

America Under the Affordable Care Act

December 2010

Matthew Buettgens

Bowen Garrett

John Holahan

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.

About the Authors

Matthew Buettgens is a research associate, Bowen Garrett is a senior research associate, and John Holahan is director of the Urban Institute's Health Policy Center.

Acknowledgements

This research was funded by the Robert Wood Johnson Foundation. Development of the Health Insurance Policy Simulation Model (HIPSM) was funded by the Stoneman Foundation, the Kaiser Commission on Medicaid and the Uninsured, and the Robert Wood Johnson Foundation. The authors thank Lynn Blewett, Linda Blumberg, Gary Claxton, Sharon Long, and Robert Reischauer for helpful comments and Caitlin Carroll for excellent research assistance. The authors have sole responsibility for any errors or omissions.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years, the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.

Summary



With the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, the Patient Protection and Affordable Care Act (ACA) became law, fundamentally changing health insurance and access to health care in the United States. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimate how the ACA would affect the types of health insurance coverage Americans have, the number of those without insurance, and America's overall spending on health care. For ease of comparison, we simulate the ACA as if fully implemented in 2010 and contrast the results with HIPSM's pre-reform baseline results for 2010. Our single-year estimates complement the 10-year cost estimates previously released by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, providing many results—particularly for coverage and transitions in coverage—that are either new or broken out by more detailed characteristics than in either of those estimates.

We estimate that

- » **Under the ACA, the share of nonelderly adults without health insurance would decline by 27.8 million**, from 18.6 to 8.3 percent. The number of uninsured would decline for all income categories, but the lowest-income would see the greatest declines. For example, the number of nonelderly uninsured below 200 percent of the federal poverty level (FPL) would drop by 19.4 million.
- » **Nearly 30 percent of those at all income levels who would have been uninsured without reform would be covered by Medicaid or the Children's Health Insurance Program (CHIP)**, nearly 20 percent would be covered under the new health insurance exchanges, and an additional 10 percent would be covered by private insurance outside the exchanges. The other 40 percent would remain uninsured.
- » **Nearly 40 percent of those who would still be uninsured under the ACA are eligible for Medicaid or CHIP but would choose not to enroll.** Just over a quarter would be undocumented immigrants who are ineligible for public insurance coverage or the coverage in new exchanges.
- » **Total spending on acute health care for the non-elderly by the government, employers, and individuals would increase by 4.5 percent under the ACA** (excluding the savings from multiyear provisions) if it were fully implemented in 2010. Multiyear provisions such as Medicare and Medicaid savings and cost-containment programs were not simulated. Total costs to employers would be largely unchanged. Spending for most individuals would not change significantly, though many of those currently uninsured but ineligible for Medicaid or the most generous premium subsidies would spend more on premiums for new health insurance or individual mandate penalties.
- » **The cost of uncompensated care provided to the uninsured would drop by 61 percent.** These reductions would allow federal and state governments to reduce spending on programs that now support the uninsured (not in our government baseline). Less uncompensated care could also result in lower private premiums and higher provider revenue.
- » **The expansion of Medicaid would enroll 13.1 million new adults and 3.7 million new children.** The newly enrolled adults would be much less expensive to cover, on average, than current adult Medicaid enrollees.
- » **We estimate that 43.8 million nonelderly persons would be covered through health insurance exchanges.** About half of these, 23.1 million, would be covered by nongroup (i.e., individually purchased, not employer-related) insurance purchased in the health insurance exchanges. The remainder would obtain coverage in an exchange through their employer.

Introduction

With the enactment of the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, the Patient Protection and Affordable Care Act became law, fundamentally changing health insurance and access to health care in the United States. This brief provides an overview of how the ACA would affect the types of health insurance coverage Americans have, the number of those without insurance, and America's overall spending on acute care for the nonelderly. Multi-year cost control provisions and provisions affecting primarily the elderly,

such as Medicare payment reductions, were not simulated. After examining how the distribution of insurance coverage would change under health reform, we look more closely at the newly insured under the ACA and those still left uninsured. We then present overall health care spending by households, employers, and the government both with and without health reform. We consider Medicaid/CHIP costs and enrollment, as well as aspects of the new health insurance exchanges, such as coverage, subsidies, and employee choice vouchers.

Methods

To estimate the effects of health reform, we use the Urban Institute's Health Insurance Policy Simulation Model.¹ HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms.²

We simulate the main coverage provisions of the ACA as if they were fully implemented in 2010 and compare the results to HIPSM's pre-reform baseline results for 2010. This approach differs from those of the CBO or the CMS actuaries, which by necessity provide 10-year estimates. Our approach permits more direct comparisons of reform with the prereform baseline. The most important provisions of the ACA for the results we present are summarized below.³

- » Medicaid eligibility is expanded to 133 percent of the federal poverty level⁴ (FPL) for all adults, with the Children's Health Insurance Program remaining in place at current levels. Also, 5 percent of income is disregarded when determining eligibility, so the eligibility level is effectively 138 percent of the FPL.⁵ Medicaid maintenance-of-eligibility requirements for adults are dropped when the reforms are fully implemented, reducing the number of adults with incomes above 138 percent of the FPL who would have been eligible with maintenance of eligibility.⁶

- » New state-based health insurance exchanges (exchanges) offer plans constructed to meet actuarial value standards of 60, 70, and 80 percent.⁷ Exchange plans are guaranteed issue, as are all plans in the small-group and nongroup markets. Premiums may be rated by age and tobacco use, with age bands of up to 3:1 and tobacco-use bands of up to 1.5:1.⁸ Exchange-based insurance coverage is available to individuals and families purchasing nongroup coverage independent of an employer and to employer groups with 100 or fewer employees.⁹ Undocumented immigrants are barred from the exchanges.
- » Refundable premium tax credits (subsidies) are available to eligible families purchasing insurance through the exchange. These are provided on a sliding scale basis. They limit the maximum percentage of income that a family would have to spend on its health insurance premium. The limit is 2 percent of income for those with incomes up to 133 percent of the FPL,¹⁰ 3 to 4 percent of income for those with incomes between 133 and 150 percent of the FPL, 4 to 6.3 percent for those with incomes between 150 and 200 percent of the FPL, 6.3 to 9.5 percent for those with incomes between 200 and 300 percent of the FPL, and 9.5 percent for those with incomes between 300 and 400 percent of the FPL.¹¹
- » Cost-sharing subsidies are available to those with incomes below 250 percent of the FPL and reduced maximum out-of-pocket limits are provided to those with incomes below 400 percent of the FPL.¹²

