Reports and Research

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November 21, 2013 Board Meeting

California: Zero-net-premium bronze availability for uninsured

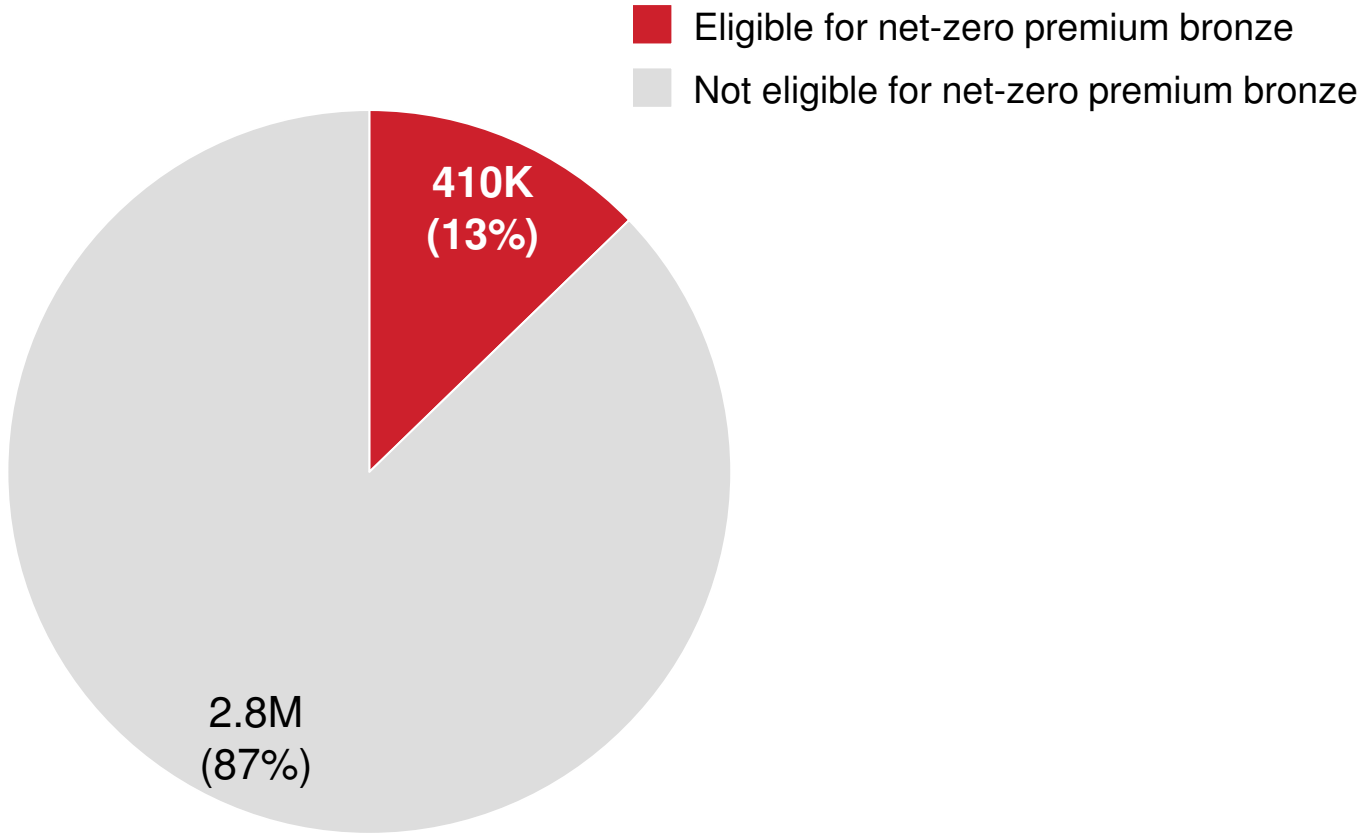
McKinsey Center for U.S. Health System Reform
Exhibits accompanying Intelligence Brief

November 2013

~13% (410K) of all California uninsured in the addressable individual market could be eligible for a zero-net premium Bronze product

Zero-net premium Bronze eligible uninsured

Total non-elderly uninsured[1], number and percent



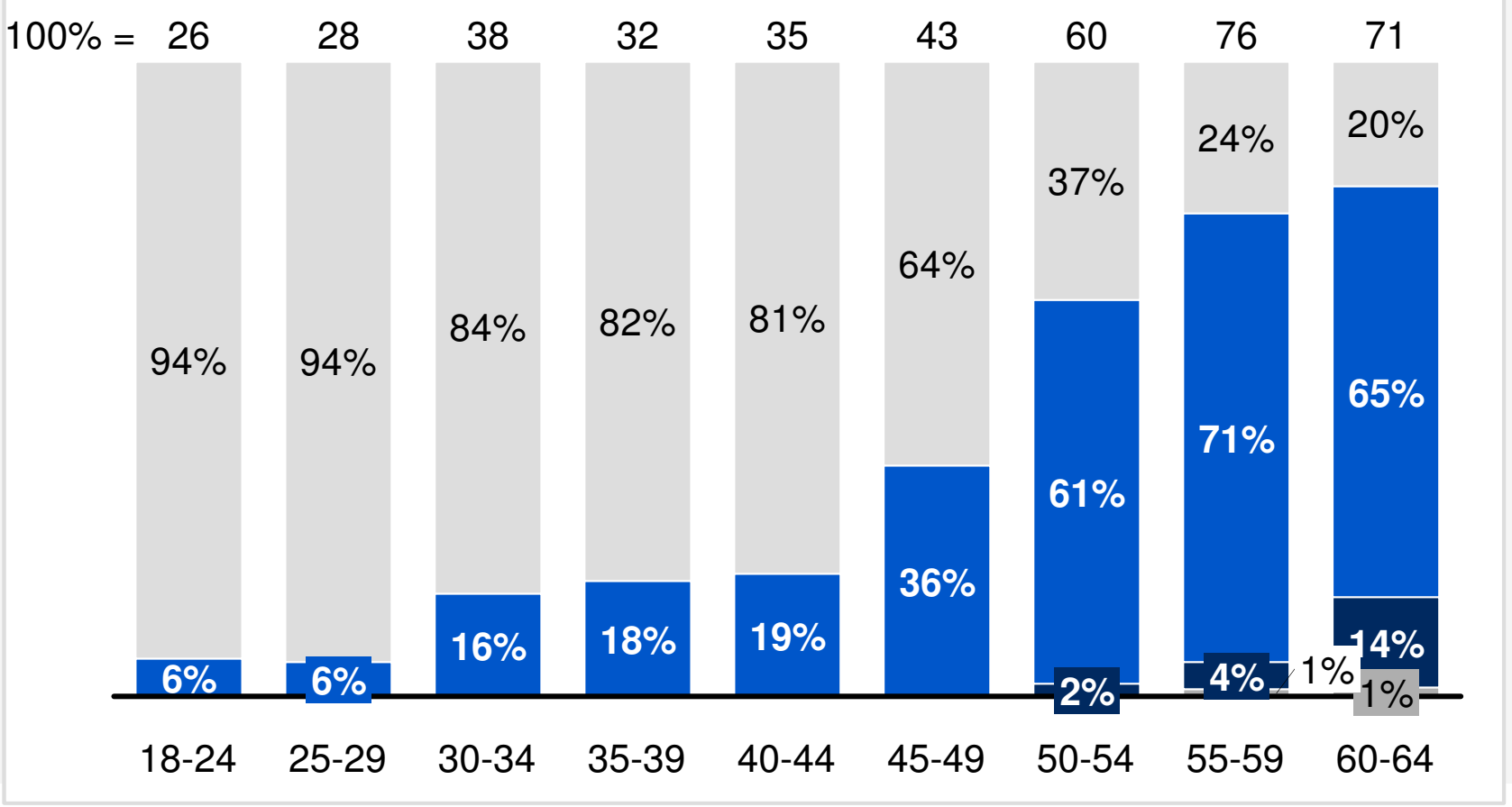
1 Defined as non-elderly uninsured (under age 65) who are above 138% FPL

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

Breakdown of age and income of the ~410K non elderly uninsured eligible for net-zero-premium bronze products

Income and age distribution of Zero-net premium eligible uninsured[1]

