



Implications of Partial Repeal of the ACA through Reconciliation

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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 There is currently no consensus around alternative health policies to enact as the ACA is repealed; consequently, partial repeal via reconciliation without replacement is possible and merits analysis.

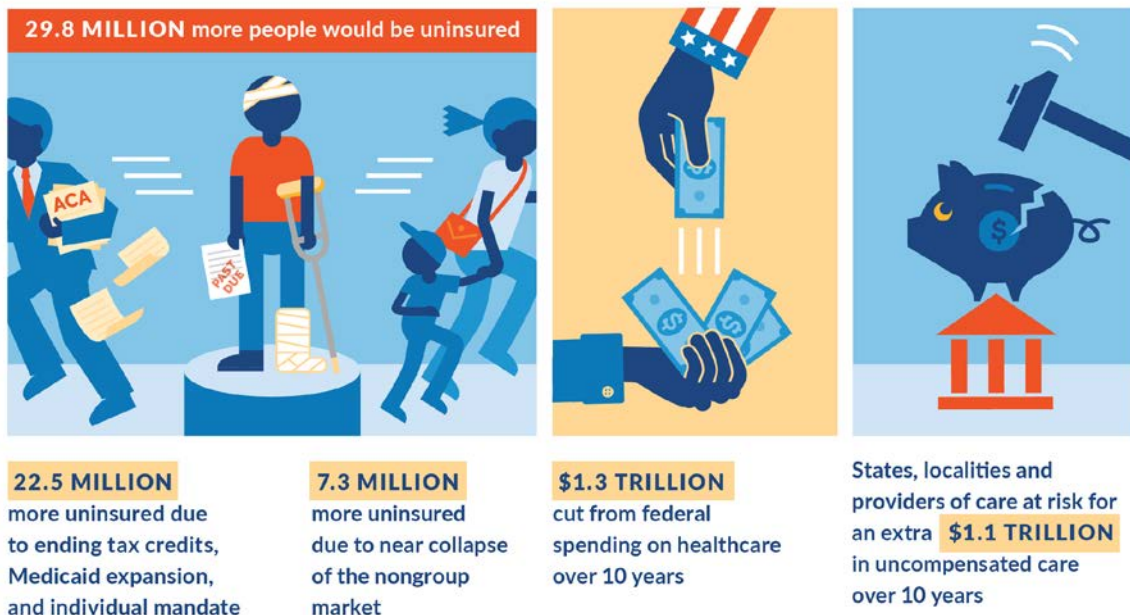
In this brief, we compare future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The key effects of passage of the anticipated reconciliation bill are as follows:

- 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.

Using the Budget Reconciliation Process to Repeal the Affordable Care Act



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.¹ Congress is now poised to pass a similar bill in early 2017.² 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.³ 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.⁴ 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

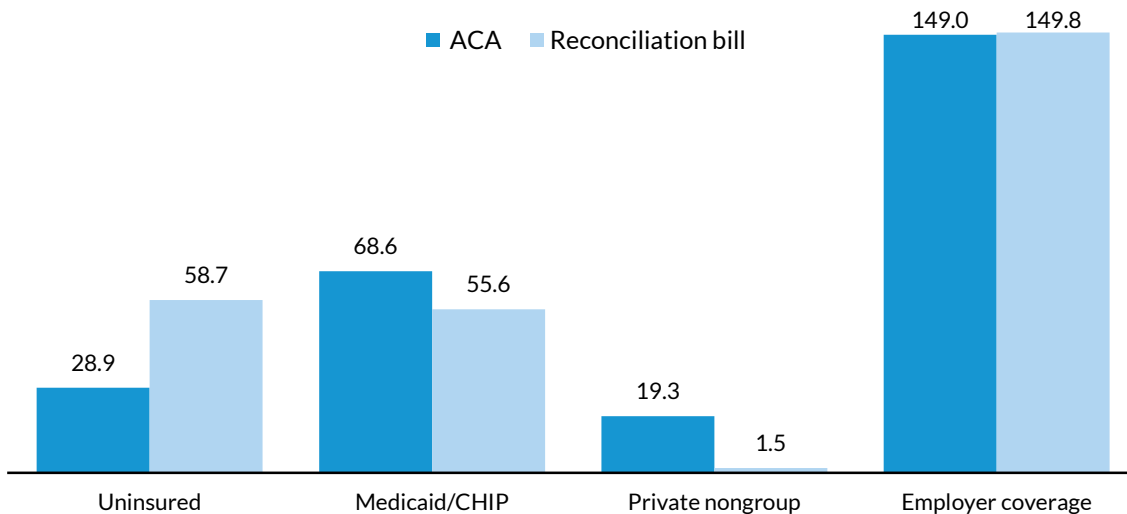
	ACA (current law)		Reconciliation Bill		Difference (thousands)
	People (thousands)	Share of US total (%)	People (thousands)	Share of US total (%)	
<i>Insured</i>	245,380	89	215,598	79	-29,782
Employer	148,974	54	149,832	55	858
Nongroup (eligible for tax credit)	9,322	3	0	0	-9,322
Nongroup (other)	9,955	4	1,560	1	-8,395
Medicaid/CHIP	68,556	25	55,632	20	-12,924
Other (including Medicare)	8,574	3	8,574	3	0
<i>Uninsured</i>	28,936	11	58,718	21	29,782
Total	274,316	100	274,316	100	0

Source: Urban Institute analysis using HIPSM 2016.

