

State-by-State Coverage and Government Spending Implications of the Better Care Reconciliation Act

Linda J. Blumberg, Matthew Buettgens, John Holahan, Bowen Garrett, and Robin Wang

Timely Analysis of Immediate Health Policy Issues

JUNE 2017

Introduction

The Better Care Reconciliation Act (BCRA) was introduced in the Senate on June 22, 2017, and is now under debate. The bill would eliminate much of the Affordable Care Act (ACA), ending the individual and employer mandates, eliminating tax revenue sources, significantly changing premium tax credits and eliminating cost-sharing subsidies for private nongroup insurance coverage, and substantially altering the financing of the Medicaid program.¹ Some changes would be made immediately, such as the repeal of the ACA's mandates; others would be implemented in the coming years.

We analyze the coverage effects of BCRA implementation on the nation and on specific states in 2022, the same year for which we analyze the effects of the House of Representatives proposal, the American Health Care Act (AHCA).² We also provide state-by-state estimates of the effects of the BCRA on federal funds for Medicaid and nongroup tax credits and cost-sharing assistance and state funds for Medicaid in 2022. We assume that states would respond to the proposed Medicaid changes by (1) eliminating their ACA Medicaid expansions by 2022; (2) maintaining pre-ACA expansions at the lower matching rate, in the seven states that had such expansions; and (3) increasing their own spending as necessary to compensate for federal funding cuts because of the lower match rate on pre-ACA expansions and the new per capita caps. Our analysis is based on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) 2017.

Our main findings are as follows:

- The number of nonelderly uninsured people would increase by 24.7 million in 2022 under the BCRA relative to current law (Summary Table). This number would grow after 2022 because the BCRA would significantly reduce the growth rates on the bill's Medicaid per capita caps starting in 2025, necessitating additional cuts in Medicaid enrollment over time. In addition, premium tax credits would grow more slowly than the projected growth in health care costs, making nongroup insurance coverage increasingly expensive over time.
- The number of people with private nongroup coverage would be 7.9 million lower under the BCRA than under current law (Table 1). The number of people enrolled in Medicaid would be 15.9 million lower.
- Of the 24.7 million additional uninsured under the BCRA in 2022, 11.9 million would have incomes below 138 percent of FPL, 6.9 million would have incomes between 138 and 400 percent of FPL, and 5.9 million would have incomes above 400 percent of FPL (Table 1).
- Changes in coverage under the BCRA would vary considerably across states. The uninsured share of the population would increase in all states under the BCRA, with the largest percent increases in states that had the largest coverage gains under the ACA. For example, the share of nonelderly uninsured in California would increase from 9.0 percent under current law to 21.4 percent under the BCRA, in Nevada from 14.6 percent to 26.1 percent, in Alaska from 15.4 percent to 24.7 percent, in West Virginia from 5.0 percent to 20.3 percent, in Ohio from 6.5 percent to 18.4 percent, and in Pennsylvania from 6.0 percent to 17.8 percent (Summary Table).
- Medicaid and Children's Health Insurance Program (CHIP) enrollment would fall the most in states that expanded Medicaid under the ACA, such as Arkansas (43.8 percent fewer nonelderly Medicaid enrollees), West Virginia (50.2 percent fewer), Kentucky (51.6 percent fewer), New Mexico (45.8 percent fewer), Nevada (41.7 percent fewer), and Colorado (46.5 percent fewer) (Table 2).
- Nongroup insurance coverage would fall the most in states with especially high ACA marketplace enrollment, such as Florida (57.0 percent fewer nongroup enrollees), Maine (51.9 percent fewer), Wisconsin (54.0 percent fewer), Delaware (47.2 percent fewer), and Utah (51.2 percent fewer) (Table 2).
- Changes in employer coverage would be small (-0.6 percent fewer people covered through employers) but would vary across states

depending on the number of people who moved from employer coverage to Medicaid under the ACA eligibility expansion and from employer to nongroup coverage in response to the availability of tax credits and cost-sharing assistance (Table 2).

- Most people who would become uninsured because of the BCRA (56.6 percent) are non-Hispanic white; more than half of newly uninsured adults have a high school education or less, and 72.1 percent are in families with at least one full-time worker (Table 4).
- Federal funding for Medicaid would be \$102.2 billion lower in 2022 under the BCRA than under the ACA (a 26.4 percent decline), and federal funding for premium tax credits and cost-sharing reductions would fall by \$38.2 billion that year (an 84.0 percent decline) (Table 6). The BCRA eliminates cost-sharing reductions entirely.
 - » Federal funding drops on these two programs would vary considerably across states. Texas would see federal funding decrease by 14.4 percent, South Dakota 13.2 percent. On

the other hand, federal funding to Alaska would drop 41.7 percent, Nevada 48.2 percent, and Kentucky 58.5 percent.

- » Large-population states that expanded Medicaid would also see substantial losses in federal funding. Pennsylvania would lose \$6.3 billion, Ohio \$6.6 billion, and Michigan \$5.3 billion—all decreases of one-third or more from current funding.
- State spending on Medicaid would increase by \$565 million in 2022 because of federal funding decreases from the per capita caps, the adjustments to federal payments to higher versus lower per capita cost states, and, in seven states, the reduced match rate for pre-ACA Medicaid expansion populations (Table 7). In aggregate, these increased costs offset the state savings from eliminating the ACA Medicaid expansions.
 - » State funding effects would vary substantially across the country. For example, states with pre-ACA expansions (Arizona, Delaware, Hawaii,

Maine, Massachusetts, New York, Vermont) would have to increase their own spending by 5.8 percent (Maine) to 14.2 percent (Massachusetts) to keep those expansions with fewer federal funds, depending upon the state and the size of its expansion. Other states with large ACA expansions would spend less once those expansions are eliminated, but these states would see larger increases in their uninsured populations (e.g., California, Oregon, Colorado).

- The growth rates in the BCRA's Medicaid per capita caps beginning in 2025 are significantly below expected growth in per capita spending in the Medicaid program. This very large change is not taken into account in this analysis; our estimates focus exclusively on the effects of the bill in 2022. But the resulting large shortfall in federal funding for the program would make it increasingly difficult for states to maintain their programs over time. Such a policy would put tremendous financial pressure on state governments, health care providers, and low-income households.

Summary Table: Effects of the Better Care Reconciliation Act on the Uninsured and Federal Health Care Spending for the Nonelderly, 2022 (Numbers of People in Thousands, Dollars in Millions)

| State | ACA (Current Law) | | | BCRA (Senate Bill) | | | | |
|----------------------|-------------------|------------------------------|------------------|--------------------|------------------------------|------------------------------|----------------------------|------------------------------------|
| | Number Uninsured | Percent Nonelderly Uninsured | Federal Spending | Number Uninsured | Percent Nonelderly Uninsured | Increase in Number Uninsured | Change in Federal Spending | Percent Change in Federal Spending |
| Alabama | 545 | 13.3% | \$5,329 | 709 | 17.3% | 164 | -\$1,138 | -21.4% |
| Alaska | 111 | 15.4% | \$1,543 | 178 | 24.7% | 67 | -\$643 | -41.7% |
| Arizona | 828 | 13.4% | \$14,270 | 1,223 | 19.8% | 395 | -\$3,637 | -25.5% |
| Arkansas | 183 | 7.1% | \$4,483 | 550 | 21.3% | 367 | -\$1,494 | -33.3% |
| California | 3,082 | 9.0% | \$39,143 | 7,373 | 21.4% | 4,291 | -\$16,078 | -41.1% |
| Colorado | 429 | 9.0% | \$7,302 | 1,004 | 21.1% | 575 | -\$3,883 | -53.2% |
| Connecticut | 174 | 5.9% | \$5,513 | 498 | 17.0% | 324 | -\$2,182 | -39.6% |
| Delaware | 72 | 9.0% | \$1,403 | 130 | 16.4% | 58 | -\$353 | -25.2% |
| District of Columbia | 29 | 5.0% | \$1,759 | 90 | 15.5% | 61 | -\$477 | -27.1% |
| Florida | 2,459 | 15.0% | \$23,920 | 3,984 | 24.3% | 1,525 | -\$8,219 | -34.4% |
| Georgia | 1,878 | 19.1% | \$10,048 | 2,279 | 23.2% | 400 | -\$1,512 | -15.0% |
| Hawaii | 101 | 7.9% | \$1,358 | 157 | 12.3% | 56 | -\$310 | -22.8% |
| Idaho | 210 | 14.0% | \$2,831 | 317 | 21.1% | 107 | -\$687 | -24.3% |
| Illinois | 1,027 | 9.2% | \$15,220 | 2,103 | 18.9% | 1,076 | -\$5,398 | -35.5% |
| Indiana | 542 | 9.4% | \$8,449 | 1,207 | 21.0% | 666 | -\$3,098 | -36.7% |
| Iowa | 173 | 6.6% | \$3,330 | 405 | 15.4% | 232 | -\$926 | -27.8% |
| Kansas | 343 | 13.6% | \$2,499 | 463 | 18.3% | 120 | -\$449 | -18.0% |
| Kentucky | 234 | 6.3% | \$10,709 | 775 | 21.0% | 541 | -\$6,261 | -58.5% |
| Louisiana | 342 | 8.9% | \$7,672 | 752 | 19.5% | 410 | -\$2,680 | -34.9% |
| Maine | 74 | 7.4% | \$1,933 | 135 | 13.4% | 60 | -\$407 | -21.1% |
| Maryland | 411 | 7.6% | \$8,206 | 939 | 17.5% | 528 | -\$3,729 | -45.4% |
| Massachusetts | 239 | 4.3% | \$9,169 | 348 | 6.3% | 109 | -\$1,328 | -14.5% |
| Michigan | 516 | 6.5% | \$14,458 | 1,530 | 19.1% | 1,014 | -\$5,335 | -36.9% |
| Minnesota | 393 | 8.3% | \$7,316 | 809 | 17.0% | 417 | -\$2,157 | -29.5% |
| Mississippi | 396 | 16.0% | \$4,437 | 495 | 20.0% | 100 | -\$700 | -15.8% |
| Missouri | 596 | 11.6% | \$8,674 | 894 | 17.5% | 297 | -\$1,710 | -19.7% |
| Montana | 84 | 10.0% | \$2,219 | 197 | 23.5% | 113 | -\$867 | -39.1% |
| Nebraska | 178 | 11.1% | \$1,780 | 283 | 17.6% | 105 | -\$438 | -24.6% |
| Nevada | 420 | 14.6% | \$3,598 | 748 | 26.1% | 328 | -\$1,733 | -48.2% |
| New Hampshire | 61 | 5.7% | \$1,431 | 179 | 16.8% | 118 | -\$614 | -42.9% |
| New Jersey | 650 | 8.7% | \$13,125 | 1,652 | 22.1% | 1,002 | -\$6,975 | -53.1% |
| New Mexico | 181 | 9.9% | \$7,064 | 498 | 27.2% | 317 | -\$3,737 | -52.9% |
| New York | 1,300 | 7.9% | \$35,818 | 2,590 | 15.7% | 1,290 | -\$8,243 | -23.0% |
| North Carolina | 1,316 | 14.6% | \$16,742 | 1,869 | 20.8% | 553 | -\$4,361 | -26.0% |

