



Research Brief

Coverage Expansion Under the ACA: Challenges for Government, Health Plans, and Providers

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Executive Summary

Executive Summary

The U.S. Supreme Court decision in June 2012 upheld the individual mandate of the Affordable Care Act (ACA), but prohibited penalties for states that elect not to expand Medicaid. The decision has created uncertainty about the volumes of the newly insured that can be expected starting in 2014. However, barring a repeal of the ACA, Truven Health AnalyticsSM estimates that the:

- Population covered by Medicaid will increase from 47 million in 2012 to 53 million in 2016
- Number of people enrolled in affordable insurance exchanges (AIEs) will be 21 million in 2016
- Number of uninsured will decrease from 49 million to about 27 million in 2016

These estimates are based on the opt-in stance of states to date, which may change now that the November 2012 elections are behind us.

A known descriptor of the newly insured population size will be its large geographic variability. States with stringent Medicaid eligibility requirements and higher rates of uninsurance will tend to see larger increases in the insured population due to the ACA. Moreover, the estimated insured population growth is not uniform within states or within specific metropolitan areas; variation in small areas is pronounced. These geographic estimates of insured population growth in small areas will be important in assisting government, health plans, and providers in planning for care of the newly insured.

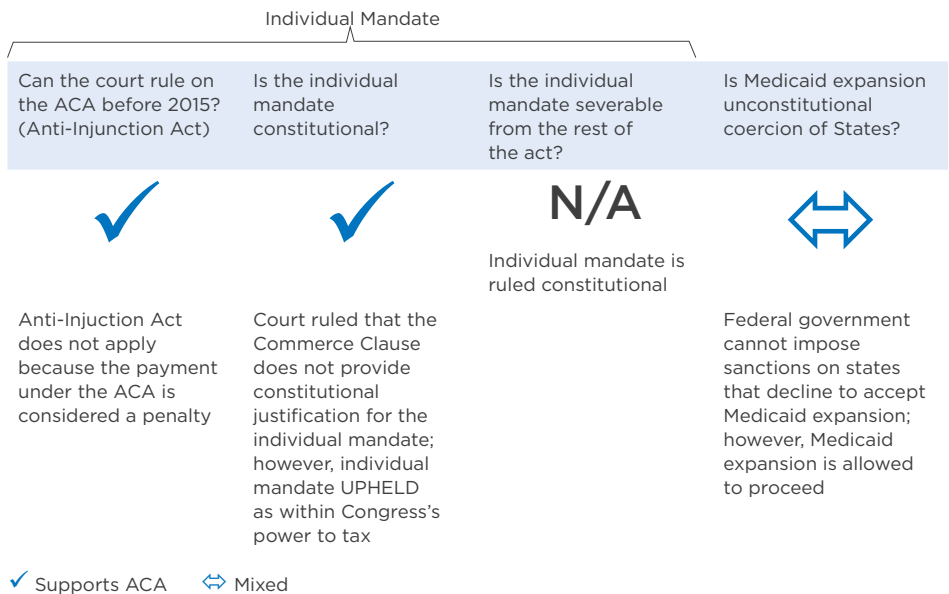
Analysis of population profiles for the newly eligible reveals a number of factors that can impact cost of care positively or negatively. A notable difference is the much lower levels of reported use of medical, dental, and hospital services by the newly eligible when compared to their insured counterparts. Other differences are important to note as well, such as demographics, biometrics, health risks, and chronic conditions. But certainly, the lower use of services stands out. It is unlikely that all of the service-use differences are due to better health. Rather, access barriers due to lack of insurance are a more likely explanation. Thus, while the population profiles of the newly eligible portray some characteristics of enrollees or patients with lower costs of care, this advantage is likely overstated.

Introduction

The morning of June 28, 2012, was suspense-packed for those tracking legal challenges to the ACA. Chief Justice Roberts, after initial commentary suggesting that the court would strike down the ACA entirely, joined the court majority in upholding the individual mandate as within the power of Congress to legislate. However, the court also ruled that the federal government cannot penalize states that elect not to expand Medicaid coverage under the ACA provisions (see Figure 1).

The decision created legal clarity, but has raised many additional questions for government, health plans, and providers. All stakeholders will need insurance coverage projections that incorporate the court ruling in order to create plans for infrastructure, provider networks, and capacity. Also, there is interest in gaining insight into the population and health characteristics of those likely to be newly insured by Medicaid or the forming AIEs.

Figure 1: Summary of June Supreme Court Ruling on the Patient Protection and Affordable Care Act



Implications of Supreme Court ACA Decision for Insurance Coverage

The result of the ruling is that implementation of AIEs will move forward as spelled out in the ACA legislation and forthcoming administrative rules. Individuals with income between 100–400 percent of the federal poverty level (FPL) will be eligible for federally subsidized premium and cost-sharing credits to help them purchase coverage through AIEs. However, states may elect to expand Medicaid, as described in the ACA, or not. In states that opt not to expand coverage, individuals with incomes less than 100 percent of the FPL, who lack coverage today, will remain uninsured. Nationally, this group was estimated to total 16 million in 2010.¹

The court's decision raised a number of questions for states regarding the flexibility for varying approaches to expansion. As documented in a letter from the National Association of Medicaid Directors to the Centers for Medicare & Medicaid Services (CMS) immediately following the ruling,² these questions included:

- Can Medicaid eligibility be extended to 100 percent of the FPL or other levels less than the 133 percent set by the ACA? What are the implications for the federal match?
- Will the 5-percent income disregards effectively make the income levels for the optional eligibility expansions 105 percent/138 percent?
- Can expansion occur after 2014?
- Can states elect partial early expansion, but opt-out of full expansion?
- Are states still subject to Maintenance of Effort requirements for eligibility prior to 2014?
- Do the ACA changes to eligibility determination (Modified Adjusted Gross Income, or MAGI) apply regardless of whether a state opts for expansion?
- How is 90/10 federal funding for new eligibility systems affected by a state's decision on expansion?

Some questions about Medicaid program expansion and AIE implementation were answered in a communication to state Governors from Health and Human Services (HHS) Secretary Kathleen Sebelius in December 2012. We now know that partial expansion of state Medicaid programs will not be allowed, although states may choose timing of expansion and may drop out of the expansion program at any time. In addition, HHS clarified that the timetable for implementation of the AIEs would not be changed.³

The court ruling on Medicaid expansion has created a conundrum for many states. State government officials have many costs and benefits to weigh regarding the choice to expand Medicaid coverage in their states, including the following:⁴

- What will be the long-term costs of covering individuals newly eligible under the ACA? While the federal government will pay 100 percent of the costs for this group in 2014-2016, states will then pay an increasing share up to 10 percent by 2020.
- How will coverage expansion increase enrollment for individuals who are currently eligible for Medicaid, but not enrolled (the “woodwork” population) and what will be the associated cost? The federal government’s share of cost for this group will be a state’s current Federal Medical Assistance Percentage (FMAP), which averages approximately 56 percent across states.
- What is the impact on administration and eligibility outreach? Will the increase in Medicaid enrollment applications result in increased costs to the state, or will these costs be covered in whole or part by the AIE?
- How will the Medicaid expansion option affect the Medicaid disproportionate share hospital (DSH) payment reductions mandated by the ACA? What about other indirect state payments for uncompensated care?
- With expanded Medicaid coverage, what savings in direct payments for the uninsured will be possible (e.g., direct payments to public hospitals)? What reductions can be expected in state-funded services for low-income residents, e.g., through behavioral health and public health programs?
- Are there positive revenue benefits for the state through federally funded Medicaid expansion and the economic activity and/or industry-specific taxes that it stimulates?

It is likely that state decisions to expand Medicaid or not will be influenced by pressure from key stakeholders (in particular, the state hospital associations). Also, electoral politics play a role; many states will announce their direction during 2013 legislative sessions.

State Actions on ACA Coverage Expansion

While most ACA coverage expansion impacts occur in 2014 and beyond, states have been active in preparing for and implementing ACA provisions affecting Medicaid and the AIEs.

The ACA has provisions and funding that allow states to implement improvements to their Medicaid programs prior to 2014. As reported by the Kaiser Family Foundation:⁵

- Eight states have received approval to expand Medicaid to adults.
- Connecticut; Washington, D.C.; and Minnesota have expanded Medicaid through an ACA option that allows states to receive federal matching funding to cover adults up to 133 percent of FPL.
- In addition, six states plus D.C. (California, Colorado, Minnesota, Missouri, New Jersey, and Washington) have received Section 1115 waivers.
- Twenty-nine states have submitted proposals to upgrade Medicaid eligibility systems.

States have also been actively preparing for implementation of the AIEs in 2013. Recent research provides the following profile of state-level AIE preparation activities:⁶

- Nineteen states (plus D.C.) have created state-based exchanges.
- Seven states are pursuing a state-federal partnership exchange, in which the federal government assumes responsibility for some exchange operations in the state.
- Twenty-five states have defaulted to a federally administered exchange.

Insurance Coverage Growth Under the ACA: State and National Impacts

Federal policymakers have supplied estimates of the effect of the ACA on insurance coverage changes in the U.S. population. A standard reference source for national impacts (and the one we adopt here) is provided by the Congressional Budget Office (CBO). Two CBO memos, the latter issued after the June Supreme Court decision, describe national estimates of insurance coverage changes over the next decade based on the ACA provisions.⁷

State governments, health plans, and healthcare providers require localized estimates of coverage that are more granular in order to implement programs, allocate resources, execute policies, and effectively care for patients. Truven Health developed the Insurance Coverage Estimates (ICE) database to address these needs.

