



RESEARCH REPORT

Racial/Ethnic Differences in Uninsurance Rates under the ACA

Are Differences in Uninsurance Rates Projected to Narrow?

*Lisa Clemans-Cope
Matthew Buettgens
Hannah Recht*

December 2014





ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

The Urban Institute is a nonprofit policy research organization. It has been incorporated and is operated as a public charity. It has received official IRS recognition of its tax-exempt status under sections 501(c)(3) and 509(a)(2) of the Internal Revenue Code. The Institute's federal ID number is 52-0880375. Donations will be tax deductible and may be disclosed to the IRS and the public, unless given anonymously. We are committed to transparent accounting of the resources we receive. In addition to required tax filings, a copy of the Urban Institute's audited financial statement is available to anyone who requests it.

ABOUT THE FUNDER

The Low-Income Working Families project builds on more than a decade of research under the Assessing the New Federalism project, which followed struggling families as many left welfare.

The Low-Income Working Families (LIWF) project tracks the well-being of low-income families over time and analyzes the risks these families face. Our researchers identify the factors that contribute to poor outcomes for these families and policy options that would reduce barriers and promote meaningful work for adults and positive outcomes for children.

This project is made possible through generous funding from the Annie E. Casey Foundation. Any opinions and conclusions expressed herein are those of the authors and do not necessarily represent the views of the Annie E. Casey Foundation or the Urban Institute and its sponsors or trustees.

Contents

Acknowledgments	v
Executive Summary	vi
Introduction	1
Methods	3
The Microsimulation Model	3
Measures of Projected Coverage Changes by Racial/Ethnic Group	5
Projected Uninsured Rate Reductions by Racial or Ethnic Group	8
Latinos, Blacks, and American Indian/Alaska Natives are Overrepresented among the Uninsured at Baseline without the ACA	8
Uninsurance Rates Projected to Fall for all Racial/Ethnic Groups under the ACA with Current Medicaid Expansion Decisions	9
Are Differences in Uninsurance Rates Projected to Narrow under the ACA with Current Medicaid Expansion Decisions?	13
Under the ACA with Full Medicaid Expansion, Uninsurance Rates Are Projected to Fall Further for All Racial/Ethnic Groups, Particularly for Blacks	14
Are Differences in Uninsurance Rates Projected to Narrow under the ACA with Full Medicaid Expansion?	14
Small Groups of States Account for Most Projected Coverage Gains by Racial or Ethnic Group	16
Whites (Tables B.3 and B.4)	16
Latinos (Tables B.5 and B.6)	16
Blacks (Tables B.7 and B.8)	17
Asian/Pacific Islanders (Tables B.9 and B.10)	17
American Indian/Alaska Natives (Tables B.11 and B.12)	18
Projected Uninsured Rate Reductions by Racial and Ethnic Subgroups	19
For Latino-Origin Groups, Uninsurance Rates Are Projected to Decrease	19
For Asian/Pacific Islander–Origin Groups, Uninsurance Rates Are Projected to Decrease, but Wide Differences Remain	22
For American Indian/Alaska Native Tribes, Uninsurance Rates Are Projected to Decrease, but Wide Differences Remain because of State Expansion Decisions	24
Conclusions	26
Appendix A. Racial and Ethnic Classifications	29

Appendix B. Additional Tables	31
Notes	44
References	47
About the Authors	48

Acknowledgments

This report is part of the Urban Institute’s Low-Income Working Families project, a multiyear effort that focuses on the private- and public-sector contexts for families’ success or failure. Both contexts offer opportunities for better helping families meet their needs. The Low-Income Working Families project is currently supported by the Annie E. Casey Foundation. Any opinions and conclusions expressed herein are those of the authors and do not necessarily represent the views of the Annie E. Casey Foundation or the Urban Institute and its sponsors or trustees.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

The authors would like to thank the Low Income Working Families project and the Annie E. Casey Foundation for their generous support of this project; the working-group participants who graciously shared their time and insights; and Mary Howard, John Keating, and Rachel Langford for their careful review.

This report has benefited from the helpful comments of Margaret Simms, Genevieve Kenney, and Stephen Zuckerman. The authors thank Dean Resnick and Victoria Lynch of the Urban Institute’s Health Policy Center for their assistance in developing data used in the Health Insurance Policy Simulation Model–American Community Survey.

Executive Summary

This report is the first state-level examination of how the Affordable Care Act (ACA) is projected to change uninsurance rates for five major racial/ethnic groups: whites, Latinos, blacks, Asian/Pacific Islanders, and American Indian/Alaska Natives. The Urban Institute's Health Insurance Policy Simulation Model–American Community Survey microsimulation projects large percentage reductions in uninsurance rates for all racial and ethnic groups under the ACA with Medicaid expansion decisions as of December 2014. We project even larger reductions under the ACA with Medicaid expansion in all states (“full Medicaid expansion”). In a more detailed subgroup examination by origin (i.e., identity relating to family ancestry or birthplace), we also find large reductions for all Latino-origin groups, all Asian/Pacific Islander–origin groups, and all American Indian/Alaska Natives tribes.

According to our projections, the ACA with current Medicaid expansion decisions can substantially narrow differences in uninsurance rates between whites and all racial/ethnic minorities, except blacks, who disproportionately live in nonexpansion states. Dramatic reductions are projected for the American Indian/Alaska Natives uninsurance rate: a decrease from 25.7 percent to 13.0 percent, or a 49.5 percent reduction that translates to 600,000 gaining coverage. Latinos have a projected decrease in the uninsurance rate from 31.2 percent to 19.0 percent: a 39.2 percent reduction that translates to 6.6 million gaining coverage. Both groups' projections lead to a narrowing of the difference in their uninsurance rates compared with whites.

Under the ACA with full Medicaid expansion, uninsurance rates are projected to fall further for all racial and ethnic groups. Compared with projections using the ACA with current Medicaid expansion decisions, dramatic uninsurance rate reductions are projected for blacks were all states to expand Medicaid: from 11.3 percent with current expansion decisions to 7.2 percent with full expansion. This is because over half of all blacks are living in states not expanding Medicaid in 2014; 1.4 million uninsured blacks are in the eligibility gap. These 1.4 million constitute 23.1 percent of the black adult uninsured adult population nationwide. Because of tribe members' locations, four American Indian/Alaska Natives tribes (Eskimo, Cherokee, Sioux, and Lumbee) are also projected to experience dramatic gains under the ACA with full Medicaid expansion compared with current expansion decisions.

Even with current Medicaid expansion decisions, the ACA is projected to shrink many of the long-standing racial/ethnic differences in health insurance coverage. Medicaid expansion in all states shows the potential for further reductions in uninsurance rates and, in contrast with projections of current Medicaid expansion decisions, would reduce racial differences in coverage between whites and blacks.

State outreach and enrollment efforts will be crucial in (1) raising enrollment rates in Medicaid and CHIP among eligible individuals and (2) increasing Marketplace enrollment among those who are eligible for, but are not using, the subsidies available in the insurance Marketplaces.

Introduction

The Affordable Care Act's (ACA's) coverage provisions are reducing uninsurance rates: initial estimates suggest reductions may be particularly marked among blacks and Latinos.¹ Several ACA provisions have contributed to this coverage expansion. The law's Medicaid expansion provision set a nationwide eligibility standard: adults with family income up to 138 percent of the federal poverty level (FPL). This Medicaid expansion was made a state option by the US Supreme Court's 2012 decision. As of December 2014, 27 states and the District of Columbia had expanded Medicaid or planned to expand by January 2015 ("expansion states").²

In addition to the Medicaid expansion, the ACA includes other provisions designed to increase rates of health insurance coverage: (1) state-based health insurance Marketplaces offering coverage starting in 2014; (2) health insurance market reforms that have been phasing in since the law passed in 2010; (3) premium subsidies for many with income below 400 percent of FPL, available through both the federal and state health insurance Marketplaces;³ and (4) a requirement that all individuals obtain health insurance coverage.

Many nonelderly adults (ages 19 to 64) with income below 138 percent of FPL who live in states that have not chosen to expand Medicaid by January 2015 ("nonexpansion states") fall into the "coverage gap": they are not eligible for Medicaid under their states' eligibility rules but are also ineligible for Marketplace premium subsidies.⁴ Because racial and ethnic compositions vary across states, these state policy decisions can have a major effect on the racial/ethnic composition of poor individuals in the Medicaid coverage gap (Kenney et al. 2012).

In addition, the ACA excludes particular immigrant groups from new coverage options. Undocumented immigrants are prohibited from enrolling in Medicaid or purchasing coverage through the Marketplaces. Undocumented immigrants are projected to compose approximately one-quarter of the uninsured population after the ACA's major provisions are implemented, including states' Medicaid expansions (as those expansion decisions stand in December 2014).⁵ Further, the ACA options available to lawfully residing immigrants vary depending on the number of years they have lived in the United States.

This study builds on a previous national analysis (Clemans-Cope et al. 2012) and is the first state-level analysis to project coverage gains for detailed racial/ethnic groups and subgroups by origin (i.e., identity relating to family ancestry or birthplace) under the ACA. Three coverage projection scenarios are compared. Each scenario projects outcomes as of 2016, at which time the current provisions of the

ACA are assumed to be fully implemented. The first scenario projects uninsurance rates in 2016 if the ACA had not been passed. The second scenario projects uninsurance rates in 2016 under the states' Medicaid expansion decisions as of December 2014. The third scenario projects uninsurance rates in 2016 if all states were to implement the ACA's Medicaid expansion.

These findings shed light on whether specific state Medicaid expansions and outreach and enrollment efforts could affect coverage gains among different racial and ethnic groups.

Methods

We use microsimulation to examine projected coverage changes for different racial and ethnic groups in 2016. We compare projected coverage in 2016 across three scenarios: (1) had the ACA not been passed, (2) the ACA with current Medicaid expansion decisions, and (3) the ACA with Medicaid expansion in all states (“full Medicaid expansion”). Comparing the second and third scenarios with projected baseline coverage in 2016 had the ACA not been passed allows us to estimate racial/ethnic coverage effects of the alternative ACA scenarios.⁶

The Microsimulation Model

The projections are based on the Urban Institute’s Health Insurance Policy Simulation Model–American Community Survey (HIPSM-ACS) (Buettgens et al. 2013). This model uses ACS data from 2009, 2010, and 2011 to obtain representative samples of nonelderly populations (ages 0 to 64) both by state and by pre-ACA insurance coverage. All estimates and projections presented in this report refer to the nonelderly population. The Health Insurance Policy Simulation Model simulates individual and family health insurance enrollment under the ACA by using eligibility for programs and subsidies, health insurance coverage and options in the family, health status, sociodemographic characteristics, any applicable penalties for remaining uninsured, and other factors.⁷ Estimates based on previous versions of HIPSM differ slightly because of revisions and updated regulations.⁸ Eligibility for subsidized marketplace coverage is determined by considering (1) state decisions to expand Medicaid under the ACA and (2) access to employer-sponsored insurance coverage.

We model eligibility status for Medicaid and the Children’s Health Insurance Program and subsidized coverage in the Marketplaces, and then use the HIPSM to simulate the decisions of employers, families, and individuals to offer or enroll in health insurance coverage. We then map those results to the ACS, using regression modeling to assign probabilities of take-up. To calculate the effects of reform options, the HIPSM uses a microsimulation based on the relative desirability (utility) of the health insurance options available to each individual and family under reform,⁹ considering people’s current choices as reported in the survey data.¹⁰ The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature (including, importantly, the price elasticities for employer-sponsored insurance and nongroup coverage).

Defining Racial/Ethnic Groups

We start by examining coverage changes for five major racial/ethnic groups:¹¹

1. White non-Latino (“white”)
2. Latino
3. Black non-Latino (“black”)
4. Non-Latino Asian/Pacific Islander (“Asian/Pacific Islander” or “A/PI”)
5. American Indian/Alaska Native (“AI/AN”)

We classify people as uninsured without the ACA if they did not report health insurance. Also, we do not count the Indian Health Service as health insurance coverage because of limitations in its scope of available services and in the geographic reach of its facilities (Turner and Boudreaux 2010). In this approach we follow previous research (Clemans-Cope et al. 2012). Because the data are collected continuously over a 12-month period, our coverage estimates represent an average day in the calendar year.