Summary Table: Continued...

| State | ACA (Current Law) | | | BCRA (Senate Bill) | | | | |
|----------------|-------------------|------------------------------|------------------|--------------------|------------------------------|------------------------------|----------------------------|------------------------------------|
| | Number Uninsured | Percent Nonelderly Uninsured | Federal Spending | Number Uninsured | Percent Nonelderly Uninsured | Increase in Number Uninsured | Change in Federal Spending | Percent Change in Federal Spending |
| North Dakota | 51 | 8.8% | \$748 | 121 | 20.9% | 70 | -\$387 | -51.8% |
| Ohio | 610 | 6.5% | \$17,238 | 1,732 | 18.4% | 1,122 | -\$6,602 | -38.3% |
| Oklahoma | 605 | 17.6% | \$5,104 | 762 | 22.2% | 157 | -\$881 | -17.3% |
| Oregon | 279 | 8.3% | \$7,429 | 791 | 23.6% | 511 | -\$4,005 | -53.9% |
| Pennsylvania | 620 | 6.0% | \$16,925 | 1,841 | 17.8% | 1,221 | -\$6,265 | -37.0% |
| Rhode Island | 53 | 6.2% | \$2,167 | 157 | 18.4% | 104 | -\$994 | -45.9% |
| South Carolina | 604 | 14.8% | \$6,589 | 819 | 20.0% | 215 | -\$1,482 | -22.5% |
| South Dakota | 95 | 12.9% | \$881 | 122 | 16.7% | 28 | -\$116 | -13.2% |
| Tennessee | 726 | 12.9% | \$10,539 | 1,079 | 19.1% | 353 | -\$2,870 | -27.2% |
| Texas | 5,098 | 20.4% | \$32,857 | 6,220 | 24.9% | 1,123 | -\$4,737 | -14.4% |
| Utah | 341 | 11.6% | \$3,511 | 586 | 20.0% | 245 | -\$772 | -22.0% |
| Vermont | 23 | 4.7% | \$1,077 | 62 | 12.7% | 39 | -\$282 | -26.1% |
| Virginia | 1,050 | 13.4% | \$6,480 | 1,496 | 19.1% | 446 | -\$1,468 | -22.7% |
| Washington | 520 | 8.4% | \$8,858 | 1,276 | 20.7% | 757 | -\$4,693 | -53.0% |
| West Virginia | 71 | 5.0% | \$3,670 | 288 | 20.3% | 218 | -\$1,795 | -48.9% |
| Wisconsin | 391 | 8.1% | \$5,358 | 677 | 14.1% | 286 | -\$1,202 | -22.4% |
| Wyoming | 69 | 13.8% | \$567 | 92 | 18.3% | 23 | -\$139 | -24.5% |
| Total | 30,780 | 11.1% | \$432,748 | 55,480 | 20.1% | 24,700 | -\$140,447 | -32.5% |

Source: Urban Institute analysis, HIPS 2017.

Note: Federal spending includes Medicaid & CHIP, nongroup premium tax credits, and cost-sharing reductions (the last only under the ACA).

Background

The Better Care Reconciliation Act would allow states to continue covering the population made eligible for Medicaid under the ACA expansion but with substantially lower federal funding support. The higher federal contribution provided to the expansion populations—95 percent of total costs in 2017, falling to 90 percent beginning in 2020—would phase out between 2020 and 2024. As of January 1, 2024, the expansion matching rate for expansion enrollees would revert to each state's traditional matching rate. In addition, the bill would impose per capita caps on Medicaid payments, ending the program's open-ended matching grant structure. The growth rates associated with these caps would begin at the medical consumer price index (MCPI) and MCPI plus 1 percent (the lower rate for nondisabled children and nonelderly adults, the higher rate for elderly people and people with disabilities) for 2020 to 2024, but the rates would fall precipitously for all four eligibility groups to the general consumer price index for urban consumers in 2025, substantially reducing federal spending on the program over time. This change would go well beyond reversing the ACA's expansion, severely cutting the program for pre-ACA recipient populations over time. Adjustment to federal allotments of 0.5 to 2 percent would also be made to decrease federal funding to states with per capita spending more than 25 percent above the national average and to increase federal funding to states with per capita spending more than 25 percent below the national average, with exceptions for the low-population-density states of Alaska, Montana, North Dakota, South Dakota, and Wyoming.

Current law limits nongroup and fully insured small-group premium age variation to no more than 3-to-1 (i.e., a 64-year-old cannot be charged more than three times the premium charged the youngest adult for the same coverage). The BCRA would eliminate that limit, proposing a 5-to-1 ratio but permitting states to use even higher ratios. For people who forgo insurance, a six-month waiting period would be required after enrollment in nongroup

insurance, according to a change made after the first draft of the bill was released. Actuarial value standards for nongroup insurance coverage, essential health benefit requirements, and maximum out-of-pocket limits can be eliminated or changed through Section 1332 waivers. Prohibitions on annual and lifetime benefit limits are tied to essential health benefits, so limiting or eliminating those requirements would also change the benefits to which annual and lifetime limits apply. Additional incentives to use Health Savings Accounts would be provided (beyond those currently available) by increasing the annual tax-free contribution limit and making other changes.

The BCRA would change the advanced premium tax credits provided under the ACA.³ Beginning in 2020, the bill would eliminate ACA cost-sharing assistance to low-income people, but it directly provides for the payment of current-law cost-sharing assistance up to 2020. The bill would replace the ACA tax credits tied to income and available premiums with a 70 percent actuarial value with tax credits that vary by income, age, and available premiums with a 58 percent actuarial value, which generally would reduce the value of the tax credits now available to people with incomes above 100 percent of FPL.⁴ ACA tax credits are available to eligible people with incomes up to 400 percent of FPL, BCRA tax credits to those with incomes up to 350 percent of FPL. In both the ACA and the BCRA, tax credits are structured as limits on the share of income an eligible person would be expected to pay for the benchmark premium, but the BCRA caps increase not only with income but also with age; in other words, older adults would generally be expected to spend higher shares of their income on health care than younger adults, beginning at income levels of 150 percent of FPL. Under the ACA, premiums for older adults are capped at the same share of income as younger adults if they have the same income, until 400 percent of FPL when the ACA caps cease.

States could use the ACA Section 1332 waivers to modify their approach, and the BCRA would significantly increase their

flexibility in doing so. States would no longer be required to demonstrate that their proposed approach would cover at least as many residents or provide coverage at least as comprehensive and affordable as that in the central reforms. However, the BCRA would require that state changes not increase the federal deficit.

A State Stability and Innovation Fund would be established to provide grants to states for several potential uses; these federal funds would total \$112 billion over nine years. The fund would provide \$50 billion in short-term funding for a reinsurance program from 2018 to 2021, and \$62 billion in long-term funding for state reinsurance programs, high-risk pools, cost-sharing subsidies, and/or direct payments to providers. States must devote a minimum amount to reinsurance, however. Beginning in 2022, states would have to provide matching funds to draw down funds for long-term purposes.

Data and Methods

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey (ACS). Estimates of pre-ACA health coverage come from the 2013 ACS. We apply edits to the ACS coverage variables.⁵ The ACS has a sample size large enough to make state-level analysis possible. We estimate eligibility for Medicaid on the 2013 ACS using the Urban Institute's pre-ACA Medicaid eligibility model for 2013.⁶

We estimate health coverage under both the ACA and BCRA using the Health Insurance Policy Simulation Model (HIPSM). We first calibrate the model to reproduce early 2017 state-by-state enrollment data from the marketplaces and Medicaid.⁷ We then benchmark the uninsured rate and employer-sponsored insurance coverage with the most recent available survey data, particularly the National Health Interview Survey.