Total non-elderly uninsured[2], measured in thousands



1 Due to Medicaid expansion, uninsured people in the 100%-138% FPL range are not eligible for zero-net-premium plans

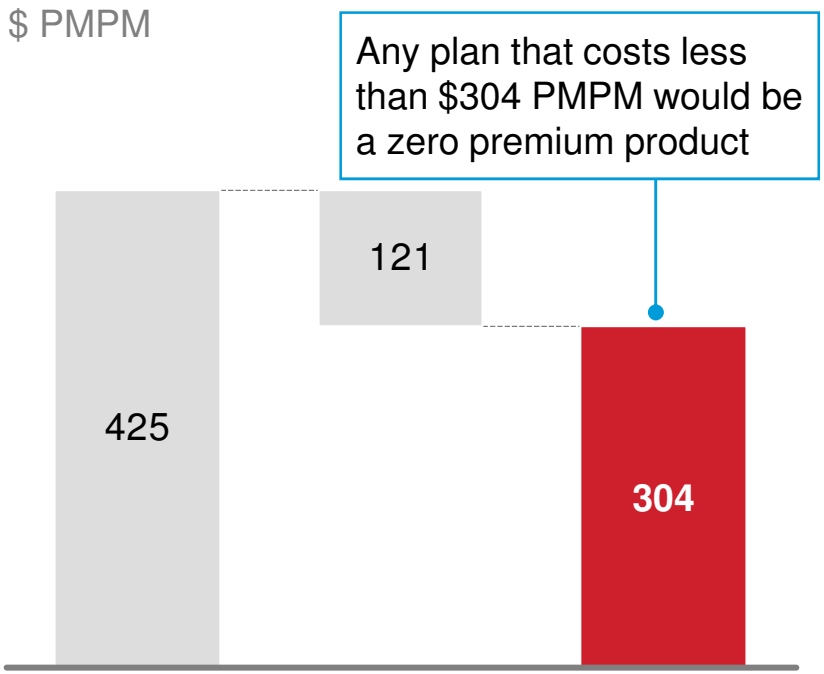
2 Includes uninsured between ages 18-64 who are over 138% FPL in Medicaid expansion states and over 100% FPL in non-Medicaid expansion states

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

Subsidy eligible individuals could pay zero premium for plans based on their subsidy amount

ILLUSTRATIVE EXAMPLE

Premium and subsidy for individual at 200% FPL[1]



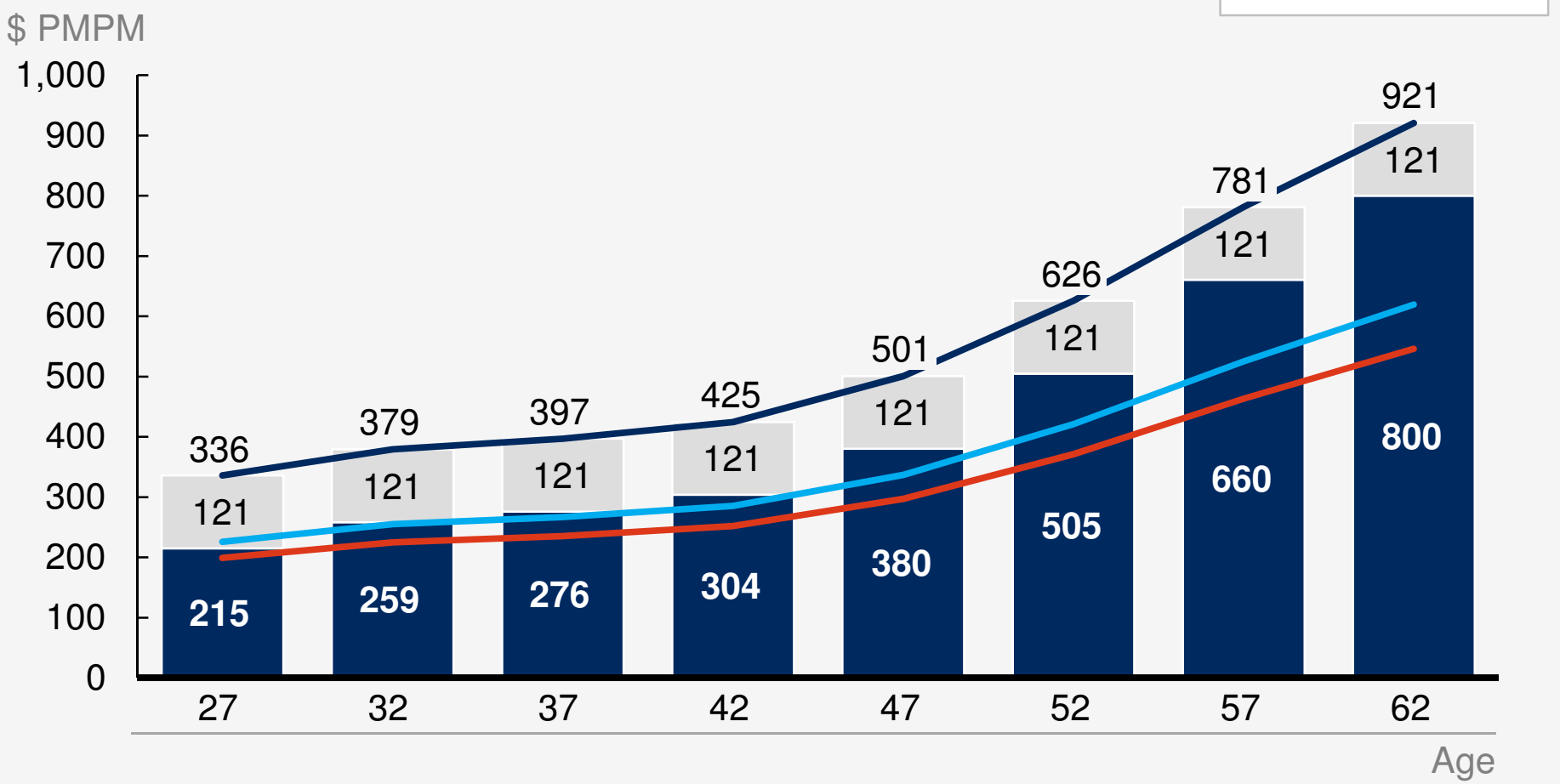
- **Zero premium plans occur when the Federal subsidy covers the entire cost of the premium**
- **Subsidy amount is affected by age, income, and anchor plan (second lowest silver) rate, which impacts the number of zero premium plans available for a given age and income**
- **Subsidy amounts are correlated with age and negatively correlated with income**
  - There are more zero premium products available for older and lower income individuals
- **A zero premium plan will most likely be a bronze or silver plan (lowest silver)**

1 Represents rates from Jackson, Mississippi

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

Premium and federal subsidy by age

Premium and subsidy by age for individual with 200% FPL (annual income ~$23,000)



1 Represents rates from Jackson, Mississippi

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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Robert Wood Johnson Foundation

Looking Beyond Technical Glitches:

A Preliminary Analysis of Premiums and Cost Sharing in the New Health Insurance Marketplaces