We then examine three racial/ethnic groups in additional detail. We analyze subgroups by origin for the Latino and Asian/Pacific Islander groups because they have relatively high proportions of foreign-born individuals compared with the three other racial/ethnic groups. We analyze American Indian/Alaska Natives subgroups by tribe. The racial/ethnic subgroups are as follows:

1. The 11 largest Latino-origin groups (Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, Spaniard, and Peruvian) and three other categories (other South American, other Central American, and other Latino not specified).
2. The five largest A/PI-origin groups (Chinese, Indian, Filipino, Vietnamese, and Korean) and all other Asian/Pacific Islanders (including those reporting multiple subgroups).
3. The nine largest identifiable AI/AN subgroups by tribe (Navajo, Cherokee, Sioux, Chippewa, Choctaw, Apache, Lumbee, Pueblo, and Eskimo), with all other American Indian/Alaska Natives (including those of mixed race and multiple tribes) grouped into an “all other American Indian/Alaska Natives” category. Because nearly three-quarters of American Indian/Alaska Natives reported either no tribal affiliation or multiple races in the ACS, and because our estimates for the individual tribes include only those who reported a sole tribal affiliation and no other race/ethnicity, we undercount the number in each tribal group gaining coverage, but not the total number of American Indian/Alaska Natives.

Latino-origin, A/PI-origin, and American Indian/Alaska Native tribes are based on self-reported answers to detailed questions on racial identity relating to family ancestry or birthplace. See appendix A for more details on race, ethnicity, tribe, and origin classification.

Assigning Undocumented Immigrant Status

The imputation process assigns undocumented status as follows: Noncitizens are those without US citizenship, including both lawfully present immigrants—some of whom are legal permanent residents—and undocumented immigrants. An undocumented immigrant is a foreign national who entered the United States either with a visa as a temporary resident, then overstaying the visa or engaging in activities forbidden by the visa, or without a visa.¹² We impute documentation status for noncitizens in each year in two stages, using both individual and family characteristics, based on an imputation methodology originally developed by Jeffrey Passel for the Current Population Survey Annual Social and Economic Supplement.

An estimated one-sixth of Latinos are undocumented, accounting for 69.7 percent of all undocumented immigrants.¹³ A forthcoming brief details coverage changes for Latinos by documentation status, which varies by origin group (Clemans-Cope et al., forthcoming).

Measures of Projected Coverage Changes by Racial/Ethnic Group

Absolute and Relative Changes in Uninsurance Rates by Race/Ethnicity Nationally

For each racial/ethnic group, we assess how uninsurance rates are projected to change at the national level under each of the three scenarios. We examine absolute difference and percent difference in the uninsurance rate for each racial/ethnic group, comparing the uninsurance rate without the ACA to those under the ACA with current Medicaid expansion decisions and those under the ACA with full Medicaid expansion for each racial/ethnic group.

The simplest method of comparing how the ACA affects different racial and ethnic groups' coverage is to examine the difference in uninsurance rates between groups. We find racial/ethnic uninsurance rate differences by subtracting the rate of uninsurance for one racial/ethnic group from

that of another, providing percentage-point differences in uninsurance rates between racial/ethnic group pairs. Whites, whose uninsurance rates are lowest in the baseline scenario, are the reference group for these differences (thus, for example, we will assess the black-white difference in uninsurance rates).¹⁴

Assessing Whether Differences in Uninsurance Rates Could Narrow by Race/Ethnicity Nationally

Though we assess the absolute and relative differences in uninsurance rates between whites and other racial/ethnic groups, that assessment may not always be sufficient to determine whether the underlying differences in health coverage between racial/ethnic groups have narrowed.¹⁵ Absolute and relative differences in uninsurance rates between groups provide different types of information and may lead to different conclusions. Moreover, as uninsurance rates for all groups decline, the relative difference between the groups will tend to increase (all other factors remaining equal).¹⁶ For example, the absolute percentage-point difference in uninsurance rates between blacks and whites is smaller under the ACA with current Medicaid expansion decisions than without the ACA (a difference of 5.0 percentage points versus a difference of 6.5 percentage points; see table 1 on page 12), suggesting that the differences in health coverage rates narrowed. But the percentage decrease in the uninsurance rate is larger for whites than for blacks under the ACA with current Medicaid expansion decisions (51.6 percent versus 42.3 percent), suggesting that differences in health coverage between blacks and whites did not narrow.¹⁷

To draw conclusions about changes in health coverage differences between racial/ethnic minorities and whites, we compute an additional metric that has advantageous properties not shared by measures that rely on absolute risk differences. Several metrics have been developed that avoid the problems of simpler measures of absolute or relative difference. The metric we use is similar to measures of association, such as relative risk, and we use it here to quantify the size of the difference in coverage rates between two groups and assess whether differences have narrowed. We calculate this metric for each racial/ethnic minority group as the correlation between two binary variables (also known as an “effect size”): being uninsured and being of a particular racial/ethnic minority group. We compute four metrics for the four race/ethnicity group pairs (black versus white, Latino versus white, American Indian/Alaska Native versus white, and Asian/Pacific Islander versus white) using whites as the reference group in each pair (table B.13). To compute this metric, we used a standard measure of association for two binary variables: the ϕ statistic based on the χ -squared test:¹⁸

$$\varphi = \sqrt{\frac{\chi^2}{N}}$$

where N is the weighted number of people in our dataset. If there were no differences in health coverage between whites and a given racial/ethnic group, this statistic would be 0. In this report, under all scenarios this statistic is greater than 0 for all racial/ethnic group pairs, meaning that differences in health coverage exist in all scenarios. For all racial/ethnic group pairs, we compute the statistic without the ACA, under the ACA with current state Medicaid expansion decisions, and under the ACA with all states expanding Medicaid. If the statistic for a given group relative to whites is lower under the ACA than without the ACA, we can conclude that the underlying difference in health coverage has narrowed.

State Changes in Uninsurance Rates by Race/Ethnicity and by Origin Group

For each racial/ethnic group, we assess how uninsurance rates are projected to change at the state level under the three projected scenarios. For the third such scenario, ACA with full Medicaid expansion, we assess how geographically concentrated the projected coverage gains would be for each racial/ethnic group. (See tables B.1–B.12 for further state-level detail.) We also produced estimates of the uninsured for each racial/ethnic group for the smallest statistically representative geographic area on the ACS.¹⁹ Additional estimates and maps are available in a *MetroTrends* blog post.²⁰ For three detailed subgroups (Latino-origin, Asian/Pacific Islander-origin, and American Indian/Alaska Native tribe) we compare projected percentage reductions in uninsurance rates.

Projected Uninsured Rate Reductions by Racial or Ethnic Group

In this section, we assess how uninsurance rates for each racial/ethnic group are projected to change nationally under each of the three scenarios. We analyze whether racial/ethnic differences in uninsurance rates are projected to narrow under each scenario.

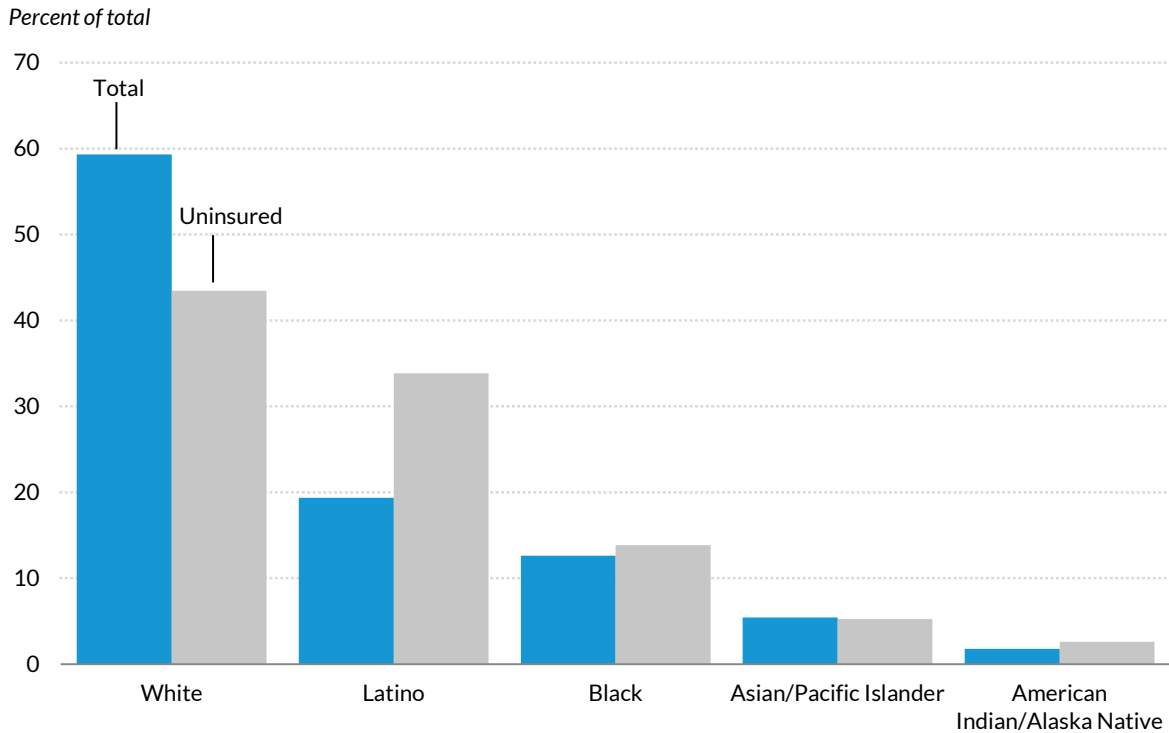
Latinos, Blacks, and American Indian/Alaska Natives Are Overrepresented among the Uninsured at Baseline without the ACA

Without the ACA, blacks make up 13.8 percent of the uninsured but only 12.6 percent of the nonelderly population (figure 1). Latinos make up 33.8 percent of the uninsured but only 19.4 percent of the population. American Indian/Alaska Natives make up 2.6 percent of the uninsured but only 1.8 percent of the population. Whites, Asian/Pacific Islanders, and other non-Latinos, in contrast, have lower uninsurance rates than their representation in the population.

FIGURE 1

Uninsured Nonelderly Population Compared with Total Nonelderly Population without the ACA, by Racial/Ethnic Group

Latinos are 19 percent of the population but 34 percent of the uninsured; whites are 59 percent of the population but 43 percent of the uninsured.



Source: HIPSM-ACS 2014.

