or 2018 (as related to the House v. Burwell case) or if some additional financial support to insurers is not provided to offset their increased risk. A delay of the repeal provisions for three years instead of two would delay our estimated effects an additional year, changing the size of the estimated effects somewhat over 10 years.

The 2016 reconciliation bill would have eliminated the individual and employer mandates immediately upon passage. If, under a 2017 reconciliation bill, the individual mandate penalties are not enforced beginning in 2017, people would have less incentive to pay premiums (especially people who are healthy and not eligible for premium tax credits); nongroup coverage would decline as enrollment falls almost immediately; the average health care costs of enrollees in the market would increase; and
these increased costs would create financial issues for insurers participating in 2017. As the number of uninsured people increases, providers would face increasing financial pressures because of higher demand for uncompensated care. Changes like these implemented during a plan year would seriously disrupt insurance markets for consumers, insurers, and providers. Thus, in addition to providing 2019 estimates for the reconciliation bill, we provide separate estimates of the immediate consequences of repealing the individual and employer mandates in 2017.

Results

We estimate insurance coverage in 2019 under the ACA and under the partial repeal expected to be included in a January 2017 reconciliation bill. We present coverage estimates for the nation as a whole and changes in the number of people uninsured for each state. We also provide detailed socioeconomic characteristics of those losing insurance coverage. We estimate the change in federal spending under each scenario in the same year, breaking out the total decrease in federal spending by Medicaid/CHIP and Marketplace financial assistance, nationally and by state. We provide estimates of the effects of elimination of the Medicaid expansion on state spending. We also show the implications of the increase in uncompensated care that would be sought as the number of uninsured increases. Finally, we estimate the financial losses of insurers if the 2017 bill, like that passed in 2016, eliminates the individual and employer mandates immediately, affecting enrollment decisions during 2017 once nongroup health insurance premiums are already fixed. Additional state-by-state detail on changes in federal and state spending in 2019 and over the 2019 to 2028 period is provided in appendix tables.

Insurance Coverage

The anticipated reconciliation bill would dramatically affect public insurance and private nongroup insurance for people covered through the Medicaid expansions, the ACA’s Marketplaces, and ACA-compliant plans outside the Marketplaces. We estimate that the partial ACA repeal would increase the number of uninsured people by 29.8 million by 2019 (table 1, figure 1), raising the total number of uninsured to 58.7 million people—21 percent of the nonelderly population—compared with 28.9 million people uninsured if the ACA remains in effect. More people would be uninsured in 2019 than the 50.0 million who were uninsured in 2009, just before passage of the ACA (Holahan 2011).

The market for nongroup coverage would virtually collapse, causing 7.3 million of the additional 29.8 million people to become uninsured. Full repeal of all components of the ACA, including the insurance market reforms, would increase the number of uninsured by 22.5 million by 2019 (data not shown). The nongroup market would unravel because of three factors:

- Eliminating premium tax credits and cost-sharing assistance would make coverage unaffordable for many of the people currently enrolled, causing them to drop coverage. Those with the fewest health problems would drop their coverage fastest.
Eliminating the individual mandate penalty would reduce the incentive to enroll for healthy people who can afford coverage.

Insurers would remain subject to the requirement to sell coverage that meets adequacy standards to all would-be purchasers, and they would remain subject to the prohibition against charging higher premiums or offering reduced benefits to those with health care needs.

**TABLE 1**

Health Insurance Coverage Distribution of the Nonelderly with the ACA and an Anticipated Reconciliation Bill, 2019

<table>
<thead>
<tr>
<th></th>
<th>ACA (current law)</th>
<th>Reconciliation Bill</th>
<th>Difference (thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People (thousands)</td>
<td>Share of US total (%)</td>
<td>People (thousands)</td>
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<tr>
<td>Insured</td>
<td>245,380</td>
<td>89</td>
<td>215,598</td>
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<tr>
<td>Employer</td>
<td>148,974</td>
<td>54</td>
<td>149,832</td>
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<tr>
<td>Nongroup (eligible for tax credit)</td>
<td>9,322</td>
<td>3</td>
<td>1,560</td>
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<tr>
<td>Nongroup (other)</td>
<td>9,955</td>
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<td>55,632</td>
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<tr>
<td>Medicaid/CHIP</td>
<td>68,556</td>
<td>25</td>
<td>8,574</td>
</tr>
<tr>
<td>Other (including Medicare)</td>
<td>8,574</td>
<td>3</td>
<td>58,718</td>
</tr>
<tr>
<td>Uninsured</td>
<td>28,936</td>
<td>11</td>
<td>149,0</td>
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<tr>
<td>Total</td>
<td>274,316</td>
<td>100</td>
<td>274,316</td>
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</table>

Notes: ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program. Columns may not sum to totals because of rounding.

**FIGURE 1**

Health Insurance of the Nonelderly in 2019, under the ACA and an Anticipated Reconciliation Bill

*Millions of people*

Note: ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program.
As increasing numbers of people continued to drop their insurance (with healthier people leaving coverage fastest), the situation would threaten the nongroup insurers both inside and outside the Marketplaces with insupportable losses, would force insurers to raise premiums by increasingly large amounts, and would drive many insurers out of the nongroup market entirely. That is why the increase in the number of uninsured due to a reconciliation bill would exceed the gains in insurance coverage achieved under the ACA.

Table 2 gives a state-by-state breakdown of where the losses of insurance coverage would occur. The effects are uneven. The hardest hit, on average, would be states that expanded Medicaid, as those states averaged the largest coverage gains under reform. In those states, the number of people uninsured would more than double, from 14.0 to 32.5 million people, an increase of 18.5 million people. The number of uninsured would increase by 11.3 million people, from 14.9 to 26.2 million, in the states that did not expand Medicaid eligibility. In California, 4.9 million people would become uninsured; over 1 million people in Illinois and New York each would also become uninsured. Over 2 million people in Florida and 2.6 million people in Texas would become uninsured, as would over 1 million people in Georgia and North Carolina each.

### Table 2

<table>
<thead>
<tr>
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<th>ACA</th>
<th>Reconciliation Bill</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of uninsured (thousands)</td>
<td>Share eligible for assistance</td>
<td>Number of uninsured (thousands)</td>
</tr>
<tr>
<td>National total</td>
<td>28,936</td>
<td>42%</td>
<td>58,718</td>
</tr>
<tr>
<td>Expansion states</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Alaska</td>
<td>117</td>
<td>78%</td>
<td>178</td>
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<td>Arizona</td>
<td>750</td>
<td>53%</td>
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<td>Arkansas</td>
<td>211</td>
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<td>California</td>
<td>3,349</td>
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<td>Colorado</td>
<td>438</td>
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<td>200</td>
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<td>Delaware</td>
<td>60</td>
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<td>District of Columbia</td>
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<td>56%</td>
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<td>Hawaii</td>
<td>88</td>
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<td>896</td>
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<td>Indiana</td>
<td>552</td>
<td>70%</td>
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<td>Iowa</td>
<td>153</td>
<td>63%</td>
<td>383</td>
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<tr>
<td>Kentucky</td>
<td>244</td>
<td>66%</td>
<td>730</td>
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<tr>
<td>Louisiana</td>
<td>363</td>
<td>62%</td>
<td>921</td>
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<td>37%</td>
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<td>Massachusetts</td>
<td>135</td>
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<tr>
<td>Nevada</td>
<td>391</td>
<td>51%</td>
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<td>New York</td>
<td>1,524</td>
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<td>North Dakota</td>
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<td>Ohio</td>
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<td>208%</td>
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<tr>
<td><strong>Expansion states total</strong></td>
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<td>51%</td>
<td>32,519</td>
<td>16%</td>
<td>18,516</td>
<td>132%</td>
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<tr>
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**Source:** Urban Institute analysis using HIPSM 2016.