ICE contains:

- Estimates of population categorized into insurance coverage categories: Medicare, Medicaid, Dual Eligibles, Private Direct (Individual Purchase), Private ESI (Employer-Sponsored Insurance), Private Exchanges, and Uninsured
- Differentiation between newly eligible for Medicaid and currently eligible not enrolled
- Geographically specific estimates: State, Core Based Statistical Area (CBSA), county, and ZIP code
- Age and gender detail
- Current estimates and 10-year annual projections of coverage

ICE was created using many interconnected statistical models. Key methodology highlights are:

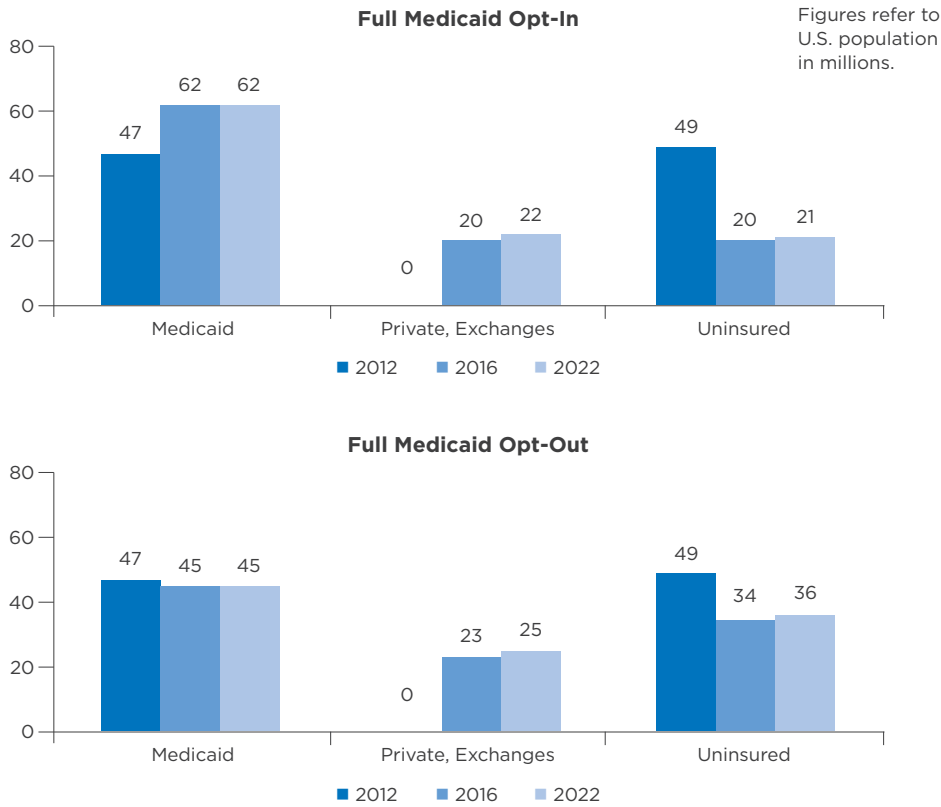
- ICE national enrollment totals by insurance type are based on March and July 2012 CBO memoranda.
- ICE creates local estimates using top-down algorithms that take into account local household income distribution, 2012 local enrollment breakdown (compiled from survey and administrative sources), 2012-2022 projected local age and gender breakdown, and state-level Medicaid eligibility regulations.
- ICE incorporates coverage transition models (starting in 2014) based on the Massachusetts experience before and after reform.
- ICE starts with a baseline estimate, which assumes that the ACA is not implemented. Due to underlying demographic and economic factors, the baseline estimate assumes:
 - Decline in the Medicaid/CHIP population (5.9 percent)
 - Moderate increase in the ESI population (4.5 percent)
 - Increase in the uninsured (9.1 percent)
 - Increase in the elderly and Medicare population
- ICE then estimates changes to the baseline estimate due to the ACA and contains two coverage estimates:
 - With full-state opt-in in 2014
 - With full-state opt-out in 2014

Full-state opt-out changes the size of the Medicaid enrolled population and the size of the AIE enrollment for the state. In computing full opt-out estimates, ICE makes no assumptions about timing of opt-in/opt-out. It also follows CBO assumptions that the number of people transitioning from private coverage (group and non-group) to Medicaid and exchanges under the ACA is relatively small.

With all states opting in, the uninsured population drops from 48.7 million in 2012 to 21.2 million by 2022, while Medicaid enrollment increases from 47.4 million in 2012 to 61.8 million in 2022 (see Figures 2 and 3). Under the full opt-in scenario, exchange enrollment grows to 20 million in 2016 and increases to 22 million in 2022.

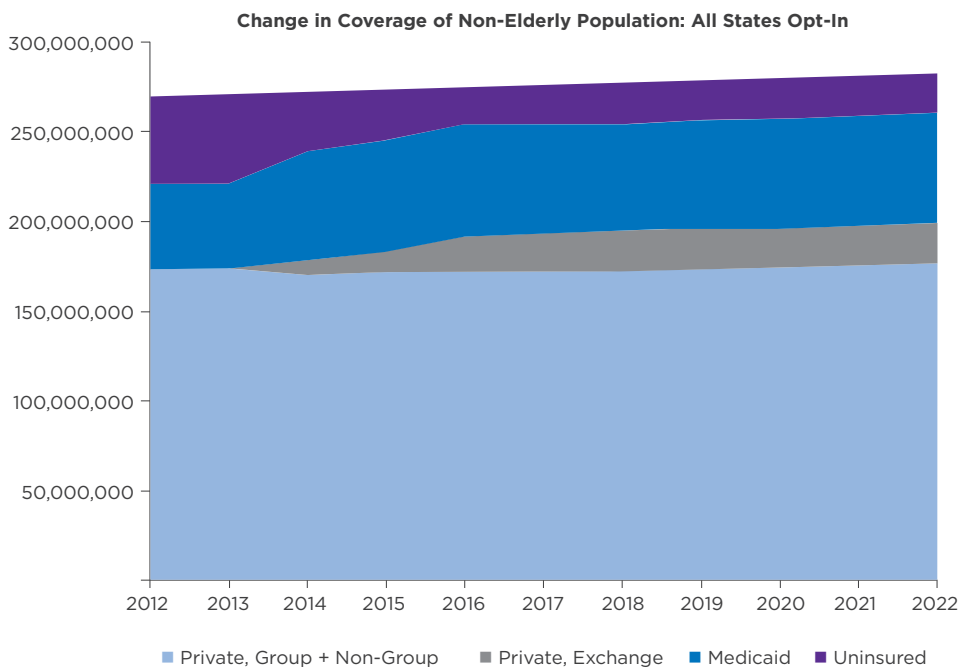
If all states were to opt-out, the uninsured population drops from 48.7 million in 2012 to 35.5 million by 2022, and Medicaid enrollment decreases from 47.4 million in 2012 to 44.8 million in 2022 based on assumed improvements in the economy and other demographic factors (Figures 2 and 4). Under the full opt-out scenario, exchange enrollment increases from 23 million in 2016 to 25 million in 2022, slightly higher numbers than when all states opt-in, reflecting additional uninsured who are eligible for exchanges and not benefiting from the Medicaid expansion.

Figure 2: Impact of Full Medicaid Opt-In and Opt-Out



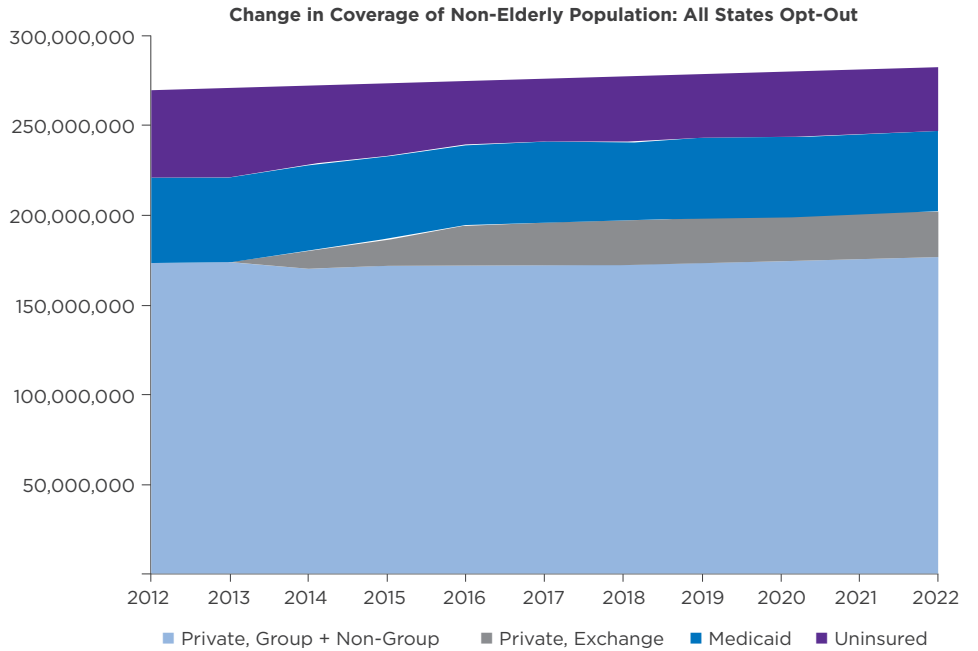
Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 3: National Coverage Changes With Opt-In