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



Source: Urban Institute analysis using HIPSM 2016.

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

Uninsured under the ACA and an Anticipated Reconciliation Bill and Their Eligibility for Financial Assistance, by State and Medicaid Expansion Status, 2019

State	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
National total	28,936	42%	58,718	15%	29,782	103%
<i>Expansion states</i>						
Alaska	117	78%	178	12%	62	53%
Arizona	750	53%	1,459	18%	709	95%
Arkansas	211	58%	572	12%	361	171%
California	3,349	33%	8,236	14%	4,887	146%
Colorado	438	54%	1,026	13%	588	134%
Connecticut	200	47%	448	25%	248	124%
Delaware	60	58%	113	32%	52	86%
District of Columbia	31	56%	63	33%	32	103%
Hawaii	88	70%	174	12%	86	99%
Illinois	896	48%	2,046	14%	1,150	128%
Indiana	552	70%	1,119	16%	566	103%
Iowa	153	63%	383	14%	230	150%
Kentucky	244	66%	730	16%	486	200%
Louisiana	363	62%	921	12%	558	154%
Maryland	385	37%	861	10%	476	123%
Massachusetts	135	43%	504	8%	369	273%
Michigan	508	70%	1,394	13%	887	175%
Minnesota	309	67%	690	31%	380	123%
Montana	85	79%	227	15%	142	168%
Nevada	391	51%	762	18%	371	95%

State	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
New Hampshire	62	63%	180	9%	118	190%
New Jersey	644	37%	1,443	14%	799	124%
New Mexico	196	50%	462	15%	266	136%
New York	1,524	55%	2,662	31%	1,139	75%
North Dakota	45	69%	114	10%	69	154%
Ohio	621	71%	1,585	14%	964	155%
Oregon	256	50%	731	11%	475	186%
Pennsylvania	711	73%	1,667	13%	956	134%
Rhode Island	57	44%	153	15%	96	170%
Vermont	27	68%	62	35%	35	129%
Washington	508	51%	1,283	12%	775	153%
West Virginia	88	71%	272	13%	184	208%
Expansion states total	14,002	51%	32,519	16%	18,516	132%
<i>Nonexpansion states</i>						
Alabama	484	32%	841	14%	357	74%
Florida	2,482	26%	4,711	12%	2,230	90%
Georgia	1,427	31%	2,433	15%	1,006	71%
Idaho	183	36%	366	11%	184	101%
Kansas	289	39%	508	12%	219	76%
Maine	78	40%	173	12%	95	122%
Mississippi	351	40%	580	16%	229	65%
Missouri	544	38%	1,048	15%	504	93%
Nebraska	149	36%	314	12%	165	111%
North Carolina	1,140	27%	2,166	12%	1,025	90%
Oklahoma	529	43%	842	16%	313	59%
South Carolina	606	42%	959	17%	353	58%
South Dakota	81	55%	155	12%	74	92%
Tennessee	664	37%	1,190	15%	526	79%
Texas	4,377	32%	6,927	13%	2,550	58%
Utah	328	45%	601	15%	273	83%
Virginia	863	35%	1,548	9%	685	79%
Wisconsin	299	63%	731	17%	431	144%
Wyoming	61	49%	108	10%	47	76%
Nonexpansion states total	14,933	33%	26,199	13%	11,266	75%

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

	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change
National total	28,936	42%	58,718	15%	29,782	103%
Expansion states	14,002	51%	32,519	16%	18,516	132%
Nonexpansion states	14,933	33%	26,199	13%	11,266	75%

Source: Urban Institute analysis using HIPSM 2016.

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

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Income level				
< 100% of FPL	7,357	25%	14%	27%
100–150% of FPL	5,004	17%	8%	28%
150–200% of FPL	3,792	13%	10%	26%
200–300% of FPL	4,059	14%	10%	20%
300–400% of FPL	2,836	10%	6%	15%
> 400% of FPL	6,733	23%	11%	18%
Total	29,782	100%	11%	21%
Age group (years)				
< 18	3,998	13%	4%	9%
18–24	4,842	16%	14%	31%
25–34	6,341	21%	18%	32%
35–44	4,967	17%	14%	26%
45–54	5,103	17%	11%	23%
55–64	4,532	15%	8%	19%
Total	29,782	100%	11%	21%

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Family employment status				
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%

Source: Urban Institute analysis using HIPSM 2016.