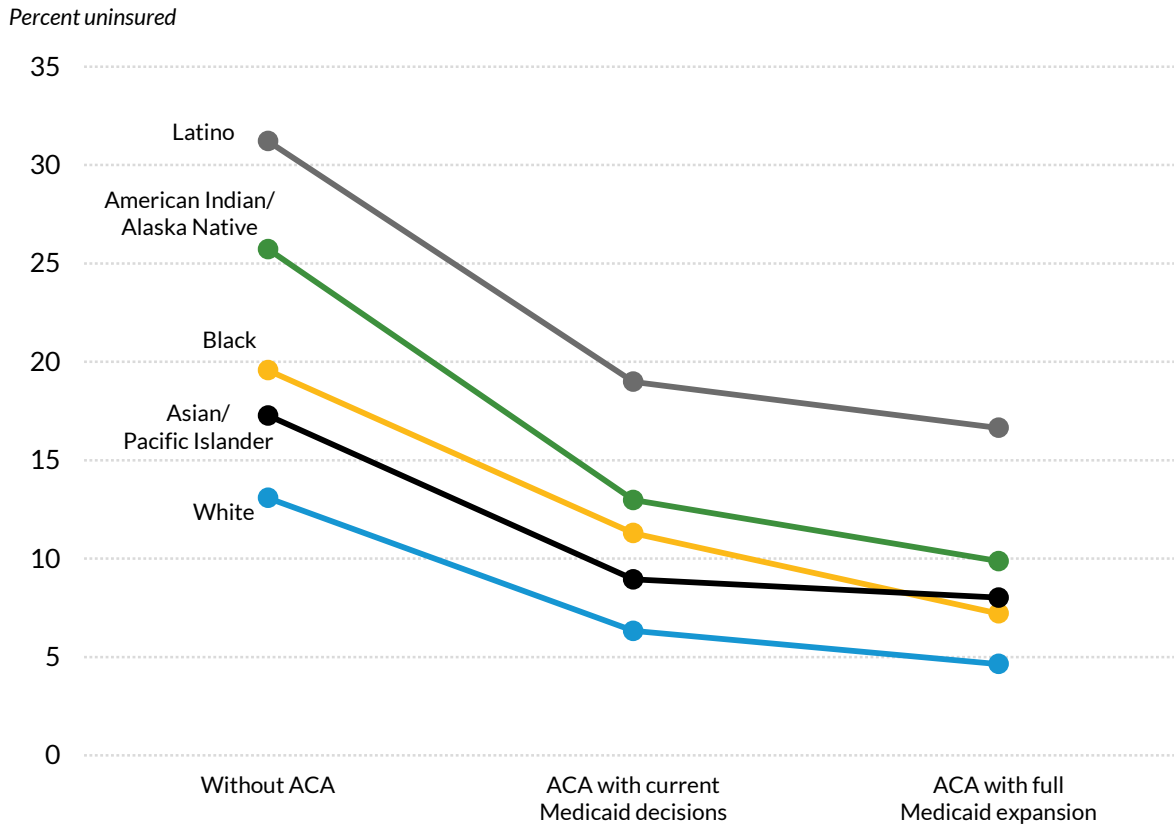
Notes: “Others” (not shown here) compose 1.5 percent of the nonelderly population and 1.1 percent of the uninsured without the ACA. These data are projections for 2016 as described in the Methods section of this report.

Uninsurance Rates Projected to Fall for all Racial/Ethnic Groups under the ACA with Current Medicaid Expansion Decisions

Without the ACA, Latinos are projected in 2016 to have the highest uninsurance rate (31.2 percent), followed by American Indian/Alaska Natives (25.7 percent), blacks (19.6 percent), and Asian/Pacific Islanders (17.3 percent; see figure 2). Whites have the lowest uninsurance rate without the ACA at 13.1 percent. The ACA with current Medicaid expansion decisions is projected to lead to large reductions in uninsurance rates for all racial/ethnic groups examined. The rank order of uninsurance rates across

racial/ethnic groups is projected to be unchanged: Latinos still with the highest (19.0 percent), followed by American Indian/Alaska Natives (13.0 percent) and blacks (11.3 percent); the lowest uninsurance rates are still projected to be among Asian/Pacific Islanders (8.9 percent) and whites (6.3 percent).

FIGURE 2
Projected Uninsurance Rates by Racial/Ethnic Group under Three ACA Scenarios



Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

The largest absolute reductions in uninsurance rates under the ACA with current Medicaid expansion decisions are projected to be among minority groups, especially American Indian/Alaskan Natives (a 12.7 percentage-point drop) and Latinos (a 12.2 percentage-point drop).²¹ The absolute reduction is somewhat less for blacks and Asian/Pacific Islanders (an 8.3 percentage-point drop for both). In comparison, the uninsurance rate among whites is expected to fall 6.8 percentage points, smaller than the drops projected for minority groups.

Uninsurance rates vary greatly by race and ethnicity in the “without ACA” scenario. Thus, the racial/ethnic groups with the largest percentage-point drops in the uninsurance rate do not correspond

to the largest relative reductions in uninsurance levels. For example, though Latinos are projected to have the largest percentage-point decrease in the uninsured rate, they also had the highest rate of uninsurance at the baseline. Consequently, the relative reduction in the uninsured rate for Latinos is projected to be smaller than for all other racial/ethnic groups.

Important projected changes in coverage under the ACA with current Medicaid expansion decisions compared to the “without ACA” scenario include the following (table 1):²²

- The uninsurance rate for whites would decrease 51.6 percent from 13.1 percent without ACA to 6.3 percent under the ACA with current Medicaid expansion decisions: 11.1 million would gain coverage. Whites would account for 48.9 percent of all coverage gains nationwide.
- For Latinos, the ACA with current Medicaid expansion decisions is projected to reduce the uninsured rate 39.2 percent compared to the “without ACA” scenario from 31.2 percent to 19.0 percent: an estimated 6.6 million Latinos would gain coverage. Although this group would still have the highest uninsurance rate of all racial and ethnic groups, its coverage gains would constitute 28.9 percent of all coverage gains.
- The uninsurance rate for blacks would decrease 42.3 percent from 19.6 percent to 11.3 percent: 2.9 million would gain coverage. Blacks would account for 12.8 percent of all coverage gains.
- The uninsurance rate for Asian/Pacific Islanders would decrease 48.2 percent from 17.3 percent to 8.9 percent: 1.3 million would gain coverage. Asian/Pacific Islanders would account for 5.5 percent of all coverage gains.
- Dramatic rate reductions are projected for American Indian/Alaska Natives, for whom the uninsurance rate is projected to decrease 49.5 percent from 25.7 percent to 13.0 percent: 600,000 would gain coverage. American Indian/Alaska Natives would account for 2.8 percent of all coverage gains.

TABLE 1

Selected Characteristics and Projected Uninsurance Rates under Three ACA Scenarios, by Race/Ethnicity

Race/ethnicity	Total nonelderly (millions)	Living in nonexpansion states (%)	Undocumented immigrants (%)	Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
				Uninsured (millions)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
White	164.3	42.3	0.7	21.5	13.1	51.6	6.3	64.5	4.6
Latino	53.6	38.1	16.4	16.7	31.2	39.2	19.0	46.7	16.6
Black	35.0	54.9	1.7	6.8	19.6	42.3	11.3	63.2	7.2
Asian/PI	15.0	22.9	12.1	2.6	17.3	48.2	8.9	53.6	8.0
AI/AN	5.0	44.4	N/A	1.3	25.7	49.5	13.0	61.6	9.9
All	277.0	41.9	4.5	49.5	17.9	45.9	9.7	57.6	7.6

Source: HIPSIM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: PI = Pacific Islander; AI/AN = American Indian/Alaska Native; N/A = not applicable. Population is all nonelderly. Cells marked “not applicable” had too small of a sample size to provide meaningful data. “All” includes a residual racial/ethnic category: those who selected “some other race” as their racial category or selected multiple races and are not Latino or American Indian/Alaska Native. Because of the small samples and heterogeneous nature of this group, this category is not analyzed. See appendix A for additional details on racial/ethnic categories.

Are Differences in Uninsurance Rates Projected to Narrow under the ACA with Current Medicaid Expansion Decisions?

Yes—in most cases the differences in uninsurance rates between racial/ethnic minority groups and whites are projected to narrow under the ACA with current Medicaid expansion decisions.

First, we examine the projected absolute percentage-point differences in uninsurance. Compared to without the ACA, the uninsurance rate difference with whites drops for all groups under the ACA with current Medicaid expansion decisions:²³

- The black-white difference in uninsurance rates is projected to fall from 6.5 percentage points to 5.0 percentage points.
- The Latino-white difference is projected to fall from 18.1 percentage points to 12.7 percentage points.
- The Asian/Pacific Islander–white difference is projected to fall from 4.2 percentage points to 2.6 percentage points.
- The American Indian/Alaskan Native–white difference is projected to fall from 12.6 percentage points to 6.7 percentage points.

To assess whether these changes signify a narrowing of the relative difference in uninsurance rates among the groups, we examine an additional statistic, effect size, to quantify the size of the difference in coverage rates between two groups (as described in the methods section). For Latinos and American Indian/Alaska Natives, the difference in uninsurance rates with whites is projected to narrow under the ACA with current Medicaid expansion decisions compared with uninsurance rates without the ACA since the statistic is smaller under the latter scenario (table B.13). In addition, the difference between Asian/Pacific Islanders' uninsurance rates and whites' rates, which started out small, is projected to narrow slightly under the ACA with current Medicaid expansion decisions. For blacks, however, the difference between their uninsurance rates and whites' rates is projected to narrow under the ACA with current Medicaid expansion decisions *only in Medicaid expansion states*. Across all states, the difference in uninsurance rates between blacks and whites is projected to stay approximately the same both under the ACA with current Medicaid expansion decisions and without the ACA.

Under the ACA with Full Medicaid Expansion, Uninsurance Rates Are Projected to Fall Further for All Racial/Ethnic Groups, Particularly for Blacks

Uninsurance rates are projected to fall further for all groups under the ACA with full Medicaid expansion compared with rates under the ACA with current Medicaid expansion decisions. Under both ACA scenarios, Latinos, American Indian/Alaska Natives, and blacks would have the largest absolute reductions in uninsurance rates.²⁴ The effects on uninsurance rates under the ACA with full Medicaid expansion are particularly strong for groups with a high share of potential Medicaid eligibles because the nonexpansion states tended to have lower Medicaid eligibility rules before the ACA than the expansion states. Blacks are projected to have the largest decreases in uninsurance rates under full Medicaid expansion: a drop from 11.3 percent (projected with current expansion decisions) to 7.2 percent (see figure 2 and table 1).

These results are driven in part by how many uninsured in each racial/ethnic group fall into the “coverage gap” in nonexpansion states. As a share of the adult uninsured population in nonexpansion states, a disproportionate share of blacks falls into the coverage gap (37.6 percent for blacks compared with 28.7 percent for whites; data not shown). Accordingly, blacks are projected to have particularly large gains from additional Medicaid expansions.

Are Differences in Uninsurance Rates Projected to Narrow under the ACA with Full Medicaid Expansion?

Yes—in most cases differences in uninsurance rates between racial/ethnic minority groups and whites are projected to narrow under the ACA with full Medicaid expansion relative to differences without the ACA.

We first examine the projected absolute percentage-point differences in uninsurance. Compared to the “without ACA” scenario, the uninsurance rate difference with whites drops for all groups under ACA with full Medicaid expansion:²⁵

- The Latino-white difference is projected to fall from 18.1 percentage points to 12.0 percentage points.

- The black-white difference in uninsurance rates is projected to fall from 6.5 percentage points to 2.6 percentage points, thus the black-white difference shrinks more under the ACA with full Medicaid expansion than under the ACA with current Medicaid expansion decisions.
- The Asian/Pacific Islander-white difference is projected to fall from 4.2 percentage points to 3.4 percentage points—a smaller decrease than under the ACA with current Medicaid expansion decisions.
- The American Indian/Alaskan Native-white difference is projected to fall from 12.6 percentage points to 5.2 percentage points.

As above, to assess whether these changes signify a narrowing of the relative difference in uninsurance rates among the groups, we examine the effect size (table B.13). In contrast to the ACA with current Medicaid expansion decisions, the national difference in uninsurance rates between blacks and whites is projected to narrow under the ACA with full Medicaid expansion as compared with the “without ACA” scenario. This is because the coverage gap in nonexpansion states contains a large numbers of blacks.

For Latinos and American Indian/Alaska Native groups, the difference in uninsurance rates with whites is also projected to narrow under the ACA with full Medicaid expansion. Coverage rates for whites are affected more than coverage rates for Latinos in a given nonexpansion state if that state were to expand; this is because a small but significant share of poor uninsured Latinos in nonexpansion states is undocumented and therefore ineligible for Medicaid. For American Indian/Alaska Natives, the sizable narrowing of the coverage difference with whites is caused by additional enrollment in nonexpansion states if those states were to expand. For Asian/Pacific Islanders, who started out with a small coverage difference with whites, the differential is not projected to narrow under the ACA with full Medicaid expansion.