**Notes:** ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program. Financial assistance under the ACA includes Medicaid/CHIP and Marketplace premium tax credits and cost-sharing reductions. Financial assistance under the anticipated reconciliation bill consists of Medicaid/CHIP. Columns may not sum to totals because of rounding.

Overall, the elimination of the Medicaid expansion would decrease coverage through that program by 12.9 million people in 2019 as people lose eligibility for the program. The near “death spiral” in the private nongroup market described earlier is likely to occur immediately after the reconciliation bill’s provisions take effect. Insurers would recognize the unsustainable financial dynamics of broad-based pooling policies (e.g., guaranteed issue, no preexisting condition exclusions, essential health benefits,
modified community rating) combined with no individual mandate and no financial assistance to spur enrollment. Similar near market collapse has occurred in the past under similar conditions. When New York’s and New Jersey’s state governments implemented community rating and guaranteed issue in their private nongroup markets without also providing for an individual requirement to obtain coverage or financial assistance to make coverage affordable for people with modest incomes, the nongroup markets unwound (Monheit et al. 2004).

We estimate that the number of people with nongroup insurance would drop from 19.3 million people to 1.6 million by the beginning of the 2019 plan year, concurrent with elimination of the premium tax credits. A small number of people otherwise covered by this market—fewer than 1 million—would obtain employer-sponsored insurance. Some insurers, such as Blue Cross-affiliated insurers, may continue to offer ACA-compliant plans at much higher premiums in the nongroup market, but without federal financial assistance, relatively few people—we estimate approximately 8 percent of those who have such coverage now—would enroll.

After the large increase in uninsured people that would result from a reconciliation bill, a much smaller share of the uninsured would be eligible for any financial assistance compared with the share eligible under the ACA (table 3). In the reconciliation bill scenario, only 15 percent of the 58.7 million uninsured would be eligible for any financial assistance (all under Medicaid or CHIP), given the elimination of both the Marketplace tax credits and the Medicaid eligibility expansion. As a consequence, there would be a much higher number of uninsured and very little room to significantly reduce that number absent substantial policy initiatives. In contrast, under the ACA, 42 percent of the remaining 28.9 million uninsured would be eligible for either Medicaid/CHIP or tax credits through the ACA’s Marketplaces in 2019. That high rate of eligibility means that additional outreach and enrollment assistance could significantly increase the number of uninsured obtaining coverage under the ACA.

Table 3
Uninsured Eligible for Financial Assistance to Obtain Coverage, Nationally and by State Medicaid Expansion Status, 2019

<table>
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Notes: ACA = Affordable Care Act. Under the ACA, assistance can take the form of Medicaid, CHIP, or Marketplace tax credits; under reconciliation, assistance can take the form of Medicaid or CHIP. Columns may not sum to totals because of rounding.
Characteristics of Those Becoming Uninsured

Table 4 provides income, age, employment, race/ethnicity, and educational attainment characteristics of the 29.8 million people becoming uninsured under the anticipated reconciliation bill. We find that approximately 53 percent of those becoming uninsured would be people with family income between 100 and 400 percent of the federal poverty level (FPL). The remaining increase in the number of uninsured would be almost evenly split between those with lower and higher incomes, 25 percent with income below 100 percent of FPL and 23 percent with income over 400 percent of FPL. These newly uninsured people would be spread broadly through the age distribution: 13 percent children under age 18, 38 percent young adults ages 18 to 34, and 49 percent adults ages 35 to 64.

The vast majority of those becoming uninsured would be members of working families (82 percent), and more than half (56 percent) would be non-Hispanic whites. The vast majority of adults becoming uninsured would lack college degrees (80 percent).

Uninsurance rates for people of all characteristics measured would increase by at least 50 percent under the reconciliation approach. For example, 10 percent of those with family income from 150 to 200 percent of the FPL are uninsured under the ACA, but that rate would increase to 26 percent under the reconciliation approach. Under the ACA, 7 percent of white, non-Hispanic people would be uninsured in 2019, but 18 percent would be uninsured under the reconciliation approach. Uninsurance rates for adults with a high school diploma would increase from 16 percent under the ACA to 30 percent.

**TABLE 4**
Characteristics of Those Losing Coverage under an Anticipated Reconciliation Bill and Uninsurance Rates under the ACA and an Anticipated Reconciliation Bill, 2019

<table>
<thead>
<tr>
<th>Income level</th>
<th>Thousands of people</th>
<th>Share losing coverage</th>
<th>Uninsurance rate under ACA</th>
<th>Uninsurance rate under reconciliation bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100% of FPL</td>
<td>7,357</td>
<td>25%</td>
<td>14%</td>
<td>27%</td>
</tr>
<tr>
<td>100–150% of FPL</td>
<td>5,004</td>
<td>17%</td>
<td>8%</td>
<td>28%</td>
</tr>
<tr>
<td>150–200% of FPL</td>
<td>3,792</td>
<td>13%</td>
<td>10%</td>
<td>26%</td>
</tr>
<tr>
<td>200–300% of FPL</td>
<td>4,059</td>
<td>14%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>300–400% of FPL</td>
<td>2,836</td>
<td>10%</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>&gt; 400% of FPL</td>
<td>6,733</td>
<td>23%</td>
<td>11%</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29,782</strong></td>
<td><strong>100%</strong></td>
<td><strong>11%</strong></td>
<td><strong>21%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Thousands of people</th>
<th>Share losing coverage</th>
<th>Uninsurance rate under ACA</th>
<th>Uninsurance rate under reconciliation bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18</td>
<td>3,998</td>
<td>13%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>18–24</td>
<td>4,842</td>
<td>16%</td>
<td>14%</td>
<td>31%</td>
</tr>
<tr>
<td>25–34</td>
<td>6,341</td>
<td>21%</td>
<td>18%</td>
<td>32%</td>
</tr>
<tr>
<td>35–44</td>
<td>4,967</td>
<td>17%</td>
<td>14%</td>
<td>26%</td>
</tr>
<tr>
<td>45–54</td>
<td>5,103</td>
<td>17%</td>
<td>11%</td>
<td>23%</td>
</tr>
<tr>
<td>55–64</td>
<td>4,532</td>
<td>15%</td>
<td>8%</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29,782</strong></td>
<td><strong>100%</strong></td>
<td><strong>11%</strong></td>
<td><strong>21%</strong></td>
</tr>
</tbody>
</table>
Thousands of people | Share losing coverage | Uninsurance rate under ACA | Uninsurance rate under reconciliation bill
---|---|---|---
No worker | 5,400 | 18% | 16% | 29%
Part-time only | 4,690 | 16% | 16% | 33%
At least one full-time worker | 19,692 | 66% | 9% | 18%
Total | 29,782 | 100% | 11% | 21%
Race and ethnicity
White, non-Hispanic | 16,623 | 56% | 7% | 18%
Black, non-Hispanic | 3,497 | 12% | 11% | 20%
Hispanic | 6,501 | 22% | 21% | 32%
Asian | 2,033 | 7% | 9% | 22%
American Indian/Alaska Native | 654 | 2% | 14% | 26%
Other, non-Hispanic | 475 | 2% | 7% | 16%
Total | 29,782 | 100% | 11% | 21%
Educational attainment
Less than high school | 3,493 | 14% | 31% | 47%
High school | 10,222 | 40% | 16% | 30%
Some college | 6,906 | 27% | 11% | 24%
College | 3,665 | 14% | 7% | 17%
Graduate school | 1,497 | 6% | 4% | 12%
Total | 25,785 | 100% | 13% | 26%

Notes: ACA = Affordable Care Act; FPL = federal poverty level. Columns may not sum to totals because of rounding.