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 2019.⁵ 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

Government Spending on Medicaid/CHIP for the Nonelderly and Marketplace Financial Assistance, 2019 and 2019–28

Billions of dollars

	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Medicaid/CHIP spending	\$525	\$453	-\$72	\$6,643	\$5,740	-\$902
Federal	\$330	\$263	-\$67	\$4,153	\$3,327	-\$826
State	\$195	\$191	-\$4	\$2,489	\$2,413	-\$76
Federal Marketplace financial assistance	\$42	\$0	-\$42	\$465	\$0	-\$465
<i>Total federal spending</i>	<i>\$372</i>	<i>\$263</i>	<i>-\$109</i>	<i>\$4,618</i>	<i>\$3,327</i>	<i>-\$1,291</i>
<i>Total state spending</i>	<i>\$195</i>	<i>\$191</i>	<i>-\$4</i>	<i>\$2,489</i>	<i>\$2,413</i>	<i>-\$76</i>
Total federal and state spending	\$567	\$453	-\$114	\$7,107	\$5,740	-\$1,367

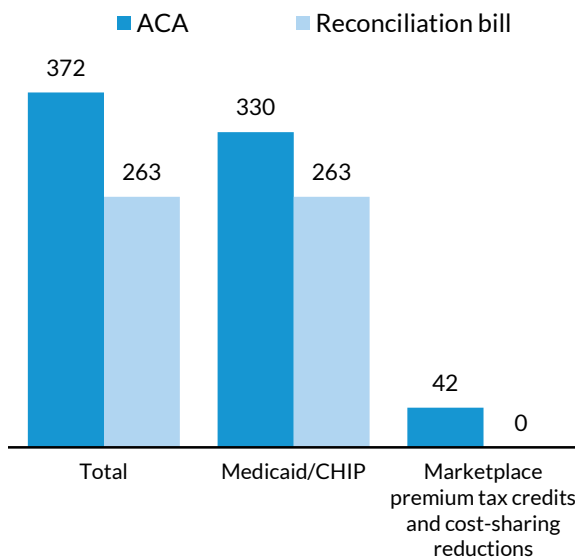
Source: Urban Institute analysis using HIPSM 2016.

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



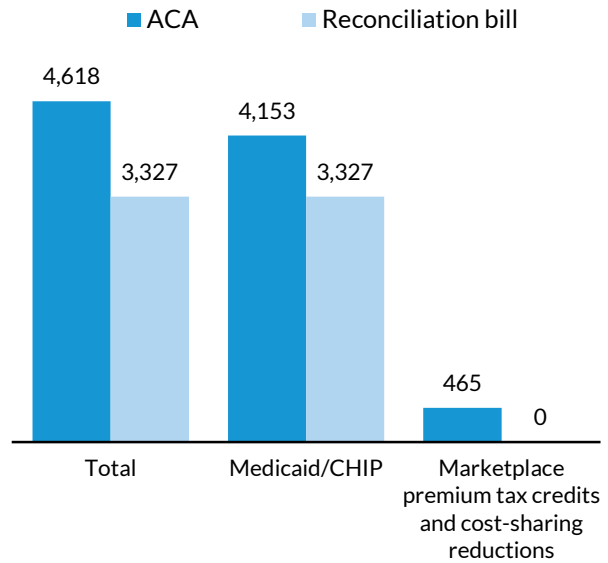
Source: Urban Institute analysis using HIPSM 2016.

Note: ACA = Affordable Care Act.

FIGURE 3

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019–28

Billions of dollars



Source: Urban Institute analysis using HIPSM 2016.