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

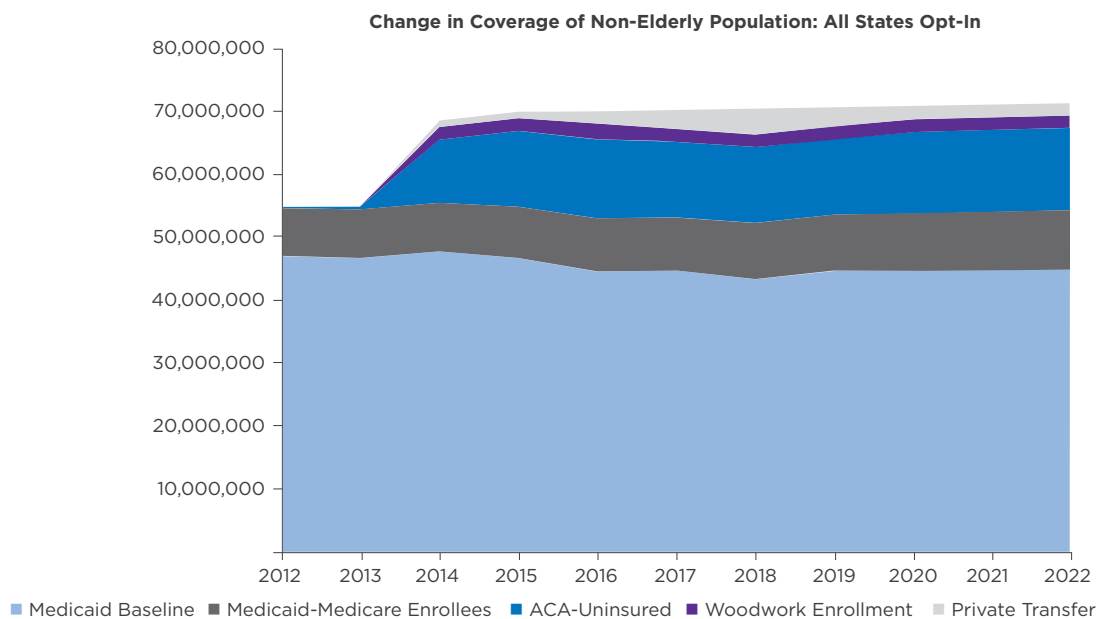
Figure 4: National Coverage Changes With Opt-Out



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Let's take a closer look at the national growth in Medicaid under the full opt-in scenario. With all states opting in, Medicaid growth is driven primarily by uninsured newly eligible under the ACA (13 million lives in 2022). To a lesser degree, enrollment increases come from those uninsured, currently Medicaid Eligible but unenrolled ("woodwork" population) and enrollment of those covered by private insurance (group or non-group). The group of dual (Medicaid-Medicare) enrollees grows from 7.5 million to 9.5 million over the next decade.⁸ The Medicaid baseline population (those eligible under current state eligibility rules) declines slightly over the next decade, reflecting assumed improvements in the economy.

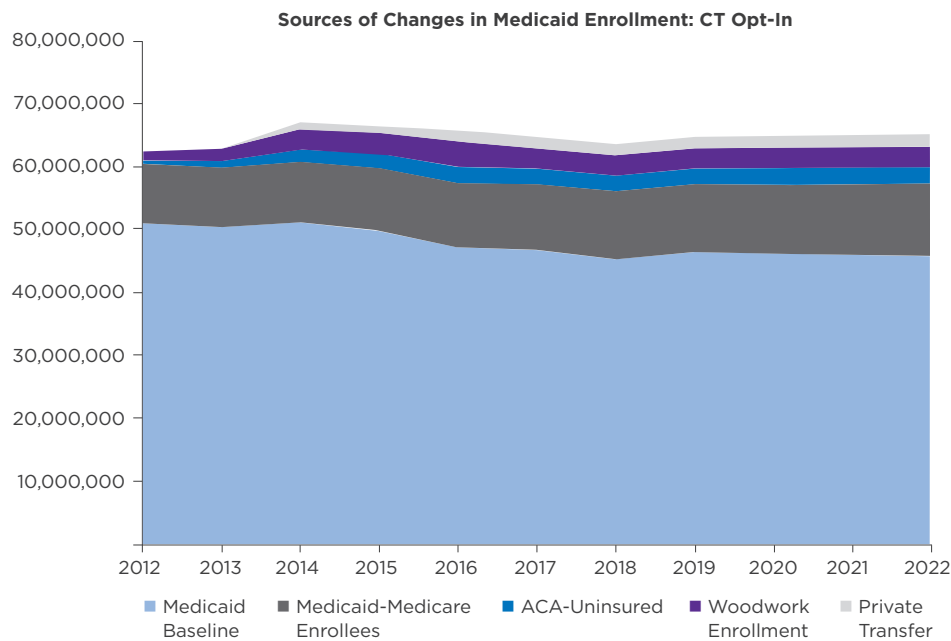
Figure 5: Medicaid Enrollment Change Detail: All States Opt-In



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

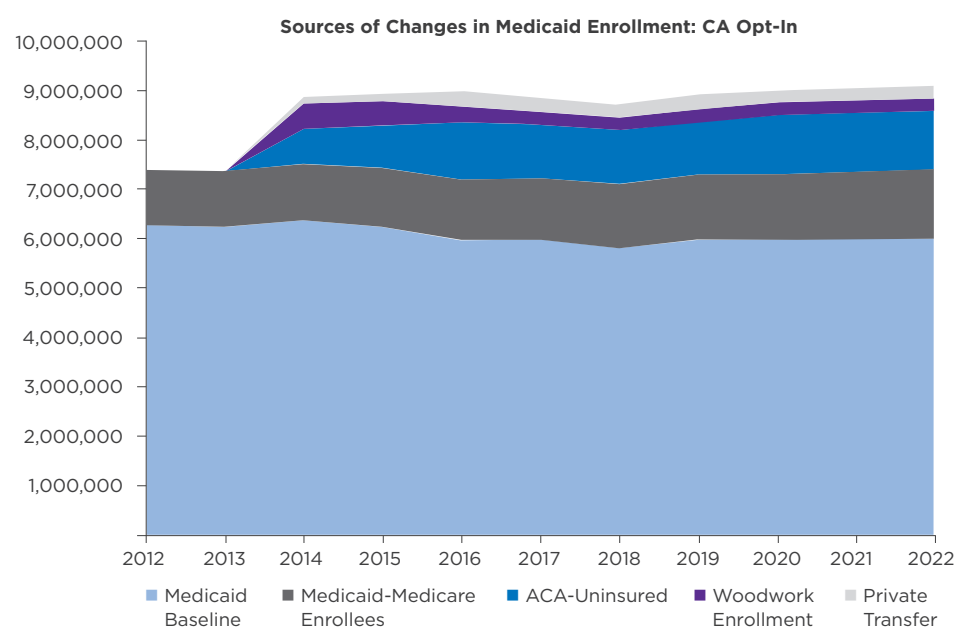
The impact of Medicaid expansion is not uniform across the states. Connecticut, for example, which has expanded Medicaid eligibility ahead of the ACA 2014 implementation date, will see relatively little impact on total Medicaid enrollment (Figure 6). In contrast, California will experience a large increase in Medicaid enrollment — nearly 1.7 million lives (Figure 7).

Figure 6: Medicaid Enrollment Change Detail: Connecticut



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 7: Medicaid Enrollment Change Detail: California



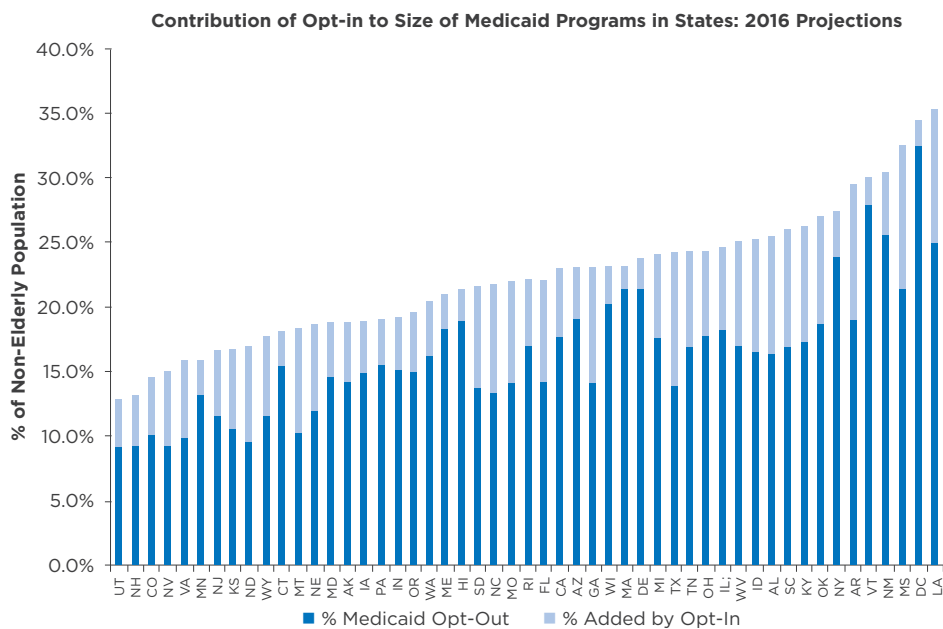
Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 8 compares the 2016 projected percentage of the non-elderly population enrolled in state Medicaid programs with full-state opt-out and additional lives added by full opt-in (Medicaid-Medicare enrollees are excluded). The impact of opt-in/opt-out varies by state and is to some extent independent of current Medicaid program size.

For example, the District of Columbia has the second-largest current Medicaid enrollment as a percentage of total non-elderly population, but the impact of full opt-in is relatively small, reflecting more “generous” current eligibility requirements due in part to its pursuit of Medicaid expansion ahead of the 2014 deadline. The situation in Connecticut is similar, but the Medicaid program is smaller in size, reflecting the household income levels in that state.