**Government Spending on Health Care and Uncompensated Care**

Under reconciliation, the federal government would spend $67 billion less on Medicaid/CHIP for the nonelderly and $42 billion less on Marketplace financial assistance (premium tax credits and cost-sharing reductions) in 2019. This reduces spending on these programs by $109 billion that year (table 5 and figure 2) and by $1.3 trillion from 2019 to 2028 (table 5). State governments would reduce their spending on Medicaid/CHIP by $4 billion in 2019 (table 5 and figure 3) and by $76 billion from 2019 to 2028 (table 5). Total government spending on these programs would therefore be $1.4 trillion below the levels estimated under the ACA.

Table 6 shows state-specific estimates for 2019 to 2028 changes in federal spending on Medicaid/CHIP and Marketplace financial assistance. States that expanded Medicaid and enrolled larger numbers of residents in the Marketplaces would lose the most federal funding under the reconciliation bill. For example, California would lose $160 billion in federal funding over the 10 years, and New York would lose $57 billion. Although they had not expanded Medicaid eligibility, Florida and Texas would lose $87 and $62 billion in federal funding for health care, respectively, because of their large populations and high rates of Marketplace enrollment. (State-by-state 2019 federal spending estimates and 2019–28 state Medicaid/CHIP spending estimates are provided in appendix tables.)
TABLE 5
Billions of dollars

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2019–28</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACA Reconciliation bill</td>
<td>ACA Reconciliation bill</td>
<td>Difference</td>
</tr>
<tr>
<td>Medicaid/CHIP spending</td>
<td>$525</td>
<td>$6,643</td>
<td>$-72</td>
</tr>
<tr>
<td>Federal</td>
<td>$330</td>
<td>$4,153</td>
<td>$-67</td>
</tr>
<tr>
<td>State</td>
<td>$195</td>
<td>$2,489</td>
<td>$-4</td>
</tr>
<tr>
<td>Federal Marketplace</td>
<td>$42</td>
<td>$465</td>
<td>$-42</td>
</tr>
<tr>
<td>financial assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total federal spending</td>
<td>$372</td>
<td>$4,618</td>
<td>$-109</td>
</tr>
<tr>
<td>Total state spending</td>
<td>$195</td>
<td>$2,413</td>
<td>$-4</td>
</tr>
<tr>
<td>Total federal and state</td>
<td>$567</td>
<td>$7,107</td>
<td>$-114</td>
</tr>
<tr>
<td>spending</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

FIGURE 2
Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019
Billions of dollars

FIGURE 3
Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019–28
Billions of dollars

Note: ACA = Affordable Care Act.
TABLE 6
Federal Spending on Medicaid/CHIP and Marketplace Financial Assistance under the ACA and under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

_Billions of dollars_

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid/CHIP</th>
<th>Medicaid/CHIP</th>
<th>Medicaid/CHIP</th>
<th>Medicaid/CHIP</th>
<th>Premium tax credits and cost-sharing reductions</th>
<th>Premium tax credits and cost-sharing reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACA</td>
<td>Reconciliation Bill</td>
<td>Difference</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expansion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>states</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>$12</td>
<td>$2</td>
<td>$13</td>
<td>$10</td>
<td>-1</td>
<td>-2</td>
</tr>
<tr>
<td>Arizona</td>
<td>$142</td>
<td>$10</td>
<td>$152</td>
<td>$110</td>
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<td>-10</td>
</tr>
<tr>
<td>Arkansas</td>
<td>$42</td>
<td>$2</td>
<td>$44</td>
<td>$34</td>
<td>-8</td>
<td>-2</td>
</tr>
<tr>
<td>California</td>
<td>$364</td>
<td>$61</td>
<td>$425</td>
<td>$265</td>
<td>-99</td>
<td>-61</td>
</tr>
<tr>
<td>Colorado</td>
<td>$74</td>
<td>$2</td>
<td>$77</td>
<td>$44</td>
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<td>-2</td>
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<tr>
<td>Connecticut</td>
<td>$52</td>
<td>$4</td>
<td>$56</td>
<td>$41</td>
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<td>-4</td>
</tr>
<tr>
<td>Delaware</td>
<td>$15</td>
<td>&lt;$1</td>
<td>$16</td>
<td>$12</td>
<td>-3</td>
<td>&lt;$1</td>
</tr>
<tr>
<td>District of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Columbia</td>
<td>$18</td>
<td>&lt;$1</td>
<td>$18</td>
<td>$17</td>
<td>-2</td>
<td>&lt;$1</td>
</tr>
<tr>
<td>Hawaii</td>
<td>$15</td>
<td>&lt;$1</td>
<td>$16</td>
<td>$12</td>
<td>-4</td>
<td>&lt;$1</td>
</tr>
<tr>
<td>Illinois</td>
<td>$158</td>
<td>$12</td>
<td>$170</td>
<td>$120</td>
<td>-37</td>
<td>-12</td>
</tr>
<tr>
<td>Indiana</td>
<td>$81</td>
<td>$5</td>
<td>$86</td>
<td>$67</td>
<td>-14</td>
<td>-5</td>
</tr>
<tr>
<td>Iowa</td>
<td>$34</td>
<td>$2</td>
<td>$36</td>
<td>$29</td>
<td>-5</td>
<td>-2</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$106</td>
<td>$3</td>
<td>$108</td>
<td>$59</td>
<td>-47</td>
<td>-3</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$74</td>
<td>$4</td>
<td>$78</td>
<td>$52</td>
<td>-23</td>
<td>-4</td>
</tr>
<tr>
<td>Maryland</td>
<td>$80</td>
<td>$4</td>
<td>$84</td>
<td>$57</td>
<td>-23</td>
<td>-4</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$95</td>
<td>$5</td>
<td>$100</td>
<td>$78</td>
<td>-17</td>
<td>-5</td>
</tr>
<tr>
<td>Michigan</td>
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<td>$8</td>
<td>$157</td>
<td>$119</td>
<td>-30</td>
<td>-8</td>
</tr>
<tr>
<td>Minnesota</td>
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<td>$2</td>
<td>$84</td>
<td>$68</td>
<td>-15</td>
<td>-2</td>
</tr>
<tr>
<td>Montana</td>
<td>$23</td>
<td>$1</td>
<td>$24</td>
<td>$14</td>
<td>-9</td>
<td>-1</td>
</tr>
<tr>
<td>Nevada</td>
<td>$35</td>
<td>$4</td>
<td>$39</td>
<td>$22</td>
<td>-13</td>
<td>-4</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$14</td>
<td>$1</td>
<td>$15</td>
<td>$10</td>
<td>-4</td>
<td>-1</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$135</td>
<td>$7</td>
<td>$142</td>
<td>$82</td>
<td>-53</td>
<td>-7</td>
</tr>
<tr>
<td>New Mexico</td>
<td>$72</td>
<td>$1</td>
<td>$74</td>
<td>$46</td>
<td>-27</td>
<td>-1</td>
</tr>
<tr>
<td>New York</td>
<td>$348</td>
<td>$10</td>
<td>$358</td>
<td>$301</td>
<td>-47</td>
<td>-10</td>
</tr>
<tr>
<td>North Dakota</td>
<td>$7</td>
<td>&lt;$1</td>
<td>$8</td>
<td>$5</td>
<td>-2</td>
<td>&lt;$1</td>
</tr>
<tr>
<td>Ohio</td>
<td>$177</td>
<td>$6</td>
<td>$183</td>
<td>$135</td>
<td>-42</td>
<td>-6</td>
</tr>
<tr>
<td>Oregon</td>
<td>$83</td>
<td>$3</td>
<td>$86</td>
<td>$47</td>
<td>-35</td>
<td>-3</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$154</td>
<td>$13</td>
<td>$167</td>
<td>$131</td>
<td>-23</td>
<td>-13</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>$21</td>
<td>&lt;$1</td>
<td>$22</td>
<td>$14</td>
<td>-7</td>
<td>&lt;$1</td>
</tr>
<tr>
<td>Vermont</td>
<td>$11</td>
<td>&lt;$1</td>
<td>$12</td>
<td>$9</td>
<td>-2</td>
<td>-$1</td>
</tr>
<tr>
<td>Washington</td>
<td>$90</td>
<td>$5</td>
<td>$95</td>
<td>$52</td>
<td>-38</td>
<td>-$5</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$35</td>
<td>$2</td>
<td>$37</td>
<td>$23</td>
<td>-12</td>
<td>-$2</td>
</tr>
<tr>
<td>Expansion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>states total</td>
<td>$2,799</td>
<td>$184</td>
<td>$2,983</td>
<td>$2,085</td>
<td>-$715</td>
<td>-$184</td>
</tr>
</tbody>
</table>