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

State	ACA			Reconciliation Bill		Difference	
	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/CHIP	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total
<i>Expansion states</i>							
Alaska	\$12	\$2	\$13	\$10	-\$1	-\$2	-\$3
Arizona	\$142	\$10	\$152	\$110	-\$32	-\$10	-\$42
Arkansas	\$42	\$2	\$44	\$34	-\$8	-\$2	-\$10
California	\$364	\$61	\$425	\$265	-\$99	-\$61	-\$160
Colorado	\$74	\$2	\$77	\$44	-\$31	-\$2	-\$33
Connecticut	\$52	\$4	\$56	\$41	-\$10	-\$4	-\$15
Delaware	\$15	<\$1	\$16	\$12	-\$3	<-\$1	-\$4
District of Columbia	\$18	<\$1	\$18	\$17	-\$2	<-\$1	-\$2
Hawaii	\$15	<\$1	\$16	\$12	-\$4	<-\$1	-\$4
Illinois	\$158	\$12	\$170	\$120	-\$37	-\$12	-\$50
Indiana	\$81	\$5	\$86	\$67	-\$14	-\$5	-\$19
Iowa	\$34	\$2	\$36	\$29	-\$5	-\$2	-\$7
Kentucky	\$106	\$3	\$108	\$59	-\$47	-\$3	-\$50
Louisiana	\$74	\$4	\$78	\$52	-\$23	-\$4	-\$27
Maryland	\$80	\$4	\$84	\$57	-\$23	-\$4	-\$28
Massachusetts	\$95	\$5	\$100	\$78	-\$17	-\$5	-\$23
Michigan	\$149	\$8	\$157	\$119	-\$30	-\$8	-\$38
Minnesota	\$82	\$2	\$84	\$68	-\$15	-\$2	-\$16
Montana	\$23	\$1	\$24	\$14	-\$9	-\$1	-\$10
Nevada	\$35	\$4	\$39	\$22	-\$13	-\$4	-\$16
<i>New</i>							
Hampshire	\$14	\$1	\$15	\$10	-\$4	-\$1	-\$5
New Jersey	\$135	\$7	\$142	\$82	-\$53	-\$7	-\$60
New Mexico	\$72	\$1	\$74	\$46	-\$27	-\$1	-\$28
New York	\$348	\$10	\$358	\$301	-\$47	-\$10	-\$57
North Dakota	\$7	<\$1	\$8	\$5	-\$2	<-\$1	-\$3
Ohio	\$177	\$6	\$183	\$135	-\$42	-\$6	-\$48
Oregon	\$83	\$3	\$86	\$47	-\$35	-\$3	-\$38
Pennsylvania	\$154	\$13	\$167	\$131	-\$23	-\$13	-\$36
Rhode Island	\$21	<\$1	\$22	\$14	-\$7	<-\$1	-\$7
Vermont	\$11	<\$1	\$12	\$9	-\$2	-\$1	-\$3
Washington	\$90	\$5	\$95	\$52	-\$38	-\$5	-\$43
West Virginia	\$35	\$2	\$37	\$23	-\$12	-\$2	-\$14
<i>Expansion states total</i>	\$2,799	\$184	\$2,983	\$2,085	-\$715	-\$184	-\$899

State	ACA			Reconciliation Bill		Difference	
	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/CHIP	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total
<i>Nonexpansion states</i>							
Alabama	\$47	\$12	\$59	\$43	-\$3	-\$12	-\$15
Florida	\$181	\$68	\$249	\$162	-\$19	-\$68	-\$87
Georgia	\$101	\$20	\$121	\$88	-\$12	-\$20	-\$33
Idaho	\$26	\$4	\$29	\$23	-\$3	-\$4	-\$6
Kansas	\$24	\$4	\$28	\$22	-\$2	-\$4	-\$6
Maine	\$17	\$4	\$21	\$17	<-\$1	-\$4	-\$5
Mississippi	\$44	\$5	\$49	\$40	-\$4	-\$5	-\$9
Missouri	\$80	\$13	\$93	\$75	-\$6	-\$13	-\$18
Nebraska	\$15	\$4	\$19	\$15	<-\$1	-\$4	-\$5
North Carolina	\$146	\$38	\$184	\$125	-\$21	-\$38	-\$59
Oklahoma	\$48	\$8	\$56	\$47	-\$2	-\$8	-\$9
South Carolina	\$54	\$11	\$65	\$53	-\$1	-\$11	-\$12
South Dakota	\$8	\$1	\$9	\$8	<-\$1	-\$1	-\$1
Tennessee	\$98	\$11	\$108	\$82	-\$16	-\$11	-\$27
Texas	\$323	\$46	\$369	\$307	-\$17	-\$46	-\$62
Utah	\$33	\$3	\$36	\$31	-\$1	-\$3	-\$5
Virginia	\$56	\$15	\$72	\$54	-\$3	-\$15	-\$18
Wisconsin	\$49	\$11	\$60	\$47	-\$2	-\$11	-\$13
Wyoming	\$5	\$2	\$6	\$4	<-\$1	-\$2	-\$2
<i>Nonexpansion states total</i>	<i>\$1,354</i>	<i>\$280</i>	<i>\$1,634</i>	<i>\$1,242</i>	<i>-\$112</i>	<i>-\$280</i>	<i>-\$392</i>
National estimate	\$4,153	\$465	\$4,618	\$3,327	-\$826	-\$465	-\$1,291

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Numbers are rounded to the nearest \$1 billion, so columns might not sum precisely to totals.

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.⁵ 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*

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

Source: Urban Institute analysis using HIPSM 2016.

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

Thousands of people

	Current law	Elimination of individual and employer mandates early in year	Difference
<i>Coverage</i>			
Medicaid	67,950	67,950	0
Medicare	3,953	3,953	0
Employer-sponsored insurance	149,511	149,511	0
Other public	4,505	4,505	0
Nongroup	18,418	14,085	-4,334
Uninsured	28,342	32,676	4,334
Total	272,680	272,680	
Premium revenue (billions)			
Total premium revenue: current law			\$46
Total premium revenue: no mandates, fixed premiums			\$37
Actuarially fair premiums necessary to cover insurer costs if mandates eliminated			\$40
Shortfall in insurer revenue caused by eliminating mandates mid-plan year			\$3

Source: Urban Institute analysis using HIPSM 2016.

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 (Zammiti, 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

(McMorrow and Holahan 2016). Accordingly, we assume that the underlying growth rate of health care costs would be the same with or without the ACA.