When simulating the BCRA, we include the following major provisions that take effect beginning in 2020: phasing down of the enhanced federal match rate for

ACA Medicaid expansion populations, introduction of Medicaid per capita caps, adjustments to federal Medicaid allotments that increase funding for low-per-capita-spending states and reduce it for high-per-capita-spending states, repeal of the ACA premium tax credits and cost-sharing reductions, introduction of new age- and income-based premium tax credits for nongroup coverage tied to lower actuarial value plans, repeal of the ACA individual and employer mandates, the State Stability and Innovation Fund, and the proposed six-month waiting period for people who fail to maintain continuous coverage. We assume that states using a 3:1 age rating limit under current law would move to 5:1 under the BCRA; states currently using tighter age rating issues are assumed to maintain them.

We assume that ACA Medicaid expansion states would cut eligibility back to 2010 levels by 2022. Seven states covered adults up to at least 100 percent of FPL before the ACA was enacted; we assume that they would return to those eligibility thresholds, but they likely would need to negotiate a new Medicaid waiver with the Centers for Medicare & Medicaid Services (CMS) to do so. Also, our model predicts that the additional enrollment under the ACA of people who were already eligible for Medicaid—variously called the “woodwork” or “welcome mat” effect—would reverse under the BCRA, leading to the loss of several million Medicaid enrollees. The BCRA lacks many of the ACA provisions that led to increased Medicaid enrollment, such as support of the “no wrong door” single-portal approach to determining eligibility for tax credits or Medicaid. And as fewer people seek nongroup coverage, fewer people would discover through that process that they were, in fact, eligible for Medicaid.

We assume that the stability fund would be used to provide reinsurance, which would not be targeted to any group but would decrease premiums by a uniform percentage. We did not see any basis for anticipating individual state decisions on using their stability fund allotment.

We assume that no states would take the Medicaid block grant for adults without disabilities, which would provide less federal funding over time than the per capita cap option and no protection for future enrollment growth. We also did not model any state waivers of essential health benefits. Models that only produce national estimates can make broad assumptions that some percentage of states would choose a given option, but we find little to no basis for predicting what individual states would choose. Even under broad assumptions, both CBO and the CMS Office of the Actuary emphasized that the impossibility of predicting state waiver and stability fund decisions added considerable uncertainty to their results. We show results state by state, so we made a consistent set of assumptions to make state results comparable. We also did not assume that any states would broaden age rating bands beyond 5:1.

Additional details about our methodology are available in Appendix B of an earlier report.⁸

Results

National Distribution of Insurance Coverage

Table 1 shows the effects of the BCRA on the national distribution of health insurance coverage for the nonelderly in total and for three income groups in 2022: people with income below 138 percent of FPL, people with incomes between 138 and 400 percent of FPL, and people with incomes at or above 400 percent of FPL. We estimate that the number of people uninsured would be 24.7 million higher under the BCRA than under the ACA, with 11.9 million additional people uninsured with incomes below 138 percent of FPL, 6.9 million additional people uninsured with incomes between 138 and 400 percent of FPL, and 5.9 million additional higher-income people uninsured. Approximately 7.9 million fewer people would have private nongroup insurance, and the bulk of that decrease (5.1 million people) would come from the income group eligible for ACA tax credits and cost-sharing reductions—people with incomes between 138 and 400 percent

of FPL. Although 14.6 million low-income people would lose Medicaid under the BCRA, approximately 2.8 million would have access to and enroll in employer-based coverage, and roughly an equal number would gain nongroup coverage as lose it.

Employer-sponsored insurance would decrease modestly under the BCRA (860,000 fewer people would have employer coverage nationally), yet the underlying dynamics of this small net change are important (not shown in the table). First, elimination of the individual mandate would lead to some coverage drop among people who had been uninsured before the ACA (as would elimination of the employer mandate, but with a substantially smaller effect). Second, some people who would lose their Medicaid coverage would accept employer-based insurance offers under the BCRA, but many do not have such offers, and those who can take advantage of employer coverage would generally receive less comprehensive coverage at a higher out-of-pocket cost compared with Medicaid. Third, the ACA individual mandate not only led some previously uninsured people to enroll in employer coverage for the first time, but it also seems to have halted the secular decline in employer-based insurance. Thus, eliminating the mandate is expected to restart that trend in declining employer coverage, even in higher-income groups.

State-by-State Changes in the Distribution of Health Insurance Coverage

Table 2 shows the absolute change and percent change in each type of health insurance coverage because of the BCRA for the nonelderly population in each state. Changes in coverage under the BCRA would vary considerably across states depending on whether they had expanded Medicaid under the ACA or before it, whether nongroup marketplace and other nongroup coverage enrollment had been high after ACA reforms, and how many people losing Medicaid or nongroup coverage would have access to employer-based insurance.

Medicaid enrollment would fall by the largest percentages in states that expanded Medicaid under the ACA, such as Arkansas (43.8 percent fewer nonelderly Medicaid enrollees), Colorado (46.5 percent fewer), Nevada (41.7 percent fewer), New Mexico (45.8 percent fewer), North Dakota (42.6 percent fewer), and Oregon (41.9 percent fewer). States that did not expand Medicaid would also lose coverage, but to a lesser extent, because of the elimination of outreach and enrollment efforts associated with the ACA and the reversal of the welcome mat effect. These states include Alabama (5.4 percent fewer nonelderly Medicaid enrollees), Mississippi (5.8 percent fewer), Missouri (7.8 percent fewer), North Carolina (10.3 percent fewer), and South Carolina (6.7 percent fewer).

Nongroup insurance coverage would fall the most in states with high ACA marketplace enrollment, such as Florida (-57.0 percent), Maine (-51.9 percent), and Utah (-51.2 percent). Changes in employer coverage would be small (-0.6 percent) but would vary across the states as a function of cutbacks in the Medicaid expansion population and losses of nongroup coverage.

The number of uninsured people would increase in every state under the BCRA, with the largest increases in large-population states and states that saw the greatest coverage gains under the ACA (Table 2 and additional detail on uninsured in Table 3). For example, the uninsurance rate in Florida would increase from 15.0 percent under the ACA to 24.3 percent under the BCRA, a 62.0 percent increase (1.5 million additional uninsured people). The number of uninsured people in Pennsylvania would just about triple, from 6.0 percent to 17.8 percent of the nonelderly population in the state (1.2 million additional uninsured people). The share of uninsured people in Ohio would increase from 6.5 percent to 18.4 percent (1.1 million more people), from 6.5 percent to 19.1 percent (1.0 million more people) in Michigan, and from 6.3 percent to 21.0 percent in Kentucky. States that did not expand Medicaid under the ACA and did not

have high nongroup enrollment would see the smallest percent increases in the number of uninsured people.

Characteristics of Uninsured People

Table 4 shows the characteristics of the uninsured under the ACA and the BCRA, along with the characteristics of those who would become newly uninsured because of the BCRA. The number of people who would become uninsured because of the BCRA (25.9 million people) is not equal to the difference between the number of uninsured under the BCRA and the ACA (55.5 million – 30.8 million = 24.7 million) because the latter is a net calculation that takes into account that fewer people uninsured under the ACA would become insured under the BCRA.

A comparison of uninsured people under the ACA and under the BCRA (the first two sets of columns) shows that a larger share of the nonelderly uninsured population would be non-Hispanic white under the BCRA than under current law. Under the ACA, 37.1 percent of uninsured people are estimated to be non-Hispanic white in 2022, compared with 46.0 percent under the BCRA. Roughly 56.6 percent of those who would become uninsured because of the BCRA are non-Hispanic white (far right column).

A higher percentage of adults uninsured under the BCRA would have at least some college education (40.0 percent versus 34.1 percent), but more than half (53.3 percent) of those who would be uninsured because of the BCRA would have a high school education or less. Approximately 72.1 percent of those who would become uninsured because of the BCRA live in families with at least one full-time worker, and another 9.3 percent have a part-time worker in the family.

Distribution of Federal Tax Credits and Cost-Sharing Reductions by Income

Table 5 shows how federal funding to assist with the costs associated with private nongroup insurance coverage would be distributed across different

income groups under the ACA and under the BCRA. The ACA provides tax credits for the purchase of nongroup insurance based on a sliding income scale, and the level of assistance takes into account the cost of coverage available in the person's area of residence. These tax credits are available to people with incomes between 100 percent of FPL (138 percent of FPL in Medicaid expansion states) and 400 percent of FPL. The ACA also provides subsidies to reduce deductibles, out-of-pocket maximums, and other cost-sharing requirements for people with incomes below 250 percent of FPL who are also eligible for premium tax credits. The BCRA would eliminate the ACA's premium tax credits and cost-sharing subsidies and replace them with premium tax credits that vary with income and age (older households are generally expected to pay more than younger households of the same income), tied to the cost of a 58 percent actuarial value plan (instead of a 70 percent actuarial value plan, as under current law). The BCRA would not provide any cost-sharing assistance after 2019.

ACA tax credits are heavily concentrated in low-income populations, with two-thirds going to people with incomes between 100 and 200 percent of FPL. All ACA tax credits go to those with incomes below 400 percent of FPL. Approximately 96 percent of ACA cost-sharing assistance goes to families with incomes between 100 and 200 percent of FPL.

By design, the BCRA tax credits are constrained to people with incomes below 350 percent of FPL. Because the bill would lead to significant reductions in Medicaid eligibility from the reduced federal match rate for ACA expansion populations, the tax credits would also be available to people with incomes below 100 percent of FPL. Approximately 24.0 percent of the BCRA tax credits would go to people with incomes below 100 percent of FPL, 53.6 percent would go to people with incomes between 100 and 200 percent of FPL, 19.8 percent would go to people with incomes between 200 and 300 percent of FPL, and the remaining 2.6 percent would go to

those with incomes between 300 and 350 percent of FPL. About one-fifth as many people would receive tax credits under the BCRA as under the ACA because fewer people would be enrolled in nongroup insurance coverage. This coverage disparity stems from the BCRA elimination of the individual mandate, the higher financial burdens for many families due to tax credits decreasing significantly for older adults, and the tying of federal assistance to the costs of local insurance policies with much higher cost-sharing requirements than under the ACA.