Monitoring the ACA's Health Insurance Marketplaces | November 2013

Background

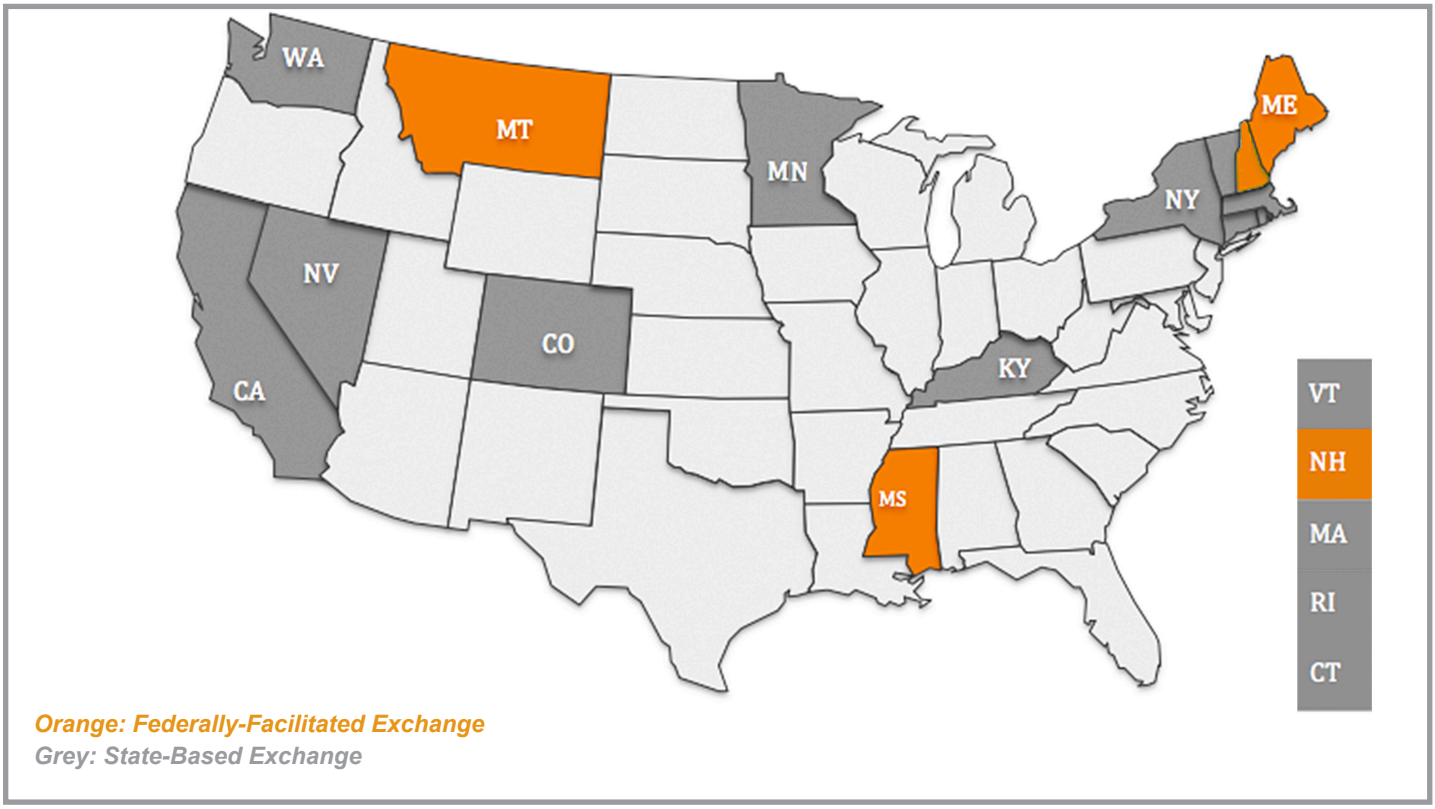
Open enrollment for the Affordable Care Act's (ACA) state health insurance exchanges, or marketplaces began on October 1, 2013. Prior to open enrollment, a great deal of attention had been focused on the premiums for the plans being sold in the new marketplaces. During the last several weeks, however, the systemic problems with healthcare.gov, the website for federally facilitated exchanges (FFEs) and, to a lesser extent, glitches with the websites for state-based exchanges (SBEs) have largely overshadowed any discussion of premiums or other benefit design features associated with these new plans.

In partnership with the Robert Wood Johnson Foundation (RWJF), Breakaway Policy Strategies (Breakaway) is undertaking a review of the plans being offered in all 50 state marketplaces (plus the District of Columbia) that goes well beyond an examination of premiums. Breakaway's researchers are compiling a range of data on the health insurance benefit design features of products offered through the exchanges. This includes, but is not limited to, cost sharing data that encompasses deductibles, out-of-pocket limits and copayment and coinsurance amounts for specific services such as physician visits and prescription drugs. RWJF and Breakaway will release periodic reports summarizing findings from its ongoing analyses, focusing on research results relevant to consumers and health care stakeholders.[1]

In this first report, we provide a snapshot of premiums, deductibles, copayments and coinsurance amounts for primary care physician (PCP) and specialist visits for silver-level plans in 96 rating areas[2] across 15 state marketplaces.[3]

The premiums and cost sharing figures reported here do not reflect premium tax credits and/or cost sharing subsidies for which many applicants will be eligible. According to one analysis[4], almost half of those predicted to buy insurance on the exchange will be eligible for tax credits that would reduce their premiums. Since premium tax credits are available to individuals and families having incomes up to 400 percent of the federal poverty level (FPL) while cost sharing subsidies are available to those with incomes up to 250 percent of the FPL, the cost sharing amounts reported here apply to more than half of the population now buying insurance in the individual market. Because premium[5] and cost sharing subsidies play an important role in plan selection for those eligible to receive them, an example of how premium tax credits and subsidies reduce an individual's out-of-pocket spending is provided at the conclusion of the report.

Figure 1: State Insurance Marketplaces Surveyed



Orange: Federally-Facilitated Exchange
Grey: State-Based Exchange

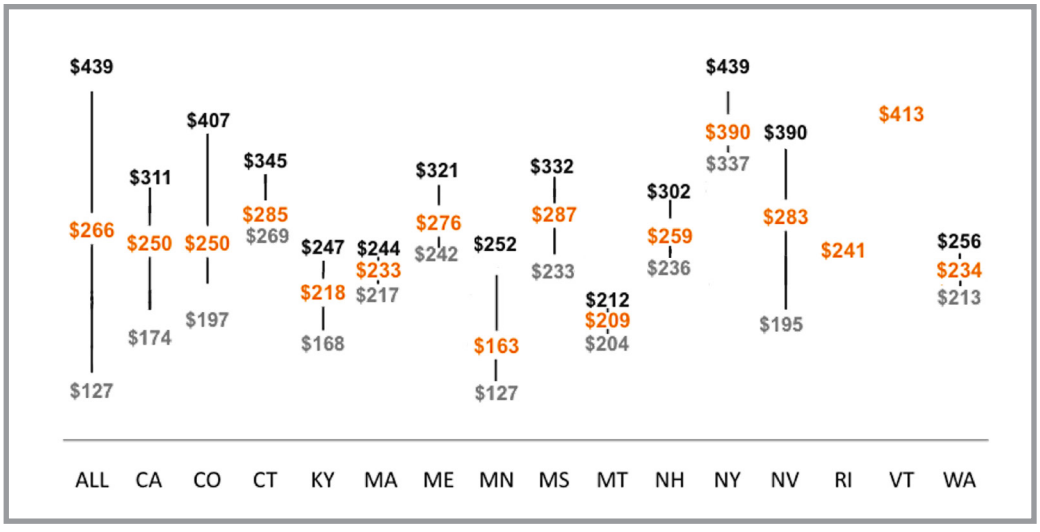
State Health Insurance Marketplaces Surveyed

From October 1 through October 11, Breakaway collected and analyzed premium and cost sharing data for 196 silver-level plans[6] in 11 SBEs and 4 FFEs (See Figure 1).[7] We obtained premium information for a 27 year-old individual from the data published by the Centers for Medicare and Medicaid Services (CMS) for plans offered in FFE states and from the state exchange websites for plans offered in SBE states.[8] Cost sharing information for plans offered in FFE states was obtained directly from the carriers' websites and data for the SBE states from either the carriers' websites or the state insurance departments.

Exchange Plan Premiums

The ACA provides federal subsidies in the form of tax credits[9] to offset premium costs for individuals with incomes up to 400 percent of the federal poverty level (FPL). The second-lowest cost silver plan (SLCSP) in an individual's rating area is used as the benchmark for determining the amount of his or her premium tax credit. For this reason, Breakaway examined premiums and deductibles associated with SLCSPs, which account for 98 of the 196 silver plans surveyed.[10] Although premiums varied from state to state and among rating areas within each state, the average premium for a 27 year-old individual across the 15 marketplaces surveyed was $266 per month. As shown in Figure 2, premiums ranged from a low of $127

Figure 2: Low, High, and Average Premiums for Second-Lowest Cost Silver Plans



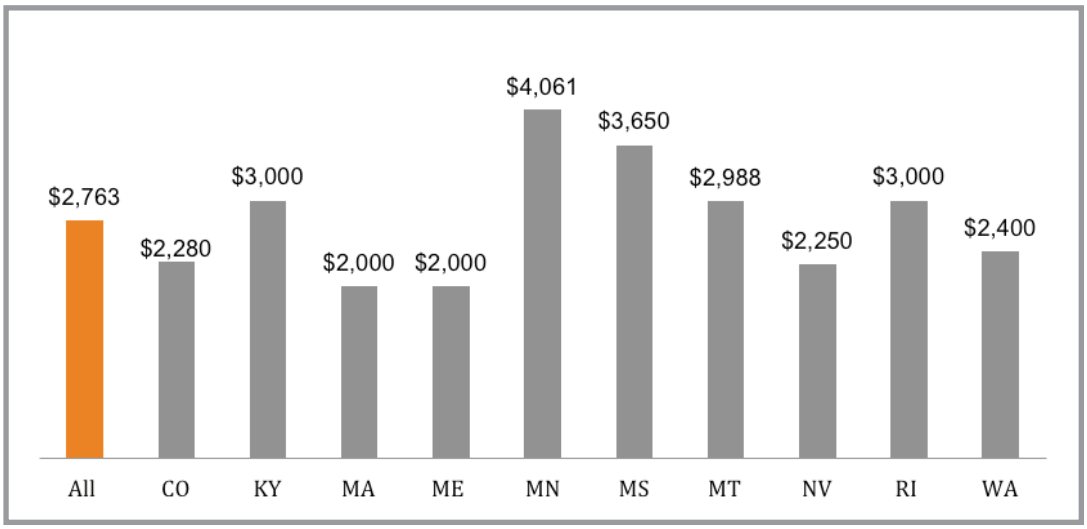
in Minnesota to a high of $439 in New York.