**IMPLICATIONS OF PARTIAL REPEAL OF THE ACA THROUGH RECONCILIATION**
As the number of uninsured increases under the reconciliation bill, the amount of uncompensated care sought would increase as well. But the source of financing this increased demand is very unclear. The uninsured use less medical care than they would if they had health insurance coverage, but they do use some care. This care is financed in different ways: some care is paid for directly by the uninsured, some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital [DSH] programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid DSH, funding for public hospitals), and some is financed by providers (e.g., hospitals, physicians, pharmaceutical companies) delivering free or reduced-price care. We assume that newly uninsured people will contribute to the costs of their own care consistent with the patterns of spending by uninsured people with similar characteristics and health needs under current law.
No source of uncompensated care funding increases automatically with an increase in the number of uninsured, so it is unclear whether funding would increase to meet the demand. We estimate that under current law, the federal government would spend $23 billion on uncompensated care in 2019 and $262 billion from 2019 to 2028 (table 7). State and local governments would spend $14 billion on uncompensated care in 2019 and $164 billion over 10 years. Providers would contribute $20 billion in services for the uninsured in 2019 and $230 billion over 10 years. These amounts are consistent with total demand for uncompensated care of $57 billion in 2019, $656 billion over 10 years.

With the uninsured increasing by almost 30 million by 2019, uninsured people would seek an additional $88 billion in uncompensated care in 2019 and an additional $1.1 trillion from 2019 to 2028. However, the federal DSH programs would not increase beyond current levels without explicit federal action, and that action was not part of the January 2016 reconciliation bill. Therefore, we assume federal uncompensated care funding would remain fixed. State and local governments could increase revenue to address the uncompensated care funding shortfall, providers could increase their provision of free services to the uninsured, unmet medical need could increase because the shortfall is not financed, or some combination of these possibilities could occur.

We provide two scenarios in table 7: the first assumes the uncompensated care shortfall is addressed by providers increasing their delivery of free and reduced price care, and the second assumes the shortfall is financed by state and local governments. While neither state and local governments nor providers are likely to be able to finance the extra care sought on their own, these scenarios show the large financing challenge facing the health care system under the reconciliation bill. If state and local governments were to assume all costs related to the increase in uncompensated care sought, their support for uncompensated care would have to increase more than sixfold. If providers were to assume all the increase in demand, their support for uncompensated care would have to more than quadruple. While some combination of increases from state and local governments and providers may occur, the large increase in services sought by the uninsured is unlikely to be met, and the increased burden on the uninsured will produce even greater financial burdens and more unmet need for health care services.
TABLE 7
Alternative Scenarios for Financing Uncompensated Care, 2019 and 2019–28

*Billions of dollars*

<table>
<thead>
<tr>
<th></th>
<th>2019 Reconciliation bill</th>
<th>Difference</th>
<th>2019–28 Reconciliation bill</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total demand for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>uncompensated care</td>
<td>$57</td>
<td>$145</td>
<td>$88</td>
<td>$656</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,723</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,067</td>
</tr>
<tr>
<td>Scenario 1: No increase</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in federal or state/local uncompensated care funds; all increase in demand borne by providers</td>
<td>$23</td>
<td>$23</td>
<td>$0</td>
<td>$262</td>
</tr>
<tr>
<td>Federal government</td>
<td>$14</td>
<td>$14</td>
<td>$0</td>
<td>$164</td>
</tr>
<tr>
<td>State/local government</td>
<td>$20</td>
<td>$108</td>
<td>$88</td>
<td>$1,296</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
<td>$1,067</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 2: No increase</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in federal uncompensated care funds or provider contributions; all increase in demand borne by states and localities</td>
<td>$23</td>
<td>$23</td>
<td>$0</td>
<td>$262</td>
</tr>
<tr>
<td>Federal government</td>
<td>$14</td>
<td>$102</td>
<td>$88</td>
<td>$1,231</td>
</tr>
<tr>
<td>State/local government</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
<td>$230</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
<td>$230</td>
</tr>
</tbody>
</table>


Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

Elimination of the Individual and Employer Mandates in 2017

So far, our analysis has focused on the 2019 effects of the reconciliation approach. In this section, we analyze the implications of eliminating the individual and employer mandates immediately after passage in 2017. We do this because the 2016 reconciliation bill would have immediately stopped collections of these penalties.

ACA-compliant nongroup premiums for 2017 were set in 2016 before the start of the open enrollment period, following months of review by state departments of insurance and, in some cases, the federal government. Before the governmental review process, insurers assess and refine their product offerings for the coming year, and their actuaries and others prepare their proposed premiums based on last year’s experiences, expected changes in the nongroup risk pool for the coming year, and other considerations. Once premiums are approved, they are locked in for the coming plan year.

Eliminating the individual mandate (and, to a much smaller degree, the employer mandate) in the middle of a plan year would change the rules of the insurance market after the year’s premiums have been set. Fewer people would keep their health insurance for the remainder of the year. Once they are informed that there would no longer be a tax penalty for remaining uninsured, some people would drop their coverage after the start of the plan year. As healthier people drop coverage, premium collections across the nongroup market would be lower than the health care costs incurred by those who remain insured. This type of pricing disconnect would affect not only those insurers providing Marketplace coverage but also those selling nongroup coverage outside the Marketplaces, since the entire ACA-compliant nongroup market is treated as a single risk pool.
If the individual and employer mandates are eliminated while the ACA’s Medicaid expansion, Marketplace tax credits and cost-sharing reductions, insurance market reforms, and other components are left in place in 2017, 4.3 million people would drop their ACA-compliant nongroup insurance coverage and become uninsured (table 8). Average health insurance claims for those remaining in the ACA-compliant private nongroup insurance markets would be about 10 percent higher than if the 4.3 million people stayed in the pool as they would under the ACA (data not shown); this would place financial pressure on the markets’ insurers. The continuation of Marketplace financial assistance is critical to averting even higher short-run increases in average claims because the lower-priced coverage provided to many modest-income people is attractive even without a mandate in place.