Small Groups of States Account for Most Projected Coverage Gains by Racial or Ethnic Group

A different group of states accounts for disproportionate gains for each racial/ethnic group under the ACA with full Medicaid expansion. These findings are driven by the underlying distribution of residence for each group. We first identify the states with the highest potential effect on coverage gains for each group; we then examine whether these states are Medicaid expansion states or nonexpansion states.²⁶

Whites (Tables B.3 and B.4)

- Under the ACA with full Medicaid expansion, 11 states are found to account for half (6.8 million) of coverage gains for whites. In descending order of size of gain, these states are California, Florida, Texas, Ohio, Pennsylvania, Michigan, Georgia, North Carolina, Indiana, Illinois, and New York.
- Because 6 of these 11 states (California, Ohio, Michigan, Illinois, New York, and Pennsylvania) have expanded Medicaid, coverage gains caused by Medicaid expansion are already included in projections that use current Medicaid expansion decisions.
- If the remaining five (Florida, Texas, Georgia, North Carolina, and Indiana) were to expand Medicaid, the number of whites projected to gain coverage nationwide would increase 25.1 percent (3.3 million) compared with the number of whites projected to gain coverage under the ACA with current Medicaid expansion decisions.

Latinos (Tables B.5 and B.6)

- Under the ACA with full Medicaid expansion, just two states (California, which expanded Medicaid, and Texas, which has not expanded Medicaid) are projected to account for half (3.4 million) of coverage gains for Latinos.

- If Texas expands Medicaid, the number of Latinos projected to gain coverage nationally would increase 11.3 percent (0.7 million) compared with the number of Latinos projected to gain coverage under the ACA with current Medicaid expansion decisions.

Blacks (Tables B.7 and B.8)

- Under the ACA with full Medicaid expansion, seven states are projected to account for half (2.2 million) of coverage gains for blacks. In descending order of size of gain, these states are Florida, Georgia, Texas, North Carolina, Louisiana, California, and Illinois.
- Because only two of these seven states (California and Illinois) have expanded Medicaid, a small share of potential coverage gains is projected to occur under the ACA with current Medicaid expansion decisions.
- If the remaining five states (Florida, Georgia, Texas, North Carolina, and Louisiana) were to expand Medicaid, the number of blacks projected to gain coverage nationwide would increase 30.2 percent (0.9 million) compared with the number of blacks projected to gain coverage under the ACA with current Medicaid expansion decisions.

Asian/Pacific Islanders (Tables B.9 and B.10)

- Under the ACA with full Medicaid expansion, three states (California, Texas, and New York) are projected to account for half (0.7 million) of coverage gains for Asian/Pacific Islanders. California would account for 35.9 percent of all national gains.
- If Texas were to expand Medicaid, coverage gains for Asian/Pacific Islanders nationwide would increase by 3.6 percent (46,000) compared with the number of Asian/Pacific Islanders projected to gain coverage under the ACA with current Medicaid expansion decisions.

American Indian/Alaska Natives (Tables B.11 and B.12)

- Under the ACA with full Medicaid expansion, seven states are projected to account for half (0.4 million) of coverage gains for American Indian/Alaska Natives. In descending order of coverage gain, these are California, Oklahoma, Arizona, New Mexico, Texas, Alaska, and North Carolina.
- If the four nonexpansion high-impact states (Oklahoma, Texas, Alaska, and North Carolina) were to expand Medicaid, coverage gains for American Indian/Alaska Natives nationally are projected to increase 11.8 percent (75,000) compared with the number of American Indian/Alaska Natives projected to gain coverage under the ACA with current Medicaid expansion decisions.

Projected Uninsured Rate Reductions by Racial and Ethnic Subgroups

We provide more disaggregated information for three detailed subgroups: Latino-origin, Asian/Pacific Islander-origin, and American Indian/Alaska Native tribe.

For Latino-Origin Groups, Uninsurance Rates Are Projected to Decrease

Changes under the ACA with current Medicaid expansion decisions and with full Medicaid expansion vary widely by Latino-origin group and are driven largely by three factors: rates of uninsurance without the ACA, state of residence, and the prevalence of undocumented immigrants.

As shown in table 1, compared with other racial/ethnic groups, Latinos have the highest rate of uninsurance without the ACA: 31.2 percent. Latino uninsurance rates vary by origin without the ACA and are estimated to range from 15.2 percent for those of Puerto Rican origin to 49.0 percent for those of Honduran origin (table 2).

Overall, the ACA with current Medicaid expansion decisions is projected to decrease uninsurance rates 39.2 percent for all Latinos, leaving 19.0 percent uninsured. Wide differences are projected to remain across Latino-origin groups. The Honduran-origin and Guatemalan-origin populations, approximately one-third of whom are undocumented, would still have the highest rates of uninsurance: 35.6 percent and 32.0 percent, respectively. Those two populations are also projected to have the smallest percentage decreases in uninsurance rate of all Latino-origin groups. The Dominican-origin population, among those with the lowest uninsurance rate without the ACA, would have among the largest percentage decrease in uninsurance rate across Latino-origin groups: from 22.9 percent to 13.1 percent uninsured, a 42.8 percent drop.

State of residence is also an important factor in projected changes in coverage under the ACA for Latino-origin groups. Though 27 states and the District of Columbia will expand Medicaid by January 2015, 38.1 percent of Latinos live in states that are not currently planning to expand Medicaid.

Consequently, the uninsurance rate for Latinos would decrease 39.2 percent under the ACA with current Medicaid expansion decisions; this decrease would be 46.7 percent with full expansion. Thus, the ACA with current Medicaid expansion decisions would lead to 1.3 million fewer insured Latinos than with full Medicaid expansion. State decisions' effect on coverage varies by Latino-origin group location. For example, four out of five uninsured Cubans live in Florida, which is not expanding Medicaid as of January 2015 (data not shown). If Florida were to expand Medicaid, an additional 73,000 Cubans would gain coverage. Nationwide, only 13.3 percent of all Cubans would remain uninsured if all states expanded Medicaid; 17.8 percent would remain uninsured with current Medicaid expansion decisions.

Under the ACA with full Medicaid expansion, 16.6 percent of Latinos would remain uninsured, a reduction of 46.7 percent compared with the project uninsurance rate without the ACA. The resulting uninsurance rates, however, would still vary among Latino-origin groups. The difference between the ACA with current expansion decisions and with full expansion would be particularly large for those of Cuban origin, over three-quarters of whom live in states that will not be expanding Medicaid by January 2015. For those of Mexican origin and several other Latino-origin groups, the difference in projected uninsurance rates between the two ACA scenarios is lessened by the prevalence of undocumented immigrants among the uninsured. See a forthcoming brief by Clemans-Cope and colleagues for more details regarding the effect of undocumented immigrants on coverage rates for Latino-origin groups (Clemans-Cope et al., forthcoming).

TABLE 2

Selected Characteristics and Projected Uninsurance Rates for Latinos by Origin under Three ACA Scenarios

Latinos by origin	Total nonelderly (millions)	Living in nonexpansion states (%)	Undocumented immigrants (%)	Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
				Uninsured (millions)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
Mexican	35.2	38.2	17.8	11.8	33.4	39.1	20.3	46.5	17.8
Puerto Rican	4.9	30.2	N/A	0.7	15.2	50.3	7.6	61.0	5.9
Salvadoran	2.0	33.2	28.1	0.8	40.0	35.6	25.8	40.1	24.0
Cuban	1.8	77.1	12.6	0.5	28.9	38.2	17.8	54.0	13.3
Dominican	1.6	16.8	9.2	0.4	22.9	42.8	13.1	47.9	11.9
Guatemalan	1.2	31.6	32.8	0.6	47.2	32.3	32.0	35.3	30.5
Colombian	1.0	48.6	20.1	0.3	28.7	40.0	17.3	48.3	14.9
Honduran	0.7	57.3	34.5	0.4	49.0	27.3	35.6	34.7	32.0
Ecuadorian	0.7	17.8	21.5	0.2	35.4	34.6	23.2	37.4	22.2
Spaniard	0.6	32.4	3.1	0.1	15.4	51.0	7.6	60.5	6.1
Peruvian	0.6	37.6	24.7	0.2	31.6	35.2	20.5	40.1	18.9
Other S. Am.	0.9	50.4	25.3	0.2	28.0	36.0	17.9	43.6	15.8
Other C. Am.	0.8	48.9	17.4	0.2	30.2	38.5	18.5	48.6	15.5
Other Latino, n.s.	1.6	33.8	3.4	0.3	20.7	50.4	10.3	60.8	8.1
All Latino	53.6	38.1	16.4	16.8	31.2	39.2	19.0	46.7	16.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: S. Am. = South American; C. Am. = Central American; n.s. = not specified. See appendix A for additional details on race/ethnicity and origin categories.

For Asian/Pacific Islander–Origin Groups, Uninsurance Rates Are Projected to Decrease, but Wide Differences Remain

Though the overall uninsurance rate for Asian/Pacific Islanders without the ACA is projected to be 17.3 percent, lower than that of all other race/ethnic groups except whites, uninsurance rates are projected to differ widely by Asian/Pacific Islander–origin groups (table 3). Those of Korean origin are projected to have the highest uninsurance rate without the ACA, 29.9 percent, followed by those of Vietnamese origin at 21.5 percent. Those of Indian origin and those of Filipino origin are projected to have much lower uninsurance rates without the ACA: 13.1 percent and 12.4 percent, respectively.

Over three-quarters of Asian/Pacific Islanders live in states that are expanding Medicaid, the highest rate of any racial/ethnic group. Under the ACA with current Medicaid expansion decisions, uninsurance rates for Asian/Pacific Islanders are projected to decrease 48.2 percent, falling from 17.3 percent to 8.9 percent. If all states expanded Medicaid, an additional 139,200 Asian/Pacific Islanders would gain coverage. More than one-quarter of these additional gains would come from those of Vietnamese origin: 34.5 percent live in states that are not currently expanding Medicaid. Additionally, this group is projected to experience the largest percentage decrease in uninsurance of any Asian/Pacific Islander–origin group under the ACA with full expansion: 60.3 percent. Because a large majority of Chinese-, Asian Indian-, Filipino-, and Korean-origin groups live in states that decided to expand Medicaid by January 2015, only marginal gains would be made with additional expansions.

TABLE 3

Selected Characteristics and Projected Uninsurance Rates for Asian/Pacific Islanders by Origin under Three ACA Scenarios

Asian/Pacific Islanders by origin	Total nonelderly (millions)	Living in nonexpansion states (%)	Undocumented immigrants (%)	Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
				Uninsured (millions)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
Chinese	3.4	16.5	11.4	0.6	16.5	47.5	8.7	50.8	8.1
Asian Indian	2.9	28.3	17.4	0.4	13.1	44.2	7.3	49.9	6.6
Filipino	2.4	16.0	10.3	0.3	12.4	49.4	6.3	52.2	5.9
Vietnamese	1.6	34.5	6.5	0.4	21.5	50.0	10.7	60.3	8.5
Korean	1.4	23.1	15.3	0.4	29.9	51.1	14.6	55.0	13.4
All other A/PI	3.2	23.9	10.8	0.6	17.7	47.6	9.3	54.1	8.1
All A/PI	15.0	22.9	12.1	2.6	17.3	48.2	8.9	53.6	8.0

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: A/PI = Asian/Pacific Islander. See appendix A for additional details on racial/ethnic and origin categories.

For American Indian/Alaska Native Tribes, Uninsurance Rates Are Projected to Decrease, but Wide Differences Remain because of State Expansion Decisions

Without the ACA, uninsurance rates are projected to vary widely for American Indian/Alaska Natives by tribe, from 24.4 percent for Chippewa to 34.2 percent for Navajo (table 4). Under the ACA with current Medicaid expansion decisions, uninsurance rates are projected to fall substantially for all American Indian/Alaska Native groups. Approximately 633,000 American Indian/Alaska Natives are projected to gain coverage. Over two-thirds (68.2 percent) of American Indian/Alaska Natives projected to gain coverage under the ACA with current Medicaid expansion decisions do not report membership in only a single tribe and thus fall into the “All Other AI/AN” category.²⁷

Only one-quarter of American Indian/Alaska Natives report only one tribal affiliation and no additional races. And though potential underreporting of tribal membership and small samples limit detail on inter-tribal differences, some findings are clear. American Indian/Alaska Natives who report only one tribal affiliation and no additional races are concentrated in states with tribal jurisdictions; those reporting no tribe, multiple tribes, or multiple races are much less geographically concentrated.²⁸ Consequently, differences in coverage gains across tribes are largely based on state Medicaid expansion decisions.