Federal Funding for Premium Tax Credits, Cost-Sharing Reductions, and Medicaid, by State

Table 6 provides estimates of federal funding for Medicaid, premium tax credits, and cost-sharing reductions that would flow to each state under the ACA in 2022, compared with the federal funding for Medicaid and tax credits under the BCRA in the same year (the BCRA would not provide cost-sharing reductions). Total federal funding would fall by 32.5 percent (\$140.4 billion) in 2022.

Percent changes in federal funding would vary considerably by state depending on whether the state expanded Medicaid under the ACA, whether the state had a pre-ACA Medicaid expansion, and how high ACA marketplace enrollment was in the state. Federal spending would fall significantly in all states, ranging from a 13.2 percent drop in South Dakota to a 58.5 percent drop in Kentucky. Even states that did not expand Medicaid would lose federal funding under the BCRA because of the bill's per capita caps and the reversal of the "welcome mat effect."

State Funding for Medicaid, by State

Table 7 provides estimates of the effect of the BCRA on state Medicaid spending. States with ACA expansions would spend less on that population once the eligibility category was dropped, but states would increase spending in response to the per capita caps, and the seven states with pre-ACA expansions would spend more

because of the lower federal match rate under the BCRA. To the extent that the reversal of the welcome mat effect and the elimination of the individual mandate lower enrollment, states' spending would also be reduced. Net changes in each state's spending would be a function of the size of these countervailing changes. Nationally, state spending on Medicaid would increase by \$565 million in 2022. States that expanded eligibility under the ACA—and would therefore see the most coverage losses—would decrease spending the most. States that expanded before the ACA and states that would be hit hardest by the new per capita caps would increase their spending the most.

Changes in 2022 state Medicaid spending under the BCRA would range from a 23.6 percent decrease (\$686 million) in Kentucky to a 14.2 percent increase (\$801 million) in Massachusetts. Kentucky saw a large eligibility expansion under the ACA and is expected to save significantly once eligibility for that group is eliminated. Massachusetts expanded eligibility before the ACA and is expected to maintain that expansion but at a significantly lower federal match rate under the BCRA. New York, a large-population state that expanded Medicaid before the ACA, is estimated to face a cost increase of \$1.6 billion (6.3 percent) in 2022; Texas, a large-population state that did not expand Medicaid, is estimated to face a cost increase of \$2.3 billion (11.5 percent) in 2022 because of the BCRA per capita caps.

Discussion

If enacted, the BCRA would make fundamental changes to the U.S. health care financing system. Changes to the Medicaid program would reduce federal funds to low-income people in all states (\$102.2 billion nationally in 2022), and federal financial assistance for the purchase of private nongroup insurance would fall significantly in almost every state (\$38.2 billion nationally in 2022). The number of people uninsured would increase by 24.7 million in 2022, with roughly 70 percent of that increase among people with incomes below 400 percent of FPL. The private nongroup market would shrink by 7.9 million

people, and Medicaid enrollment would fall by 15.9 million people.

This dramatic decrease in uninsurance would be driven by (1) the elimination of the individual mandate (and, to a much smaller degree, the elimination of the employer mandate); (2) the reduction in the federal matching rates for the Medicaid expansion population, which likely will cause states to drop eligibility for that group; (3) elimination of cost-sharing assistance, which would make practical access to care unaffordable for many low-income people currently receiving assistance; and (4) structural change in tax credits, which would increase net premiums as people age and would lead to insurers offering plans with substantially higher cost-sharing requirements.

Coverage and funding effects would vary considerably across states. These differences are largely attributable to population size, Medicaid expansion decisions, and ACA nongroup marketplace enrollment. States that saw the largest coverage gains under the ACA would face the largest coverage losses, the largest federal funding losses, and the largest state cost increases. The seven states that expanded Medicaid before the ACA would face large cost increases if they choose to maintain those expansions at the lower federal match rate under the BCRA.

The BCRA would affect some population subgroups more than others. For example, it would increase the number of uninsured non-Hispanic whites the most. Most newly uninsured people would have a high school education or less, and the vast majority would be members of working families.

We estimate that full ACA repeal without replacement would leave slightly fewer people uninsured than the BCRA would (data not shown). Thus, the BCRA is less a substitute for the ACA than a reversal of it. In addition, the BCRA would fundamentally alter the federal financing of the Medicaid program, changing it from an open-ended federal matching grant to a program with federal funding

limited to a specified trend. The Medicaid changes affect groups who were eligible for Medicaid assistance long before the ACA, in addition to those who were made newly eligible. The growth rates in the BCRA per capita caps beginning in 2025 are significantly below expected growth in per capita spending in the Medicaid program, and the resulting large shortfall in federal funding for the program would make it increasingly difficult for states to maintain their programs over time. Such an outcome would put tremendous financial pressure on state governments,

health care providers, and ultimately households. Though the differences may not be large over the course of one year, they would compound over time, getting continuously larger.

Limited growth rates in the federal premium tax credits would make private nongroup coverage less affordable over time. This would encourage states to adopt other policies included in the BCRA but not modeled in this analysis; these measures include waivers of essential health benefit requirements, waivers to

increase out-of-pocket maximums, and permitting age rating bands broader than a 5:1 ratio.¹⁰ These policies could lower premiums for young and healthy people, but at the expense of greater financial burdens and increased barriers to care for older people and people with health problems. These changes likely would drive uninsurance upward over time and place increasing financial burdens on families, particularly those with low and middle incomes and those with health problems.

Comparison of Urban Institute Estimates of Coverage Implications of the AHCA and the BCRA

We estimate that an additional 23.0 million people would be uninsured because of the House of Representatives' American Health Care Act, compared with an additional 24.7 million people uninsured because of the Senate's Better Care Reconciliation Act. Why do we find that the Senate bill would reduce coverage by more than the House bill? The most significant factors are as follows:

- The actuarial value of the plans offered under the BCRA would be lower than those offered under the AHCA because the latter did not eliminate the ACA out-of-pocket maximum standard. By tying premium tax credits to a 58 percent actuarial value and allowing that value to be as low as 54 percent (because of permissible variation), the BCRA leads to higher out-of-pocket limits and makes nongroup coverage less attractive. Plans with lower actuarial value would have lower take-up because the return for the premium is lower.
- The AHCA would offer tax credits to middle-income and some upper-middle-income taxpayers, who thus would be more likely to purchase coverage; the BCRA limits tax credits to people with incomes below 350 percent of FPL. Also, the high percent-of-income tax credit caps in the BCRA make that bill's tax credits have lower value for many people with incomes below 350 percent of FPL.
- The AHCA provides significantly more federal funds for reinsurance than the BCRA does; this funding lowers nongroup insurance premiums further and thus increases purchase.
- The AHCA premium surcharge for not maintaining continuous enrollment is not as effective as the ACA individual mandate, but it would be more effective than the BCRA six-month waiting period. Our analysis of this provision may explain why we find the BCRA to increase the number of uninsured by more than the AHCA, while CBO finds the opposite.
- Lower enrollment in nongroup coverage leads to greater adverse selection under the BCRA, which drives premiums higher than under the AHCA.

Table 1. The Distribution of Health Insurance Coverage Under the ACA and the BCRA, 2022
(Thousands of People)

| Panel A. All Nonelderly | | ACA | | BCRA | | Change from ACA | |
|-------------------------|-----------------------------------|----------------|---------------|----------------|---------------|-----------------|--------------|
| Insured | Total Insured | 245,894 | 88.9% | 221,194 | 79.9% | -24,700 | -8.9% |
| | Total Medicaid & CHIP | 69,864 | 25.3% | 53,933 | 19.5% | -15,932 | -5.8% |
| | <i>Expansion Eligible Adults</i> | 13,031 | 4.7% | 0 | 0.0% | -13,031 | -4.7% |
| | <i>Other Adults</i> | 11,642 | 4.2% | 11,073 | 4.0% | -569 | -0.2% |
| | <i>Children</i> | 35,078 | 12.7% | 33,030 | 11.9% | -2,048 | -0.7% |
| | <i>Nonelderly with Disability</i> | 10,112 | 3.7% | 9,829 | 3.6% | -283 | -0.1% |
| | Employer | 148,110 | 53.5% | 147,249 | 53.2% | -860 | -0.3% |
| | Total Nongroup | 19,302 | 7.0% | 11,394 | 4.1% | -7,908 | -2.9% |
| | <i>With Tax Credits</i> | 9,810 | 3.5% | 3,332 | 1.2% | -6,478 | -2.3% |
| | <i>Other Nongroup</i> | 9,492 | 3.4% | 8,062 | 2.9% | -1,430 | -0.5% |
| | Medicare and other public | 8,617 | 3.1% | 8,617 | 3.1% | 0 | 0.0% |
| Uninsured | | 30,780 | 11.1% | 55,480 | 20.1% | 24,700 | 8.9% |
| Total | | 276,674 | 100.0% | 276,674 | 100.0% | 0 | 0.0% |

| Panel B. Nonelderly with Income Under 138% FPL | | ACA | | BCRA | | Change from ACA | |
|--|-----------------------------------|---------------|---------------|---------------|---------------|-----------------|---------------|
| Insured | Total Insured | 81,383 | 83.2% | 69,501 | 71.0% | -11,882 | -12.1% |
| | Total Medicaid & CHIP | 54,822 | 56.0% | 40,269 | 41.1% | -14,552 | -14.9% |
| | <i>Expansion Eligible Adults</i> | 13,031 | 13.3% | 0 | 0.0% | -13,031 | -13.3% |
| | <i>Other Adults</i> | 8,879 | 9.1% | 8,327 | 8.5% | -551 | -0.6% |
| | <i>Children</i> | 23,781 | 24.3% | 23,056 | 23.6% | -725 | -0.7% |
| | <i>Nonelderly with Disability</i> | 9,131 | 9.3% | 8,886 | 9.1% | -245 | -0.2% |
| | Employer | 18,553 | 19.0% | 21,349 | 21.8% | 2,796 | 2.9% |
| | Total Nongroup | 3,907 | 4.0% | 3,781 | 3.9% | -126 | -0.1% |
| | <i>With Tax Credits</i> | 2,620 | 2.7% | 1,731 | 1.8% | -889 | -0.9% |
| | <i>Other Nongroup</i> | 1,287 | 1.3% | 2,050 | 2.1% | 763 | 0.8% |
| | Medicare and other public | 4,101 | 4.2% | 4,101 | 4.2% | 0 | 0.0% |
| Uninsured | | 16,482 | 16.8% | 28,365 | 29.0% | 11,882 | 12.1% |
| Total | | 97,865 | 100.0% | 97,865 | 100.0% | 0 | 0.0% |