Exchange Plan Deductibles[11]

Of the 98 SLCSPs surveyed[12], approximately half offer integrated deductibles, under which medical expenses and expenses for prescription drugs all accumulate toward a single deductible.

As shown in Figure 3, average integrated deductibles among the plans surveyed range from a low of $2,000 in Massachusetts and Maine to a high of $4,061 in Minnesota. The average integrated deductible among the 15 marketplaces is $2,763.

Figure 3: Average Integrated Deductibles



The other approximately half of plans include two separate deductibles: a medical deductible towards which expenses for medical services accumulate and a drug deductible toward which expenses for prescription drugs accumulate. Among the plans summarized in these findings that include separate medical and prescription drug deductibles, the average medical deductible is $2,770 (See Figure 4), and the average prescription drug deductible is $933.

Exchange Plan Physician Cost Sharing

In addition to premiums and deductibles, Breakaway examined the cost sharing for PCP and specialist visits under the plans analyzed. For this analysis, Breakaway limited its review to cost sharing amounts for in-network services. Where plans reported cost sharing information for more than one in-network tier, amounts for the first tier were utilized. Of the 196 silver plans surveyed, approximately 75 percent (147 plans) charge a copayment for a PCP visit, while 25 percent (49 plans) utilize coinsurance to determine an individual's cost sharing.

Copayments for a PCP visit range from $0 to $45 with an average of $30 (See Figure 5). Coinsurance ranges from 0 to 40 percent with an average of 15 percent (See Figure 6).

For specialist visits, 70 percent (137 plans) charge a copayment; 30 percent (59 plans) utilize coinsurance. Copayments for specialist visits range from $0 to $80 with an average of $47 (See Figure

Figure 4: Low, High, and Average Medical Deductibles for Second-Lowest Cost Silver Plans

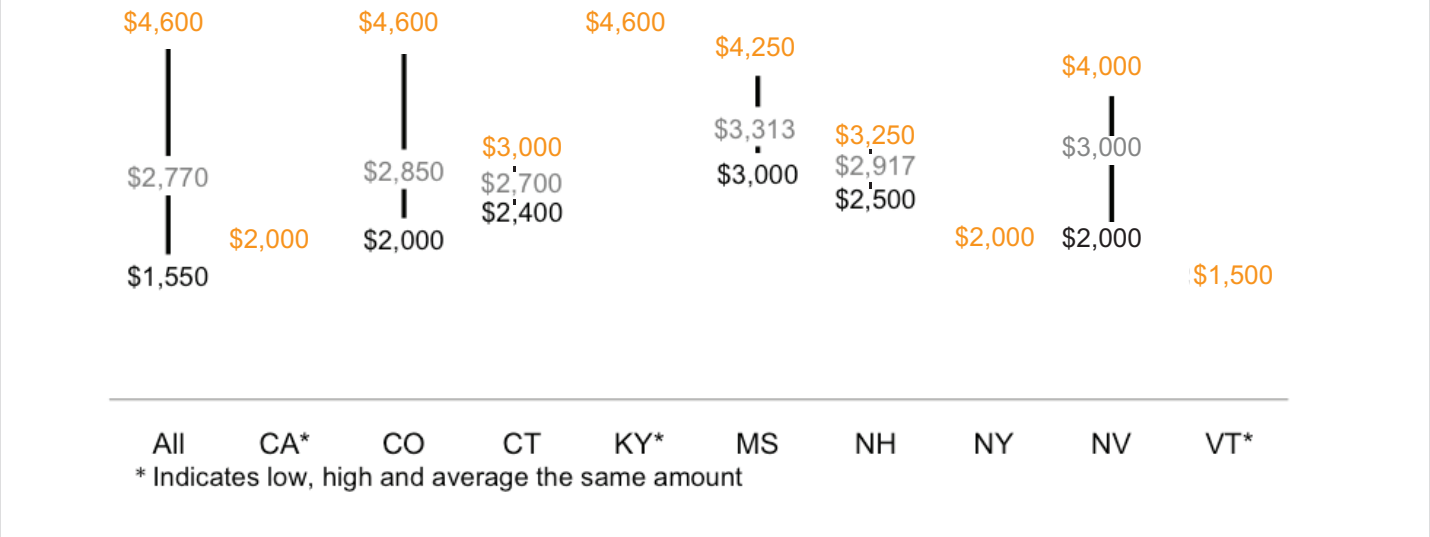


Figure 5: Average Copayments for PCP Visits

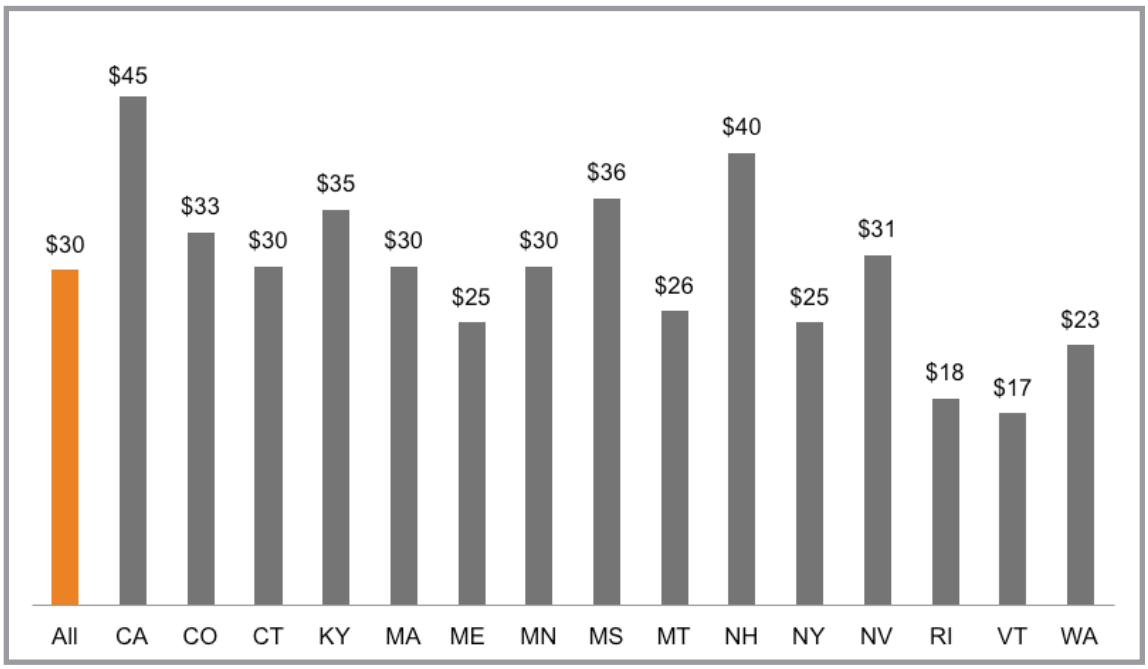
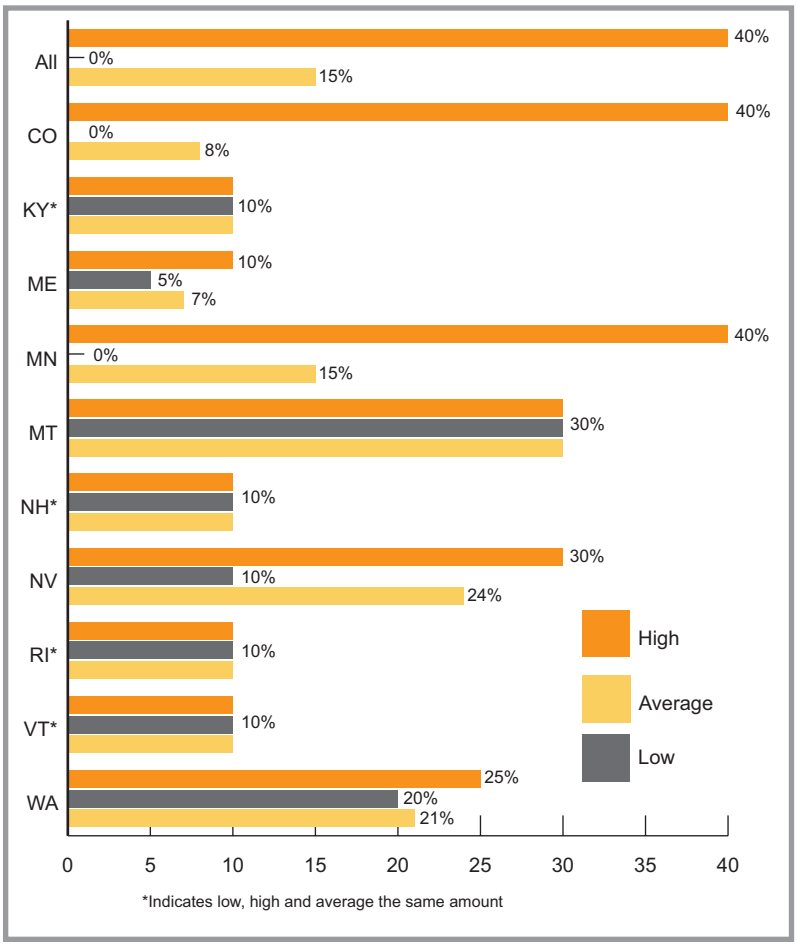