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

State	ACA			Reconciliation Bill			Difference		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
National	330,191	194,951	525,142	262,720	190,654	453,374	-67,471	-4,298	-71,768
<i>Expansion states</i>									
Alaska	903	756	1,659	795	795	1,591	-107	40	-68
Arizona	11,138	4,594	15,732	8,567	4,176	12,743	-2,571	-418	-2,989
Arkansas	3,328	1,215	4,544	2,699	1,151	3,850	-629	-64	-693
California	29,016	23,213	52,229	20,963	20,963	41,927	-8,053	-2,250	-10,302
Colorado	5,920	3,402	9,322	3,412	3,269	6,681	-2,508	-134	-2,642
Connecticut	4,156	3,123	7,279	3,290	3,220	6,511	-866	97	-769
Delaware	1,192	687	1,879	970	765	1,735	-222	78	-144
District of Columbia	1,455	521	1,977	1,316	564	1,880	-139	43	-97
Hawaii	1,220	818	2,038	914	849	1,764	-306	31	-274
Illinois	12,618	8,954	21,572	9,543	9,051	18,594	-3,074	97	-2,978
Indiana	6,450	2,433	8,883	5,304	2,581	7,885	-1,146	148	-998
Iowa	2,726	1,513	4,239	2,280	1,594	3,874	-446	81	-365
Kentucky	8,512	2,257	10,769	4,679	1,998	6,677	-3,834	-259	-4,092
Louisiana	5,986	2,819	8,805	4,126	2,618	6,744	-1,860	-201	-2,062
Maryland	6,379	4,466	10,846	4,472	4,472	8,943	-1,908	5	-1,903
Massachusetts	7,593	6,166	13,759	6,179	5,976	12,155	-1,414	-190	-1,604
Michigan	12,023	4,525	16,548	9,510	4,785	14,295	-2,513	260	-2,253
Minnesota	6,485	4,907	11,392	5,292	5,292	10,583	-1,193	385	-808
Montana	1,797	621	2,418	1,099	535	1,634	-698	-86	-784
Nevada	2,758	1,063	3,821	1,730	995	2,725	-1,028	-68	-1,096
New Hampshire	1,144	780	1,924	815	815	1,630	-329	35	-295
New Jersey	10,906	5,916	16,822	6,544	6,265	12,809	-4,363	350	-4,013
New Mexico	5,808	1,735	7,544	3,608	1,606	5,213	-2,201	-130	-2,330
New York	27,846	21,110	48,956	23,880	23,235	47,116	-3,966	2,126	-1,840
North Dakota	559	336	895	390	386	776	-169	49	-119
Ohio	14,233	6,156	20,389	10,735	6,299	17,034	-3,498	143	-3,355
Oregon	6,624	2,115	8,739	3,747	2,115	5,861	-2,877	-1	-2,878
Pennsylvania	12,257	7,912	20,169	10,373	8,614	18,987	-1,883	702	-1,182

State	ACA			Reconciliation Bill			Difference		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
Rhode Island	1,691	1,228	2,920	1,136	1,131	2,267	-556	-98	-653
Vermont	917	554	1,471	746	608	1,354	-171	54	-117
Washington	7,221	4,131	11,352	4,121	4,043	8,164	-3,100	-88	-3,188
West Virginia	2,860	782	3,642	1,849	726	2,575	-1,011	-56	-1,067
Expansion states total	223,722	130,811	354,533	165,085	131,492	296,576	-58,638	681	-57,956
<i>Nonexpansion states</i>									
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

Source: Urban Institute analysis using HIPSIM 2016.

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

State	Premium tax credits	Cost-sharing reductions	Total
National	35,338	6,427	41,765
<i>Expansion states</i>			
Alaska	150	21	171
Arizona	827	49	877
Arkansas	159	35	194
California	4,783	752	5,534
Colorado	190	33	223
Connecticut	348	43	391
Delaware	71	10	81
District of Columbia	7	0	8
Hawaii	42	6	47
Illinois	1,001	122	1,122
Indiana	385	78	463
Iowa	156	24	180
Kentucky	213	46	259
Louisiana	316	50	366
Maryland	332	53	385
Massachusetts	415	75	491
Michigan	633	118	750
Minnesota	163	2	165
Montana	97	12	109
Nevada	262	50	312
New Hampshire	70	16	85
New Jersey	513	94	607
New Mexico	77	16	93
New York	771	120	891
North Dakota	47	7	54
Ohio	438	97	535
Oregon	255	41	296
Pennsylvania	1,074	121	1,195
Rhode Island	50	10	60
Vermont	83	9	91
Washington	352	73	425
West Virginia	143	21	164
Expansion states total	14,423	2,203	16,626
<i>Nonexpansion states</i>			
Alabama	931	147	1,078
Florida	5,106	1,013	6,119
Georgia	1,430	381	1,811
Idaho	276	56	331
Kansas	329	60	389
Maine	331	57	388
Mississippi	390	85	475
Missouri	960	212	1,172
Nebraska	345	52	397
North Carolina	2,947	475	3,421
Oklahoma	601	87	689