Table 1. Continued...

| Panel C. Nonelderly with Income of 138%-400% FPL | | ACA | | BCRA | | Change from ACA | |
|--|-----------------------------------|---------------|---------------|---------------|--------------|-----------------|--------------|
| Insured | Total Insured | 85,516 | 87.8% | 78,589 | 80.7% | -6,927 | -7.1% |
| | Total Medicaid & CHIP | 13,486 | 13.8% | 12,137 | 12.5% | -1,349 | -1.4% |
| | <i>Expansion Eligible Adults</i> | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| | <i>Other Adults</i> | 2,352 | 2.4% | 2,345 | 2.4% | -8 | 0.0% |
| | <i>Children</i> | 10,596 | 10.9% | 9,275 | 9.5% | -1,322 | -1.4% |
| | <i>Nonelderly with Disability</i> | 537 | 0.6% | 518 | 0.5% | -19 | 0.0% |
| | Employer | 59,983 | 61.6% | 59,458 | 61.1% | -525 | -0.5% |
| | Total Nongroup | 9,488 | 9.7% | 4,435 | 4.6% | -5,053 | -5.2% |
| | <i>With Tax Credits</i> | 7,190 | 7.4% | 1,601 | 1.6% | -5,589 | -5.7% |
| | <i>Other Nongroup</i> | 2,298 | 2.4% | 2,834 | 2.9% | 536 | 0.6% |
| | Medicare and other public | 2,559 | 2.6% | 2,559 | 2.6% | 0 | 0.0% |
| | Uninsured | 11,857 | 12.2% | 18,784 | 19.3% | 6,927 | 7.1% |
| Total | 97,373 | 100.0% | 97,373 | 100.0% | 0 | 0.0% | |

| Panel D. Nonelderly with Income Above 400% FPL | | ACA | | BCRA | | Change from ACA | |
|--|-----------------------------------|---------------|---------------|---------------|--------------|-----------------|--------------|
| Insured | Total Insured | 78,995 | 97.0% | 73,104 | 89.8% | -5,891 | -7.2% |
| | Total Medicaid & CHIP | 1,557 | 1.9% | 1,527 | 1.9% | -31 | 0.0% |
| | <i>Expansion Eligible Adults</i> | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| | <i>Other Adults</i> | 411 | 0.5% | 401 | 0.5% | -10 | 0.0% |
| | <i>Children</i> | 701 | 0.9% | 700 | 0.9% | -1 | 0.0% |
| | <i>Nonelderly with Disability</i> | 445 | 0.5% | 426 | 0.5% | -19 | 0.0% |
| | Employer | 69,573 | 85.4% | 66,442 | 81.6% | -3,131 | -3.8% |
| | Total Nongroup | 5,908 | 7.3% | 3,178 | 3.9% | -2,729 | -3.4% |
| | <i>With Tax Credits</i> | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| | <i>Other Nongroup</i> | 5,908 | 7.3% | 3,178 | 3.9% | -2,729 | -3.4% |
| | Medicare and other public | 1,957 | 2.4% | 1,957 | 2.4% | 0 | 0.0% |
| | Uninsured | 2,441 | 3.0% | 8,332 | 10.2% | 5,891 | 7.2% |
| Total | 81,436 | 100.0% | 81,436 | 100.0% | 0 | 0.0% | |

Source: Urban Institute analysis, HIPSM 2017.

Table 2. Absolute Difference and Percent Difference In Insurance Coverage (by Type of Coverage) Between ACA and BCRA, by State, 2022 (Thousands of People)

| State | Employer | | Nongroup | | Medicaid & CHIP | | Uninsured | |
|----------------------|------------|-------------------------|------------|-------------------------|-----------------|-------------------------|------------|-------------------------|
| | Difference | Percent Change from ACA | Difference | Percent Change from ACA | Difference | Percent Change from ACA | Difference | Percent Change from ACA |
| Alabama | -22 | -1.0% | -92 | -34.6% | -50 | -5.4% | 164 | 30.1% |
| Alaska | -23 | -5.9% | -1 | -3.7% | -43 | -29.2% | 67 | 60.8% |
| Arizona | -112 | -3.7% | -98 | -29.0% | -185 | -10.4% | 395 | 47.7% |
| Arkansas | 91 | 7.6% | -37 | -30.7% | -421 | -43.8% | 367 | 200.2% |
| California | 872 | 5.2% | -786 | -31.8% | -4,377 | -38.4% | 4,291 | 139.2% |
| Colorado | 58 | 2.3% | -15 | -5.4% | -618 | -46.5% | 575 | 134.1% |
| Connecticut | 3 | 0.2% | -68 | -38.9% | -260 | -33.9% | 324 | 186.6% |
| Delaware | -18 | -3.9% | -20 | -47.2% | -20 | -10.4% | 58 | 81.0% |
| District of Columbia | -5 | -1.6% | -3 | -10.0% | -53 | -29.8% | 61 | 208.0% |
| Florida | 61 | 0.8% | -1,234 | -57.0% | -353 | -9.6% | 1,525 | 62.0% |
| Georgia | -167 | -3.3% | -278 | -39.6% | 45 | 2.4% | 400 | 21.3% |
| Hawaii | -21 | -2.8% | -11 | -21.4% | -25 | -8.9% | 56 | 55.6% |
| Idaho | -15 | -1.9% | -59 | -38.1% | -32 | -10.6% | 107 | 50.8% |
| Illinois | -189 | -2.9% | -266 | -40.6% | -622 | -22.4% | 1,076 | 104.8% |
| Indiana | -55 | -1.6% | -112 | -37.0% | -498 | -35.5% | 666 | 122.9% |
| Iowa | -44 | -2.6% | -19 | -14.1% | -169 | -28.1% | 232 | 134.0% |
| Kansas | -51 | -3.4% | -68 | -38.7% | -1 | -0.2% | 120 | 34.9% |
| Kentucky | 180 | 10.1% | -17 | -13.5% | -704 | -51.6% | 541 | 231.1% |
| Louisiana | 17 | 0.9% | -43 | -18.1% | -384 | -29.2% | 410 | 119.7% |
| Maine | 1 | 0.2% | -48 | -51.9% | -14 | -5.1% | 60 | 81.2% |
| Maryland | 18 | 0.6% | -101 | -36.5% | -446 | -35.6% | 528 | 128.5% |
| Massachusetts | 61 | 2.0% | -164 | -47.7% | -6 | -0.3% | 109 | 45.5% |
| Michigan | -86 | -1.9% | -253 | -47.2% | -675 | -30.7% | 1,014 | 196.4% |
| Minnesota | -125 | -4.1% | -72 | -25.4% | -220 | -23.5% | 417 | 106.0% |
| Mississippi | -6 | -0.5% | -54 | -42.8% | -40 | -5.8% | 100 | 25.2% |
| Missouri | -86 | -2.9% | -130 | -36.0% | -82 | -7.8% | 297 | 49.9% |
| Montana | -5 | -1.1% | -27 | -36.0% | -81 | -33.5% | 113 | 134.3% |
| Nebraska | -44 | -4.5% | -58 | -38.8% | -3 | -1.2% | 105 | 59.0% |
| Nevada | -17 | -1.1% | -47 | -30.6% | -264 | -41.7% | 328 | 78.1% |
| New Hampshire | -12 | -1.7% | -25 | -37.5% | -81 | -37.7% | 118 | 194.5% |
| New Jersey | -164 | -3.6% | -216 | -48.3% | -622 | -37.9% | 1,002 | 154.2% |
| New Mexico | 72 | 10.3% | -24 | -31.2% | -365 | -45.8% | 317 | 175.5% |
| New York | 29 | 0.3% | -768 | -62.8% | -551 | -11.4% | 1,290 | 99.2% |
| North Carolina | -50 | -1.1% | -288 | -37.8% | -215 | -10.3% | 553 | 42.0% |

Table 2. Continued...