Thus, though just 13.0 percent of all American Indian/Alaska Natives are projected to be uninsured under the ACA with current Medicaid expansion decisions, rates vary based on state of residence. Navajos and Pueblos, with fewer than 10 percent of members living in nonexpansion states, are projected to have uninsurance rates of 11.8 percent and 11.9 percent, respectively. Lumbees and Eskimos, with nearly all residents living in nonexpansion states (North Carolina and Alaska, respectively) are projected to have uninsurance rates of 17.5 percent and 16.3 percent, respectively.

If all states expanded Medicaid, the uninsurance rate among all American Indian/Alaska Natives would drop to 9.9 percent, a decrease of 61.6 percent compared with projections without the ACA. The projected uninsurance rates with full expansion would range from 8.7 percent for the Cherokee to 11.7 percent for Pueblos. Eskimos, 9.0 percent of whom would remain uninsured, would see the largest percentage decrease in uninsurance: 72.7 percent if all states (including Alaska) expanded Medicaid.

TABLE 4

Uninsurance Rates and Decreases for American Indian/Alaska Natives by Tribe

American Indian/ Alaska Natives by tribe	Total nonelderly (thousands)	Living in nonexpansion states (%)	Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
			Uninsured (thousands)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
Navajo	347.2	9.9	118.7	34.2	65.6	11.8	68.3	10.8
Cherokee	283.4	68.9	70.1	24.7	43.4	14.0	64.7	8.7
Sioux	141.4	68.3	44.2	31.3	41.4	18.3	67.3	10.2
Chippewa	130.6	24.2	31.9	24.4	56.7	10.6	61.2	9.5
Choctaw	89.1	79.5	24.8	27.9	46.1	15.0	64.3	9.9
Apache	76.9	17.8	23.5	30.5	57.0	13.1	65.0	10.7
Lumbee	76.4	96.3	20.3	26.5	34.1	17.5	65.9	9.0
Pueblo	68.0	5.4	21.8	32.1	63.0	11.9	63.6	11.7
Eskimo	66.8	94.5	22.0	33.0	50.5	16.3	72.7	9.0
All other AI/AN	3,688.5	44.0	900.7	24.4	48.0	12.7	59.7	9.9
All AI/AN	4,968.2	44.4	1,278.0	25.7	49.5	13.0	61.6	9.9

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Note: AI/AN = American Indian/Alaska Native. Population is all nonelderly. See appendix A for additional details on racial/ethnic categories.

Conclusions

This study is the first state-based examination of how the ACA is projected to change uninsurance rates for five major racial and ethnic groups: whites, blacks, Latinos, Asian/Pacific Islanders, and American Indian/ Alaska Natives. The Urban Institute's HIPSM-ACS microsimulation model projects large reductions in uninsurance rates for all racial/ethnic groups under the ACA with Medicaid expansion decisions as of December 2014. We project even larger reductions under the ACA with full Medicaid expansion. In a more detailed subgroup examination by origin, we also find large reductions for each Latino-origin group, Asian/Pacific Islander-origin group, and American Indian/Alaska Natives tribe examined.

According to our projections, the ACA with current Medicaid expansion decisions could substantially narrow differences in uninsurance rates between whites and all racial/ethnic minorities except blacks, who disproportionately live nonexpansion states. In particular, dramatic reductions are projected for American Indian/Alaska Natives, with a projected decrease in the uninsurance rate from 25.7 percent to 13.0 percent—a 49.5 percent reduction that translates to 600,000 gaining coverage. Latinos would see a projected decrease in the uninsured rate from 31.2 percent to 19.0 percent—a 39.2 percent reduction, translating to 6.6 million gaining coverage. Both groups would see a narrowing of the differences in uninsurance rates with whites.

Under the ACA with Medicaid expansion in all states, uninsurance rates are projected to fall further for all racial/ethnic groups. Compared to projections with current Medicaid expansion decisions, dramatic uninsurance rate reductions are projected for blacks were all states to expand Medicaid: from 11.3 percent with current decisions to 7.2 percent with full expansion. Given that over half of all blacks are living in states not expanding Medicaid in 2014, 1.4 million uninsured blacks are in the eligibility gap. These 1.4 million constitute 23.1 percent of the black adult uninsured adult population nationwide. Overall, 2.7 million whites, 13.8 percent of the white adult uninsured population, falls into this gap. Because of tribe members' locations, four American Indian/Alaska Natives tribes (Eskimo, Cherokee, Sioux, and Lumbee) are also projected to experience dramatic gains under the ACA with full Medicaid expansion as compared with current expansion decisions.

Even with current Medicaid expansion decisions, the ACA is projected to shrink many of the persistent racial and ethnic differences in health insurance coverage. The ACA with Medicaid expansion in all states shows the potential for further reductions in uninsurance rates and, in contrast with projections of current Medicaid expansion decisions, would substantially narrow racial/ethnic

differences in coverage between whites and blacks. Thus, the promise of reducing long-standing racial/ethnic differences in access to health care and health status likely depends in part on the expansion decisions of the remaining 23 states.

Even so, state outreach and enrollment efforts will be important to (1) raise enrollment rates among eligibles in Medicaid and the Children's Health Insurance Program and (2) increase the number of eligible people who purchase subsidized coverage through the new insurance Marketplaces:

- Further coverage gains among Latinos will depend heavily on reaching Latinos in California (a Medicaid expansion state), many of whom are immigrants with limited English proficiency; those gains will also depend on Medicaid expansion decisions in Texas and Florida.
- California will also be pivotal for Asian/Pacific Islanders, many of whom have limited English proficiency, and for low-income whites, for whom low health insurance literacy may be the most important obstacle.
- Further coverage gains among blacks will depend on effective Medicaid and Marketplace outreach and enrollment efforts in California and Illinois (also a Medicaid expansion state) and Medicaid expansion decisions in Florida, Georgia, Texas, North Carolina, and Louisiana.
- Further coverage gains for American Indian/Alaska Natives will depend heavily on outreach and enrollment efforts in Oklahoma and Alaska, which have not expanded Medicaid, as well as California, Arizona, and New Mexico, which expanded Medicaid in 2014.
- Further coverage gains for whites will depend on outreach and enrollment in California, Ohio, and Pennsylvania (three Medicaid expansion states), and Florida and Texas (two nonexpansion states). Those gains also depend on Medicaid expansion decisions in Florida, Texas, Georgia, North Carolina, and Indiana.

The extent to which these high-impact states are maximizing outreach and enrollment efforts across racial/ethnic groups is unknown.²⁹ But four lessons for racial/ethnic group enrollment identified during the first open enrollment season may be instructive. First, an effective enrollment process requires enrollment assistance for those with limited English proficiency. This includes high-quality translations of print materials, greater availability of one-on-one in-person assistance, and a well-functioning website with culturally and linguistically appropriate versions languages besides English (Brooks 2014). Translation services are particularly important for those with limited English proficiency (Jahnke, Siddiqui, and Andrulis 2014). Second, the identity verification process posed problems. The process relied heavily on whether an individual could provide a Social Security number and answer

'identity proofing' questions drawn from credit history.³⁰ The process was cited as a barrier for many immigrant families and those with limited credit history during the first open enrollment season (Kanchinadam and Jee 2014).³¹ Third, improving health insurance literacy is likely to improve enrollment. Health insurance literacy is low among those who are eligible for Medicaid. This impedes enrollment, and some racial/ethnic groups, such as Latinos, face larger health insurance literacy gaps than other groups (Long and Goin 2014). Lastly, effective outreach will likely require more communication at the community level, such as through partnerships with local ethnic media and through work with trusted individuals in the community who can address misperceptions and misinformation around the ACA.³²

Appendix A. Racial and Ethnic Classifications

Changes in coverage were examined for six racial/ethnic categories based on the combined responses to two questions on the ACS. Racial groups were identified using responses to the ACS question, “What is Person X’s race?” There were 15 response selections, including “some other race” (the complete question and response choices are provided in this appendix). Responses were then grouped into six categories, more than one of which could be true for a respondent: White, Black, American Indian or Alaska Natives, Asian, Pacific Islander, and Other. Latino ethnicity was identified using responses to the ACS question, “Is Person X of Hispanic, Latino, or Spanish origin?” The racial/ethnic categories used in this report are as follows:

1. **White, non-Latino**, referred to as “white,” includes those who are not Latino and who selected only “white” as their race.
2. **Latino** includes those of Hispanic, Latino, or Spanish origin who are of any race or multiple races, and not American Indian/Alaska Natives.
3. **Black, non-Latino**, referred to as “black,” includes those who are not Latino and who selected only “black, African Am., or negro” as their race.
4. **Asian/Pacific Islander, non-Latino**, referred to as “Asian/Pacific Islander,” includes those who are not Latino and who selected only Asian or Pacific Islander racial subcategories (Asian Indian, Japanese, Native Hawaiian, Chinese, Korean, Guamanian or Chamorro, Filipino, Vietnamese, Samoan, other Asian, or other Pacific Islander).
5. **American Indian/Alaska Natives** includes all those who selected American Indian or Alaska Natives as their race, regardless of ethnicity or additional races identified.

A residual racial/ethnic category includes those who selected “some other race” as their racial category or selected multiple races and are not Latino or American Indian/Alaska Natives. Because of the small samples and heterogeneous nature of this group, this category is not analyzed.³³

We then examine three racial/ethnic groups in additional detail. We analyze subgroups by origin for the Latino and Asian/Pacific Islander groups, since they have a relatively high proportion of foreign-born compared to the three other racial/ethnic groups. We analyze American Indian/Alaska Natives subgroups by tribe.

1. The 11 largest Latino-origin groups (Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, Spaniard, and Peruvian) and three other categories (Other South American, Other Central American, and Other Latino not specified). Classifications are based on responses given to Question 5 below.
2. The five largest Asian/Pacific Islander-origin groups (Chinese, Indian, Filipino, Vietnamese, and Korean) and all other Asian/Pacific Islanders (including those reporting multiple subgroups). Classifications are based on responses to in Question 6 below, with those selecting multiple Asian/Pacific Islander subgroups included in the “all other Asian/Pacific Islander” category.
3. The nine largest identifiable tribes as self-identified in Question 6 below. All other American Indian/Alaska Natives, including those of mixed race and multiple or unspecified tribes, are included in the “all other American Indian/Alaska Natives” subcategory.