TABLE 8
Nonelderly Coverage Distribution and Insurers’ Premium Revenue in 2017

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Current law</th>
<th>Elimination of individual and employer mandates early in year</th>
<th>Difference</th>
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</thead>
<tbody>
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<td>Medicaid</td>
<td>67,950</td>
<td>67,950</td>
<td>0</td>
</tr>
<tr>
<td>Medicare</td>
<td>3,953</td>
<td>3,953</td>
<td>0</td>
</tr>
<tr>
<td>Employer-sponsored insurance</td>
<td>149,511</td>
<td>149,511</td>
<td>0</td>
</tr>
<tr>
<td>Other public</td>
<td>4,505</td>
<td>4,505</td>
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</tr>
<tr>
<td>Nongroup</td>
<td>18,418</td>
<td>14,085</td>
<td>-4,334</td>
</tr>
<tr>
<td>Uninsured</td>
<td>28,342</td>
<td>32,676</td>
<td>4,334</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>272,680</strong></td>
<td><strong>272,680</strong></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Premium revenue (billions)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total premium revenue: current law</td>
<td>$46</td>
</tr>
<tr>
<td>Total premium revenue: no mandates, fixed premiums</td>
<td>$37</td>
</tr>
<tr>
<td>Actuarially fair premiums necessary to cover insurer costs if mandates eliminated</td>
<td>$40</td>
</tr>
<tr>
<td>Shortfall in insurer revenue caused by eliminating mandates mid-plan year</td>
<td>$3</td>
</tr>
</tbody>
</table>


Note: Premium revenue includes direct payments by enrollees and premium tax credits financed by the federal government.

Under current law, insurers would collect an estimated $46 billion in premiums (combining those paid directly by enrollees and the premium tax credits provided by the federal government). If the individual mandate is eliminated early in 2017, insurer premium revenue would drop almost $10 billion to $37 billion, yet this revenue would fall more than $3 billion short of covering insurers’ claims and administrative costs. Facing significant financial losses, insurers could request midyear premium adjustments, absorb the financial losses and remain in the markets, or exit the markets entirely. Midyear premium adjustments are likely unfeasible because the standard premium development, review, and approval processes require several months. Some larger insurers could decide to remain in the markets and internalize the losses, but others would surely leave. As a result, even if some insurers remain in some areas, more people would become uninsured in 2017, insurers would suffer financial
losses, and many consumers would be displaced from coverage and provider networks they chose during 2017 open enrollment. Financial burdens for consumers with insurers that leave the market during the year would increase because enrollees would lose credit for deductibles and cost-sharing already paid, even if they are able to enroll with a different insurer. The number of insurers leaving the nongroup market and the effect on consumers would likely be significantly larger in 2018 than in 2017. The 2016 reconciliation bill would have immediately stopped the reinsurance program as well. That would cause further financial losses to insurers than we have estimated here.

The bottom line is that eliminating the individual mandate penalties midyear would lead to a much faster unwinding of private nongroup insurance markets than would occur if the mandate were repealed in 2019. The 2019 estimates presented earlier would still hold, but the effects would begin earlier if the mandates were eliminated prior to the other changes. The effects would begin in 2017 but would likely accelerate in 2018. Any changes to the market rules, mandate, or financial assistance after premiums are set for the plan year would significantly disrupt coverage and care and would cause private financial losses for households and insurers.

Our analysis does not include the additional disruptions to insurers and consumers that would occur if the federal government immediately ceased paying cost-sharing reductions on behalf of low-income Marketplace enrollees. This is the issue under consideration in the *House v. Burwell* case. We have analyzed the potential implications of the case elsewhere (Blumberg and Buettgens 2016) but not in combination with the issues analyzed here. Eliminating the cost-sharing reductions immediately would impose greater losses on Marketplace insurers than estimated here and would force more insurers out of the Marketplaces, resulting in much broader immediate disruptions for consumers.

**Discussion**

We estimate that the effects of passing and implementing the reconciliation bill would be large and swift. Yet actual effects would likely be larger, for the following reasons.

- We assume that no additional states would adopt Medicaid expansions if the ACA remains in effect. If additional states expanded Medicaid, the drop in coverage relative to what would occur under current law would be greater than we estimate here.

- The ACA’s individual mandate penalties increase in 2016 to their maximum level. These higher penalties, which will be felt in early 2017 when taxpayers file their returns, could lead to more people enrolling in coverage the next plan year. We do not include this possible bump in insurance coverage in our ACA estimates. Therefore, we may be underestimating the future coverage gains under the ACA as well as the decline in coverage resulting from partial repeal using a reconciliation approach.

- Many of those remaining uninsured under the ACA are eligible for Medicaid or subsidized private Marketplace coverage. Additional targeted outreach and enrollment assistance could increase health coverage further if the ACA remains in place (Blumberg et al. 2016); by ignoring
this pool of potential coverage expansion, we likely understate the decline in coverage relative to what might occur under current law.

- Repeal would mean that states that had expanded insurance coverage before the ACA using Medicaid waivers would likely need to renegotiate those waivers to keep program eligibility where it was before 2014. However, the new administration may not grant such waivers or may require substantial changes to them that would affect states’ ability to provide coverage to the same number of people that they had before the ACA.

In addition, this analysis only covers the decrease in federal health care spending and does not provide a complete picture of the effect of the anticipated reconciliation bill on the federal budget. Specifically, we do not estimate the revenue consequences of eliminating the high-cost plan or “Cadillac” tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. Therefore, our estimates cannot be interpreted as federal budget effects, only decreases in spending on health care. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending estimated in this analysis. As a number of states have reported, the Medicaid expansion has led to additional state budgetary spending, and its repeal could have significant negative economic consequences for states.7

It is also possible that particular states would raise revenues to offset some of the coverage losses created by such a federal approach. But the state revenue required makes this response unlikely, and any state action of this sort would likely be concentrated in the highest-income states. Massachusetts was the only state that had significantly expanded coverage through its own reforms prior to the ACA, and even that state relied heavily on federal Medicaid dollars via a waiver to finance the financial assistance that was provided. Given those caveats, our central findings are that the anticipated reconciliation bill would have the following effects:

- The number of uninsured people would increase by 29.8 million by 2019.
- The number of people with Medicaid or CHIP coverage would decrease by 12.9 million, and 17.7 million fewer people would have private nongroup insurance by 2019.
- About 56 percent of those losing coverage would be non-Hispanic whites, 82 percent would be in working families, and 80 percent of adults would have less than a college degree.
- Federal spending on health care would be $109 billion lower in 2019 and $1.3 trillion lower between 2019 and 2028.
- State and local spending on Medicaid and CHIP would be $4 billion lower in 2019 and $76 billion lower between 2019 and 2028. However, uncompensated care pressures on state and local governments and on health care providers would increase significantly with the growing number of uninsured. The newly uninsured would seek an additional $1.1 trillion in uncompensated care between 2019 and 2028. Increases in uncompensated care funding would not occur automatically, and if governments or providers do not increase the funding of care for
the uninsured substantially from current levels, unmet medical need would increase even further and fiscal pressures on providers would intensify significantly.