| State | Employer | | Nongroup | | Medicaid & CHIP | | Uninsured | |
|----------------|-------------|-------------------------|---------------|-------------------------|-----------------|-------------------------|---------------|-------------------------|
| | Difference | Percent Change from ACA | Difference | Percent Change from ACA | Difference | Percent Change from ACA | Difference | Percent Change from ACA |
| North Dakota | -17 | -4.7% | -16 | -31.6% | -37 | -42.6% | 70 | 138.2% |
| Ohio | -94 | -1.7% | -157 | -36.3% | -871 | -33.8% | 1,122 | 183.9% |
| Oklahoma | -52 | -3.0% | -95 | -41.7% | -10 | -1.4% | 157 | 25.9% |
| Oregon | -36 | -2.0% | -65 | -29.7% | -411 | -41.9% | 511 | 183.0% |
| Pennsylvania | -158 | -2.5% | -297 | -43.2% | -766 | -30.6% | 1,221 | 196.8% |
| Rhode Island | 26 | 5.6% | -23 | -45.7% | -106 | -39.6% | 104 | 196.4% |
| South Carolina | -24 | -1.1% | -130 | -42.3% | -61 | -6.7% | 215 | 35.5% |
| South Dakota | -15 | -3.6% | -15 | -23.3% | 3 | 2.2% | 28 | 29.1% |
| Tennessee | 66 | 2.4% | -119 | -31.7% | -300 | -19.3% | 353 | 48.6% |
| Texas | -440 | -3.5% | -768 | -44.2% | 85 | 1.8% | 1,123 | 22.0% |
| Utah | -83 | -4.5% | -149 | -51.2% | -13 | -3.4% | 245 | 71.9% |
| Vermont | 0 | 0.0% | -16 | -44.8% | -23 | -15.7% | 39 | 169.5% |
| Virginia | -184 | -3.9% | -280 | -45.2% | 18 | 1.8% | 446 | 42.4% |
| Washington | 3 | 0.1% | -49 | -15.4% | -711 | -41.0% | 757 | 145.6% |
| West Virginia | 63 | 8.9% | -17 | -34.0% | -264 | -50.2% | 218 | 309.1% |
| Wisconsin | -57 | -1.9% | -197 | -54.0% | -32 | -3.3% | 286 | 73.2% |
| Wyoming | -7 | -2.4% | -15 | -35.0% | -1 | -1.1% | 23 | 33.1% |
| Total | -860 | -0.6% | -7,908 | -41.0% | -15,932 | -22.8% | 24,700 | 80.2% |

Source: Urban Institute analysis, HIPSMS 2017.

Table 3. Uninsured by State, 2022 (Thousands of People)

| State | ACA | As a Percent of State Nonelderly Population | BCRA | As a Percent of State Nonelderly Population | Difference | Percent Change from ACA |
|----------------------|-------|---|-------|---|------------|-------------------------|
| Alabama | 545 | 13.3% | 709 | 17.3% | 164 | 30.1% |
| Alaska | 111 | 15.4% | 178 | 24.7% | 67 | 60.8% |
| Arizona | 828 | 13.4% | 1,223 | 19.8% | 395 | 47.7% |
| Arkansas | 183 | 7.1% | 550 | 21.3% | 367 | 200.2% |
| California | 3,082 | 9.0% | 7,373 | 21.4% | 4,291 | 139.2% |
| Colorado | 429 | 9.0% | 1,004 | 21.1% | 575 | 134.1% |
| Connecticut | 174 | 5.9% | 498 | 17.0% | 324 | 186.6% |
| Delaware | 72 | 9.0% | 130 | 16.4% | 58 | 81.0% |
| District of Columbia | 29 | 5.0% | 90 | 15.5% | 61 | 208.0% |
| Florida | 2,459 | 15.0% | 3,984 | 24.3% | 1,525 | 62.0% |
| Georgia | 1,878 | 19.1% | 2,279 | 23.2% | 400 | 21.3% |
| Hawaii | 101 | 7.9% | 157 | 12.3% | 56 | 55.6% |
| Idaho | 210 | 14.0% | 317 | 21.1% | 107 | 50.8% |
| Illinois | 1,027 | 9.2% | 2,103 | 18.9% | 1,076 | 104.8% |
| Indiana | 542 | 9.4% | 1,207 | 21.0% | 666 | 122.9% |
| Iowa | 173 | 6.6% | 405 | 15.4% | 232 | 134.0% |
| Kansas | 343 | 13.6% | 463 | 18.3% | 120 | 34.9% |
| Kentucky | 234 | 6.3% | 775 | 21.0% | 541 | 231.1% |
| Louisiana | 342 | 8.9% | 752 | 19.5% | 410 | 119.7% |
| Maine | 74 | 7.4% | 135 | 13.4% | 60 | 81.2% |
| Maryland | 411 | 7.6% | 939 | 17.5% | 528 | 128.5% |
| Massachusetts | 239 | 4.3% | 348 | 6.3% | 109 | 45.5% |
| Michigan | 516 | 6.5% | 1,530 | 19.1% | 1,014 | 196.4% |
| Minnesota | 393 | 8.3% | 809 | 17.0% | 417 | 106.0% |
| Mississippi | 396 | 16.0% | 495 | 20.0% | 100 | 25.2% |
| Missouri | 596 | 11.6% | 894 | 17.5% | 297 | 49.9% |
| Montana | 84 | 10.0% | 197 | 23.5% | 113 | 134.3% |
| Nebraska | 178 | 11.1% | 283 | 17.6% | 105 | 59.0% |
| Nevada | 420 | 14.6% | 748 | 26.1% | 328 | 78.1% |
| New Hampshire | 61 | 5.7% | 179 | 16.8% | 118 | 194.5% |
| New Jersey | 650 | 8.7% | 1,652 | 22.1% | 1,002 | 154.2% |
| New Mexico | 181 | 9.9% | 498 | 27.2% | 317 | 175.5% |
| New York | 1,300 | 7.9% | 2,590 | 15.7% | 1,290 | 99.2% |
| North Carolina | 1,316 | 14.6% | 1,869 | 20.8% | 553 | 42.0% |

Table 3. Continued...

| State | ACA | As a Percent of State Nonelderly Population | BCRA | As a Percent of State Nonelderly Population | Difference | Percent Change from ACA |
|----------------|---------------|---|---------------|---|---------------|-------------------------|
| North Dakota | 51 | 8.8% | 121 | 20.9% | 70 | 138.2% |
| Ohio | 610 | 6.5% | 1,732 | 18.4% | 1,122 | 183.9% |
| Oklahoma | 605 | 17.6% | 762 | 22.2% | 157 | 25.9% |
| Oregon | 279 | 8.3% | 791 | 23.6% | 511 | 183.0% |
| Pennsylvania | 620 | 6.0% | 1,841 | 17.8% | 1,221 | 196.8% |
| Rhode Island | 53 | 6.2% | 157 | 18.4% | 104 | 196.4% |
| South Carolina | 604 | 14.8% | 819 | 20.0% | 215 | 35.5% |
| South Dakota | 95 | 12.9% | 122 | 16.7% | 28 | 29.1% |
| Tennessee | 726 | 12.9% | 1,079 | 19.1% | 353 | 48.6% |
| Texas | 5,098 | 20.4% | 6,220 | 24.9% | 1,123 | 22.0% |
| Utah | 341 | 11.6% | 586 | 20.0% | 245 | 71.9% |
| Vermont | 23 | 4.7% | 62 | 12.7% | 39 | 169.5% |
| Virginia | 1,050 | 13.4% | 1,496 | 19.1% | 446 | 42.4% |
| Washington | 520 | 8.4% | 1,276 | 20.7% | 757 | 145.6% |
| West Virginia | 71 | 5.0% | 288 | 20.3% | 218 | 309.1% |
| Wisconsin | 391 | 8.1% | 677 | 14.1% | 286 | 73.2% |
| Wyoming | 69 | 13.8% | 92 | 18.3% | 23 | 33.1% |
| Total | 30,780 | 11.1% | 55,480 | 20.1% | 24,700 | 80.2% |

Source: Urban Institute analysis, HIPSMS 2017.

Table 4. Characteristics of Uninsured and Those Losing Coverage Under the BCRA, 2022
(Thousands of People)

| Characteristics | Uninsured under ACA | | Uninsured under BCRA | | Newly Uninsured under BCRA | |
|------------------------------|---------------------|------------------|----------------------|------------------|----------------------------|----------------------------------|
| | Number of Uninsured | Percent of Total | Number of Uninsured | Percent of Total | Number of Newly Uninsured | Percent of Total Newly Uninsured |
| Race & Ethnicity | | | | | | |
| White, non-Hispanic | 11,412 | 37.1% | 25,546 | 46.0% | 14,677 | 56.6% |
| Hispanic | 12,590 | 40.9% | 17,671 | 31.9% | 5,443 | 21.0% |
| Black, non-Hispanic | 3,996 | 13.0% | 6,909 | 12.5% | 3,139 | 12.1% |
| Asian & Pacific Islander | 1,616 | 5.2% | 3,193 | 5.8% | 1,636 | 6.3% |
| Other | 1,167 | 3.8% | 2,161 | 3.9% | 1,046 | 4.0% |
| Gender | | | | | | |
| Male | | | | | | |
| <i>Subtotal</i> | 16,809 | | 29,311 | | 13,118 | |
| <i>0-18</i> | 1,888 | 11.2% | 3,965 | 13.5% | 2,144 | 16.3% |
| <i>19-34</i> | 7,354 | 43.7% | 11,677 | 39.8% | 4,501 | 34.3% |
| <i>35-54</i> | 5,837 | 34.7% | 10,554 | 36.0% | 4,907 | 37.4% |
| <i>55-64</i> | 1,731 | 10.3% | 3,115 | 10.6% | 1,567 | 11.9% |
| Female | | | | | | |
| <i>Subtotal</i> | 13,971 | | 26,170 | | 12,824 | |
| <i>0-18</i> | 1,784 | 12.8% | 3,739 | 14.3% | 2,013 | 15.7% |
| <i>19-34</i> | 5,241 | 37.5% | 9,391 | 35.9% | 4,322 | 33.7% |
| <i>35-54</i> | 5,122 | 36.7% | 9,594 | 36.7% | 4,669 | 36.4% |
| <i>55-64</i> | 1,824 | 13.1% | 3,446 | 13.2% | 1,821 | 14.2% |
| Education (Age 19-64) | | | | | | |
| <i>Subtotal</i> | 27,108 | | 47,776 | | 21,786 | |
| <i>Less than High School</i> | 6,699 | 24.7% | 9,327 | 19.5% | 2,889 | 13.3% |
| <i>High School</i> | 11,154 | 41.1% | 19,362 | 40.5% | 8,704 | 40.0% |
| <i>Some College</i> | 5,862 | 21.6% | 11,273 | 23.6% | 5,652 | 25.9% |
| <i>College Graduate</i> | 3,393 | 12.5% | 7,815 | 16.4% | 4,541 | 20.8% |
| Working Status | | | | | | |
| <i>No Worker in Family</i> | 6,547 | 21.3% | 10,957 | 19.7% | 4,841 | 18.7% |
| <i>Part-Time in Family</i> | 2,636 | 8.6% | 4,847 | 8.7% | 2,410 | 9.3% |
| <i>Full-Time in Family</i> | 21,598 | 70.2% | 39,677 | 71.5% | 18,692 | 72.1% |
| Total | 30,780 | 100.0% | 55,480 | 100.0% | 25,942 | 100.0% |