In contrast, states such as Louisiana, Texas, and Georgia face fairly substantial increases in Medicaid program size under full opt-in; they have sizable uninsured populations below 138 percent of FPL that are currently not eligible for Medicaid coverage.

Figure 8: State Medicaid Enrollment Rates in 2016: Full Opt-In Impacts

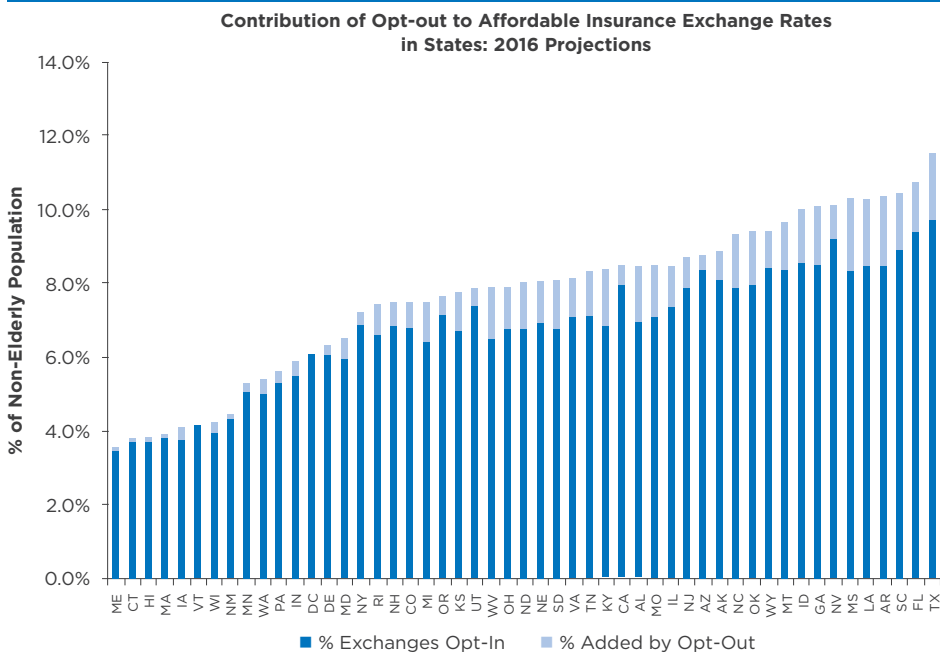


Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 9 shows the 2016 projected percentage of the non-elderly population in insurance exchanges with full-state opt-in and additional lives added by full opt-out. Full-state opt-out creates subsidized coverage in exchanges for those uninsured between 100–133 percent FPL.

The impact of opt-in/opt-out on AIEs varies by state. Full opt-out has a small impact on states such as Maine, Connecticut, Hawaii, and Massachusetts, where fewer people between 100 and 133 percent FPL are uninsured. In contrast, states such as Louisiana, Mississippi, Arkansas, and Texas face more substantial increases in exchange enrollment rates under full opt-out, based on uninsured rates for those individuals between 100 and 133 percent FPL.

Figure 9: State Affordable Insurance Exchange Enrollment Rates in 2016: Opt-In and Opt-Out Impacts

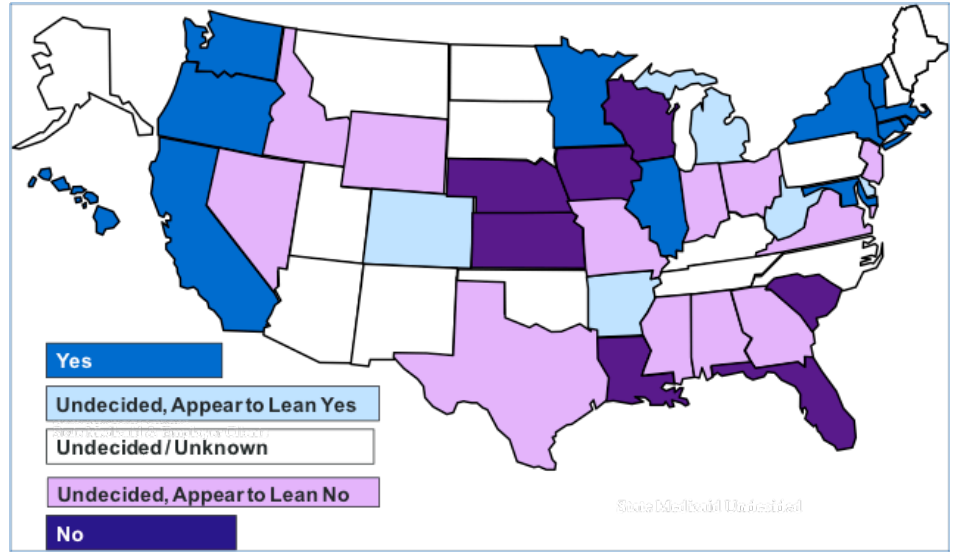


Source: Truven Health AnalyticsSM Insurance Coverage Estimates

What can we say about the increase in Medicaid and AIE enrollment based on the opt-out options states have?

Based on research conducted by Truven Health, states are divided on their position on Medicaid expansion (see Figure 10).⁹ As of mid-July, there were seven states firmly “no” and 12 more that were “leaning no.” In contrast, 12 states were firmly “yes” and five more were “leaning yes.” This leaves 14 states undecided about Medicaid expansion, with equal numbers in the “yes” and “no” camps. About the same distribution of stances is obtained if we substitute population counts for state counts.

Figure 10: States' Intent to Expand Medicaid (as of July 11, 2012)



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

To simulate a scenario between full opt-in and opt-out, we assigned opt-in likelihoods based on the opt-in stance of each state (see Figure 10), then calculated coverage changes based on these likelihoods. This calculation assumes that states opt-in with different likelihoods based on their current position: yes = 100 percent, lean yes = 75 percent, undecided = 50 percent, lean no = 25 percent, and no = 0 percent.

In this simulation, uninsurance rates drop to 10.2 percent or 29 million people in 2022 (see Table 1). Medicaid enrollment rates increase slightly to 18.7 percent, with 53 million enrollees in 2022. The exchanges grow to 24 million enrollees in 2022. In total, the partial opt-in scenario results in 8 million more uninsured than full opt-in.

Table 1: Impact of Current State Opt-In Positions on 2016 and 2022 Coverage (Millions)

Insurance Coverage	2012: Baseline	2016: Full Opt-In	2016: Partial Opt-In	2016: Full Opt-Out	2022: Full Opt-In	2022: Partial Opt-In	2022: Full Opt-Out
Medicaid	47	62	53	45	62	53	45
Private, Group + Non-Group	173	172	172	172	177	177	177
Private, Exchanges	0	20	21	23	22	24	25
Uninsured	49	20	27	34	21	29	36

Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Since July 2012, news reports indicate that the positions of a number of states have changed. While several governors have declared that they will not expand Medicaid, the primary trend has been for states to move to an “undecided” status (n=25),¹⁰ as they continue to evaluate the costs and benefits of expansion. The partial opt-in simulation described here represents one intermediate estimate given the fluidity of states’ views on Medicaid expansion.

Insurance Coverage Growth Under the ACA: Local Estimates

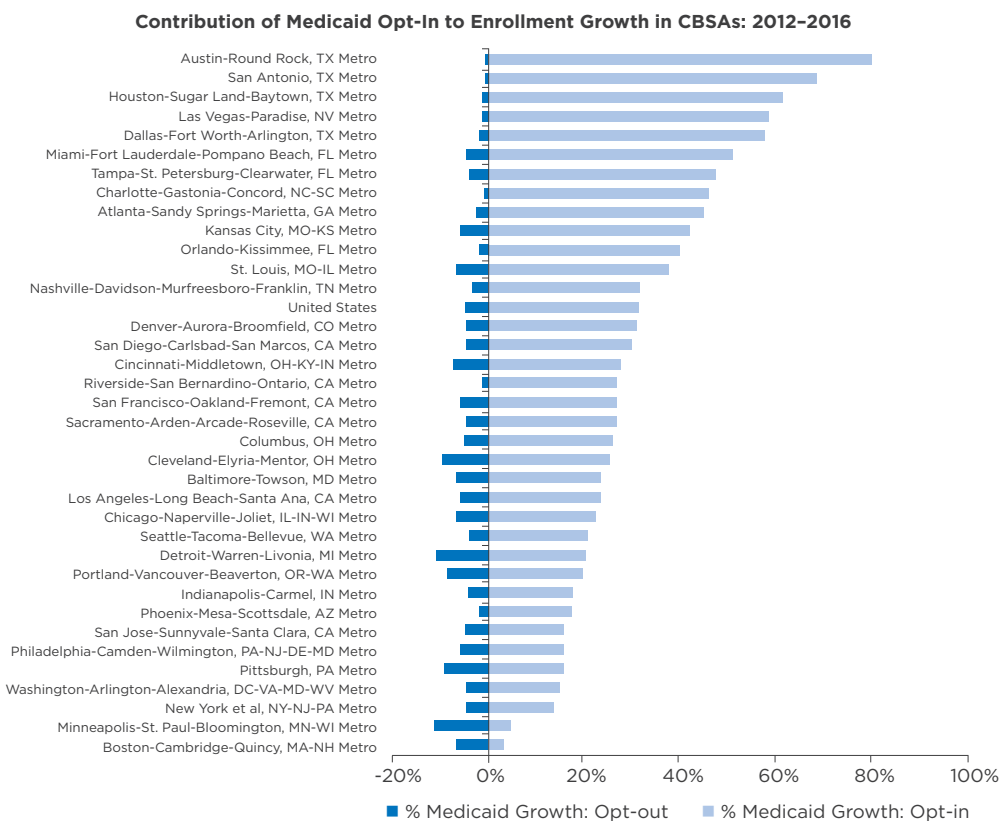
The ICE database contains geographic detail not only at the state level, but also the CBSA, county, and ZIP-code levels.