- » There is an individual mandate introducing a penalty for remaining uninsured. Undocumented immigrants, Native Americans, prisoners, and those below the tax filing threshold will be exempt from the mandate. Exemptions will also be granted for hardships in obtaining coverage, religious conscience and if no affordable insurance coverage is available.¹³ The penalty when fully phased in will be the greater of 2.5 percent of income or \$695 for an individual or \$2,085 for a family (in 2016 dollars), not to exceed an applicable national average premium.
- » Regardless of income, employees of firms that offer coverage would be ineligible for subsidized coverage in the exchange unless the employee's share of the premium exceeds 9.5 percent of income or if the actuarial value of the employer's plan is less than 60 percent.
- » Employee choice vouchers are available to workers whose employers offer health insurance coverage through the workplace, whose incomes are below 400 percent of the FPL and whose share of the lowest offered employer-sponsored insurance (ESI) premium is between 8 and 9.8 percent of income. Qualified workers would receive a voucher for the amount that their employer would have contributed to their insurance premium if they had enrolled in the employer's plan. They can then apply this voucher to help pay for insurance through an exchange.¹⁴
- » A small group tax credit is available to firms that offer health insurance, have 25 or fewer employees, and have workers with an average pay of less than \$50,000.
- » New assessments may apply to employers with more than 50 employees. If such a firm does not offer coverage and has at least one full-time employee who receives a subsidy in the exchange, a fee of \$2,000 per full-time employee is assessed, excluding the first 30 employees. Employers that do offer coverage but have at least one full-time employee who receives a subsidy are assessed the lesser of \$3,000 for each employee getting subsidies or \$2,000 per full-time employee.
- » There is risk adjustment in the nongroup and small-group ESI markets between plans both inside and outside the exchange.
- » Most health insurance market reforms apply to all nongroup and small-group (up to 100 workers) ESI policies issued inside or outside the exchange, except for grandfathered plans.¹⁵

Many provisions of the ACA, particularly those related to the exchanges, allow states considerable freedom in implementation. Some of the provisions that we model with a single national policy will likely vary by state.

To model the individual mandate, we begin with the baseline HIPSM model, in which behavior is calibrated to reflect the results of the empirical health economics literature. The resulting model behavior is applicable for a voluntary health insurance regime; however, we must simulate how behavior would change in the presence of a mandate. Since a similar law only exists in Massachusetts after its health reforms, the only available empirical data are from that state.¹⁶ We thus use the Massachusetts Health Insurance Survey to inform the behavioral effects of individuals under a mandate. Our simulation of how behavior would change under the mandate has three components:¹⁷

1. **The applicable financial penalty.** A computation of whether or not the penalty is applicable and the amount of the penalty as defined by the law, i.e., the fully phased in amount discounted to present dollars.
2. **An additional "disutility" of not complying with the mandate.** The mandate is more than a dollar amount, it is a legal requirement. Desire to comply with the law, or at least to avoid enforcement and the stigma of noncompliance, has often led to behavioral responses much stronger than the amount of the nominal penalty would suggest. The mandate has the effect of making being uninsured less desirable—we operationalize this in the model by applying an additional "psychic" penalty to being uninsured.¹⁸
3. **A relatively small "spillover" disutility of being uninsured on populations not bound by the mandate.** The mandate in Massachusetts was associated with an increase in coverage among those not actually bound by the mandate. We assume that this association was driven, in part, by a spillover effect of the mandate on those who were not bound by it who either mistakenly assumed they were or who reacted to a new social norm to have coverage. In addition to uncertainty about the current applicability of the mandate, people may also be making a judgment about whether they will lose their mandate exemption in the future due to rising income. For those exempt from the mandate, the amount of additional disutility of being uninsured is far smaller than for those bound by the mandate.

Results

Changes in Health Insurance Coverage

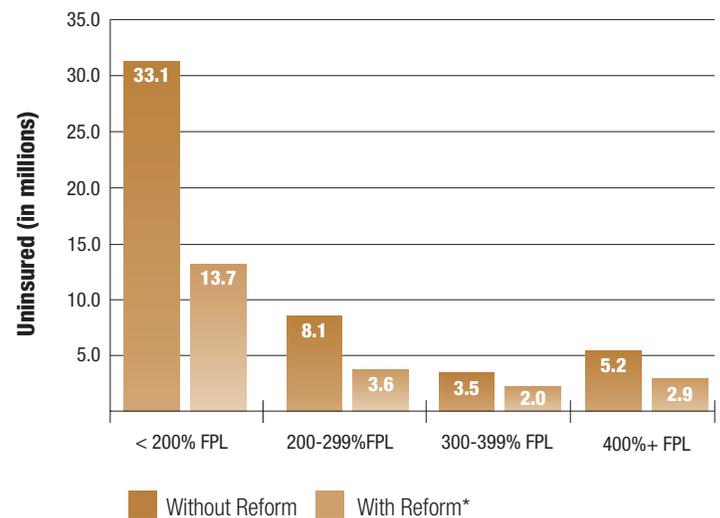
We first consider how health insurance coverage changes under the ACA. *Table 1* compares the distribution of coverage with and without health reform. Without reform, there would be 49.9 million nonelderly persons without health insurance (18.6 percent of the nonelderly population), as opposed to 22.1 million uninsured with reform (8.3 percent).¹⁹ Thus, the ACA achieves a major goal of health reform, decreasing the uninsured by more than half. Below, we consider in more detail those insured under the ACA who would not have had insurance without reform and those still without insurance coverage under the ACA.

The number of persons covered by insurance through an employer under the ACA would remain largely unchanged (by 0.5 million people or 0.2 percent of the nonelderly population). More than half of nonelderly Americans (151.1 million or 56.4 percent) would still obtain coverage through an employer; 20.7 million of these would be covered by employer-sponsored plans in the new health insurance exchanges.