Source: Urban Institute analysis, HIPSMS 2017.

Table 5. Distribution of Advanced Premium Tax Credits and Cost-Sharing Reductions by Income Relative to the Federal Poverty Level (FPL), 2022 (\$Million)

| Income Group | ACA APTC | | ACA CSR | | BCRA APTC | |
|--------------|-----------------|---------------|----------------|---------------|----------------|---------------|
| | Amount | Percent | Amount | Percent | Amount | Percent |
| 0-100 FPL | \$544 | 1.4% | \$25 | 0.4% | \$1,753 | 24.0% |
| 100-200 FPL | \$25,964 | 66.9% | \$6,409 | 95.6% | \$3,912 | 53.6% |
| 200-300 FPL | \$8,349 | 21.5% | \$270 | 4.0% | \$1,444 | 19.8% |
| 300-400 FPL | \$3,930 | 10.1% | \$0 | 0.0% | \$186 | 2.6% |
| 400-500 FPL | \$0 | 0.0% | \$0 | 0.0% | \$0 | 0.0% |
| 500-600 FPL | \$0 | 0.0% | \$0 | 0.0% | \$0 | 0.0% |
| 600 FPL + | \$0 | 0.0% | \$0 | 0.0% | \$0 | 0.0% |
| Total | \$38,787 | 100.0% | \$6,704 | 100.0% | \$7,295 | 100.0% |

Source: Urban Institute analysis, HIPSMS 2017.

Note: APTC = advanced premium tax credits; CSR = cost sharing reductions

Table 6. Federal Spending on the Nonelderly Under the ACA and the BCRA, 2022 (\$Million)

| State | ACA | | | BCRA | | | Difference in 2022 | |
|----------------------|-----------------|----------------|------------------------|-----------------|---------|------------------------|------------------------|-------------------------|
| | Medicaid & CHIP | APTCs and CSRs | Total Federal Spending | Medicaid & CHIP | APTCs | Total Federal Spending | Total Federal Spending | Percent Change from ACA |
| Alabama | \$4,279 | \$1,050 | \$5,329 | \$3,960 | \$231 | \$4,191 | -\$1,138 | -21.4% |
| Alaska | \$1,427 | \$116 | \$1,543 | \$837 | \$63 | \$900 | -\$643 | -41.7% |
| Arizona | \$13,311 | \$959 | \$14,270 | \$10,504 | \$130 | \$10,634 | -\$3,637 | -25.5% |
| Arkansas | \$4,286 | \$197 | \$4,483 | \$2,962 | \$27 | \$2,989 | -\$1,494 | -33.3% |
| California | \$33,708 | \$5,435 | \$39,143 | \$22,493 | \$573 | \$23,066 | -\$16,078 | -41.1% |
| Colorado | \$7,100 | \$202 | \$7,302 | \$3,356 | \$63 | \$3,419 | -\$3,883 | -53.2% |
| Connecticut | \$5,103 | \$410 | \$5,513 | \$3,259 | \$72 | \$3,331 | -\$2,182 | -39.6% |
| Delaware | \$1,311 | \$92 | \$1,403 | \$1,042 | \$8 | \$1,050 | -\$353 | -25.2% |
| District of Columbia | \$1,750 | \$9 | \$1,759 | \$1,282 | \$0 | \$1,282 | -\$477 | -27.1% |
| Florida | \$16,819 | \$7,101 | \$23,920 | \$14,645 | \$1,057 | \$15,702 | -\$8,219 | -34.4% |
| Georgia | \$8,348 | \$1,699 | \$10,048 | \$8,124 | \$411 | \$8,535 | -\$1,512 | -15.0% |
| Hawaii | \$1,288 | \$70 | \$1,358 | \$1,033 | \$16 | \$1,048 | -\$310 | -22.8% |
| Idaho | \$2,457 | \$373 | \$2,831 | \$2,089 | \$55 | \$2,144 | -\$687 | -24.3% |
| Illinois | \$14,017 | \$1,202 | \$15,220 | \$9,758 | \$63 | \$9,821 | -\$5,398 | -35.5% |
| Indiana | \$7,911 | \$539 | \$8,449 | \$5,321 | \$31 | \$5,351 | -\$3,098 | -36.7% |
| Iowa | \$3,158 | \$171 | \$3,330 | \$2,368 | \$35 | \$2,403 | -\$926 | -27.8% |
| Kansas | \$2,097 | \$402 | \$2,499 | \$1,981 | \$68 | \$2,049 | -\$449 | -18.0% |
| Kentucky | \$10,496 | \$213 | \$10,709 | \$4,426 | \$22 | \$4,448 | -\$6,261 | -58.5% |
| Louisiana | \$7,035 | \$637 | \$7,672 | \$4,697 | \$294 | \$4,991 | -\$2,680 | -34.9% |
| Maine | \$1,566 | \$366 | \$1,933 | \$1,446 | \$80 | \$1,526 | -\$407 | -21.1% |
| Maryland | \$7,851 | \$355 | \$8,206 | \$4,446 | \$31 | \$4,477 | -\$3,729 | -45.4% |
| Massachusetts | \$8,571 | \$597 | \$9,169 | \$7,738 | \$103 | \$7,841 | -\$1,328 | -14.5% |
| Michigan | \$13,643 | \$815 | \$14,458 | \$9,083 | \$40 | \$9,123 | -\$5,335 | -36.9% |
| Minnesota | \$7,052 | \$264 | \$7,316 | \$5,117 | \$41 | \$5,159 | -\$2,157 | -29.5% |
| Mississippi | \$4,029 | \$408 | \$4,437 | \$3,643 | \$94 | \$3,737 | -\$700 | -15.8% |
| Missouri | \$7,601 | \$1,073 | \$8,674 | \$6,772 | \$192 | \$6,964 | -\$1,710 | -19.7% |
| Montana | \$2,018 | \$202 | \$2,219 | \$1,263 | \$90 | \$1,352 | -\$867 | -39.1% |
| Nebraska | \$1,349 | \$432 | \$1,780 | \$1,256 | \$87 | \$1,343 | -\$438 | -24.6% |
| Nevada | \$3,242 | \$356 | \$3,598 | \$1,836 | \$29 | \$1,865 | -\$1,733 | -48.2% |
| New Hampshire | \$1,335 | \$96 | \$1,431 | \$806 | \$11 | \$817 | -\$614 | -42.9% |
| New Jersey | \$12,431 | \$694 | \$13,125 | \$6,091 | \$59 | \$6,150 | -\$6,975 | -53.1% |
| New Mexico | \$6,965 | \$99 | \$7,064 | \$3,315 | \$11 | \$3,326 | -\$3,737 | -52.9% |
| New York | \$33,994 | \$1,824 | \$35,818 | \$27,398 | \$177 | \$27,574 | -\$8,243 | -23.0% |
| North Carolina | \$13,307 | \$3,435 | \$16,742 | \$11,474 | \$907 | \$12,381 | -\$4,361 | -26.0% |

Table 6. Continued...