Another way of looking at the impact of Medicaid expansion is to estimate its contribution to growth of Medicaid enrollment. Medicaid enrollment growth within CBSAs is a function of CBSA population change, levels of employment and income in the CBSAs, and the size of the Medicaid eligible population, either under opt-in or opt-out.

CBSAs in Texas, Florida, and Nevada top the list for percentage Medicaid enrollment growth, 2012–2016 (see Figure 11). These are all areas where population growth is greater than average and current lower Medicaid enrollment rates create a larger pool of future eligibles.

In contrast, CBSAs such as Minneapolis, Boston, New York, and Washington have the lowest estimated rates of growth, but for different reasons. Boston and New York have negative projected total population growth over the period coupled with currently high rates of Medicaid enrollment. Washington and Minneapolis have much lower current enrollment rates and opt-in growth, reflecting income conditions in those CBSAs.

Figure 11: Percentage Growth in Medicaid Enrollment in Major CBSAs, 2012–2016: Opt-In and Opt-Out Impacts

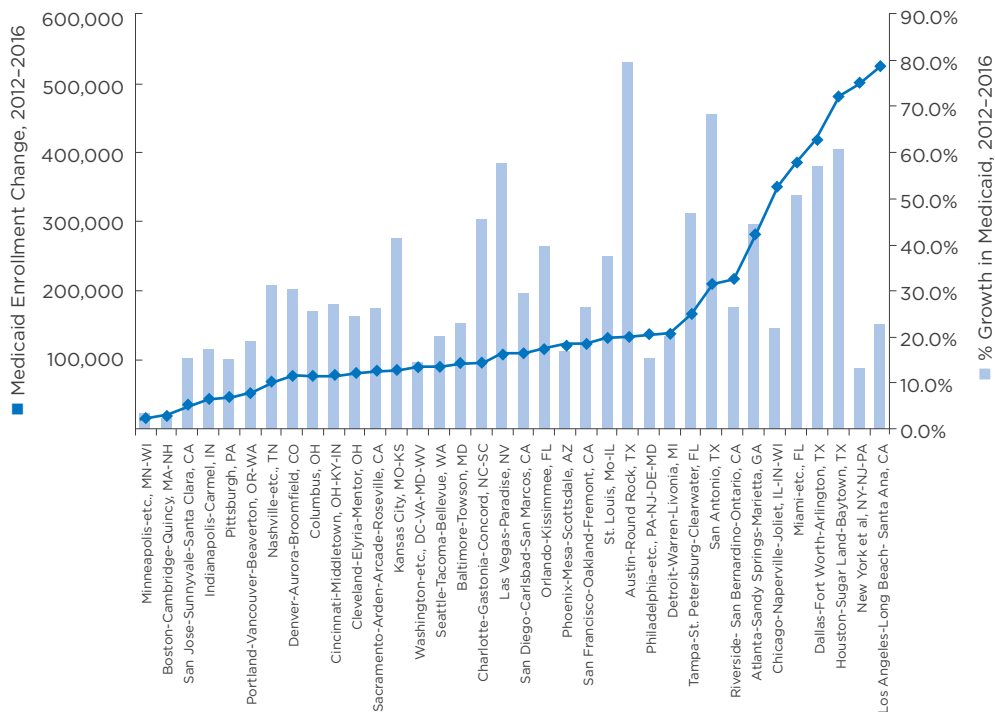


Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Keep in mind that percentage growth does not equate to absolute growth in enrollment. Figure 12 depicts the estimates of absolute Medicaid enrollment change and percentage growth between 2012 and 2016.

Los Angeles and New York CBSAs have the largest absolute increase in enrollment but modest percentage growth. In contrast, high-percentage growth CBSAs such as Austin and Las Vegas contribute relatively few new Medicaid enrollees.

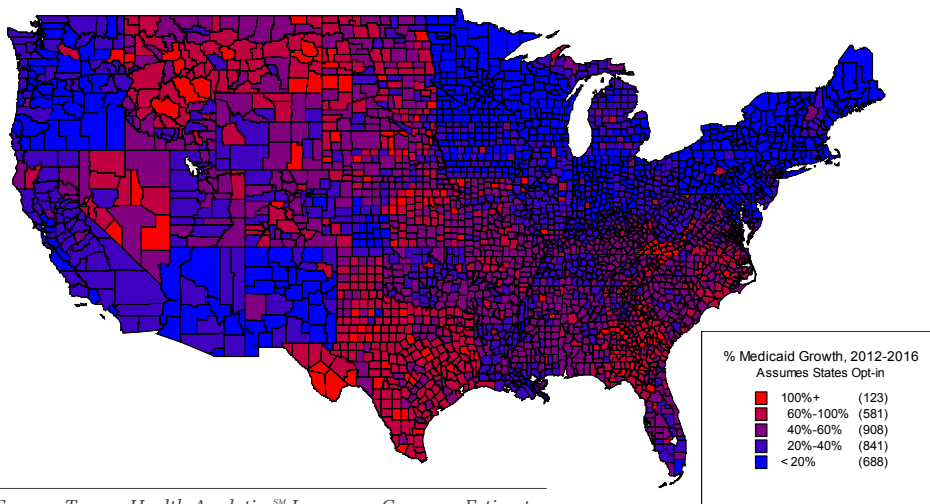
Figure 12: Percentage and Absolute Growth in Medicaid Enrollment in Major CBSAs, 2012–2016: Full Opt-In Impacts



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

The variation in Medicaid enrollment growth becomes more pronounced when we drill into greater geographic detail. Figure 13 is a heat map of Medicaid growth, by county, between 2012 and 2016. This assumes that all states opt-in to Medicaid expansion. There is substantial county-to-county variation, even within states, for growth in Medicaid enrollment. It is not unusual for counties to have Medicaid estimated enrollment increases greater than 100 percent.

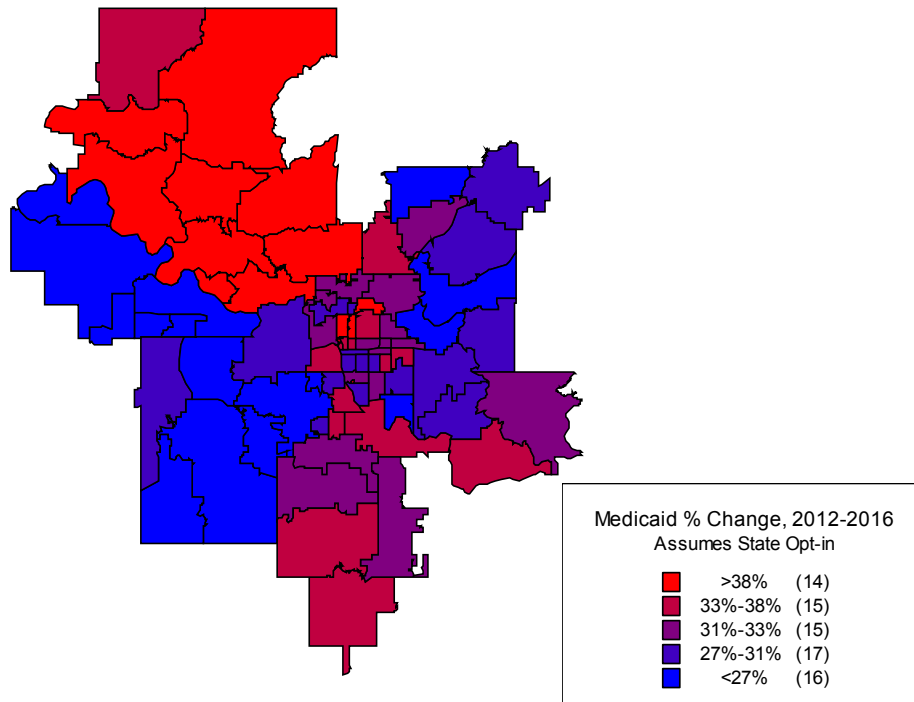
Figure 13: Percentage Growth in Medicaid Enrollment in Counties, 2012–2016: Opt-In Impacts



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Medicaid program growth will also vary within CBSAs and more local estimates of coverage change can be produced. Figure 14 is a map of Medicaid growth in a sample CBSA, by ZIP code, between 2012 and 2016. Even within fairly small geographic areas, growth in coverage will not be uniform. Within-CBSA growth variation will need to be understood to plan for the network and delivery system needed to care for the newly insured.