The new nongroup health insurance exchanges would insure 23.1 million nonelderly Americans (8.7 percent). Nongroup insurance outside the exchange would cover only 3.3 million (1.2 percent). Taking these two together, the nongroup market would grow dramatically in size from 14.8 million nonelderly persons covered without reform to 26.5 million after reform.

The Medicaid expansion under the ACA leads to significantly higher Medicaid/CHIP enrollment (59.7 million or 22.3 percent of the nonelderly) than without reform (42.9 million or 16 percent). Other types of public insurance coverage do not change significantly.

Figure 1: Number of Uninsured by Income Group



Source: Urban Institute analysis, HIPS M 2010.

* We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

Table 1: Health Insurance Coverage Distribution of the Nonelderly in Baseline and Reform

	Without Reform		With Reform ^a		Change	
Coverage (in millions)						
Insured	218.0	81.3%	245.9	91.8%	27.8	10.5%
Employer (non-exchange)	151.6	56.6%	130.4	48.7%	-21.2	-7.9%
Employer (exchanges)	0.0	0.0%	20.7	7.7%	20.7	7.7%
Nongroup (non-exchange)	14.8	5.5%	3.3	1.2%	-11.6	-4.3%
Nongroup (exchanges)	0.0	0.0%	23.1	8.7%	23.1	8.7%
Medicaid/CHIP	42.9	16.0%	59.7	22.3%	16.7	6.3%
Other (including Medicare)	8.7	3.2%	8.7	3.2%	0.0	0.0%
Uninsured	49.9	18.6%	22.1	8.3%	-27.8	-10.3%
Total	268.0	100.0%	268.0	100.0%	0.0	0.0%

Source: Urban Institute analysis, HIPS M 2010.

a. We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

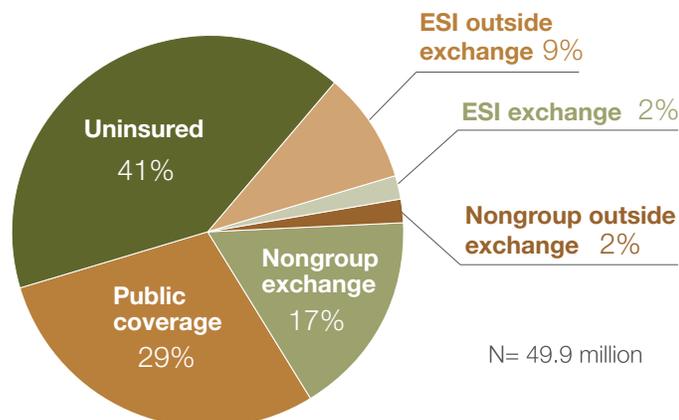
Changes in Those without Health Insurance

As we have seen, health reform would reduce the number of nonelderly Americans without health insurance by more than half to 22.1 million. *Figure 1* shows the distribution of the uninsured before and after reform by income group. The majority of the prereform uninsured (33.1 million) have household incomes below 200 percent of the FPL. The number of uninsured in this income category falls to 13.7 million under the ACA, a decrease of nearly 60 percent. In the next income group, from 200 to 299 percent of the FPL, the number of uninsured drops 56 percent from 8.1 million to 3.6 million under the ACA. Higher income categories also see significant declines in the uninsured, but there are far fewer uninsured in these groups to begin with. Note that there are more uninsured in the 400+ percent of the FPL group than in the 300 to 400 percent of the FPL group because there are about three times as many people in that income group; the uninsured rate is much lower in the higher income group.

Those Newly Insured under the ACA

In *Figure 2*, we take a closer look at the 49.9 million nonelderly Americans who would be uninsured without reform and see what type of insurance coverage they would obtain under the ACA, if any. The majority (59 percent) would be covered by public or private insurance, but 41 percent of them would remain uninsured. Medicaid and CHIP would cover 29 percent. The new health insurance exchanges, either nongroup or ESI, would cover 19 percent, 17 percent in nongroup exchanges and 2 percent in ESI exchanges. ESI outside the exchange would cover 9 percent, and nongroup insurance outside the exchange would cover 2 percent.

Figure 2: Those Uninsured without Reform—What Coverage Would They Have with Reform?



The Remaining Uninsured

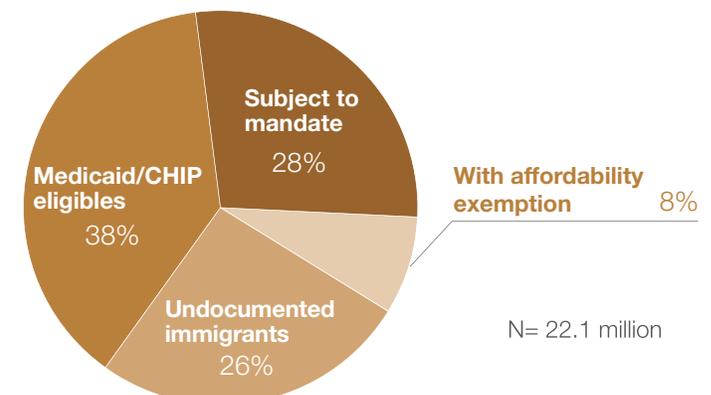
In *Figure 3*, we examine the 22.1 million nonelderly Americans who would be left without insurance under the ACA. More than a quarter of these would be undocumented immigrants, who are barred from both public coverage and the new health insurance exchanges. Nearly two-fifths of the remaining uninsured are eligible for Medicaid or CHIP, but have not enrolled. This group could be reached by more effective outreach or automatic enrollment. Eight percent are legal residents, ineligible for Medicaid and CHIP, and qualify for an affordability exemption from the individual mandate penalties. Finally, 28 percent (just over 6 million people) are subject to the mandate but choose to opt out of insurance coverage and risk the relevant penalties.²⁰

Changes in Health Care Spending

Table 2 shows how spending on acute care for the nonelderly by different payers varies with and without reform. As noted earlier, we do not simulate multiyear cost control provisions or provisions such as Medicare payment reductions affecting primarily the elderly. Overall spending by individuals, employers, the government, and uncompensated care would be higher under the ACA than without reform by \$53.1 billion or 4.5 percent. As noted above, this does not account for various Medicare, Medicaid, and cost-containment provisions that would reduce net new spending. For comparison, *Table 1* shows that the number of nonelderly Americans with health insurance coverage is 12.7 percent higher under the ACA than without reform.