American Community Survey Questions, 2009.³⁴

5. Is Person 1 of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican Am., Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin -- *Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.* _____

6. What is Person 1's race? Mark (X) one or more boxes.

- White
 - Black, African Am., or Negro
 - American Indian or Alaska Natives -- *Print name of enrolled or principal tribe.* _____
- | | | |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Samoan |
- Other Asian -- *Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on.* _____
- Other Pacific Islander -- *Print race, for example, Fijian, Tongan, and so on.* _____
- Some other race -- *Print race.* _____

Appendix B. Additional Tables

TABLE B.1

Projected Number of Nonelderly Uninsured without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	681.7	489.1	192.6	28.3	264.8	416.9	61.2
Alaska	140.9	73.5	67.4	47.8	50.5	90.4	64.1
Florida	4,153.1	2,592.3	1,560.7	37.6	1,621.3	2,531.7	61.0
Georgia	1,967.8	1,369.3	598.5	30.4	856.4	1,111.4	56.5
Idaho	271.6	174.7	96.9	35.7	103.8	167.8	61.8
Indiana	939.1	614.4	324.6	34.6	344.1	595.0	63.4
Kansas	380.3	258.5	121.8	32.0	160.6	219.7	57.8
Louisiana	820.3	557.5	262.8	32.0	301.1	519.1	63.3
Maine	143.5	81.2	62.3	43.4	52.1	91.4	63.7
Mississippi	531.0	367.3	163.7	30.8	191.9	339.1	63.9
Missouri	815.9	538.8	277.1	34.0	296.0	519.9	63.7
Montana	190.3	110.3	80.1	42.1	61.2	129.2	67.9
Nebraska	222.1	141.0	81.1	36.5	91.0	131.1	59.0
North Carolina	1,612.3	1,007.9	604.4	37.5	623.5	988.8	61.3
Oklahoma	706.6	464.6	242.0	34.3	300.1	406.5	57.5
South Carolina	805.3	543.0	262.3	32.6	327.2	478.2	59.4
South Dakota	107.1	67.1	40.0	37.3	35.5	71.7	66.9
Tennessee	951.2	624.2	327.0	34.4	385.6	565.6	59.5
Texas	6,287.8	4,333.9	1,953.9	31.1	2,932.1	3,355.7	53.4
Utah	436.4	272.6	163.8	37.5	183.2	253.1	58.0
Virginia	1,009.3	683.6	325.7	32.3	436.9	572.4	56.7
Wisconsin ^a	537.0	221.5	315.5	58.7	199.5	337.6	62.9
Wyoming	88.1	50.9	37.2	42.2	32.5	55.6	63.2
All nonexpansion states	23,798.7	15,637.2	8,161.4	34.3	9,850.9	13,947.8	58.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

^a Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment closed.

TABLE B.2

Projected Number of Nonelderly Uninsured without ACA and with ACA and Current Medicaid Expansion Decisions, (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	1,191.5	488.0	703.4	59.0
Arkansas	503.7	194.8	308.9	61.3
California	7,456.5	3,069.6	4,386.9	58.8
Colorado	821.0	382.4	438.6	53.4
Connecticut	330.7	166.0	164.7	49.8
Delaware	89.1	47.9	41.2	46.2
District of Columbia	48.9	23.9	25.0	51.0
Hawaii	104.4	42.4	61.9	59.3
Illinois	1,767.0	749.5	1,017.5	57.6
Iowa	279.3	116.2	163.1	58.4
Kentucky	636.6	232.6	404.0	63.5
Maryland	651.0	331.2	319.8	49.1
Massachusetts	306.7	143.6	163.1	53.2
Michigan	1,219.2	436.7	782.5	64.2
Minnesota	490.9	242.5	248.4	50.6
Nevada	627.8	304.7	323.1	51.5
New Hampshire	139.8	49.1	90.6	64.8
New Jersey	1,250.6	632.3	618.2	49.4
New Mexico	455.1	207.6	247.6	54.4
New York	2,435.1	1,364.9	1,070.2	43.9
North Dakota	69.4	25.2	44.2	63.7
Ohio	1,384.2	479.4	904.8	65.4
Oregon	656.6	281.2	375.3	57.2
Pennsylvania	1,302.3	495.4	806.9	62.0
Rhode Island	127.2	57.8	69.4	54.5
Vermont	57.0	27.4	29.7	52.0
Washington	997.4	450.3	547.1	54.9
West Virginia	274.1	91.4	182.7	66.6
All expansion states	25,673.0	11,134.2	14,538.8	56.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

TABLE B.3

Projected Number of Uninsured Whites without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	360.8	244.6	116.3	32.2	123.9	236.9	65.7
Alaska	63.9	31.7	32.2	50.4	22.9	41.0	64.1
Florida	1,632.8	1,016.0	616.8	37.8	579.7	1,053.1	64.5
Georgia	768.0	486.3	281.7	36.7	262.1	505.9	65.9
Idaho	194.5	117.9	76.6	39.4	62.0	132.5	68.1
Indiana	665.8	412.8	253.0	38.0	213.4	452.5	68.0
Kansas	225.1	142.1	83.0	36.9	75.6	149.5	66.4
Louisiana	376.5	239.1	137.4	36.5	131.9	244.6	65.0
Maine	134.4	75.9	58.5	43.5	47.8	86.6	64.5
Mississippi	247.9	159.6	88.3	35.6	86.8	161.1	65.0
Missouri	578.2	367.6	210.6	36.4	194.8	383.4	66.3
Montana	140.8	80.2	60.6	43.0	43.1	97.7	69.4
Nebraska	139.8	81.5	58.3	41.7	45.4	94.4	67.5
North Carolina	762.5	467.9	294.6	38.6	260.0	502.5	65.9
Oklahoma	370.7	233.4	137.3	37.0	138.9	231.8	62.5
South Carolina	401.7	248.5	153.2	38.1	143.3	258.4	64.3
South Dakota	66.0	40.1	25.9	39.2	21.7	44.3	67.1
Tennessee	596.1	361.9	234.2	39.3	206.9	389.2	65.3
Texas	1,578.4	965.2	613.2	38.8	569.7	1,008.7	63.9
Utah	251.1	138.1	113.0	45.0	76.5	174.6	69.5
Virginia	452.8	282.5	170.3	37.6	153.9	298.9	66.0
Wisconsin ^a	356.4	137.8	218.6	61.3	120.4	236.0	66.2
Wyoming	66.1	37.1	28.9	43.8	22.8	43.3	65.5
All nonexpansion states	10,430.3	6,367.9	4,062.4	38.9	3,603.3	6,827.0	65.5

Source: HIPS-M-ACS 2014. ACA simulated as fully implemented in 2016.

^a Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment closed.

TABLE B.4

Projected Number of Uninsured Whites without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	421.7	139.5	282.3	66.9
Arkansas	325.9	106.1	219.8	67.4
California	1,643.0	577.4	1,065.6	64.9
Colorado	407.6	146.6	261.0	64.0
Connecticut	156.2	62.3	93.9	60.1
Delaware	47.3	21.2	26.1	55.1
District of Columbia	10.3	4.5	5.8	56.3
Hawaii	29.2	9.8	19.4	66.5
Illinois	718.4	267.9	450.5	62.7
Iowa	210.2	75.9	134.2	63.9
Kentucky	507.9	169.3	338.7	66.7
Maryland	219.0	85.0	134.0	61.2
Massachusetts	177.5	69.7	107.7	60.7
Michigan	822.8	276.0	546.7	66.5
Minnesota	322.8	141.5	181.2	56.1
Nevada	229.5	80.6	148.8	64.9
New Hampshire	122.1	40.1	82.0	67.1
New Jersey	416.3	159.8	256.6	61.6
New Mexico	101.6	36.4	65.2	64.2
New York	869.3	426.6	442.7	50.9
North Dakota	48.3	16.8	31.5	65.2
Ohio	1,013.7	334.0	679.7	67.0
Oregon	428.0	145.8	282.2	65.9
Pennsylvania	874.4	298.7	575.7	65.8
Rhode Island	70.2	22.7	47.4	67.6
Vermont	51.6	24.6	27.1	52.4
Washington	563.3	205.4	357.9	63.5
West Virginia	250.4	81.6	168.9	67.4
All expansion states	11,058.4	4,025.9	7,032.5	63.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

TABLE B.5

Projected Number of Uninsured Latinos without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	77.9	65.6	12.3	15.8	58.7	19.2	24.6
Alaska	7.5	5.1	2.4	32.2	4.1	3.4	45.4
Florida	1,583.8	977.3	606.4	38.3	692.1	891.7	56.3
Georgia	435.1	355.5	79.6	18.3	314.2	120.9	27.8
Idaho	60.5	46.1	14.4	23.7	35.6	24.9	41.1
Indiana	122.5	98.3	24.3	19.8	75.2	47.3	38.6
Kansas	94.6	74.1	20.5	21.7	59.9	34.7	36.7
Louisiana	70.1	54.9	15.2	21.7	46.1	23.9	34.2
Maine	2.0	N/A	N/A	N/A	N/A	N/A	N/A
Mississippi	32.6	26.5	6.1	18.8	22.8	9.8	30.0
Missouri	64.0	49.1	14.9	23.3	36.9	27.1	42.3
Montana	7.6	5.1	2.5	32.6	4.3	3.3	43.7
Nebraska	51.1	39.8	11.2	22.0	33.0	18.1	35.4
North Carolina	366.4	231.0	135.4	37.0	199.8	166.6	45.5
Oklahoma	123.0	94.5	28.5	23.2	79.5	43.5	35.4
South Carolina	107.0	88.2	18.9	17.6	79.8	27.3	25.5
South Dakota	4.3	3.2	1.1	25.9	2.5	1.8	42.0
Tennessee	125.4	104.3	21.1	16.8	94.6	30.8	24.6
Texas	3,751.2	2,732.5	1,018.7	27.2	1,994.8	1,756.4	46.8
Utah	147.6	109.2	38.4	26.0	92.3	55.3	37.4
Virginia	209.5	166.2	43.3	20.7	149.1	60.4	28.8
Wisconsin ^a	92.7	47.8	44.8	48.4	45.0	47.6	51.4
Wyoming	13.4	7.9	5.5	41.3	6.3	7.1	53.1
All nonexpansion states	7,549.8	5,383.6	2,166.2	28.7	4,128.0	3,421.8	45.3

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked “not applicable” had too small of a sample size to provide meaningful data.

^a Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.

TABLE B.6

Projected Number of Uninsured Latinos without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	580.9	281.5	299.4	51.5
Arkansas	68.3	49.9	18.3	26.8
California	4,414.2	1,955.2	2,459.0	55.7
Colorado	320.1	195.5	124.6	38.9
Connecticut	108.3	70.2	38.1	35.2
Delaware	19.2	14.9	4.3	22.4
District of Columbia	10.1	7.2	2.9	28.8
Hawaii	9.6	3.8	5.9	61.0
Illinois	589.9	304.9	285.0	48.3
Iowa	40.2	28.1	12.1	30.1
Kentucky	46.3	33.9	12.4	26.8
Maryland	159.3	124.2	35.1	22.0
Massachusetts	65.8	40.5	25.2	38.4
Michigan	102.0	57.4	44.5	43.7
Minnesota	71.1	53.5	17.6	24.7
Nevada	288.6	178.8	109.7	38.0
New Hampshire	8.2	4.2	4.0	49.0
New Jersey	507.2	320.7	186.5	36.8
New Mexico	248.6	134.3	114.4	46.0
New York	834.8	513.0	321.8	38.5
North Dakota	2.5	N/A	N/A	N/A
Ohio	90.5	43.4	47.1	52.1
Oregon	151.6	103.3	48.2	31.8
Pennsylvania	159.3	89.0	70.3	44.1
Rhode Island	38.9	25.5	13.4	34.5
Vermont	1.3	N/A	N/A	N/A
Washington	247.3	161.4	85.9	34.7
West Virginia	4.3	1.8	2.6	59.2
All expansion states	9,188.4	4,797.5	4,390.9	47.8

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.7

Projected Number of Uninsured Blacks without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	218.9	161.8	57.1	26.1	70.6	148.3	67.8
Alaska	3.5	2.4	1.1	30.8	1.8	1.7	49.3
Florida	731.0	476.5	254.5	34.8	270.8	460.2	63.0
Georgia	635.1	441.9	193.2	30.4	220.9	414.2	65.2
Idaho	1.9	N/A	N/A	N/A	N/A	N/A	N/A
Indiana	110.9	78.0	32.9	29.6	38.9	72.0	64.9
Kansas	28.9	20.8	8.2	28.2	10.7	18.3	63.2
Louisiana	335.4	236.9	98.5	29.4	105.9	229.5	68.4
Maine	1.0	N/A	N/A	N/A	N/A	N/A	N/A
Mississippi	233.0	169.4	63.6	27.3	74.1	158.9	68.2
Missouri	130.8	92.6	38.2	29.2	45.8	85.0	65.0
Montana	1.1	N/A	N/A	N/A	N/A	N/A	N/A
Nebraska	14.0	8.9	5.2	36.8	5.4	8.6	61.4
North Carolina	377.3	243.8	133.4	35.4	123.9	253.4	67.2
Oklahoma	52.7	35.7	17.0	32.3	18.2	34.5	65.5
South Carolina	266.8	187.1	79.7	29.9	90.9	175.9	65.9
South Dakota	2.0	1.0	1.0	49.0	N/A	N/A	N/A
Tennessee	191.1	131.8	59.3	31.0	66.0	125.0	65.4
Texas	616.1	414.6	201.5	32.7	216.9	399.2	64.8
Utah	4.9	3.9	1.0	21.1	2.6	2.3	46.6
Virginia	241.9	164.4	77.6	32.1	83.6	158.3	65.4
Wisconsin ^a	48.2	18.9	29.3	60.8	17.4	30.7	63.8
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All nonexpansion states	4,247.1	2,892.8	1,354.3	31.9	1,466.6	2,780.5	65.5

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked “not applicable” had too small of a sample size to provide meaningful data.