- Eliminating the individual mandate in 2017 would lead to a significant erosion of the private nongroup insurance markets inside and outside the Marketplaces that year, with lower coverage (an additional 4.3 million uninsured), some midyear insurer exits, substantial financial losses for insurers ($3 billion), and displacement and financial losses for consumers having to change plans.

These changes in coverage and spending add up to substantial decreases in health care spending on nonelderly adults and children, with a disproportionate share of that decrease falling on middle- and low-income people, although we have not included these estimated effects here. The decrease in spending would reduce hospital admissions, visits to doctors and other health care providers, prescriptions filled, and other forms of health care, despite possible increases in public spending on uncompensated care. This scenario does not just move the country back to the situation before the ACA. Because it would lead to a near-collapse of the nongroup insurance market, it moves the country to a situation with higher uninsurance rates than before the ACA’s reforms. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

**Methods**

Our estimates are based on the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM). The model has been used in a broad array of analyses of the ACA at the federal and state levels. The Supreme Court majority cited HIPSM analysis in the *King v. Burwell* case. The model has accurately forecast the stability of employer-based health insurance under the ACA. The model’s estimates of the effect of the ACA on overall coverage and federal government costs compare favorably in accuracy to that of other microsimulation models, including that of the Congressional Budget Office (Glied, Arora, and Solis-Roman 2015).

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey. Its large sample size enables state-level analysis. We use the latest available enrollment data from the Marketplaces and Medicaid to impute new coverage. As a result, our estimates of enrollees in each state match actual enrollment. After calibrating HIPSM to reproduce 2016 Medicaid and Marketplace enrollment, we estimate that 10.3 percent of the nonelderly are uninsured in that year. This estimate almost exactly matches the National Health Interview Survey’s January–June 2016 estimate of 10.4 percent of the nonelderly uninsured at the time of interview (Zammitti, Cohen, and Martinez 2016, 13). HIPSM coverage estimates represent an annual average number of people in each coverage status.

Our estimates of coverage under the ACA after 2016 do not assume notably higher take-up of Medicaid or Marketplace coverage than in 2016. We recognize that participation rates could increase over time. Nonetheless, we ignore this possibility because we choose to base our estimate of ACA effects on what has already happened. We also adopt conservative assumptions for the cost of health care. Although some studies have found that the ACA contributed to the slowing growth of health care costs in recent years, there is no generally accepted estimate of how large that contribution was.
The methods used here are generally consistent with those described in our earlier analysis of full repeal of the ACA (Buettgens et al. 2016). Additional detail on our methods can be found in that document. We have made three changes in our methods. First, this analysis leaves the ACA components with no budgetary implications (i.e., the insurance market reforms in the nongroup insurance market and the small group insurance market) in place. As explained in the results section of this paper, this difference has substantial ramifications for the viability of the private nongroup insurance market and leads to larger coverage effects than our earlier simulations. Second, this analysis focuses on 2019 and the 10-year budget window of 2019 to 2028 instead of 2017 to 2026.

Third, we take a somewhat different approach to allocating the costs associated with increased demand for uncompensated care. We compute the demand for uncompensated care in the same way as prior analyses, but we present the implications for federal, state, and local governments and providers differently than in the last report. We calculate the demand for uncompensated care for each uninsured person based upon their characteristics and health risk. We calibrate uncompensated care costs so that the uncompensated care provided to the uninsured in 2013 matches the estimated amount spent on uncompensated care that year. We inflate the value of uncompensated care over time for each person by the projected per capita growth in medical costs. We also assume that newly uninsured people will spend money on their own care and that their levels of spending will be consistent with those of people of similar health circumstances and characteristics observed under current law. However, in the current analysis we recognize that policy changes would be required in order for federal or state/local spending on uncompensated care to increase significantly beyond current levels. In the prior analysis, we assumed all sources of uncompensated care funding would increase proportionately with the increase in demand for such care. Given that Congress did not include an increase over current levels in federal spending on uncompensated care programs in the 2016 reconciliation bill, we assume a 2017 reconciliation bill would keep federal spending at current levels as well. Therefore, we show the estimated increase in uncompensated care sought due to the increase in the uninsured and compute the relative increase in spending that it would require from states and localities or the relative increase in free care provided by doctors, hospitals, and other providers if they were to finance an increase of that magnitude.

This analysis does not include estimates of the revenue reductions of eliminating the Cadillac tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. We provide decreases in federal spending on health programs, but we do not provide overall federal budget effects. The latter would be considerably smaller than the former. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending shown here. As a number of states have reported, the Medicaid expansion has led to additional state budgetary savings, and its repeal could have significant negative economic consequences for states; those consequences are not included in this analysis.
## APPENDIX TABLE A.1

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

### Millions of dollars

<table>
<thead>
<tr>
<th>State</th>
<th>ACA</th>
<th>Reconciliation Bill</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Federal</td>
<td>State</td>
<td>Total</td>
</tr>
<tr>
<td>National</td>
<td>330,191</td>
<td>194,951</td>
<td>525,142</td>
</tr>
<tr>
<td><strong>Expansion states</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>903</td>
<td>756</td>
<td>1,659</td>
</tr>
<tr>
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<td>11,138</td>
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<td>15,732</td>
</tr>
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<td>3,328</td>
<td>1,215</td>
<td>4,544</td>
</tr>
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<td>California</td>
<td>29,016</td>
<td>23,213</td>
<td>52,229</td>
</tr>
<tr>
<td>Colorado</td>
<td>5,920</td>
<td>3,402</td>
<td>9,322</td>
</tr>
<tr>
<td>Connecticut</td>
<td>4,156</td>
<td>3,123</td>
<td>7,279</td>
</tr>
<tr>
<td>Delaware</td>
<td>1,192</td>
<td>687</td>
<td>1,879</td>
</tr>
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<td>District of Columbia</td>
<td>1,455</td>
<td>521</td>
<td>1,977</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1,220</td>
<td>818</td>
<td>2,038</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,618</td>
<td>8,954</td>
<td>21,572</td>
</tr>
<tr>
<td>Indiana</td>
<td>6,450</td>
<td>2,433</td>
<td>8,883</td>
</tr>
<tr>
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<td>2,726</td>
<td>1,513</td>
<td>4,239</td>
</tr>
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<td>8,512</td>
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<td>10,769</td>
</tr>
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<td>5,986</td>
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<td>8,805</td>
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<td>Maryland</td>
<td>6,379</td>
<td>4,466</td>
<td>10,846</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>7,593</td>
<td>6,166</td>
<td>13,759</td>
</tr>
<tr>
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<td>12,023</td>
<td>4,525</td>
<td>16,548</td>
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<tr>
<td>Minnesota</td>
<td>6,485</td>
<td>4,907</td>
<td>11,392</td>
</tr>
<tr>
<td>Montana</td>
<td>1,797</td>
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<td>2,418</td>
</tr>
<tr>
<td>Nevada</td>
<td>2,758</td>
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<td>New Hampshire</td>
<td>1,144</td>
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<td>1,924</td>
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<tr>
<td>New Jersey</td>
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<td>16,822</td>
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<td>New Mexico</td>
<td>5,808</td>
<td>1,735</td>
<td>7,544</td>
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<tr>
<td>North Dakota</td>
<td>559</td>
<td>336</td>
<td>895</td>
</tr>
<tr>
<td>Ohio</td>
<td>14,233</td>
<td>6,156</td>
<td>20,389</td>
</tr>
<tr>
<td>Oregon</td>
<td>6,624</td>
<td>2,115</td>
<td>8,739</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>12,257</td>
<td>7,912</td>
<td>20,169</td>
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### Table: Impact of Partial Repeal of the ACA Through Reconciliation