Government spending on acute care for the nonelderly (excluding all spending on the elderly and Medicaid long-term care spending on the non-elderly) would increase under the ACA

Figure 3: Those Left Uninsured under Reform



by \$69.1 billion—from \$244.2 billion to \$313.3 billion. This is due mainly to the Medicaid expansion and increased enrollment by those already eligible for public coverage (\$53.6 billion) and premium and cost-sharing subsidies for households in the exchange (\$33 billion in premium and cost-sharing subsidies). The government also would pay \$4.5 billion in small employer tax subsidies and would collect \$21.9 billion in employer and individual penalties. The latter are not actually health care spending, but are the result of the ACA, so we include them.

Employer spending would be 0.6 percent lower under reform (\$510.2 billion) than without reform (\$515.3 billion). A decrease of \$19.2 billion in employer premium contributions is offset by \$17.6 billion in assessments paid by firms with 50 or more employees. Firms with fewer than 25 employees would receive \$4.5 billion in subsidies (tax credits). Employers would pay \$3 billion in employee choice vouchers their workers would use for purchasing exchange-based coverage.

Individuals would spend \$29.5 billion (or 8.7 percent) more for health care under the ACA than without reform (\$370 billion versus \$340.5 billion). The \$29.5 billion is less than one half of one percent of personal income of the nonelderly population. This increase is due almost entirely to spending on new health coverage and individual mandate penalties for those uninsured before reform (\$28 billion, not shown in the table). The 102.3 million nonelderly persons with incomes below 200 percent of the FPL would spend \$10.7 billion less under the ACA due to the Medicaid expansion and the substantial subsidies available to this group. The 71.6 million nonelderly with incomes between 200 and 400 percent of the FPL would see a total rise in spending of \$12.6 billion, reflecting a large increase in coverage and use of health care services. This group is eligible for some subsidies, but their generosity is phased down substantially as income increases. Finally, the 94.2 million nonelderly with incomes above 400 percent of the FPL would spend \$27.6 billion more. Most of these—in particular, those with ESI coverage—would see little increase in spending. The increase in both of the latter groups is due primarily to new premium spending by the previously uninsured.

Uncompensated care provided to those without insurance is a significant cost (\$69.7 billion without reform) currently paid by the federal government, state and local governments, health care providers, and others. The ACA would cut uncompensated care costs by 61 percent, to \$27.3 billion. These reductions would allow the government to cut outlays for programs that now support the uninsured. They could also result in lower private premiums and higher provider revenue.

Table 2: Health Care Spending of Government, Employers, Individuals, and Uncompensated Care in Baseline and Reform

	Baseline (in millions)	After Reform (in millions)	Change (in millions)	Percent Change
Government Spending				
Medicaid/SCHIP ^a	\$244,180	\$297,740	\$53,560	21.9%
Premium subsidies	\$0	\$26,860	\$26,860	n.a.
Cost-sharing subsidies	\$0	\$6,090	\$6,090	n.a.
Employer subsidies	\$0	\$4,479	\$4,479	n.a.
Individual mandates	\$0	-\$4,290	-\$4,290	n.a.
Employer assessments	\$0	-\$17,601	-\$17,601	n.a.
Net Government Spending	\$244,180	\$313,277	\$69,097	28.3%
Employer Spending				
ESI premiums	\$513,293	\$494,068	-\$19,225	-3.7%
Employer assessments	\$0	\$17,601	\$17,601	n.a.
Voucher amount	\$0	\$2,995	\$2,995	n.a.
Employer subsidies	\$0	-\$4,479	-\$4,479	n.a.
Net Employer Spending	\$513,293	\$510,185	-\$3,108	-0.6%
Individual Spending				
Net out-of-pocket premiums	\$180,786	\$211,538	\$30,752	17.0%
Net out-of-pocket cost-sharing	\$159,694	\$154,138	-\$5,556	-3.5%
Individual mandates	\$0	\$4,290	\$4,290	n.a.
Total Individual Spending	\$340,479	\$369,966	\$29,487	8.7%
<200% FPL	\$70,513	\$59,824	-\$10,689	-15.2%
200-399% FPL	\$100,316	\$112,871	\$12,555	12.5%
>400% FPL	\$169,650	\$197,271	\$27,621	16.3%
Uncompensated Care				
Total uncompensated spending	\$69,633	\$27,250	-\$42,383	-60.9%
Overall Spending	\$1,167,586	\$1,220,679	\$53,093	4.5%

Source: Urban Institute analysis, HIPS 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

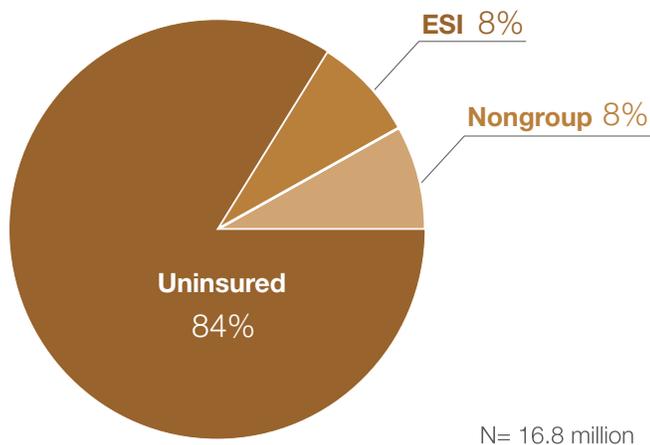
a. Spending on acute care costs for the nonelderly.

In total, \$1,167.6 billion would be spent without health reform and \$1,220.7 billion would be spent under the ACA, an increase of 4.5 percent. As noted above, these estimates are for a single year based on health care costs for 2010. Provisions in the ACA such as multiyear cost-control provisions and savings from Medicare and Medicaid were not simulated.²¹ This increase in costs would fund an increase in insurance coverage of 12.8 percent.