| State | ACA | | | BCRA | | | Difference in 2022 | |
|----------------|------------------|-----------------|------------------------|------------------|----------------|------------------------|------------------------|-------------------------|
| | Medicaid & CHIP | APTCs and CSRs | Total Federal Spending | Medicaid & CHIP | APTCs | Total Federal Spending | Total Federal Spending | Percent Change from ACA |
| North Dakota | \$688 | \$60 | \$748 | \$356 | \$5 | \$361 | -\$387 | -51.8% |
| Ohio | \$16,649 | \$589 | \$17,238 | \$10,596 | \$39 | \$10,635 | -\$6,602 | -38.3% |
| Oklahoma | \$4,319 | \$785 | \$5,104 | \$4,043 | \$181 | \$4,223 | -\$881 | -17.3% |
| Oregon | \$7,121 | \$308 | \$7,429 | \$3,348 | \$77 | \$3,425 | -\$4,005 | -53.9% |
| Pennsylvania | \$15,379 | \$1,547 | \$16,925 | \$10,497 | \$164 | \$10,660 | -\$6,265 | -37.0% |
| Rhode Island | \$2,109 | \$58 | \$2,167 | \$1,168 | \$5 | \$1,173 | -\$994 | -45.9% |
| South Carolina | \$5,486 | \$1,103 | \$6,589 | \$4,893 | \$214 | \$5,107 | -\$1,482 | -22.5% |
| South Dakota | \$735 | \$146 | \$881 | \$715 | \$50 | \$765 | -\$116 | -13.2% |
| Tennessee | \$9,455 | \$1,083 | \$10,539 | \$7,386 | \$283 | \$7,669 | -\$2,870 | -27.2% |
| Texas | \$28,748 | \$4,109 | \$32,857 | \$27,489 | \$631 | \$28,120 | -\$4,737 | -14.4% |
| Utah | \$2,943 | \$568 | \$3,511 | \$2,702 | \$36 | \$2,738 | -\$772 | -22.0% |
| Vermont | \$993 | \$84 | \$1,077 | \$783 | \$12 | \$796 | -\$282 | -26.1% |
| Virginia | \$5,013 | \$1,467 | \$6,480 | \$4,828 | \$183 | \$5,012 | -\$1,468 | -22.7% |
| Washington | \$8,470 | \$388 | \$8,858 | \$4,072 | \$93 | \$4,165 | -\$4,693 | -53.0% |
| West Virginia | \$3,510 | \$161 | \$3,670 | \$1,845 | \$30 | \$1,876 | -\$1,795 | -48.9% |
| Wisconsin | \$4,368 | \$989 | \$5,358 | \$4,075 | \$80 | \$4,156 | -\$1,202 | -22.4% |
| Wyoming | \$410 | \$158 | \$567 | \$386 | \$43 | \$429 | -\$139 | -24.5% |
| Total | \$387,249 | \$45,498 | \$432,748 | \$285,005 | \$7,295 | \$292,300 | -\$140,447 | -32.5% |

Source: Urban Institute analysis, HIPSIM 2017.

Note: APTC = advanced premium tax credits; CSR = cost sharing reductions

Table 7. State Medicaid & CHIP Spending on the Nonelderly Under the ACA and the BCRA, 2022 (\$Million)

| State | ACA | BCRA | Difference in 2022 | |
|----------------------|----------|----------|--------------------|----------------|
| | | | Amount | Percent Change |
| Alabama | \$1,896 | \$1,992 | \$96 | 5.0% |
| Alaska | \$957 | \$940 | -\$17 | -1.8% |
| Arizona | \$5,630 | \$6,312 | \$682 | 12.1% |
| Arkansas | \$1,573 | \$1,494 | -\$79 | -5.0% |
| California | \$27,172 | \$24,968 | -\$2,204 | -8.1% |
| Colorado | \$4,183 | \$3,518 | -\$665 | -15.9% |
| Connecticut | \$3,790 | \$3,610 | -\$180 | -4.7% |
| Delaware | \$789 | \$853 | \$64 | 8.2% |
| District of Columbia | \$632 | \$669 | \$37 | 5.8% |
| Florida | \$11,520 | \$11,424 | -\$96 | -0.8% |
| Georgia | \$4,193 | \$4,722 | \$529 | 12.6% |
| Hawaii | \$913 | \$986 | \$73 | 8.0% |
| Idaho | \$952 | \$981 | \$29 | 3.1% |
| Illinois | \$10,143 | \$10,149 | \$7 | 0.1% |
| Indiana | \$2,986 | \$2,920 | -\$66 | -2.2% |
| Iowa | \$1,807 | \$1,833 | \$26 | 1.4% |
| Kansas | \$1,524 | \$1,609 | \$85 | 5.6% |
| Kentucky | \$2,901 | \$2,215 | -\$686 | -23.6% |
| Louisiana | \$3,447 | \$3,365 | -\$82 | -2.4% |
| Maine | \$956 | \$1,012 | \$56 | 5.8% |
| Maryland | \$5,511 | \$5,108 | -\$403 | -7.3% |
| Massachusetts | \$5,658 | \$6,459 | \$801 | 14.2% |
| Michigan | \$5,308 | \$5,252 | -\$56 | -1.0% |
| Minnesota | \$5,671 | \$5,842 | \$172 | 3.0% |
| Mississippi | \$1,453 | \$1,553 | \$99 | 6.8% |
| Missouri | \$4,502 | \$4,626 | \$124 | 2.8% |
| Montana | \$747 | \$709 | -\$38 | -5.1% |
| Nebraska | \$1,115 | \$1,179 | \$64 | 5.8% |
| Nevada | \$1,300 | \$1,207 | -\$93 | -7.1% |
| New Hampshire | \$927 | \$891 | -\$36 | -3.9% |
| New Jersey | \$6,976 | \$6,501 | -\$475 | -6.8% |
| New Mexico | \$2,176 | \$1,851 | -\$325 | -14.9% |
| New York | \$25,487 | \$27,093 | \$1,606 | 6.3% |
| North Carolina | \$6,791 | \$6,805 | \$13 | 0.2% |

Table 7 Continued...

| State | ACA | BCRA | Difference in 2022 | |
|----------------|------------------|------------------|--------------------|----------------|
| | | | Amount | Percent Change |
| North Dakota | \$410 | \$384 | -\$26 | -6.4% |
| Ohio | \$7,329 | \$7,106 | -\$223 | -3.0% |
| Oklahoma | \$2,428 | \$2,637 | \$209 | 8.6% |
| Oregon | \$2,438 | \$2,128 | -\$309 | -12.7% |
| Pennsylvania | \$9,629 | \$9,536 | -\$93 | -1.0% |
| Rhode Island | \$1,522 | \$1,319 | -\$203 | -13.3% |
| South Carolina | \$2,288 | \$2,445 | \$157 | 6.9% |
| South Dakota | \$633 | \$690 | \$57 | 9.0% |
| Tennessee | \$4,820 | \$4,543 | -\$277 | -5.7% |
| Texas | \$19,615 | \$21,868 | \$2,253 | 11.5% |
| Utah | \$1,212 | \$1,348 | \$137 | 11.3% |
| Vermont | \$620 | \$667 | \$47 | 7.6% |
| Virginia | \$4,878 | \$5,255 | \$378 | 7.7% |
| Washington | \$4,963 | \$4,397 | -\$566 | -11.4% |
| West Virginia | \$1,000 | \$809 | -\$190 | -19.0% |
| Wisconsin | \$2,959 | \$3,093 | \$135 | 4.6% |
| Wyoming | \$402 | \$419 | \$17 | 4.3% |
| Total | \$228,728 | \$229,293 | \$565 | 0.2% |

Source: Urban Institute analysis, HIPSM 2017.

NOTES

- 1 See: Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (2017). <https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf>. An excellent summary of the components of the BCRA can be found at: Kaiser Family Foundation. June 2017. *Summary of the Better Care Reconciliation Act*. <http://files.kff.org/attachment/Summary-of-the-Better-Care-Reconciliation-Act>.
- 2 Blumberg LJ, Buettgens M, Holahan J, Garrett B, Wang R. *State-by-State Coverage and Government Spending Implications of the American Health Care Act*. Washington: Urban Institute; 2017.
- 3 Three changes would be implemented before 2020, however. For people who owe back excess tax credits received at the end of the year, the ACA cap on repayments is eliminated. In addition, the penalty for erroneous claims of premium tax credits would be increased to 25 percent. Third, premium tax credits could not be received for insurance plans that cover abortion.
- 4 Actuarial value represents the average percentage of health care spending on services covered by the insurance policy that are reimbursed by the insurer. Higher-actuarial-value policies therefore indicate lower out-of-pocket spending for the average enrollee. Because of the variation permitted around actuarial value (as modified by the current administration), the benchmark could be associated with a plan as low as 54 percent actuarial value.
- 5 Lynch V, Boudreaux M, Davern M. *Applying and Evaluating Logical Coverage Edits to Health Insurance Coverage in the American Community Survey*. Suitland, MD: US Census Bureau, Housing and Household Economic Statistics Division; 2010.
- 6 Haley JM, Lynch V, Kenney GM. *The Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model*. Washington: Urban Institute; 2014. <http://www.urban.org/research/publication/urban-institute-health-policy-centers-medicaidchip-eligibility-simulation-model>.
- 7 Effectuated enrollment for 2017 was not available at the time the model was calibrated, so we used marketplace plan selections from the open enrollment report, discounted by the attrition between plan selections and effectuated enrollment observed in 2016.
- 8 Blumberg LJ, Buettgens M, Holahan J. *Implications of Partial Repeal of the ACA through Reconciliation*. Washington: Urban Institute; 2016. <http://www.urban.org/research/publication/implications-partial-repeal-aca-through-reconciliation>.
- 9 A small percentage of tax credits go to those below 100 percent of FPL. These families qualify for the tax credits (even though they have lower incomes) through a provision of the law that grants marketplace assistance to recent immigrants who would otherwise be ineligible for Medicaid because of their immigration status.
- 10 Blumberg LJ. No state would be immune from the GOP's health-care bill. *Washington Post*. May 30, 2017. https://www.washingtonpost.com/opinions/no-state-would-be-immune-from-the-gops-health-care-bill/2017/05/30/97f71a34-449a-11e7-bcde-624ad94170ab_story.html.

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 & ACKNOWLEDGMENTS

Linda J. Blumberg is a Senior Fellow, Matthew Buettgens is a Senior Research Associate, John Holahan is an Institute Fellow, Bowen Garrett is a Senior Fellow, and Robin Wang is a Research Associate, all in The Urban Institute's Health Policy Center. The authors are grateful for comments and suggestions from Stephen Zuckerman and for copyediting by Vicky Gan.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit <http://www.urban.org/policy-centers/health-policy-center>.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.