<table>
<thead>
<tr>
<th>State</th>
<th>ACA 1st Year Federal</th>
<th>ACA 1st Year State</th>
<th>ACA 1st Year Total</th>
<th>ACA 2nd Year Federal</th>
<th>ACA 2nd Year State</th>
<th>ACA 2nd Year Total</th>
<th>Reconciliation Bill Federal</th>
<th>Reconciliation Bill State</th>
<th>Reconciliation Bill Total</th>
<th>Difference Federal</th>
<th>Difference State</th>
<th>Difference Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island</td>
<td>1,691</td>
<td>1,228</td>
<td>2,920</td>
<td>1,136</td>
<td>1,131</td>
<td>2,267</td>
<td>-556</td>
<td>-98</td>
<td>-653</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>917</td>
<td>554</td>
<td>1,471</td>
<td>746</td>
<td>608</td>
<td>1,354</td>
<td>-171</td>
<td>54</td>
<td>-117</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>7,221</td>
<td>4,131</td>
<td>11,352</td>
<td>4,121</td>
<td>4,043</td>
<td>8,164</td>
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<td>-88</td>
<td>-3,188</td>
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<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>2,860</td>
<td>782</td>
<td>3,642</td>
<td>1,849</td>
<td>726</td>
<td>2,575</td>
<td>-1,011</td>
<td>-56</td>
<td>-1,067</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expansion states total</strong></td>
<td><strong>223,722</strong></td>
<td><strong>130,811</strong></td>
<td><strong>354,533</strong></td>
<td><strong>165,085</strong></td>
<td><strong>131,492</strong></td>
<td><strong>296,576</strong></td>
<td><strong>-58,638</strong></td>
<td><strong>681</strong></td>
<td><strong>-57,956</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nonexpansion states

| Alabama        | 3,710                 | 1,642              | 5,353              | 3,439                 | 1,525               | 4,964              | -271                     | -117                     | -388                      |
| Florida        | 14,230                | 9,728              | 23,958             | 12,719                | 8,732               | 21,452             | -1,511                   | -996                     | -2,507                     |
| Georgia        | 7,834                 | 3,929              | 11,763             | 6,881                 | 3,454               | 10,334             | -953                     | -475                     | -1,428                     |
| Idaho          | 2,006                 | 777                | 2,784              | 1,798                 | 698                 | 2,496              | -208                     | -79                      | -288                      |
| Kansas         | 1,877                 | 1,363              | 3,240              | 1,734                 | 1,258               | 2,992              | -143                     | -105                     | -248                      |
| Maine          | 1,376                 | 839                | 2,215              | 1,335                 | 820                 | 2,155              | -41                      | -19                      | -60                       |
| Mississippi    | 3,498                 | 1,263              | 4,761              | 3,185                 | 1,150               | 4,335              | -313                     | -112                     | -426                      |
| Missouri       | 6,389                 | 3,784              | 10,173             | 5,946                 | 3,534               | 9,480              | -444                     | -250                     | -694                      |
| Nebraska       | 1,162                 | 960                | 2,122              | 1,149                 | 950                 | 2,100              | -12                      | -10                      | -22                       |
| North Carolina | 11,436                | 5,817              | 17,254             | 9,803                 | 5,009               | 14,811             | -1,634                   | -808                     | -2,442                     |
| Oklahoma       | 3,810                 | 2,141              | 5,951              | 3,675                 | 2,065               | 5,740              | -135                     | -76                      | -211                      |
| South Carolina | 4,287                 | 1,788              | 6,075              | 4,200                 | 1,751               | 5,951              | -88                      | -37                      | -124                      |
| South Dakota   | 645                   | 555                | 1,200              | 624                   | 537                 | 1,162              | -21                      | -18                      | -39                       |
| Tennessee      | 7,717                 | 3,961              | 11,678             | 6,457                 | 3,346               | 9,803              | -1,260                   | -615                     | -1,875                     |
| Texas          | 25,288                | 17,257             | 42,545             | 23,978                | 16,363             | 40,341             | -1,310                   | -894                     | -2,204                     |
| Utah           | 2,529                 | 1,041              | 3,569              | 2,412                 | 992                 | 3,405              | -116                     | -48                      | -165                      |
| Virginia       | 4,415                 | 4,299              | 8,713              | 4,210                 | 4,100               | 8,311              | -204                     | -198                     | -403                      |
| Wisconsin      | 3,899                 | 2,643              | 6,542              | 3,742                 | 2,533               | 6,276              | -157                     | -109                     | -266                      |
| Wyoming        | 360                   | 353                | 713                | 350                   | 343                 | 692                | -10                      | -10                      | -21                       |

| **Nonexpansion states total** | **106,469** | **64,141** | **170,609** | **97,636** | **59,162** | **156,798** | **-8,833** | **-4,979** | **-13,812** |

## APPENDIX TABLE A.2

Forgone Federal Spending on Marketplace Financial Assistance under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

### Millions of dollars

<table>
<thead>
<tr>
<th>State</th>
<th>Premium tax credits</th>
<th>Cost-sharing reductions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>35,338</td>
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<td>41,765</td>
</tr>
<tr>
<td>Expansions states</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>150</td>
<td>21</td>
<td>171</td>
</tr>
<tr>
<td>Arizona</td>
<td>827</td>
<td>49</td>
<td>877</td>
</tr>
<tr>
<td>Arkansas</td>
<td>159</td>
<td>35</td>
<td>194</td>
</tr>
<tr>
<td>California</td>
<td>4,783</td>
<td>752</td>
<td>5,534</td>
</tr>
<tr>
<td>Colorado</td>
<td>190</td>
<td>33</td>
<td>223</td>
</tr>
<tr>
<td>Connecticut</td>
<td>348</td>
<td>43</td>
<td>391</td>
</tr>
<tr>
<td>Delaware</td>
<td>71</td>
<td>10</td>
<td>81</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>7</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Hawaii</td>
<td>42</td>
<td>6</td>
<td>47</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,001</td>
<td>122</td>
<td>1,122</td>
</tr>
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<td>Indiana</td>
<td>385</td>
<td>78</td>
<td>463</td>
</tr>
<tr>
<td>Iowa</td>
<td>156</td>
<td>24</td>
<td>180</td>
</tr>
<tr>
<td>Kentucky</td>
<td>213</td>
<td>46</td>
<td>259</td>
</tr>
<tr>
<td>Louisiana</td>
<td>316</td>
<td>50</td>
<td>366</td>
</tr>
<tr>
<td>Maryland</td>
<td>332</td>
<td>53</td>
<td>385</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>415</td>
<td>75</td>
<td>491</td>
</tr>
<tr>
<td>Michigan</td>
<td>633</td>
<td>118</td>
<td>750</td>
</tr>
<tr>
<td>Minnesota</td>
<td>163</td>
<td>2</td>
<td>165</td>
</tr>
<tr>
<td>Montana</td>
<td>97</td>
<td>12</td>
<td>109</td>
</tr>
<tr>
<td>Nevada</td>
<td>262</td>
<td>50</td>
<td>312</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>70</td>
<td>16</td>
<td>85</td>
</tr>
<tr>
<td>New Jersey</td>
<td>513</td>
<td>94</td>
<td>607</td>
</tr>
<tr>
<td>New Mexico</td>
<td>77</td>
<td>16</td>
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</tr>
<tr>
<td>New York</td>
<td>771</td>
<td>120</td>
<td>891</td>
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### Nonexpansion states