^a Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.

TABLE B.8

Projected Number of Uninsured Blacks without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	40.3	14.0	26.3	65.2
Arkansas	84.2	27.1	57.2	67.9
California	336.0	117.7	218.3	65.0
Colorado	34.8	14.6	20.2	58.0
Connecticut	40.6	19.0	21.7	53.3
Delaware	17.0	8.9	8.0	47.2
District of Columbia	25.9	11.0	14.9	57.5
Hawaii	1.0	N/A	N/A	N/A
Illinois	336.8	123.9	212.9	63.2
Iowa	13.6	4.1	9.5	69.8
Kentucky	63.3	21.5	41.8	66.0
Maryland	207.3	88.1	119.2	57.5
Massachusetts	28.6	13.2	15.4	53.9
Michigan	225.7	75.4	150.4	66.6
Minnesota	41.6	20.7	20.9	50.1
Nevada	43.7	15.1	28.6	65.4
New Hampshire	2.5	1.2	1.3	52.8
New Jersey	171.9	70.4	101.5	59.1
New Mexico	5.1	2.1	3.0	59.6
New York	390.4	224.7	165.6	42.4
North Dakota	1.7	N/A	N/A	N/A
Ohio	224.5	79.4	145.1	64.6
Oregon	11.8	3.5	8.3	70.3
Pennsylvania	187.0	69.8	117.2	62.7
Rhode Island	9.2	4.8	4.4	47.4
Vermont	N/A	N/A	N/A	N/A
Washington	39.3	18.1	21.2	53.9
West Virginia	11.7	5.0	6.8	57.8
All expansion states	2,596.4	1,054.9	1,541.5	59.4

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.9

Projected Number of Uninsured Asian/Pacific Islanders without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	10.2	7.2	2.9	28.8	5.5	4.7	45.7
Alaska	11.4	6.5	4.9	42.9	4.8	6.6	57.8
Florida	116.9	69.1	47.7	40.9	45.3	71.6	61.3
Georgia	92.3	61.2	31.1	33.7	43.3	49.0	53.1
Idaho	3.2	2.1	1.1	33.5	1.3	1.8	57.6
Indiana	19.1	12.6	6.5	34.0	10.0	9.1	47.7
Kansas	12.0	8.3	3.7	30.7	6.2	5.9	48.9
Louisiana	20.5	14.5	6.0	29.1	9.9	10.6	51.8
Maine	2.2	N/A	N/A	N/A	1.0	1.2	55.1
Mississippi	8.0	5.3	2.7	33.7	4.2	3.8	47.3
Missouri	15.7	10.6	5.1	32.6	7.9	7.8	49.9
Montana	1.8	N/A	N/A	N/A	N/A	N/A	N/A
Nebraska	5.3	4.1	1.2	23.1	3.2	2.1	39.3
North Carolina	41.7	24.7	17.0	40.7	16.9	24.8	59.5
Oklahoma	14.8	9.6	5.2	35.1	6.8	8.1	54.5
South Carolina	15.0	10.0	5.0	33.6	8.1	6.9	45.8
South Dakota	1.0	N/A	N/A	N/A	N/A	N/A	N/A
Tennessee	18.1	12.4	5.7	31.3	9.3	8.8	48.7
Texas	227.2	146.3	80.9	35.6	100.8	126.5	55.6
Utah	13.1	9.2	3.8	29.5	5.7	7.3	56.3
Virginia	74.4	50.0	24.4	32.8	36.8	37.6	50.6
Wisconsin ^a	17.6	8.1	9.4	53.7	7.8	9.8	55.9
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All nonexpansion states	741.8	475.5	266.2	35.9	336.3	405.5	54.7

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked “not applicable” had too small of a sample size to provide meaningful data.

^a Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.

TABLE B.10

Projected Number of Uninsured Asian/Pacific Islanders without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	30.4	15.0	15.4	50.7
Arkansas	11.0	5.0	6.0	54.9
California	833.6	334.8	498.9	59.8
Colorado	26.1	12.1	14.0	53.6
Connecticut	16.2	9.5	6.7	41.4
Delaware	2.5	1.5	1.0	38.6
District of Columbia	1.8	N/A	N/A	N/A
Hawaii	45.5	22.8	22.7	50.0
Illinois	95.7	42.5	53.3	55.6
Iowa	5.8	3.2	2.6	44.6
Kentucky	7.6	3.7	3.9	51.1
Maryland	48.4	25.6	22.7	47.0
Massachusetts	21.9	13.3	8.6	39.2
Michigan	33.6	15.6	18.0	53.5
Minnesota	25.8	13.7	12.1	46.9
Nevada	41.2	20.6	20.6	49.9
New Hampshire	4.0	2.5	1.4	36.2
New Jersey	117.7	59.8	57.9	49.2
New Mexico	5.2	2.7	2.5	47.3
New York	272.8	162.5	110.3	40.4
North Dakota	N/A	N/A	N/A	N/A
Ohio	27.0	12.2	14.7	54.6
Oregon	29.3	14.8	14.5	49.5
Pennsylvania	55.1	27.1	28.0	50.8
Rhode Island	4.8	3.0	1.9	38.5
Vermont	1.8	N/A	N/A	N/A
Washington	85.6	41.2	44.4	51.9
West Virginia	1.8	N/A	N/A	N/A
All expansion states	1,852.9	868.5	984.4	53.1

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.11

Projected Number of Uninsured American Indian/Alaska Natives without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	10.1	7.1	3.0	30.1	4.7	5.4	53.8
Alaska	53.3	27.3	26.0	48.8	16.6	36.7	68.9
Florida	42.9	26.5	16.4	38.2	15.7	27.2	63.4
Georgia	19.0	12.4	6.6	34.7	8.4	10.6	55.8
Idaho	10.5	7.1	3.4	32.7	4.1	6.5	61.4
Indiana	11.2	6.8	4.4	39.2	3.7	7.5	67.2
Kansas	15.8	10.5	5.2	33.1	6.7	9.1	57.8
Louisiana	13.2	9.1	4.1	31.3	5.8	7.5	56.5
Maine	3.7	1.6	2.1	57.3	1.4	2.3	62.4
Mississippi	7.5	5.2	2.3	30.7	3.1	4.5	59.4
Missouri	19.1	13.1	6.0	31.3	7.7	11.5	60.0
Montana	37.8	22.5	15.3	40.6	12.1	25.7	67.9
Nebraska	9.2	5.8	3.5	37.6	3.2	6.0	64.8
North Carolina	50.6	32.2	18.3	36.3	18.1	32.5	64.2
Oklahoma	139.7	87.4	52.3	37.4	54.1	85.7	61.3
South Carolina	7.0	5.2	1.8	25.9	2.6	4.4	62.7
South Dakota	33.8	22.3	11.4	33.8	10.1	23.6	70.0
Tennessee	12.9	9.1	3.8	29.6	5.8	7.1	54.7
Texas	77.7	52.0	25.8	33.1	35.2	42.5	54.7
Utah	15.9	9.5	6.4	40.2	4.5	11.4	71.7
Virginia	14.9	9.8	5.1	34.0	6.8	8.1	54.5
Wisconsin ^a	16.6	7.0	9.6	57.8	6.7	9.9	59.6
Wyoming	7.1	4.6	2.5	35.4	2.9	4.2	59.0
All nonexpansion states	629.5	394.1	235.5	37.4	239.8	389.7	61.9

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

^a Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.

TABLE B.12

Projected Number of Uninsured American Indian/Alaska Natives without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	107.8	34.3	73.5	68.2
Arkansas	11.1	5.2	6.0	53.7
California	144.5	54.1	90.4	62.5
Colorado	24.6	10.5	14.1	57.4
Connecticut	3.5	1.5	1.9	56.4
Delaware	2.0	N/A	N/A	N/A
District of Columbia	N/A	N/A	N/A	N/A
Hawaii	2.4	N/A	N/A	N/A
Illinois	13.0	5.1	7.9	60.8
Iowa	7.0	3.9	3.1	44.5
Kentucky	6.7	2.7	4.0	59.8
Maryland	8.0	4.2	3.8	47.2
Massachusetts	3.5	1.6	1.9	53.8
Michigan	21.1	7.7	13.4	63.5
Minnesota	21.5	9.8	11.7	54.4
Nevada	15.5	5.5	10.0	64.7
New Hampshire	1.6	N/A	N/A	N/A
New Jersey	17.4	11.9	5.5	31.8
New Mexico	93.0	31.3	61.7	66.3
New York	29.9	15.7	14.2	47.4
North Dakota	15.8	6.3	9.5	59.9
Ohio	12.9	4.4	8.5	66.0
Oregon	27.3	10.9	16.4	59.9
Pennsylvania	9.6	3.1	6.5	67.6
Rhode Island	1.6	N/A	N/A	N/A
Vermont	1.0	N/A	N/A	N/A
Washington	41.9	16.3	25.6	61.1
West Virginia	4.0	1.5	2.6	63.6
All expansion states	648.5	250.8	397.7	61.3

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.13

Projected Statistic (Effect Size) to Assess Whether Coverage Rates for Racial/Ethnic Minority Groups Narrow Compared with White Coverage Rates under the ACA

	Black	Latino	Asian/Pacific Islander	American Indian/ Alaska Native
All states				
Without ACA (A)	0.071	0.205	0.034	0.063
ACA with current Medicaid decisions (B)	0.073	0.187	0.029	0.045
ACA with full Medicaid expansion (C)	0.044	0.195	0.043	0.041
<i>Difference (narrowing coverage differential with white is negative; widening is positive)</i>				
Without ACA vs. ACA with current Medicaid decisions (B minus A)	0.002	-0.019	-0.005	-0.017
Without ACA vs. ACA with full Medicaid decisions (C minus A)	-0.026	-0.010	0.009	-0.021
Medicaid expansion states				
Without ACA (A)	0.051	0.193	0.041	0.060
ACA with current Medicaid decisions (B)	0.041	0.177	0.048	0.039
<i>Relative differences (narrowing is negative; widening is positive)</i>				
Without ACA vs ACA with current Medicaid decisions (B minus A)	-0.010	-0.016	0.007	-0.021
Nonexpansion states				
Without ACA (A)	0.079	0.230	0.039	0.065
ACA with current Medicaid decisions (B)	0.080	0.213	0.034	0.051
ACA with full Medicaid expansion (C)	0.044	0.224	0.043	0.044
<i>Relative differences (narrowing is negative; widening is positive)</i>				
Without ACA vs. ACA with current Medicaid decisions (B minus A)	0.001	-0.016	-0.005	-0.013
Without ACA vs. ACA with full Medicaid decisions (C minus A)	-0.035	-0.005	0.004	-0.021

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Note: The statistic presented is an “effect size” as described in the methods section.