Figure 6: High, Low, and Average Coinsurance for PCP Visits



7). Coinsurance ranges from 0 to 40 percent with an average of 17 percent.

In reviewing the copayments and coinsurance for PCP and specialist visits, we noted that some carriers have taken completely different tactics with respect to cost sharing for physician visits. For example:

• In Vermont, one carrier does not charge for the first 3 PCP visits and then imposes a $30 copay for each visit thereafter.

• In New Hampshire, one carrier applies a $40 copay to the first 3 PCP visits but does not indicate what will be charged for subsequent visits.

• In Montana, one carrier applies a $30 copay for the first 3 PCP visits and 30 percent coinsurance for each visit thereafter.

Impact of Cost Sharing Reductions

Under the ACA, individuals with incomes up to 250 percent of the federal poverty level (FPL) who purchase a silver-level plan through an exchange can receive cost sharing reductions (CSRs) that will lower their out-of-pocket spending. Especially for individuals with lower incomes, these CSRs can substantially reduce cost sharing amounts by effectively increasing the plan's actuarial value. As previously noted, the cost sharing amounts outlined above do not reflect amounts that eligible individuals will pay after the application of CSRs.

To illustrate the impact of CSRs on out-of-pocket spending, we have provided the cost sharing amounts for New York's standard silver plan[13], (i.e., the amounts that would be paid by an individual who is not eligible for CSRs) along with the amounts that would be paid by individuals eligible for CSRs. As shown in the chart in Figure 8, the actuarial value of the plans available to these individuals varies by income. For example, coverage for a 27 year-old individual with an income of $30,000, which is greater than 250 percent of the FPL ($11,490 for 2013)[14], would be subject to a deductible of $2,000, whereas the same coverage for an individual with an income at or below the FPL would not be subject to any deductible.

Figure 7: Copayments for Physician Specialist Visits

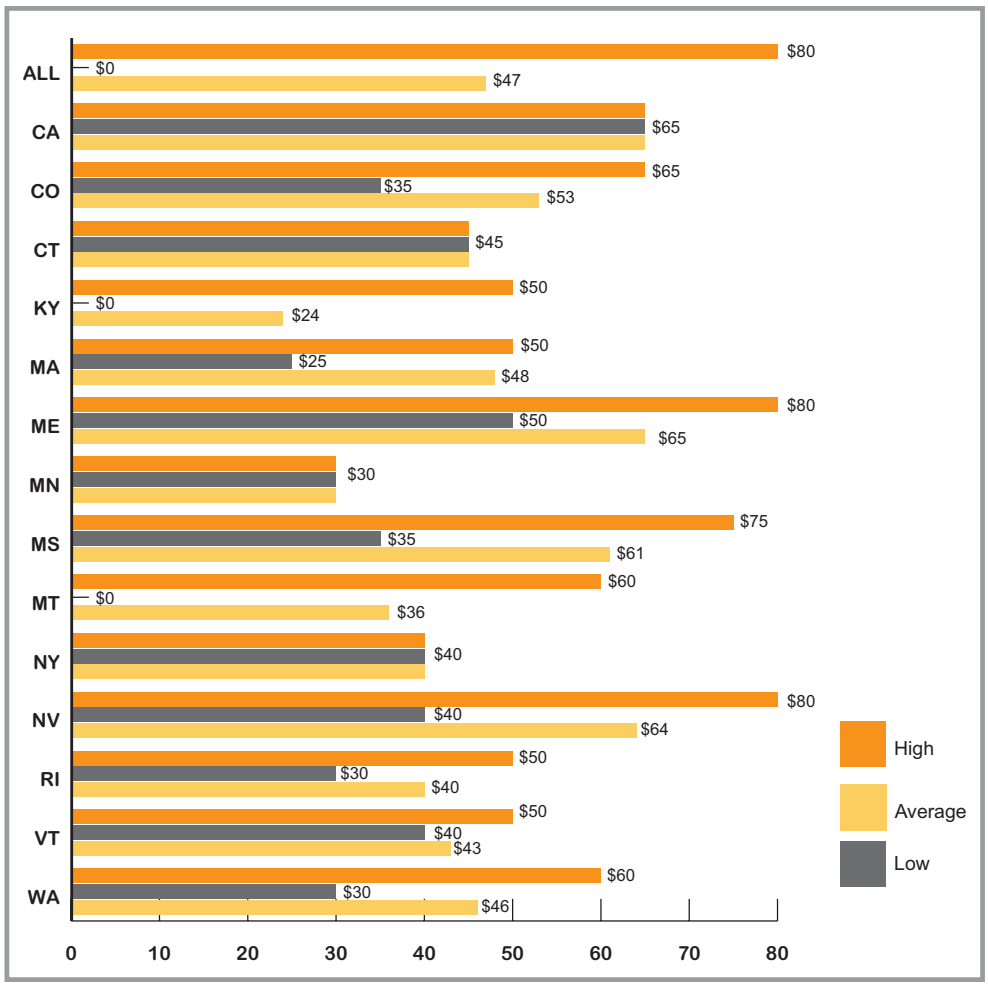


Figure 8: New York Standardized Silver Plan and CSR Variations

	Standard Silver Plan 68-72% Actuarial Value	200-250% FPL 72-74% Actuarial Value	150-200% FPL 86-88% Actuarial Value	100-150% FPL 93-95% Actuarial Value
Deductible	$2,000	$1,750	$250	$0
Maximum Out-of-Pocket Limit	$5,500	$4,000	$2,000	$1,000
PCP Visit	$30	$30	$15	$10
Specialist Visit	$50	$50	$35	$20

Initial Takeaways, Future Work

When it comes to benefit design features of plans offered through the marketplaces, early attention has been focused on premiums, which vary significantly both across states and among rating areas within individual states. Premiums alone, however, do not give a complete picture of the potential out-of-pocket health costs that consumers may face when purchasing coverage offered through the exchanges. For that complete picture, consumers also will need to consider cost sharing.

This preliminary analysis shows that some silver-level plans offered through health insurance exchanges have adopted a number of cost sharing features that may add to the total amount of out-of-pocket costs consumers enrolling in such plans experience. For example, in Nevada and Minnesota, at least one plan requires an $80 copay for a specialist visit. In California and Maine, the average specialist visit copayment is $65. Even with an out-of-pocket maximum, for individuals who do not qualify for CSRs, the higher cost sharing may present challenges in accessing services. It will be important for consumers to look beyond premiums when determining which plan best meets their needs.