The Medicaid Expansion

We now consider the ACA Medicaid expansion in greater detail. Without health reform, 42.9 million nonelderly people would be enrolled in Medicaid or CHIP during 2010. Under the ACA, the expansion of Medicaid to 133 percent of the FPL plus a 5 percent income disregard increases overall enrollment in Medicaid and CHIP to 60.2 million.²² Of the 16.8 million nonelderly persons who would newly enroll in Medicaid or CHIP under the ACA, 84 percent would have been uninsured without reform (Figure 4).

Figure 4: Those Who Newly Enroll in Medicaid Under the ACA—What Coverage Would They Have Had without Reform?



The remainder would have been covered by either ESI (8 percent) or nongroup (8 percent) policies.

In Table 3, we see that the expansion enrolls many more adults (13.1 million) than children (3.7 million). Children in this income range tend to already be eligible for CHIP. Also, the newly enrolled nonparent adults have dramatically lower expenses on average than current nonparent adult enrollees, \$3,601 versus \$13,833. Considered in aggregate, enrollment for adult nonparents increases 111 percent while the amount spent on them increases by only 28.7 percent. Under pre-ACA rules, adult nonparent enrollees have particularly high average costs. Many, for example, are in Medicaid because they are medically needy or enrolled in SSI. The drop in average costs under the ACA for this group is largely a result of eligibility being based on an income threshold rather than special eligibility categories whose members often have a disproportionately greater need for health care services.

Figure 5: Those Covered by the Nongroup Exchange—What Coverage Would They Have Had without Reform?

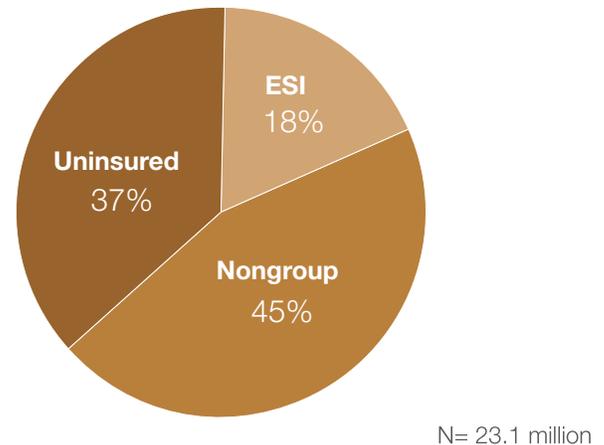


Table 3: Medicaid/CHIP Enrollment and Costs, with and without Reform

	Without Reform			With Reform ^a				Change		Percent Change	
	Enrollees (millions)	Cost (billions \$)	Average cost (\$)	Enrollees (millions)	Cost (billions \$)	Average cost (\$)	Cost per new enrollee (\$)	Enrollees	Cost	Enrollees	Cost
Children	27.6	70.0	2,536	31.3	75.7	2,419	2,046	3.7	5.7	13.4%	8.1%
Adult parents	6.3	51.6	8,190	9.4	61.8	6,574	3,459	3.1	10.2	49.2%	19.8%
Adult Nonparents	9.0	124.5	13,833	19.0	160.2	8,432	3,601	10.0	35.7	111.1%	28.7%
Total	42.9	246.1	5,737	59.7	297.7	4,987	3,175	16.8	51.6	39.2%	21.0%

Source: Urban Institute analysis, HIPS 2010.

a. We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

The Nongroup Exchanges

Under the ACA, 23.1 million nonelderly persons would be covered under the new nongroup health insurance exchanges; 45 percent of these would have had nongroup coverage without reform (*Figure 5*). The exchange will, to a large extent, replace the existing nongroup market. There will, as we have seen, be a significant expansion of nongroup insurance coverage as well. Thirty-seven percent of those in a nongroup exchange would have been uninsured without health reform, and 18 percent would have had employer-sponsored coverage.

In *Tables 4 and 5*, we give an overview of coverage, subsidies, and vouchers in the nongroup exchange. More than two-thirds of the 23.1 million nonelderly Americans covered under the nongroup exchange are in the premium subsidy eligibility range (below 400

percent of the FPL) (*Table 4*). Nearly half of the single policies are held by those with incomes below 200 percent of the FPL and only 22.7 percent are above 400 percent of the FPL. The distribution of family policies is very different, with 39.3 percent of policies held by those above 400 percent of the FPL. Most of the families in this income group enrolled in the exchange do not have an ESI offer, but the age-rating and choice of plans with a lower actuarial value than comprehensive ESI make the exchange attractive to some with offers as well, particularly younger workers.

Those below 200 percent of the FPL account for 55.3 percent of those receiving subsidies, 64.4 percent of premium subsidies, and 92.4 percent of cost-sharing subsidies (*Table 5*). The benefits of the voucher program are much more evenly distributed among those below 400 percent of the FPL.

Table 4: Enrollment in the Nongroup Exchange by Income Group

	With Reform					
	Single policies (millions)	Percent of total	Family policies (millions)	Percent of total	Persons covered (millions)	Percent of total
<200% FPL	6.1	46.8%	1.1	27.0%	8.2	35.4%
200-300% FPL	2.6	20.2%	0.9	21.5%	4.8	20.6%
300-400% FPL	1.3	10.3%	0.5	12.2%	2.7	11.7%
400%+ FPL	2.9	22.7%	1.6	39.3%	7.4	32.3%
Total	12.9	100.0%	4.2	100.0%	23.1	100.0%

Source: Urban Institute analysis, HIPSIM 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

Comparison with CBO Estimates

In *Table 6*, we compare our estimates of the distribution of health insurance coverage under health reform with those of the Congressional Budget Office.²³ The focus of the CBO estimates is on multiyear spending and revenue projections, whereas in this research, we use a single-year simulation to present more detail in other areas. For example, under CBO estimates, provisions such as the exchanges phase in over several years. Thus, our estimates should be compared with their estimates of the earliest year in which the most important provisions are fully phased in, which is 2017. For comparison, we simulated the ACA in 2017 using the methodology developed in a series of papers last year.²⁴ We age our data using demographic and economic projections from 2010 to 2017.²⁵ The behavior of households and firms is then simulated based on 2017. Thus, the results differ from the 2010