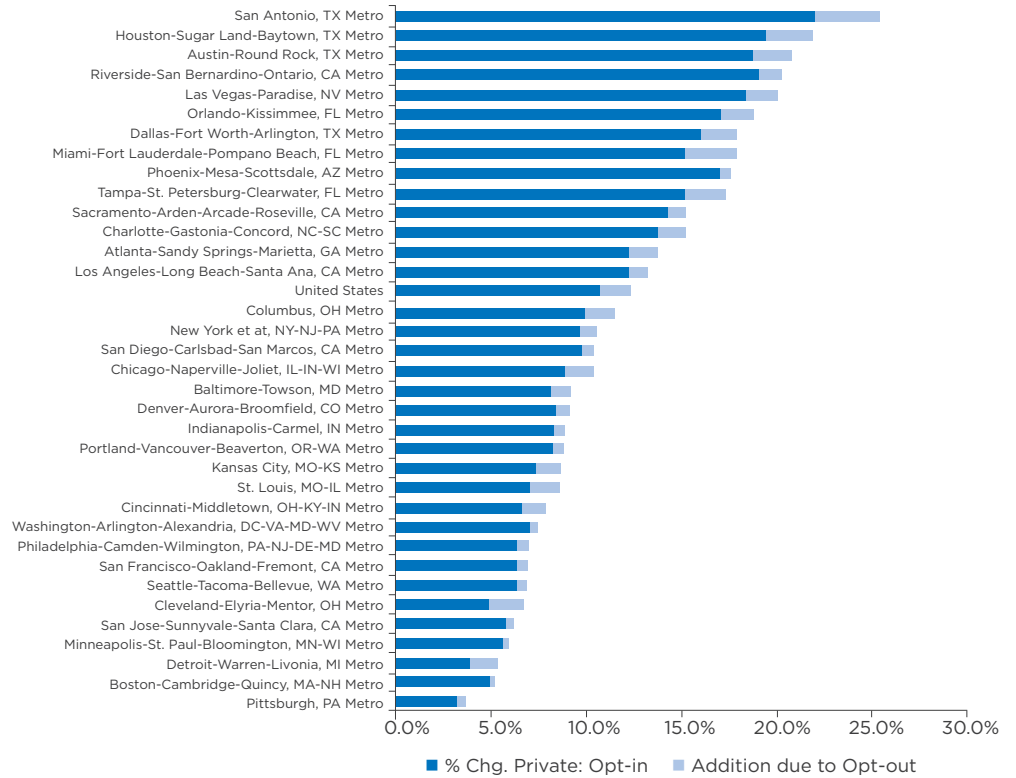
Figure 14: Percentage Growth in Medicaid Enrollment in Sample CBSA, 2012–2016: Opt-In Impacts



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

AIE local growth patterns can also be studied geographically. In Figure 15, CBSAs in Texas, Florida, California, Nevada, and Arizona top the list for private insurance market growth, 2012–2016. In contrast, CBSAs such as Minneapolis, Detroit, Boston, and Pittsburgh have the lowest estimated rates of growth, but for different reasons. Detroit and Pittsburgh have declining base populations of privately insured individuals. Exchanges add back private enrollment, but are offset by these declines. Boston and Minneapolis have among the highest base private insurance enrollment rate. This high rate, and the income distributions of the CBSAs, leaves a smaller pool of subsidy-eligible exchange eligibles.

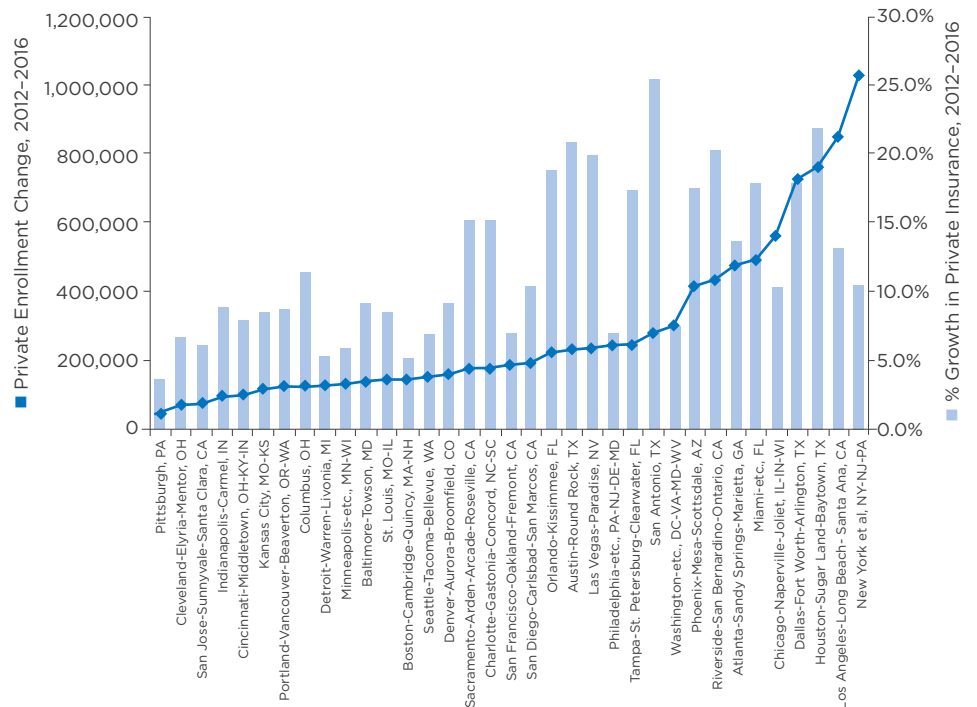
Figure 15: Percentage Growth in Private Insurance, Major CBSAs, 2012–2016: Exchange Impacts



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 16 depicts the estimates of absolute private insurance enrollment change (blue markers) and percentage growth (blue bars) between 2012 and 2016. Los Angeles and New York CBSAs have the largest absolute increase in enrollment, but modest percentage growth. San Antonio and Austin both have large percentage increases in private enrollment but add relatively few lives in absolute numbers.

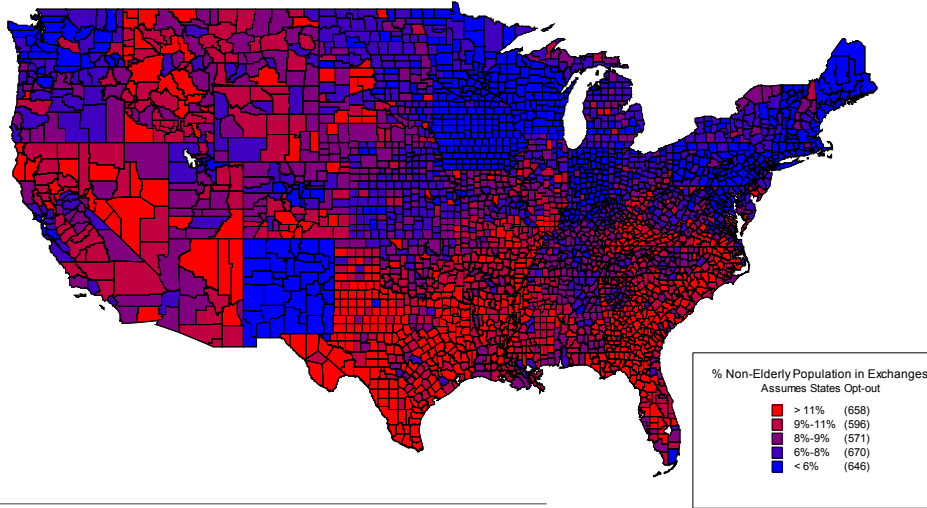
Figure 16: Percentage and Absolute Growth in Private Insurance, Major CBSAs, 2012–2016: Exchange Impacts



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 17 is a map of estimated AIE enrollment rates, by county in 2016. This assumes that all states opt-out of ACA Medicaid expansion. County-to-county variation in enrollment rates is large, even within states. For example, California has counties with the lowest and the highest enrollment rate categories.

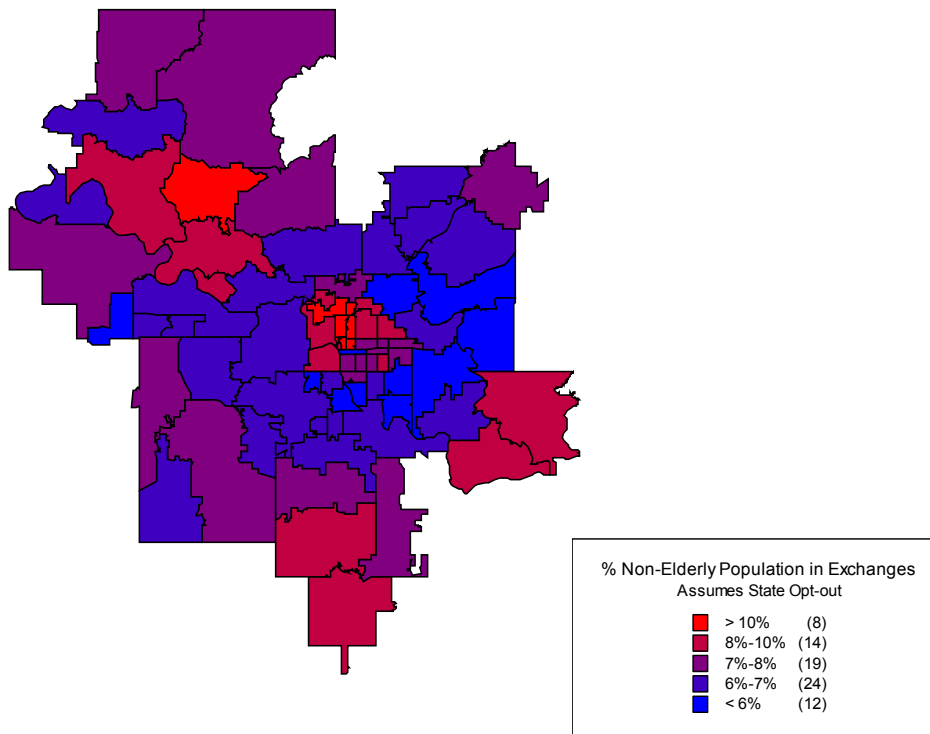
Figure 17: Affordable Insurance Exchange Enrollment Rates, Counties: 2016



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Exchange enrollment will also vary within CBSAs. Figure 18 is a map of estimated AIE enrollment rates in a sample CBSA, by ZIP code, for 2016. Within-CBSA enrollment variation will need to be understood to attract and care for new exchange enrollees.