Breakaway is expanding this preliminary snapshot by compiling premium and cost sharing data for all 50 states, expanding the metal level of plans to be examined, and analyzing trends related to a range of additional health benefits. We will be releasing additional reports based on these more comprehensive analyses over the coming months.

Notes

1 It is our hope that the stepped up efforts of federal and state governments to resolve exchange website problems will improve both the accuracy and accessibility of plan data. Regardless, Breakaway will continue to verify data integrity and accuracy and provide updates to our reports as necessary.

2 The ACA requires that each state have a set number of geographic rating areas that all issuers in the state must uniformly use as part of their rate setting. CCIIO, Market Rating Reforms, State Specific Geographic Rating Areas, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html.

3 As has been widely reported, SBE websites have experienced fewer glitches than healthcare.gov, thereby making data for SBEs more accessible. For this reason, 11 of the 15 state marketplaces surveyed in this initial report are SBEs.

4 Kaiser Family Foundation Issue Brief, Quantifying Tax Credits For People Now Buying Insurance on Their Own, August 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8469-quantifying-tax-credits-for-people-now-buying-insurance-on-their-own.pdf.

5 In its August 2013 report, the Kaiser Family Foundation projects that in the portion of the population it studied (people currently buying individual insurance) qualifying for premium tax credits, the credits would reduce the premium for the second lowest cost silver plan by an average of 66 percent. The reduction will vary by income. The Kaiser report also notes that the premium would subsidize a greater share of a bronze plan premium. Bronze plans, however, have a lower actuarial value than silver plans, so more costs will be passed to the consumer – most likely in the form of higher cost sharing.

6 The total number of silver plans offered in the 15 states surveyed was actually 198, but information was unavailable for 2 plans in Maine.

7 The 196 plans surveyed were distributed among the states as follows: California - 16, Colorado - 43, Connecticut - 4, Kentucky - 8, Maine-7, Massachusetts - 19 Minnesota - 16, Mississippi - 9, Montana - 8, Nevada – 22, New Hampshire - 3, New York - 15, Rhode Island - 3, Washington - 17 and Vermont – 6

8 "Health Plan Information for Individuals and Families," https://www.healthcare.gov/health-plan-information/. This analysis is based on data available as of October 11, 2013.

9 Premium tax credits are determined by calculating the maximum percentage of income that an individual must pay toward health insurance, which is based on a sliding scale for people earning up to 400 percent of the federal poverty level (FPL) – $45,960 for an individual and $94,200 for a family of four in 2013. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2013 Federal Poverty Guidelines, -http://aspe.hhs.gov/poverty/13poverty.cfm. That amount is then subtracted from the cost of the SLCSP offered in the individual's rating area.

10 Premium tax credits are set based on the premium charged by the SLCSP, but can be used to pay the premium for any bronze, silver, gold or platinum plan offered on an exchange.

11 Plans on each "metal level" or benefit tier must meet an "actuarial value", or share of covered health spending paid by the insurer rather than out of pocket by the patient, set by statute. However, except for federal limits on out-of-pocket spending and the standardized cost sharing imposed in some states, plans generally have discretion in how they set specific deductible, copayment, and coinsurance amounts.

12 As previously noted, since the SCLSP in an individual's rating area is used as the benchmark for determining the amount of his or her premium tax credit, Breakaway examined the premiums and deductibles for those plans.

13 To participate in their exchanges, a number of states require issuers to offer a minimum number of "standardized" plans per metal level which contain uniform cost sharing provisions. To allow for some variation and innovation in the insurance market, most of these states also permit insurers to offer a limited number of non-standard plans (usually 1-3) per metal level. States with standardized plans include: California, Connecticut, Massachusetts, New York, Oregon, and Vermont.

14 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2013 Federal Poverty Guidelines, http://aspe.hhs.gov/poverty/13poverty.cfm.

About Breakaway Policy Strategies

Breakaway Policy Strategies is a health policy firm that provides research, analysis, practical advice and strategic solutions to a wide range of health care stakeholders. Breakaway's health care experts offer creative, sophisticated guidance to help hospitals, health plans, physicians, employers, consumers, patients, government agencies, biopharmaceutical and device companies, foundations and investors successfully navigate the transformative changes taking place in the American health care system. Learn more at www.breakawaypolicy.com

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November 2013 | Issue Brief

State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act

Key provisions of the 2010 Affordable Care Act (ACA) create new Marketplaces for people who purchase insurance directly and provide new premium tax credits to help people with low or moderate incomes afford that coverage. We estimate that about 17 million people who are now uninsured or who buy insurance on their own ("nongroup purchasers") will be eligible for premium tax credits in 2014. This issue brief provides national and state estimates for tax credit eligibility for people in these groups. We also estimate that about 29 million people nationally could look to new Marketplaces as a place to purchase coverage.

ELIGIBILITY FOR PREMIUM TAX CREDITS

A key focus of the ACA is to reduce the number of uninsured by expanding the number of people who buy nongroup coverage. It does this by removing existing barriers that keep people with health problems from obtaining coverage and by providing financial assistance through premium tax credits for low and moderate income people who purchase coverage through new state Marketplaces operated by states or the federal government. The Congressional Budget Office estimates that by 2018 around 20 million people covered in marketplaces will receive premium tax credits to assist them with their premium costs.[1]

Under the law, people with incomes between 100 percent and 400 percent of the federal poverty level may be eligible for premium tax credits when they purchase coverage in a Marketplace. People who are eligible for other types of public or private coverage, for example Medicaid or coverage through an employer-provided plan, generally cannot claim a premium tax credit. These tax credits also are not available to people who are not lawfully present in the country or who are incarcerated. Legally residing immigrants who recently arrived in the country are eligible for premium tax credits despite being ineligible for Medicaid; they may qualify if their income does not exceed 400 percent of the federal poverty level.[2]

The amount of tax credit that a person receives depends on their family income and the cost of health insurance where they live. The law establishes a maximum percentage of income that people within the 100 to 400 percent of poverty income range must pay for a benchmark plan where they live. The percentages range from 2% of income for people with income at the federal poverty line to 9.5% of income for people with incomes at four times federal poverty. If the premium that a person or family faces for the benchmark plan in their area is higher than the maximum percent of income defined in the law for their income, they are eligible for a tax credit, and the tax credit is equal to the difference between the premium for the benchmark plan and the defined percent of their income. The benchmark plan is the second-lowest-cost plan in the silver cost-sharing tier offered through the marketplace for the area where they live.[3] Additional explanations and examples are available by using the Kaiser Premium Subsidy Calculator.

People who are eligible for a premium tax credit can apply it to reduce the premium for any plan (other than catastrophic plans) offered in the marketplace. Their cost will be the actual premium for the plan that they enroll in minus the value of the premium tax credit they receive. One thing to note is that because marketplace premiums vary by age in most states, people with the same income but different ages will qualify for different premium tax credit amounts. In some cases, the premium for a benchmark plan for people at younger ages will be less than the defined percentage of income specified in the law; in this case the person would not receive a premium tax credit and would have to pay the full premium for any plan that they choose. However, they would still be able to purchase coverage, and their cost as a share of income will match the cost for others with comparable incomes. Premiums also vary by geographic area, which means that premium tax credits may differ for otherwise similar people if they live in different places.

HOW MANY PEOPLE ARE ELIGIBLE FOR PREMIUM TAX CREDITS

We used data from the 2012 and 2013 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to estimate the number of people eligible for premium tax credits for marketplace coverage. The ASEC provides detailed information on family composition, income and insurance status for national and state samples of residents. We use that information to determine whether each individual would be eligible to purchase coverage through a marketplace and whether they would be eligible to receive a premium tax credit.