Table 5: Subsidies and Vouchers in the Nongroup Exchange by Income Group

	With Reform							
	Persons receiving subsidies (millions)	Percent of total	Total premium subsidies (billions \$)	Percent of total	Total cost-sharing subsidies (billions \$)	Percent of total	Persons receiving vouchers (millions)	Total voucher amount (billions \$)
<200% FPL	5.8	55.3%	17.3	64.4%	4.1	92.4%	0.1	0.8
200-300% FPL	3.6	34.0%	7.4	27.7%	0.3	7.6%	0.1	1.3
300-400% FPL	1.1	10.6%	2.1	7.7%	0.0	0.0%	0.1	0.8
400%+ FPL	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.1
Total	10.5	100.0%	26.8	100.0%	4.4	100.0%	0.4	3.0

Source: Urban Institute analysis, HIPSIM 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

Table 6: Comparison of Estimated Coverage and Selected Costs for 2017 under the ACA

	CBO	HIPSM
Coverage (in millions)		
Employer (exchange and non-exchange)	57%	55%
Nongroup and other public	9%	4%
Exchange nongroup	8%	8%
Medicaid/CHIP	19%	24%
Uninsured	8%	9%
Selected Government Costs (in billions \$)		
Medicaid/CHIP costs due to the expansion	87	101
Premium and cost-sharing subsidies	75	51
Total	162	152

Source: Urban Institute analysis, HIPSM 2010 and CBO analysis, March 20, 2010.

results presented elsewhere. These 2017 results are presented only for comparison with CBO's 2017 results.

The two estimates of coverage are very similar despite differences in the simulation models used. The largest coverage differences are for Medicaid/CHIP and nongroup and other public. These are in part due to higher Medicaid/CHIP take-up rates and in part to differences in aging from 2010 to 2017 (explained below). To show that our costs are not incompatible with the CBO's, we compare estimates of the two largest components of government costs, the Medicaid/CHIP expansion and subsidies in the exchanges. The CBO has higher subsidy costs and lower Medicaid costs than our estimates, but the total of these two is very similar.²⁶ The following are likely explanations of these differences, with further explanations of our methodology where needed:

- » The most important difference is in Medicaid take-up rates. We assume somewhat higher rates than the CBO appears to assume. We calibrate the behavior of our model so that

a standard expansion of Medicaid and CHIP achieves take-up rates consistent with the empirical literature.²⁷ We start with target take-up rates for the uninsured between 60 and 70 percent, depending on person type and income group. But, the ACA contains important provisions that would increase take-up. States are required to establish a web site capable of determining eligibility for Medicaid and automatically enrolling eligibles. Hospitals would be able to make presumptive eligibility determinations. There would be other new requirements for simplifying enrollment and renewal of Medicaid and CHIP. After taking these and other factors into account, HIPSM generates a take-up rate of about 73 percent for the uninsured who are newly eligible. This rate is higher than the initial rate due to outreach and enrollment simplification provisions in the ACA, as well as a modest indirect effect of the individual mandate as observed in health reform in Massachusetts.

- » Our economic projections from 2010 to 2017 are not identical to those used by CBO. Also, we project that current trends in the distribution of income will continue. CBO's income distribution projections may differ from ours.²⁶ These differences could explain much of the difference in ESI, Medicaid/CHIP, and nongroup coverage.
- » The nongroup and other public category in the CBO report combines multiple forms of coverage, making it more difficult to explain differences. An important reason for the difference is very likely to be in projections of nongroup coverage outside the exchange. As explained above, we simulate risk adjustment between the nongroup markets inside and outside the exchange and standards for premium rating and benefit packages that apply to both. We do not simulate grandfathered plans. Reflected in our estimates is the view that it will be difficult for non-grandfathered plans outside the exchange to differentiate themselves from exchange plans unless a state aggressively restricts the number of plans allowed into the exchange. As grandfathered plans decline, the non-exchange, nongroup market is likely to be small and may disappear entirely in some states.

Discussion

A Large Expansion of Insurance Coverage. Health reform would cut the number of nonelderly persons without health insurance by more than half, from 49.9 million to 22.3 million. Of the 27.6 million who would gain insurance coverage under health reform, slightly more than half would gain public coverage through the Medicaid expansion; the rest would purchase private insurance. Our analysis of those left uninsured under the ACA suggests some policy changes that could significantly increase insurance coverage. Nearly two-fifths of the 22.3 million left uninsured would be eligible for Medicaid or CHIP. These could be reached by increased outreach or an expansion of automatic enrollment programs. Tax returns, for example, could be examined to identify and enroll eligibles. Similarly, tax filers could be automatically notified of health insurance subsidies in the exchange for which they would be eligible. Just over a quarter of the uninsured are undocumented immigrants. These are barred by law from all of the benefits of health reform and are even prevented from purchasing coverage in the exchange with their own money.

Little Change in Employer Coverage. The number of people covered by employer-sponsored insurance plans would remain largely unchanged under the ACA; 56 percent of nonelderly persons would still be covered by ESI plans. Many of these would be covered by plans in the new exchanges offered as benefits by small employers. Some small employers would drop, but others would begin offering coverage resulting from increased worker demand due to the mandate and other factors. A forthcoming policy brief will examine ESI under health reform in greater detail.

Expansion of the Nongroup Market in Exchanges. Nearly 10 percent of the nonelderly would be covered by nongroup insurance policies. The vast majority of these would be covered by the exchanges. Undocumented immigrants cannot purchase coverage in the exchange, so those purchasing coverage would do so outside the exchange. However, the individual mandate and associated penalties do not apply to them. With risk adjustment and minimum benefit requirements, how nongroup policies outside the exchange would differentiate themselves from those inside and remain competitive is not clear. A nongroup market outside the exchange would almost certainly need more than demand from undocumented immigrants to remain viable; such coverage may vanish entirely outside the exchange in some states.

More than two-thirds of those enrolled in the nongroup exchanges would be in the subsidy eligibility range, below 400 percent of the FPL. More than half of those in the nongroup exchanges would be covered under single policies, and nearly half of those would be held by persons below 200 percent of the FPL. Those below 200 percent of the FPL, single or family, account for nearly two-thirds of premium subsidy costs and more than 90 percent of cost-sharing subsidy costs. The benefits of employee choice vouchers are distributed much more evenly among those below 400 percent of the FPL.