Figure 18: Affordable Insurance Exchange Enrollment Rates in Sample CBSA: 2016



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Population Profiles of the Newly Insured

Government agencies, health plans, and healthcare providers are asking a similar question: How do the newly insured compare to existing members (patients) regarding health and use of healthcare services?

We have used three national surveys to compare those currently insured and those newly eligible under the ACA expansion provisions. The American Community Survey (2011) was used to measure demographic, disability and Activities of Daily Living (ADL) differences.¹¹ The National Health and Nutrition Examination Survey (2007-2008 and 2009-2010) was used to compare the populations on biometrics (e.g., body mass index or blood pressure).¹² Self-reported data from the National Health Interview Survey (2010 and 2011) was used to describe differences in insurance history, health status, health risks, chronic conditions, and use of healthcare services.¹³

We should mention that the state-level Behavioral Risk Factor Surveillance Survey (BRFSS) datasets are another useful source of information about the health status of the future Medicaid eligible population.¹⁴ We have not used these datasets here since our focus is on a national profile of the newly insured.

For all surveys, current Medicaid enrollees were identified by those reporting Medicaid as insurance coverage at the time of survey. The future Medicaid eligible were identified as those uninsured with household incomes below 138 percent of FPL at the time of survey.

Similarly, the privately insured were identified as those reporting private insurance coverage (either group or non-group) at the time of survey. The “future exchange likely” were identified as those uninsured at the time of survey with household incomes between 138 percent and 400 percent of FPL. In the case of the “future exchange likely,” no attempt was made to differentially weight the likelihood of exchange enrollment based on household income. It is likely that lower-income households eligible for larger subsidies will be more likely to enroll in the exchanges, all other things being equal. We also made no attempt to judge whether a given household was exempt from the ACA individual mandate.

Most of the profile data we discuss here focuses on the non-elderly adult population (age 19–64). Uninsured adults represent a significant majority of those who will enroll in Medicaid or AIEs, and they are the main focus of the profiles that follow.

Table 2 summarizes key findings from profiling the newly insured. There are many differences between the newly eligible and comparison populations on the profile factors measured.

Table 2: Population Profile Summary: Future Medicaid Eligible and Exchange Likely Adults

Profile Factor	Key Findings: How Future Medicaid Eligible Adults Compare to Current Medicaid Adults	Impact on Per-Capita Cost	Key Findings: How Future Exchange Likely Adults Compare to Current Privately Insured (Group + Non-Group)	Impact on Per-Capita Cost
Demographics	<ul style="list-style-type: none"> Similar in age, fewer women More likely to be of Hispanic origin Less likely to be U.S. born or citizens More likely to be employed (full or part-time) 	?	<ul style="list-style-type: none"> Fewer women, more in 18–44 age group More likely to be of Hispanic origin Less likely to be U.S. born or citizens Less likely to be employed 	?
Insurance History	<ul style="list-style-type: none"> Have been uninsured for more than 3 years or have never had insurance at high rates Report cost as dominant factor for uninsurance 	↑	<ul style="list-style-type: none"> Have been uninsured for more than 3 years or have never had insurance at high rates Report cost as dominant factor for uninsurance 	↑
Biometrics	<ul style="list-style-type: none"> Lower body mass index (BMI) and blood glucose 	↓	<ul style="list-style-type: none"> Have slightly lower BMI 	↓
Health Status	<ul style="list-style-type: none"> Report slightly better health status Report lower levels of health deterioration, disability (aliased by income), and activities of daily living (ADL) problems 	↓	<ul style="list-style-type: none"> Report slightly worse health status Report higher levels of health deterioration, disability (aliased by income), and ADL problems 	↑
Health Risks	<ul style="list-style-type: none"> Exercise more; tobacco/ alcohol use similar Health-risk levels not favorable 	?	<ul style="list-style-type: none"> Use tobacco at much higher rates and exercise less Health-risk levels not favorable 	↑
Chronic Conditions	<ul style="list-style-type: none"> Two times less likely to report mental health issues, but are almost 3 times less likely to have seen a mental health professional Report lower levels of many chronic conditions, including diabetes, heart and respiratory disease 	↓↓	<ul style="list-style-type: none"> Report mental health issues at a similar rate, but are much less likely to have seen a mental health professional Report similar levels for many chronic conditions, but lower rates for arthritis and heart disease 	?
Use of Healthcare Services	<ul style="list-style-type: none"> Consistently report lower rates of visits with medical and dental professionals Have slightly lower rates of emergency room (ER) use and lower rates of surgeries 	↓↓	<ul style="list-style-type: none"> Consistently report lower rates of visits with medical and dental professionals Have slightly higher rates of ER use and lower rates of surgeries 	↓↓

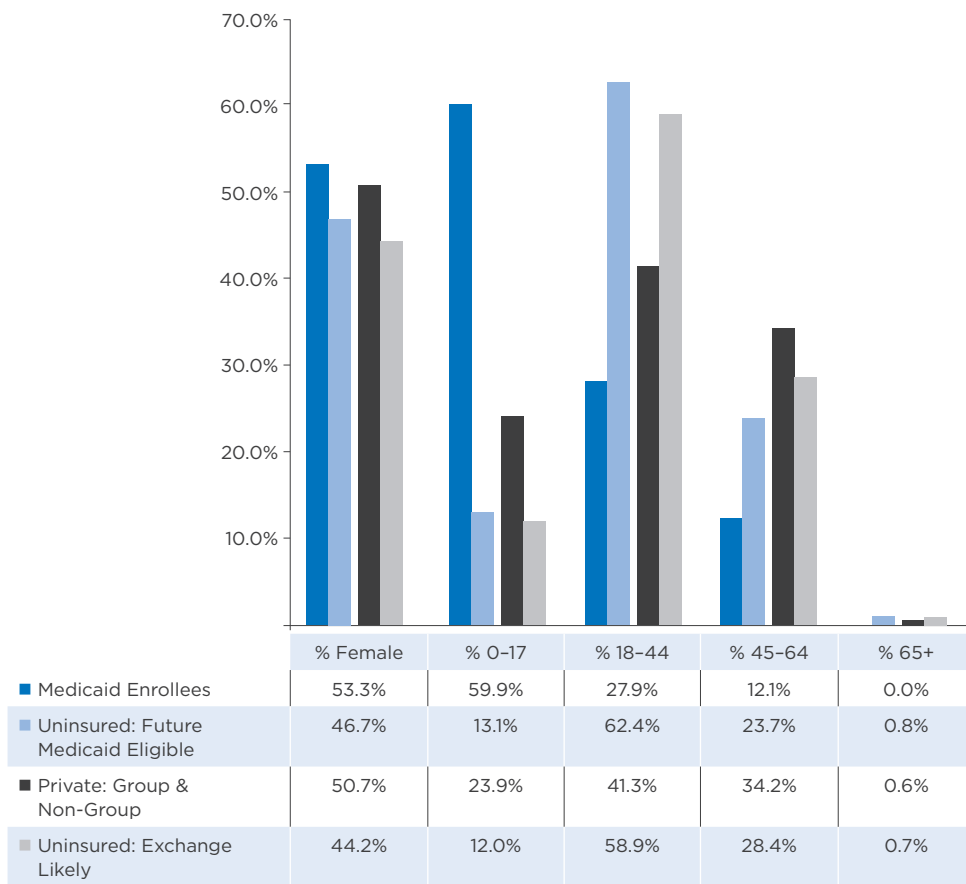
In the charts that follow, we profile existing Medicaid enrollees in dark blue and future Medicaid eligibles in light blue. Current privately covered enrollees will be shaded dark gray and future “exchange likely” enrollees will be shaded in light gray.

The first step in analyzing population profile differences is to understand key demographic characteristics.

For age and gender, both newly eligible populations (Medicaid and exchanges) have fewer females than their comparators (Figure 19). Future Medicaid-eligible adults are similar in age to their enrolled counterparts. Future exchange likely adults are about 5 years younger than those currently privately insured.