The analysis starts with a pool of people who have no insurance or who purchase nongroup insurance. People who are covered by a public program or by employer-based coverage are assumed to retain that coverage and would not be eligible for premium tax credits. Two other groups of people were then removed from this potential pool of tax-credit eligible individuals: uninsured adults and children whose incomes would make them eligible for Medicaid or CHIP and people who are not legally residing in the United States. Neither group is eligible for premium tax credits under the ACA. For those remaining in the pool, we looked at their family incomes under ACA rules and the premiums that they would face for benchmark coverage to determine whether they would qualify for a premium tax credit. The vast majority of potential eligibles with incomes between 100 percent and 400 percent of poverty would qualify for a tax credits; those who do not qualify in this income range are younger people who face a premium that is lower than the defined percent of income under the law. As a final step, we removed approximately 16 percent of potential eligibles because research shows that some people who are uninsured or have nongroup coverage have access to employer-based coverage, either through an offer from their own employer or through an offer through a spouse or parent. Those that remain in the potential pool constitute our estimate of tax-credit eligible individuals. A more complete description of this data and our methods is provided in the methods section below.

We estimate that over 17 million people nationally will be eligible for tax credits in 2014. The national and state totals are shown in Table 1. Three states (Texas, California, and Florida) each have more than 1 million tax-credit-eligible residents, and another seven states have more than 500,000 tax-credit-eligible residents. At the lower end, seven states have fewer than 50,000 tax-credit-eligible residents, with the District of Columbia (9,500) and Vermont (27,000) having the fewest. The five states with the most tax-credit-eligible individuals account for about 40 percent of all such individuals nationally.

Table 1

Estimated Number of Tax-Credit-Eligible Individuals and Potential Market for Marketplace Coverage, By State		
	Number of Tax Credit Eligible Residents	Potential Market Size
National	**17,187,000**	**28,605,000**
Alabama	270,000	464,000
Alaska	55,000	78,000
Arizona	313,000	551,000
Arkansas	150,000	227,000
California	1,903,000	3,291,000
Colorado	254,000	501,000
Connecticut	109,000	216,000
Delaware	29,000	48,000
District of Columbia	9,000	36,000
Florida	1,587,000	2,545,000
Georgia	654,000	1,063,000
Hawaii	29,000	58,000
Idaho	130,000	202,000
Illinois	501,000	937,000
Indiana	354,000	525,000
Iowa	127,000	262,000
Kansas	161,000	298,000
Kentucky	192,000	302,000
Louisiana	344,000	489,000
Maine	77,000	122,000
Maryland	201,000	419,000
Massachusetts	118,000	259,000
Michigan	436,000	725,000
Minnesota	90,000	298,000
Mississippi	204,000	298,000
Missouri	386,000	657,000
Montana	97,000	152,000
Nebraska	122,000	239,000
Nevada	155,000	249,000
New Hampshire	81,000	137,000
New Jersey	400,000	628,000
New Mexico	118,000	193,000
New York	779,000	1,264,000
North Carolina	684,000	1,073,000
North Dakota	43,000	77,000
Ohio	544,000	812,000
Oklahoma	256,000	446,000
Oregon	187,000	337,000
Pennsylvania	715,000	1,276,000
Rhode Island	40,000	70,000
South Carolina	336,000	491,000
South Dakota	70,000	118,000
Tennessee	387,000	645,000
Texas	2,049,000	3,143,000
Utah	206,000	331,000
Vermont	27,000	45,000
Virginia	518,000	823,000
Washington	272,000	507,000
West Virginia	71,000	117,000
Wisconsin	301,000	482,000
Wyoming	47,000	80,000

Source: KFF analysis of March 2012 and 2013 CPS. See Methods for more details.

HOW MANY PEOPLE MIGHT LOOK TO STATE MARKETPLACES FOR COVERAGE?

People eligible for premium tax credits are likely to look to new marketplaces when they want coverage because tax credits are only available to marketplace enrollees. Others looking to purchase coverage on their own also might want to purchase in new marketplaces, although nongroup policies will be available outside of marketplaces as well. Generally, nongroup policies written inside and outside of marketplaces will provide the same benefits, have the same cost-sharing tiers, and be subject to the same market rules.

We estimate the potential market for coverage in marketplaces by starting with current nongroup purchasers and uninsured people who are legally residing in the United States and who are not eligible for Medicaid or CHIP. We then excluded two groups from among the current uninsured. The first group is people with incomes above Medicaid eligibility levels but below poverty, referred to as the gap group. Because they are not eligible for financial assistance, few will have the means to afford nongroup coverage. We also excluded current uninsured people who are in a household of a full-time worker who either has or is offered employer-based insurance. As noted above, these people would be ineligible for premium tax credits, so we assume that they would choose employer-based coverage rather than nongroup coverage if they choose to become insured.[4]

This calculation leaves about 29 million people nationally who might look to the new marketplaces. The largest potential markets are in the states with the largest tax-credit eligible population: California, Texas, and Florida. Six states have a potential market of more than 1 million people, and another 12 have a potential market of more than 500,000 people.

DISCUSSION

The Congressional Budget Office (CBO) projects that 7 million people will enroll in health insurance exchanges in 2014, including 6 million who will be receiving tax credits to subsidize their premiums. Based on our analysis above, these enrollment levels would mean that 25% of potential exchange enrollees would choose to participate in year one of the ACA, with a slightly higher proportion of people eligible for tax credits (35%) buying coverage in an exchange.

From the perspective of delivering assistance to people eligible for it, enrollment in exchanges is a key measure, since tax credits are only available to those who buy coverage on their own in an exchange. It often takes time for enrollment in a new program to ramp up, and consistent with this view, CBO projects the number of people receiving tax credits in exchanges to triple by 2016.

The take-up of tax credits may vary significantly across states, for a variety of reasons. In the early stages of open enrollment, it's clear that the enrollment process is working more smoothly in some state-based exchanges than in others, and the difficulties with the federal marketplace have been widely reported. In addition, significantly greater outreach and consumer assistance resources are available in state-based exchanges due to the availability of federal grants under the ACA and limited budget for implementation of the federal marketplace. Our estimates of the number of people eligible for tax credits by state can serve as a barometer for tracking the success of enrollment efforts.

The overall enrollment in Marketplace coverage is likely to be a metric that is watched closely. While it is not, in fact, the most relevant measure for assessing the stability of the individual insurance market, it may provide some signals as to the health of the market and where premiums may be heading in 2015.

More important than how many enroll is who enrolls – Are they disproportionately younger and healthier or older and sicker? And, it is the composition of the entire individual market that is important, not just who enrolls in exchanges. That is because insurers are required to set premiums for individual insurance market coverage across all plans they offer, inside and outside of exchanges. Also, the risk adjustment system – which will redistribute money from plans that serve disproportionately healthy enrollees to those that enroll a disproportionately sick population – applies to plans inside and outside exchanges as well.

However, the likelihood of getting a balanced mix of enrollees in the individual market is related to the total number of new signups. It is expected that people who have a pre-existing condition and have been excluded from the individual insurance market previously will likely be among the early entrants. In addition, many people in state-based high risk pools will likely switch over to the individual market as well. Therefore, low enrollment levels may indicate a disproportionately sick risk pool, while higher enrollment levels may suggest a more balanced pool. And, it is likely that many new entrants to the individual market will enter through Marketplaces, so the number and composition of Marketplace enrollment may be suggestive of how the market is doing overall. Because insurance pools operate at the state level, the composition of enrollment state-by-state will be what drives the stability of insurance markets. Enrolling a large number of young and healthy people in California, for example, would not offset low take-up in Texas.

METHODS

The analysis uses pooled data from the 2012 and 2013 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information that can be used for national and state estimates.

Estimating eligibility for Medicaid, CHIP and premium tax credits for marketplace coverage requires grouping individuals together in different ways to determine their income under the different program rules. Our approach is described here. We analyzed people without coverage or with nongroup coverage to determine their potential eligibility for premium-tax-credits and as potential marketplace participants. The first step was to remove adults and children with incomes below Medicaid and CHIP eligibility levels in their state.[5] We also removed people who are not legal residents from the pool of potential eligibles. The ASEC does not ask about legal status of non-citizens, so we imputed documentation status as described here. Programming code to create the households and to perform the immigration status imputation is available upon request.

Premium tax credits. We analyzed the sample of remaining uninsured and nongroup people to determine eligibility for premium tax credits based on the income for their tax household and the premiums in the state where they lived. More than 40 percent of the unweighted records in the 2012-2013 CPS have a county identified -- so a second lowest silver plan premium for that county was directly merged on to these records. Other records were assigned a premium based on the within-state average premium for all undisclosed counties, weighted by the Census Bureau's 2010 Small Area Health Insurance Estimates (SAHIE) of the uninsured population of those counties. Premiums were adjusted for age based on the age-rating curve in each state. We assumed that all eligible members of a tax household would enroll in nongroup coverage and calculated their premium as a percent of household income. This premium percentage was compared to the maximum percentages in the ACA that families in the tax credit range (100 to 400 percent of poverty) must pay

toward the cost of the second-lowest cost silver plan where they live. People in families with incomes between 100 and 400 percent of poverty and whose household premium exceeded the maximum ACA percentage were identified as potentially tax credit eligible, subject to one additional adjustment described below.