State	Premium tax credits	Cost-sharing reductions	Total
South Carolina	787	164	951
South Dakota	90	15	105
Tennessee	834	132	966
Texas	3,234	822	4,057
Utah	242	46	288
Virginia	1,122	252	1,374
Wisconsin	837	139	976
Wyoming	122	30	152
<i>Nonexpansion states total</i>	20,914	4,225	25,139

Source: Urban Institute analysis using HIPSMS 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

State	ACA		Reconciliation Bill		Difference	
	Federal	State	Federal	State	Federal	State
<i>Expansion states</i>						
Alaska	\$11,516	\$9,756	\$10,198	\$10,198	-\$1,318	\$442
Arizona	\$142,127	\$59,683	\$110,043	\$53,638	-\$32,084	-\$6,044
Arkansas	\$41,909	\$15,586	\$34,148	\$14,565	-\$7,761	-\$1,021
California	\$363,744	\$295,051	\$264,676	\$264,676	-\$99,068	-\$30,375
Colorado	\$74,434	\$44,204	\$43,583	\$41,713	-\$30,851	-\$2,491
Connecticut	\$51,903	\$39,643	\$41,431	\$40,547	-\$10,472	\$904
Delaware	\$14,978	\$8,821	\$12,287	\$9,687	-\$2,690	\$866
District of Columbia	\$18,223	\$6,671	\$16,564	\$7,099	-\$1,659	\$427
Hawaii	\$15,314	\$10,506	\$11,586	\$10,759	-\$3,728	\$253
Illinois	\$157,567	\$113,855	\$120,198	\$113,893	-\$37,369	\$38
Indiana	\$81,176	\$31,465	\$67,268	\$32,725	-\$13,908	\$1,260
Iowa	\$34,394	\$19,436	\$28,998	\$20,265	-\$5,396	\$829
Kentucky	\$105,571	\$29,683	\$58,774	\$25,098	-\$46,797	-\$4,585
Louisiana	\$74,411	\$35,939	\$51,729	\$32,817	-\$22,682	-\$3,122
Maryland	\$80,069	\$57,286	\$56,627	\$56,627	-\$23,443	-\$660
Massachusetts	\$95,075	\$78,018	\$77,912	\$75,343	-\$17,163	-\$2,675
Michigan	\$148,780	\$57,731	\$118,792	\$59,758	-\$29,988	\$2,026
Minnesota	\$82,245	\$63,400	\$67,686	\$67,686	-\$14,559	\$4,286
Montana	\$22,512	\$8,091	\$13,945	\$6,790	-\$8,568	-\$1,302
Nevada	\$35,236	\$14,091	\$22,328	\$12,835	-\$12,908	-\$1,256
New Hampshire	\$14,138	\$9,874	\$10,172	\$10,172	-\$3,966	\$299
New Jersey	\$135,378	\$76,052	\$82,380	\$78,785	-\$52,998	\$2,733
New Mexico	\$72,465	\$22,723	\$45,594	\$20,293	-\$26,871	-\$2,430
New York	\$347,954	\$267,729	\$300,605	\$292,248	-\$47,349	\$24,520
North Dakota	\$7,043	\$4,357	\$4,980	\$4,928	-\$2,063	\$571
Ohio	\$176,730	\$78,643	\$134,545	\$78,951	-\$42,185	\$308
Oregon	\$82,541	\$27,876	\$47,423	\$26,745	-\$35,118	-\$1,131
Pennsylvania	\$154,018	\$101,149	\$131,365	\$109,020	-\$22,654	\$7,871
Rhode Island	\$21,045	\$15,610	\$14,316	\$14,254	-\$6,728	-\$1,357