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*Source: Urban Institute analysis using HIPSM 2016.*
APPENDIX TABLE A.3
Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

_Millions of dollars_

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Note: ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program.
### APPENDIX TABLE A.4


*Millions of dollars*

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<td>4,338</td>
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<td>Utah</td>
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<td>Virginia</td>
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<td>Wisconsin</td>
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<tr>
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<tr>
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<tr>
<td>Vermont</td>
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<td>Washington</td>
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<tr>
<td>West Virginia</td>
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<td><strong>Expansion states total</strong></td>
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<tr>
<td><strong>National total</strong></td>
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<td><strong>National total</strong></td>
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*Note: ACA = Affordable Care Act.*
## APPENDIX TABLE A.5

Total Federal and State Spending on Medicaid/CHIP and Marketplace Assistance under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

_Millions of dollars_

<table>
<thead>
<tr>
<th>State</th>
<th>ACA Federal</th>
<th>ACA State</th>
<th>ACA Reconciliation Bill Federal</th>
<th>ACA Reconciliation Bill State</th>
<th>ACA Difference</th>
<th>ACA State Difference</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>$264,676</td>
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<td>Colorado</td>
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<td>$40,547</td>
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<td>$904</td>
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<td>Delaware</td>
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<td>$866</td>
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<td>$6,671</td>
<td>$16,564</td>
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<td>$120,198</td>
<td>$113,893</td>
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<td>$1,260</td>
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<td>$36,376</td>
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<td>$829</td>
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<tr>
<td>Kentucky</td>
<td>$108,432</td>
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<td>$25,098</td>
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<td>-$4,585</td>
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<td>$84,408</td>
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<td>$56,627</td>
<td>-$27,781</td>
<td>-$660</td>
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<td>Massachusetts</td>
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<td>$67,686</td>
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<tr>
<td>Montana</td>
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<tr>
<td>Nevada</td>
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<td>-$1,256</td>
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<td>-$57,202</td>
<td>$24,520</td>
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<td>North Dakota</td>
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<td>$4,980</td>
<td>$4,928</td>
<td>-$2,655</td>
<td>$571</td>
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<td>Ohio</td>
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<tr>
<td>Oregon</td>
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<td>$27,876</td>
<td>$47,423</td>
<td>$26,745</td>
<td>-$38,403</td>
<td>-$1,131</td>
</tr>
</tbody>
</table>
Rhode Island | $21,698 | $15,610 | $14,316 | $14,254 | -$7,382 | -$1,357  
Vermont | $12,269 | $9,566 | $9,346 | $7,612 | -$2,924 | $656  
Washington | $95,038 | $53,511 | $52,283 | $51,284 | -$42,755 | -$2,227  
West Virginia | $37,068 | $10,101 | $23,027 | $9,047 | -$14,042 | -$1,054  
**Expansion states total** | **$2,983,457** | **$1,673,497** | **$2,084,808** | **$1,660,058** | **-$898,649** | **-$13,439**  
Nonexpansion states |  
Alabama | $58,695 | $20,673 | $43,341 | $19,203 | -$15,353 | -$1,470  
Florida | $248,890 | $123,567 | $161,626 | $110,954 | -$87,265 | -$12,613  
Georgia | $121,154 | $50,498 | $88,488 | $44,414 | -$32,666 | -$6,084  
Idaho | $29,380 | $9,944 | $23,025 | $8,936 | -$6,355 | -$1,008  
Kansas | $28,087 | $17,247 | $21,975 | $15,922 | -$6,113 | -$1,325  
Maine | $21,276 | $10,412 | $16,566 | $10,179 | -$4,710 | -$233  
Mississippi | $49,048 | $15,814 | $39,928 | $14,420 | -$9,120 | -$1,393  
Missouri | $93,391 | $47,643 | $74,971 | $44,535 | -$18,420 | -$3,108  
Nebraska | $19,131 | $12,181 | $14,581 | $12,056 | -$4,550 | -$126  
North Carolina | $183,881 | $74,079 | $124,923 | $124,923 | -$58,958 | -$10,255  
Oklahoma | $56,006 | $27,159 | $46,666 | $26,227 | -$9,341 | -$932  
South Carolina | $64,691 | $22,566 | $53,036 | $22,118 | -$11,655 | -$448  
South Dakota | $9,414 | $7,103 | $7,979 | $6,871 | -$1,435 | -$232  
Tennessee | $108,339 | $50,078 | $81,654 | $42,303 | -$26,685 | -$7,775  
Texas | $369,083 | $220,741 | $306,920 | $209,439 | -$62,162 | -$11,303  
Utah | $35,975 | $13,459 | $31,221 | $12,842 | -$4,754 | -$617  
Virginia | $71,664 | $54,756 | $53,659 | $52,232 | -$18,004 | -$2,524  
Wisconsin | $60,704 | $33,442 | $47,447 | $32,108 | -$12,627 | -$1,334  
Wyoming | $6,236 | $4,467 | $4,432 | $4,343 | -$1,804 | -$124  
**Nonexpansion states total** | **$1,634,415** | **$815,830** | **$1,242,436** | **$752,926** | **-$391,979** | **-$62,904**  
**National total** | **$4,617,872** | **$2,489,327** | **$3,327,244** | **$2,412,984** | **-$1,290,628** | **-$76,218**  

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.
Notes


4. A number of other provisions of the 2016 reconciliation bill that would have affected coverage would have taken effect immediately or before two years. These include the early repeal of the maintenance-of-effort requirement for eligibility of children under Medicaid/CHIP and the elimination of the tax credit reconciliation caps. These provisions are not included in the estimates presented here.

5. We assume that federal DSH payments increase very modestly over the 10-year period. The Medicare DSH cuts in the ACA were left in place in the prior reconciliation bill, as were all Medicare savings provisions. We assume that would still be the case. The ACA’s Medicaid DSH cuts have never been implemented, and we assume that they are restored permanently and held constant and that there would be no congressional interest in increasing them. Medicaid supplemental payments contribute in part to funding uncompensated care, and states could increase their use of them, but there would be fewer Medicaid patients to attach them to. Other sources of federal funding for uncompensated care could increase, but these would be modest given the new administration’s commitment to budget cuts.

6. The Congressional Budget Office (2016) estimates Marketplace premium tax credits in the amount of $60 billion and cost-sharing reductions in the amount of $12 billion in 2019. Those larger federal spending estimates are the result of an estimate of subsidized Marketplace enrollment of 16 million people in 2019. This level of subsidized enrollment is significantly higher than that produced by HIPSM and would represent a very large increase in enrollment relative to administrative data. According to the Department of Health and Human Services, subsidized Marketplace enrollment was 9.4 million people in March 2016 (US Department of Health and Human Services, Centers for Medicare and Medicaid Services, “March 31, 2016 Effectuated Enrollment Snapshot,” media release, June 30, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html), and Marketplace enrollment has fallen somewhat over the course of each calendar year from March levels. Our 2019 subsidized Marketplace enrollment of 9.3 million represents an average for calendar year 2019; thus, while conservative, it represents a modest increase in coverage between 2016 and 2019.


References


About the Authors

Linda Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the King v. Burwell Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

Matthew Buettgens is a senior research associate in the Health Policy Center, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state by state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments, small firm self-insurance under the Affordable Care Act and its effect on the fully insured market, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage.

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.
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