As a final step, we reduced the number of people eligible for premium tax credits to reflect offers of employer-sponsored coverage. Under the law, people offered employer-sponsored coverage that meets minimum standards are not eligible to receive premium tax credits, even if they purchase nongroup coverage in a marketplace. The ASEC does not ask whether respondents were offered coverage at work, so we derived offer rates using data from Wave 6 of the 2008 Survey of Income and Program Participation (SIPP). Wave 6 asks respondents if they were offered health insurance at their main job. We assume that people who live with a spouse or parent that has coverage or an offer of coverage through a job also was offered coverage. We calculated offer rates for people without insurance and with nongroup insurance, stratified by age and income. We applied these percentages to the ASEC sample to reduce each state's count of uninsured and current nongroup individuals potentially eligible for premium tax credits.

Potential Market. As with our estimates for tax-credit eligibles, the estimate for the number of people who might look for coverage in Marketplaces starts with people legally residing in the United States who are uninsured or have nongroup coverage and have incomes above Medicaid and CHIP eligibility levels. We retain all remaining nongroup purchasers, even those with low incomes, as potential Marketplace purchasers because they are purchasing nongroup coverage now. Among the current uninsured, we excluded two groups from potential purchasers. The first group is people with access to employer-based coverage. As discussed above, we assume that these people would choose coverage through a job rather than nongroup coverage if they want to get insurance. We used information from Wave 6 in SIPP, as described above, to remove them from the number of potential marketplace purchasers. Excluding currently uninsured people with access to employer-sponsored insurance reduces the number of potential purchasers by a little over five million people. The second group we excluded was uninsured people with incomes below poverty, referred to as the gap group. These uninsured adults live in states that elected not to adopt the ACA Medicaid expansion and are not eligible for financial assistance to help them get coverage in exchanges. We assume that few would have sufficient resources to purchase nongroup coverage. Excluding this gap group reduces the number of potential purchasers by about 4.8 million people.

The issue brief was prepared by Gary Claxton, Larry Levitt, Anthony Damico, Rachel Garfield, Nirmita Panchal, Cynthia Cox and Matthew Rae.

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[1] http://cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

[2] Recent legally residing immigrants with incomes below the poverty line are treated as if their income were at the poverty line, making them eligible for premium tax credits.

[3] Health plans sold in the individual market in a state all have essentially the same benefits. Plans are organized into five tiers based on the amount of cost sharing (e.g., deductibles, copayments, coinsurance) they have. The five tiers are catastrophic, bronze, silver, gold and platinum. For more information, see http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8303.pdf.

[4] We did not remove current nongroup purchasers with an offer of employer-based coverage from the potential market total. These people have already made the decision not to take employer-provided coverage and to purchase nongroup coverage.

[5] Because some states have chosen to take the optional Medicaid expansion under the ACA and others have not, people with incomes from 100 to 138 percent of poverty will have different forms of financial assistance dependent on the state's decision. These people will be eligible for Medicaid in states taking the expansion but will be potentially eligible for premium tax credits in states not expanding Medicaid.

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

Timely Analysis of Immediate Health Policy Issues

October 2013

Matthew Buettgens, Genevieve M. Kenney, Hannah Recht, and Victoria Lynch

Summary

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

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

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

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

Introduction

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

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

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

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

Methods

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

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

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

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

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

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

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

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

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

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

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

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

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

Enrollment of the uninsured in nongroup coverage. We complete the simulation by estimating additional enrollment in non-group coverage outside the exchange by those currently uninsured with no ESI offer in the family who would not enroll in steps 1 or 2. This would result largely from the effect of the mandate. There would be some additional coverage for the undocumented here as well, since nongroup coverage would be their only option without an ESI offer.

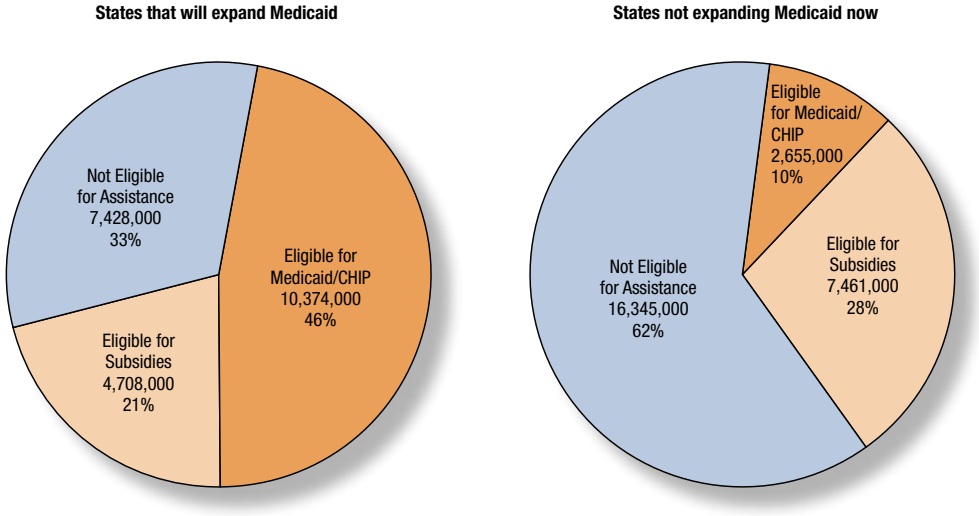
Transition from single to family ESI. The individual mandate will provide incentives for families to obtain coverage for all members. In particular, the expected utility model in HIPSM predicts that a certain number of single ESI policyholders in families where other members are uninsured or taking non-group coverage would purchase family ESI to cover the entire family. We model such transitions on the ACS based on the behavior of single ESI policyholders in HIPSM with mixed coverage in other members. Such families are not common, but this transition captures a behavioral response to the individual mandate.

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

Results

In Table 1, we show the estimated number uninsured in each state before the ACA, using data from 2008 and 2010. We then estimate the number who would be eligible for Medicaid or CHIP under the ACA and the number who would be eligible for subsidized coverage in the ACA's new health insurance marketplaces. As indicated above, our estimates take into account each state's current decision on expanding Medicaid. As of September 2013, 24 states and the District of Columbia are committed to expanding Medicaid under the ACA. Of the 26 remaining states, legislative debate about the Medicaid expansion is ongoing in four states.

Figure 1: Eligibility for Assistance Among Those Currently Uninsured.



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

Among all states expanding Medicaid, 67 percent of the uninsured would be eligible for assistance (Figure 1). About 10.4 million would be eligible for Medicaid or CHIP, and 4.7 million eligible for subsidized private coverage in the marketplaces. Among all states not currently expanding Medicaid, 38 percent of the uninsured would be eligible for assistance: 2.7 million eligible for Medicaid/CHIP, and 7.5 million eligible for subsidized private coverage. The number eligible for subsidized coverage includes some with incomes between 100 and 138 percent of the FPL which would become eligible for Medicaid if their state chooses to expand eligibility.

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

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

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

In Table 2, we look closely at those we project will remain uninsured under the ACA, particularly those who are eligible for Medicaid, CHIP, or subsidized coverage, but have not enrolled. The remaining uninsured people not eligible for any assistance program include undocumented immigrants (who would make up about a quarter of the remaining uninsured nationwide) and those who choose not to purchase private insurance and potentially face a penalty under the ACA's individual coverage requirement.

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

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

There may be changes in state decisions about the Medicaid expansion for some time to come. In most of the states not currently expanding, Medicaid expansion will likely be an issue again in 2014 as state legislatures convene and governor's budgets are issued. Also, several states currently planning to expand Medicaid are exploring an approach that is likely to require a waiver from HHS. Arkansas' waiver was approved at the end of September 2013, but waiver applications are pending for Iowa and Michigan.

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

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

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

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

* Currently Undecided, Treated as Not Expanding

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

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

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

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

* Currently Undecided, Treated as Not Expanding

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

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

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

Endnotes

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

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

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

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

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

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