State	ACA		Reconciliation Bill		Difference	
	Federal	State	Federal	State	Federal	State
Vermont	\$11,281	\$6,956	\$9,346	\$7,612	-\$1,935	\$656
Washington	\$90,347	\$53,511	\$52,283	\$51,284	-\$38,064	-\$2,227
West Virginia	\$35,274	\$10,101	\$23,027	\$9,047	-\$12,247	-\$1,054
<i>Expansion states total</i>	<i>\$2,799,399</i>	<i>\$1,673,497</i>	<i>\$2,084,808</i>	<i>\$1,660,058</i>	<i>-\$714,591</i>	<i>-\$13,439</i>
<i>Nonexpansion states</i>						
Alabama	\$46,751	\$20,673	\$43,341	\$19,203	-\$3,410	-\$1,470
Florida	\$180,752	\$123,567	\$161,626	\$110,954	-\$19,126	-\$12,613
Georgia	\$100,670	\$50,498	\$88,488	\$44,414	-\$12,182	-\$6,084
Idaho	\$25,670	\$9,944	\$23,025	\$8,936	-\$2,645	-\$1,008
Kansas	\$23,772	\$17,247	\$21,975	\$15,922	-\$1,797	-\$1,325
Maine	\$17,064	\$10,412	\$16,566	\$10,179	-\$498	-\$233
Mississippi	\$43,816	\$15,814	\$39,928	\$14,420	-\$3,888	-\$1,393
Missouri	\$80,482	\$47,643	\$74,971	\$44,535	-\$5,510	-\$3,108
Nebraska	\$14,733	\$12,181	\$14,581	\$12,056	-\$152	-\$126
North Carolina	\$145,642	\$74,079	\$124,923	\$63,824	-\$20,719	-\$10,255
Oklahoma	\$48,324	\$27,159	\$46,666	\$26,227	-\$1,659	-\$932
South Carolina	\$54,112	\$22,566	\$53,036	\$22,118	-\$1,075	-\$448
South Dakota	\$8,248	\$7,103	\$7,979	\$6,871	-\$269	-\$232
Tennessee	\$97,562	\$50,078	\$81,654	\$42,303	-\$15,908	-\$7,775
Texas	\$323,489	\$220,741	\$306,920	\$209,439	-\$16,568	-\$11,303
Utah	\$32,712	\$13,459	\$31,221	\$12,842	-\$1,492	-\$617
Virginia	\$56,263	\$54,756	\$53,659	\$52,232	-\$2,604	-\$2,524
Wisconsin	\$49,352	\$33,442	\$47,447	\$32,108	-\$1,905	-\$1,334
Wyoming	\$4,555	\$4,467	\$4,432	\$4,343	-\$123	-\$124
<i>Nonexpansion states total</i>	<i>\$1,353,966</i>	<i>\$815,830</i>	<i>\$1,242,436</i>	<i>\$752,926</i>	<i>-\$111,530</i>	<i>-\$62,904</i>
National estimate	\$4,153,365	\$2,489,327	\$3,327,244	\$2,412,984	-\$826,121	-\$76,342

Source: Urban Institute analysis using HIPSM 2016.

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

APPENDIX TABLE A.4

Forgone Federal Spending on Marketplace Financial Assistance under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

State	Federal Marketplace financial assistance	State	Federal Marketplace financial assistance
<i>Expansion states</i>		<i>Nonexpansion states</i>	
Alaska	1,900	Alabama	11,944
Arizona	10,017	Florida	68,139
Arkansas	2,147	Georgia	20,484
California	61,116	Idaho	3,710
Colorado	2,479	Kansas	4,316
Connecticut	4,305	Maine	4,212
Delaware	898	Mississippi	5,232
District of Columbia	85	Missouri	12,909
Hawaii	532	Nebraska	4,398
Illinois	12,483	North Carolina	38,239
Indiana	5,095	Oklahoma	7,682
Iowa	1,982	South Carolina	10,580
Kentucky	2,861	South Dakota	1,166
Louisiana	4,048	Tennessee	10,777
Maryland	4,338	Texas	45,594
Massachusetts	5,361	Utah	3,262
Michigan	8,177	Virginia	15,400
Minnesota	1,875	Wisconsin	10,722
Montana	1,205	Wyoming	1,681
Nevada	3,529	<i>Nonexpansion states total</i>	280,449
New Hampshire	927		
New Jersey	6,694		
New Mexico	1,027		
New York	9,853		
North Dakota	592		
Ohio	5,842		
Oregon	3,286		
Pennsylvania	13,276		
Rhode Island	653		
Vermont	989		
Washington	4,691		
West Virginia	1,794		
<i>Expansion states total</i>	184,058		
National total	464,507	National total	464,507

Source: Urban Institute analysis using HIPSMS 2016.