Notes

1. Robin A. Cohen and Michael E. Martinez, “Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2010–March 2014,” National Center for Health Statistics, accessed November 21, 2014, http://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2010_2014Q11.pdf.
2. “State Medicaid and CHIP Income Eligibility Standards,” Centers for Medicare and Medicaid Services, accessed November 21, 2014. In addition, Pennsylvania is slated to expand Medicaid eligibility in January 2015. See Marilyn Tavenner, letter to Secretary Mackereth, August 28, 2014, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf>.
3. Those whose incomes are between 100 and 400 percent of FPL, who are not eligible for any public coverage program such as Medicaid, who are legally present in the United States, and who do not have an affordable offer of coverage from an employer are eligible for subsidized private coverage in the health insurance Marketplaces. This means that in a state that has expanded Medicaid eligibility, subsidy eligibility ends at 138 percent of FPL. Legally present immigrants who do not qualify for Medicaid because they have not been residing in the United States for five years are also eligible for subsidized coverage, even if their incomes are below 100 percent of FPL.
4. Also, many adults with family income between 100 and 138 percent of FPL who live in expansion states and would have been eligible for Medicaid are barred from subsidized Marketplace coverage because of an offer of employer-sponsored insurance coverage to a family member. If any family member is offered single coverage for which his or her share of the premium is less than 9.5 percent of family income, then the entire family is ineligible for subsidized coverage.
5. Authors’ tabulations using HIPSMS-ACS, 2014.
6. “State Medicaid and CHIP Income Eligibility Standards,” Centers for Medicare and Medicaid Services. In addition, Pennsylvania is slated to expand Medicaid eligibility in January 2015. See Marilyn Tavenner, letter to Secretary Mackereth, August 28, 2014, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf>.
7. For an overview of HIPSMS, see Urban Institute (2010). For more information about methodology, see “Further Methodological Information for ‘Tax Preparers Could Help Most Uninsured Get Covered,’” Urban Institute, accessed November 11, 2014, http://www.urban.org/health_policy/health_care_reform/taxfilingmethodology.cfm.
8. Previous estimates based on HIPSMS (e.g., Holahan et al. 2012) differ slightly, particularly in the estimate of potential new Medicaid eligibles. Our current estimates take into account final HHS and Treasury regulations on how Medicaid eligibility should be computed under the ACA. In addition, previous estimates were based on the 2010 ACS, while the current estimates are based on three years of the ACS aged to 2016. Further, the number of uninsured has declined since 2010, disproportionately reducing the number of very low income uninsured, and economic conditions and thus the underlying income distribution have also changed since 2010.
9. The approach allows new coverage options to be assessed without simply extrapolating from historical data. It considers such factors as affordability (premiums and out-of-pocket health care costs for available insurance products), health care risk, whether the individual mandate would apply, and family disposable income.
10. For example, if someone is currently eligible for Medicaid but not enrolled, he or she (or his or her parents) have shown a preference against Medicaid. He or she will be less likely to enroll in Medicaid under the ACA than a similar person who becomes newly eligible for Medicaid and thus has not had a chance to express a preference. We use such preferences to customize individual utility functions so that people’s current choices score the highest among their current coverage choices, and these preferences affect their behavior under the ACA.
11. See appendix A for classification details. The 4.1 million nonelderly adults in the “other non-Latino” racial/ethnic category are not discussed in this paper because that category combines heterogeneous groups. Overall, findings for the “other non-Latino” group largely mirror findings for whites.

12. "Summary of Immigrant Eligibility Restrictions under Current Law," Assistant Secretary for Planning and Evaluation, last modified April 28, 2011, accessed November 24, 2014, <http://aspe.hhs.gov/hsp/immigration/restrictions-sum.shtml>.
13. For comparison, the second-largest concentration of undocumented individuals is among Asians and Pacific Islanders. Fully 14.4 percent of the undocumented are estimated to be Asians and Pacific Islanders. Undocumented individuals are estimated to make up 12.1 percent of Asians and Pacific Islanders.
14. Percentage-point differences are not shown in the tables; computations are based on projections in the tables.
15. James P. Scanlan, "How Measures Are Affected by the Prevalence of an Outcome," letter in response to Clemans-Cope et al. (2012), http://content.healthaffairs.org/content/31/5/920.full/reply#healthaff_el_476249.
16. When two groups differ in their uninsurance rate, if the overall uninsurance rate (i.e., the rate of uninsurance across both groups) decreases without any change in the underlying difference between the groups, then (1) the relative difference in uninsurance rates between the groups tends to be greater, and (2) the relative difference in rates of having health coverage tends to be smaller.
17. If the relative changes in both the uninsured and insured rates are consistent—either larger or smaller for one group compared to another group—we can conclude that the difference in health coverage between the two groups has narrowed (or widened). If the relative changes in the uninsured and insured rates are not in the same direction, however, we cannot draw conclusions about relative differences in uninsurance rates between groups without additional information. In all cases presented here, the relative changes in the uninsured and insured rates were not consistent, suggesting that computation of a measure such as "effect size" was necessary.
18. For general information on the measure computed here, effect size, see Harper and Lynch (2005). Also see Scanlan (2013).
19. The Public Use Microdata Areas are the smallest statistically representative geographic area on the ACS.
20. Lisa Clemans-Cope, Hannah Recht, and Anna Spencer, "Racial/Ethnic Differences in Uninsurance Rates under the ACA: Where You Live Matters," *MetroTrends* (blog), December 16, 2014, <http://blog.metrotrends.org/2014/12/raciaethnic-differences-uninsurance-rates-aca-live-matters>.
21. Calculations based on table 1.
22. Estimates include calculations based on table 1.
23. Calculations based on table 1.
24. Calculations based on table 1.
25. Calculations based on table 1.
26. Although we define high-impact states as those that together account for half the projected coverage gains under the ACA with full Medicaid expansion, the actual proportions are slightly over 50 percent because of the need to include whole states. High-impact states make up 50.6 percent (black) to 54.0 percent (Latino) of coverage gains by race.
27. Calculations based on table 9.
28. The share of American Indian/Alaska Natives in the "All other Asian/Pacific Islander" category is low for several states. In four states, the share of American Indian/Alaska Natives in the "All other Asian/Pacific Islander" category is less than half (19 percent in New Mexico, 21 percent in South Dakota, 36 percent in North Dakota, and 46 percent in Arizona). In another five states, the share in the "All other Asian/Pacific Islander" category is less than the national average (52 percent in North Carolina, 53 percent in Utah, 54 percent in Minnesota, 56 percent in Alaska, and 59 percent in Mississippi). See appendix A for details on race and tribe classification.
29. For example, California recently turned down an offer from the California Endowment of \$6 million toward the renewal process for those newly enrolled in Medi-Cal, a decision that has led to some criticism, given the backlog of Medi-Cal applicants. See Anna Gorman, "Advocates Say California Is Rejecting 'Free Money' to Renew Poor People's Insurance," *Kaiser Health News*, July 4, 2014,

<http://capsules.kaiserhealthnews.org/index.php/2014/07/advocates-say-california-is-rejecting-free-money-to-renew-poor-peoples-insurance/>

30. Consumer Reports, "Having trouble proving your identity to HealthCare.gov?" December 18, 2013, <http://www.consumerreports.org/cro/news/2013/12/how-to-prove-your-identity-on-healthcare-gov/index.htm>.
31. See also Sonya Schwartz, "We Can Fix This, People! More than Half of Uninsured Parents Are Latino," *CHIRblog*, September 12, 2014, <http://chirblog.org/we-can-fix-this-people-more-than-half-of-uninsured-parents-are-hispanic>; and "Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities," Asian & Pacific Islander American Health Forum, September 2014, accessed November 24, 2014, <http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro>.
32. "Improving the Road to ACA Coverage," September 2014.
33. This group of 4.1 million nonelderly who selected neither American Indian/Alaska Native as a race nor Latino as an ethnicity is made up of 3.6 million who selected multiple races and 566,000 nonelderly respondents who selected only "other race."
34. "Questions on the Form and Why We Ask," US Census Bureau, accessed November 24, 2014, http://www.census.gov/acs/www/about_the_survey/questions_and_why_we_ask/.

References

- Brooks, Tricia A. 2014. "Open Enrollment, Take Two." *Health Affairs* 33 (6): 927–30.
- Buettgens, Matthew, Dean Resnick, Victoria Lynch, and Caitlin Carroll. 2013. *Documentation on the Urban Institute's American Community Survey-Health Insurance Policy Simulation Model (ACS-HIPSM)*. Washington, DC: Urban Institute. <http://www.urban.org/publications/412841.html>.
- Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Buettgens, Caitlin Carroll, and Fredric Blavin. 2012. "The Affordable Care Act's Coverage Expansions Will Reduce Differences in Uninsurance Rates by Race and Ethnicity." *Health Affairs* 31 (5): 920–30. <http://content.healthaffairs.org/cgi/content/abstract/31/5/920?ijkey=to7RiPsbOigAQ&keytype=ref&siteid=healthaff>.
- Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Buettgens, and Hannah Recht. Forthcoming. *Coverage Gains under the Affordable Care Act for Latino-Origin Groups Impacted by Undocumented Immigrants and State of Residence*. Washington, DC: Urban Institute.
- Harper, Sam, and John Lynch. 2005. *Methods for Measuring Cancer Disparities: Using Data Relevant to Healthy People 2010 Cancer-Related Objectives*. NCI Cancer Surveillance Monograph Series, no 6. NIH Publication No. 05-5777. Bethesda, MD: National Cancer Institute. http://seer.cancer.gov/archive/publications/disparities/measuring_disparities.pdf.
- Jahnke, Lauren R., Nadia J. Siddiqui, and Dennis P. Andrulis. 2014. *Marketplace Consumer Assistance Programs and Promising Practices for Enrolling Racially and Ethnically Diverse Communities*. Austin: The Texas Health Institute. http://www.texashealthinstitute.org/uploads/1/3/5/3/13535548/thi-tsff_aca_marketplace_equity_report_05.22.2014.pdf.
- Kanchinadam, Keerti, and Joanne Jee. 2014. *Early State Experiences with the First Open Enrollment under the Affordable Care Act*. Princeton, NJ: Robert Wood Johnson Foundation. <http://www.maxenroll.org/files/maxenroll/resources/early.state.experiences.with.first.open.enrollment.under.ACA.pdf>.
- Kenney, Genevieve M., Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley, and Nathaniel Anderson. 2012. *Opting In to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Washington, DC: Urban Institute. <http://www.urban.org/publications/412630.html>.
- Long, Sharon K., and Dana Goin. 2014. *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach*. Washington, DC: Urban Institute. <http://hrms.urban.org/briefs/literacy-by-race.html>.
- Scanlan, James P. 2013. "Measuring Health and Healthcare Disparities." 2013 Research Conference of the Federal Committee on Statistical Methodology. http://fcsml.sites.usa.gov/files/2014/05/J4_Scanlan_2013FCSM.pdf.
- Turner, Joanna, and Michel Boudreaux. 2010. "Health Insurance Coverage in the American Community Survey: A Comparison to Two Other Federal Surveys." In *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. Washington, DC: National Academies Press.
- Urban Institute. 2010. *The Urban Institute's Health Microsimulation Capacities*. Washington, DC: Urban Institute. <http://www.urban.org/publications/412154.html>.

About the Authors

Lisa Clemans-Cope is a senior research associate in the Health Policy Center at the Urban Institute. Her areas of expertise include health insurance reform legislation and regulation, Medicaid and the Children’s Health Insurance Program (CHIP), dual health spending, access to and use of health care, private insurance, eligibles health-related survey data, and Medicaid claims data. Her current work includes quantitative and qualitative analyses of federal and state implementation of the Affordable Care Act, and an evaluation of children’s access to and use of health services in CHIP. Clemans-Cope has a BA in economics from Princeton University and a PhD in health economics from the Johns Hopkins Bloomberg School of Public Health.

Matthew Buettgens is a senior research analyst in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model (HIPSM). The model is currently being 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. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

Hannah Recht is a research assistant in the Health Policy Center at the Urban Institute, where she works with the Health Insurance Policy Simulation Model to predict and analyze the effects of the Affordable Care Act. Her recent work has included providing technical assistance for New York State, state-level analysis of the current uninsured, an examination of children in complex coverage situations, and the implications of

Medicaid expansion. Recht received her BA in mathematics and statistics from the University of Rochester.



2100 M Street NW
Washington, DC 20037

www.urban.org