Increased Medicaid Coverage. The Medicaid expansion in the ACA would increase the enrollment of nonelderly Americans in Medicaid and CHIP by 16.8 million, with total enrollment reaching 59.7 million people. Most of the new enrollees will be adults, particularly adults who are not parents. Children below 138 percent of the FPL are already eligible for CHIP in many states, so they are much less likely to gain eligibility for public coverage. Since Medicaid eligibility under the ACA is based on an income threshold rather than on eligibility pathways that may depend on combinations of income, health status, and spending, the new adults enrolled will be dramatically cheaper to cover, on average, than current Medicaid-enrolled adults. For example, the average cost of a newly enrolled nonelderly adult nonparent would be about \$3,600, while the average cost of a nonelderly adult nonparent enrolled under prereform Medicaid would be more than \$13,800.

Increased Overall Spending. Total system spending on acute care for the nonelderly would be 4.5 percent higher under health reform than without health reform. It should be noted that our results are based on health expenditures for 2010; the effects of various Medicare and Medicaid savings and cost-control provisions over time are not simulated. Those who would gain insurance coverage under the ACA are in general less expensive than those who are currently insured. An important reason for this is that in the current voluntary health insurance markets, those with high health costs have a higher demand for insurance and those with low costs are more likely to take the risk of going without it. The ACA covers more of the latter, both with carrots, such as exchange subsidies, and sticks, such as the individual mandate. Also, there will likely be administrative cost savings associated with the new health insurance exchanges.

Little Change in Total Employer Spending. The total health care costs to employers would be nearly the same under the ACA as without reform. A savings of \$19.2 billion in premium contributions would be offset by \$17.6 billion in assessments on employers with more than 50 employees. The smallest employers would receive \$4.5 billion in tax credits, and employers would pay \$3 billion in employee choice vouchers. Employers may deduct the full amount of any vouchers they issue from their taxes. We do not simulate corporate income taxes, so the savings from this deduction are not included.

Increased Total Individual Spending for Those Uninsured Without Reform. Individual spending on health care would increase by 8.7 percent under the ACA, due mostly to spending on new health insurance by those uninsured before reform. As noted, the increase in individual spending is less than one half of one percent of personal income. Nonelderly Americans under 200 percent of the FPL would spend significantly less in total on health care under reform due to the Medicaid expansion and generous subsidies available in the exchange. Those with incomes between 200 and 400 percent of the FPL would in total spend somewhat more. Exchange subsidies are available for this group, but their generosity is far less than for those below 200 percent of the FPL. The total health care spending of those above 400 percent of the FPL—and thus ineligible for subsidies—would also increase. Most middle- and higher-income Americans—in particular, those with ESI coverage—would see little increase in spending. The increase is due primarily to new premium spending by the previously uninsured.

The results from *Table 2* are aggregate costs, determined both by the number of people covered and their average cost. It must be emphasized that individual health care costs alone are not enough to judge whether an individual or family is better off. Health insurance hedges against the risk of high health care expenses. Spending more money to purchase a more comprehensive insurance policy may well be a better choice for an individual or family. This is particularly true of those currently uninsured. They do not pay premiums, but they incur risk. Further, much of the health care cost of the uninsured ends up as uncompensated care.

Substantially Reduced Uncompensated Care. The cost of uncompensated care provided to the uninsured declines by 60 percent, resulting in savings of \$42.3 billion. It is a substantial offset to the increase in other costs under the ACA, equal to 61 percent of the net amount spent by the government. Not all of the savings would be realized by the government as some uncompensated care is paid for by others such as health care providers. However, it has been estimated that about three-quarters of uncompensated care is financed by federal, state, and local governments, through DSH payments and other provisions.²⁹

In this paper, we have provided an overview of the effects of the ACA compared to what the situation would be without health reform. Our single-year estimates complement the 10-year cost estimates previously released by CBO and the CMS Office of the Actuary, providing many results—particularly for coverage and transitions in coverage—that are either new or presented in greater detail. Forthcoming research will build on what is presented here and will focus on specific issues in health reform.

Endnotes

- ¹ For more about HIPSM and a list of recent research using it, see <http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf>. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, “The Coverage and Cost Impacts of Expanding Medicaid” (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), <http://www.urban.org/url.cfm?ID=411905>.
- ² HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.
- ³ For more details, see, for example, the Kaiser Family Foundation’s Summary of New Health Reform Law, <http://www.kff.org/healthreform/8061.cfm>.
- ⁴ In the 48 contiguous states and the District of Columbia, the 2009 federal poverty level is \$14,570 for a family of two and \$22,050 for a family of four. The 2009 levels were still in effect for 2010 at the time of writing. For more information, see <http://aspe.hhs.gov/poverty/09poverty.shtml>.
- ⁵ The requirement that eligibility for Medicaid be based on modified AGI would eliminate certain income disregards currently used in determining eligibility. The 5 percent disregard was intended as a substitute.
- ⁶ For this simulation, we drop maintenance of effort for adults above 138 percent of the FPL who gain Medicaid eligibility through Section 1115 waivers or special state programs. States may be more or less aggressive in rescinding maintenance of eligibility than simulated here. We preserve Medicaid and CHIP maintenance-of-eligibility requirements for children, since these are mandated until 2019.
- ⁷ Actuarial value reflects the share of average covered benefits paid by the insurer, where the remaining amount is the responsibility of the enrollee. The ACA allows exchange plans to offer a 90 percent actuarial value plan as well. We do not model this in the exchange. Such a package would be significantly more comprehensive than a typical ESI plan now; even the 80 percent plan would be more comprehensive than many current ESI plans for small and medium-sized firms. In Massachusetts under health reform, the most generous policy in the Connector (a program similar to the ACA’s nongroup exchanges) has low enrollment. We do not model the catastrophic-only plan available to some young adults and to those exempt from the individual mandate. The experience of Massachusetts under health reform suggests that this provision would have not have a large impact. We also do not model the option for a state basic health plan. A forthcoming policy brief will focus on this option.
- ⁸ This means, for example, that the premium charged to the oldest policyholders may be at most three times the premium charged to the youngest policyholders and tobacco users can be charged 1.5 times as much as nonusers.
- ⁹ We model a merged exchange providing coverage to both individual and small-group purchasers. States can choose to have separate exchanges for these two markets. We have simulated the latter option and the results do not differ substantially from those presented here. The SHOP exchanges are implemented as follows. Employers offer the same policies as in the nongroup exchanges. Total premiums for an employer’s SHOP plan are based on the age and tobacco use distribution of their workers, i.e., employers contribute the same to all workers regardless of age or tobacco use. There are currently some small firms who self-insure. We simulate this and allow them to continue if they choose to do so. Some believe that more small firms may start self-insuring to avoid certain insurance market reforms; we do not simulate such behavior.
- ¹⁰ Those eligible for Medicaid would not be eligible for subsidies. Note that legal immigrants with incomes below 138 percent of the FPL who have been in the United States less than five years are not eligible for Medicaid but would be eligible for subsidies in the exchange.
- ¹¹ It is not entirely clear how the computation of premium subsidies would be affected by tobacco rating; this will be determined through regulations. The use of age-rated premiums is explicit in the legislation, that is, the maximum amount a subsidy-eligible person would have to pay in premiums would not vary by age, but that is not true of tobacco rating. The most likely interpretation, which we simulate, is that the additional cost of a tobacco-use policy is borne by the subsidy-eligible policyholder rather than the government.
- ¹² The cost-sharing subsidies are 94 percent actuarial value (AV) for 100 to 150 percent of the FPL, 85 percent AV for 150 to 200 percent of the FPL, and 73 percent AV for 200 to 250 percent of the FPL.
- ¹³ Specifically, under the ACA, an uninsured *individual* is exempt from penalty if the individual premium he or she faces is more than 8 percent of *family* income. According to the Joint Committee on Taxation’s *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010, as amended, in combination with the Patient Protection and Affordable*