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

State	ACA		Reconciliation Bill		Difference	
	Federal	State	Federal	State	Federal	State
<i>Expansion states</i>						
Alaska	\$13,416	\$9,756	\$10,198	\$10,198	-\$3,218	\$442
Arizona	\$152,144	\$59,683	\$110,043	\$53,638	-\$42,101	-\$6,044
Arkansas	\$44,056	\$15,586	\$34,148	\$14,565	-\$9,908	-\$1,021
California	\$424,860	\$295,051	\$264,676	\$264,676	-\$160,184	-\$30,375
Colorado	\$76,913	\$44,204	\$43,583	\$41,713	-\$33,330	-\$2,491
Connecticut	\$56,209	\$39,643	\$41,431	\$40,547	-\$14,778	\$904
Delaware	\$15,876	\$8,821	\$12,287	\$9,687	-\$3,589	\$866
District of Columbia	\$18,308	\$6,671	\$16,564	\$7,099	-\$1,744	\$427
Hawaii	\$15,846	\$10,506	\$11,586	\$10,759	-\$4,261	\$253
Illinois	\$170,051	\$113,855	\$120,198	\$113,893	-\$49,852	\$38
Indiana	\$86,271	\$31,465	\$67,268	\$32,725	-\$19,003	\$1,260
Iowa	\$36,376	\$19,436	\$28,998	\$20,265	-\$7,378	\$829
Kentucky	\$108,432	\$29,683	\$58,774	\$25,098	-\$49,658	-\$4,585
Louisiana	\$78,459	\$35,939	\$51,729	\$32,817	-\$26,730	-\$3,122
Maryland	\$84,408	\$57,286	\$56,627	\$56,627	-\$27,781	-\$660
Massachusetts	\$100,435	\$78,018	\$77,912	\$75,343	-\$22,523	-\$2,675
Michigan	\$156,956	\$57,731	\$118,792	\$59,758	-\$38,164	\$2,026
Minnesota	\$84,119	\$63,400	\$67,686	\$67,686	-\$16,434	\$4,286
Montana	\$23,717	\$8,091	\$13,945	\$6,790	-\$9,773	-\$1,302
Nevada	\$38,765	\$14,091	\$22,328	\$12,835	-\$16,437	-\$1,256
New Hampshire	\$15,065	\$9,874	\$10,172	\$10,172	-\$4,893	\$299
New Jersey	\$142,073	\$76,052	\$82,380	\$78,785	-\$59,693	\$2,733
New Mexico	\$73,492	\$22,723	\$45,594	\$20,293	-\$27,899	-\$2,430
New York	\$357,807	\$267,729	\$300,605	\$292,248	-\$57,202	\$24,520
North Dakota	\$7,635	\$4,357	\$4,980	\$4,928	-\$2,655	\$571
Ohio	\$182,572	\$78,643	\$134,545	\$78,951	-\$48,027	\$308
Oregon	\$85,826	\$27,876	\$47,423	\$26,745	-\$38,403	-\$1,131
Pennsylvania	\$167,294	\$101,149	\$131,365	\$109,020	-\$35,930	\$7,871

Rhode Island	\$21,698	\$15,610	\$14,316	\$14,254	-\$7,382	-\$1,357
Vermont	\$12,269	\$6,956	\$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
<i>Nonexpansion states</i>						
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	\$63,824	-\$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	\$60,074	\$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

Source: Urban Institute analysis using HIPSIM 2016.

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

Notes

1. Alex Moe, "Congress Sends Obamacare Repeal to President for First Time," NBC News, January 6, 2016, <http://www.nbcnews.com/news/us-news/congress-send-obamacare-repeal-president-n491316>.
2. Steven T. Dennis and Billy House, "GOP Eyes Lightning Strike on Obamacare to Kick Off Trump Era," Bloomberg, November 29, 2016, <http://www.bloomberg.com/politics/articles/2016-11-29/gop-eyes-lightning-strike-on-obamacare-to-kick-off-trump-era>; and Lisa Mascaro, "Repeal and Replace Obamacare? It Won't Happen on Trump's First Day," *Los Angeles Times*, November 29, 2016, <http://www.latimes.com/nation/politics/trailguide/la-na-trailguide-updates-1480442605-htmstory.html>.
3. "Summary of the Byrd rule," US House of Representatives Committee on Rules, accessed November 22, 2016, http://archives.democrats.rules.house.gov/archives/byrd_rule.htm.
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.
7. See, for example, Brian Fanney, Michael R. Wickline, and Spencer Williams, "Arkansas House Speaker Details Cuts if Medicaid Plan Fails," *Arkansas Online*, April 12, 2016, <http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/>. Medicaid expansion in Arkansas was extended on April 21, 2016; see David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," *Kaiser Health News*, April 21, 2016, <http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion>; and Dorn et al. (2015).

References

- Blumberg, Linda J., and Matthew Buettgens. 2016. "The Implications of a Finding for the Plaintiffs in *House v. Burwell*." Washington, DC: Urban Institute.
- Blumberg, Linda J., Michael Karpman, Matthew Buettgens, and Patricia Solleveld. 2016. *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us about How to Reach Them?* Washington, DC: Urban Institute.

- Buettgens, Matthew, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe. 2016. "The Cost of ACA Repeal." Washington, DC: Urban Institute.
- Congressional Budget Office. 2016. *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016 to 2026*. Washington, DC: Congressional Budget Office.
- Dorn, Stan, Norton Francis, Laura Snyder, and Robin Rudowitz. 2015. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Menlo Park, CA: Kaiser Family Foundation.
- Glied, Sherry A., Anupama Arora, and Claudia Solís-Román. 2015. *The CBO's Crystal Ball: How Well Does It Forecast the Effects of the Affordable Care Act?* New York: The Commonwealth Fund.
- Holahan, John. 2011. "The 2007–09 Recession and Health Insurance Coverage." *Health Affairs* 30 (1): 145–52. doi: 10.1377/hlthaff.2010.1003.
- McMorrow, Stacey, and John Holahan. 2016. *The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act; An Update*. Washington, DC: Urban Institute.
- Monheit, Alan C., Joel C. Cantor, Margaret Koller, and Kimberley S. Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey." *Health Affairs* 23 (4): 167–75. doi: 10.1377/hlthaff.23.4.167.
- Zammiti, Emily P., Robin A. Cohen, and Michael E. Martinez. 2016. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2016." Hyattsville, MD: National Center for Health Statistics.

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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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