Care Act” (JCX-18-10, March 21, 2010), if self-only coverage is affordable for the worker but family coverage is not, the employee will be subject to the penalty for nonenrollment, while the family members eligible for employer coverage through that employee would not be penalized. It is unclear at the present time whether those family members would then be eligible for subsidies for coverage purchased through the exchange. JCT’s explanation of this provision highlighted the lack of clarity in the language of the statute. Their interpretation is not binding; the precise rules will be specified in regulations issued by the executive branch. It is, however, the most authoritative interpretation currently available, so we use it in our modeling. The ACA also allows other financial hardship exemptions to be granted. The requirements for these are left to the discretion of the Secretary of the Department of Health and Human Services.

- ¹⁴ For more about vouchers, see Matthew Buettgens and Linda Blumberg, “Making Health Reform More Affordable for Working Families: The Effect of Employee Choice Vouchers” (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=412025>.
- ¹⁵ Certain market reforms do apply to large employers and grandfathered plans, for example, the prohibition against rescissions, and lifetime and annual benefit limits. For more detail, see Linda J. Blumberg, “How Will the Patient Protection and Affordable Care Act Affect Small, Medium, and Large Businesses?” (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/UploadedPDF/412180-ppaca-businesses.pdf>.
- We do not simulate grandfathered plans. These will largely disappear over time, and our intent is to simulate the ACA in a steady-state marketplace.
- ¹⁶ Sharon K. Long, Allison Cook, and Karen Stockley, “Access to Health Care in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey” (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=1001403>. See also earlier work using the Massachusetts Health Insurance Survey by Sharon Long and other co-authors.
- ¹⁷ For more details, see Matthew Buettgens, Bowen Garrett, and John Holahan, “Why the Individual Mandate Matters” (Washington, DC: The Urban Institute, forthcoming).
- ¹⁸ Behavior in HIPSIM is modeled in an expected utility framework. This “penalty” is thus the utility of complying with the law.
- ¹⁹ The number of uninsured without health insurance is based on results from the 2009 Current Population Survey aged to 2010. This was the latest CPS available at the time of writing. The aging takes into account demographic changes projected by the Census

Bureau as well as economic changes, such as changes in the unemployment rate. The latest 2010 CPS released mid-September showed an estimated 50.7 million uninsured. Our 2010 estimate is somewhat lower due primarily to the Medicaid undercount adjustment, which results in fewer uninsured than the unadjusted CPS.

- ²⁰ There is a provision for hardship exemptions from the mandate. These are left up to the discretion of the HHS secretary. No guidelines have been issued yet, so these exemptions could not be modeled.
- ²¹ The CBO projects the 10-year cost of the ACA to be roughly \$1 trillion with savings offsetting about half of the cost.
- ²² This increase of 16.8 million is larger than that projected by the CBO, which projects 16 million in 2019. The state-level estimates in John Holahan and Irene Headen, “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% Poverty” (Washington, DC: The Urban Institute, 2009) are based on lower Medicaid take-up rates for the uninsured similar to CBO, as well as a set of higher take-up assumptions.
- ²³ Congressional Budget Office, “Estimate of the direct spending and revenue effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010,” March 20, 2010.
- ²⁴ Bowen Garrett, Matthew Buettgens, Lan Doan, Irene Headen, and John Holahan, “The Cost of Failure to Enact Health Reform: 2010-2020,” (Washington, DC: The Urban Institute, 2010) <http://www.urban.org/url.cfm?ID=412049>.
- ²⁵ Specifically, we use the projections of the “Best Case” scenario in Garrett, Buettgens, Doan, Headen, and Holahan 2010.
- ²⁶ We emphasize that these cost estimates are for 2017 only. The \$1 trillion in government costs projected by the CBO and frequently quoted in the media is a 10-year total.
- ²⁷ See, for example, Bowen Garrett, John Holahan, Allison Cook, Irene Headen, and Aaron Lucas, “The Coverage and Cost Impacts of Expanding Medicaid” (Washington, DC: The Urban Institute, 2009), <http://www.kff.org/medicaid/upload/7901.pdf>.
- ²⁸ For details, see Garrett, Buettgens, Doan, Headen, and Holahan 2010.
- ²⁹ Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, “Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,” *Health Affairs* Web Exclusive, August 25, 2008.