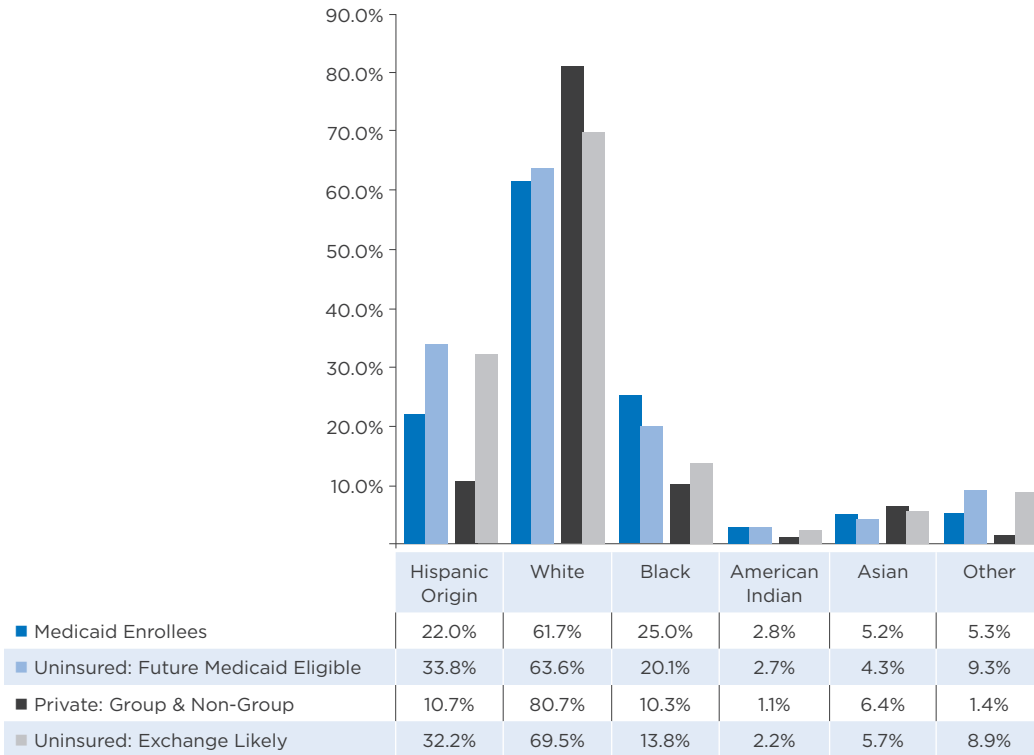
From a race and ethnicity perspective, what stands out is that both future Medicaid eligibles and future exchange likely adults have a higher percentage of Hispanic members (Figure 20). Somewhat related is nativity. Both newly eligible groups are less likely to be U.S. citizens and have more difficulty with the English language (Figure 21). Future Medicaid eligibles are more likely to be employed; the opposite is true for future exchange likely adults (Figure 22).

Figure 19: Age/Gender Profile of the Newly Eligible, Ages 0-64



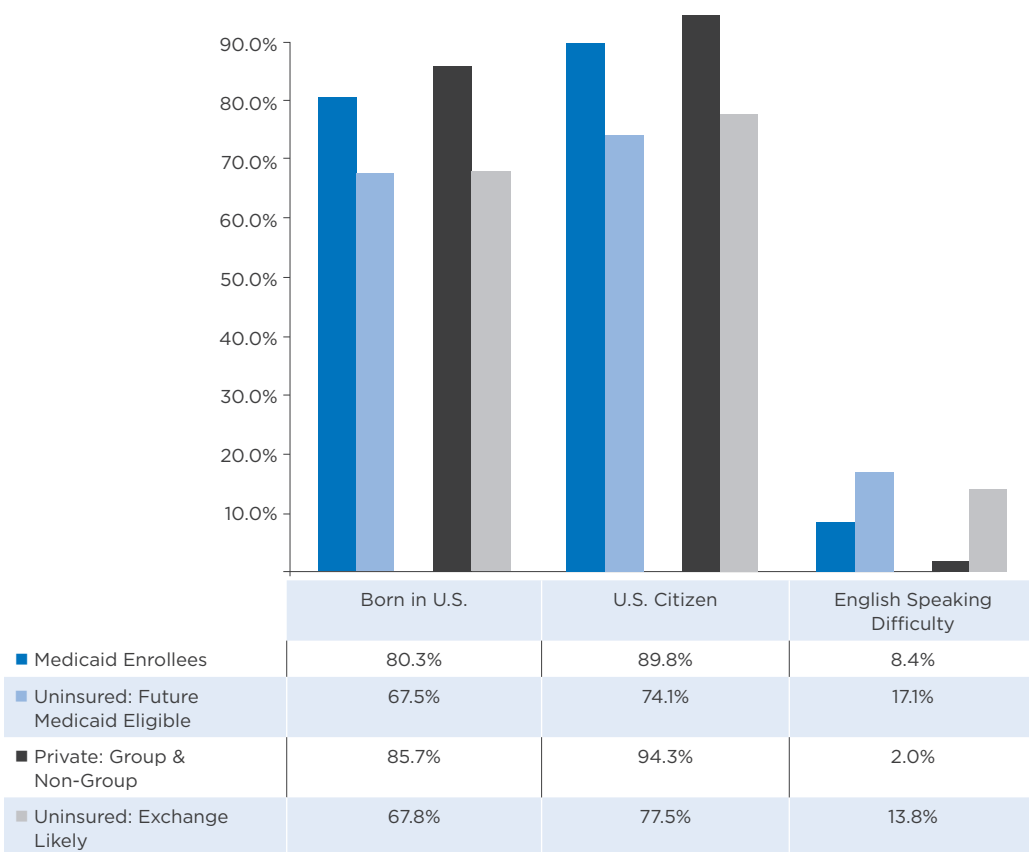
Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 20: Ethnicity/Race Profile of the Newly Eligible



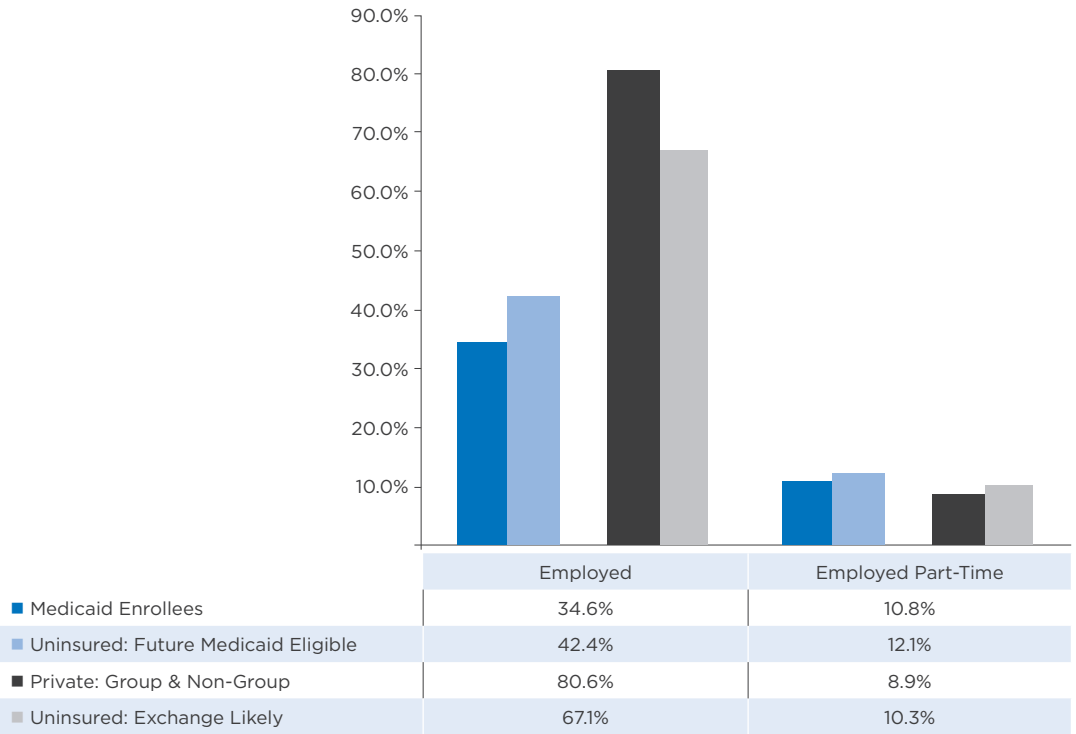
Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 21: Nativity Profile of the Newly Eligible



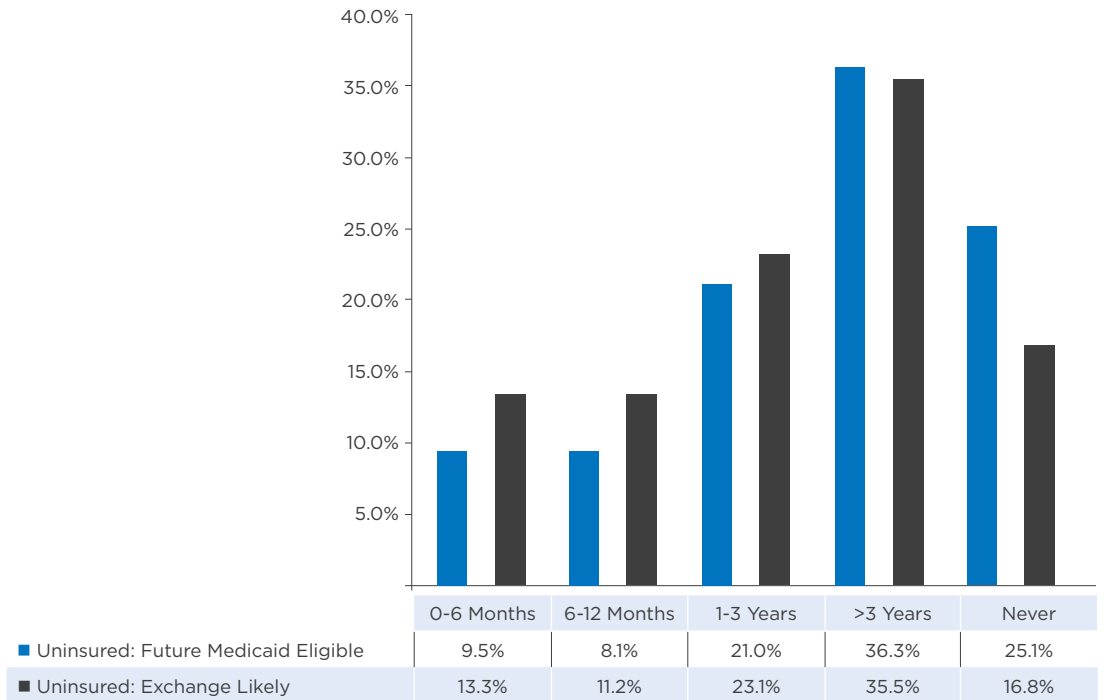
Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 22: Employment Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

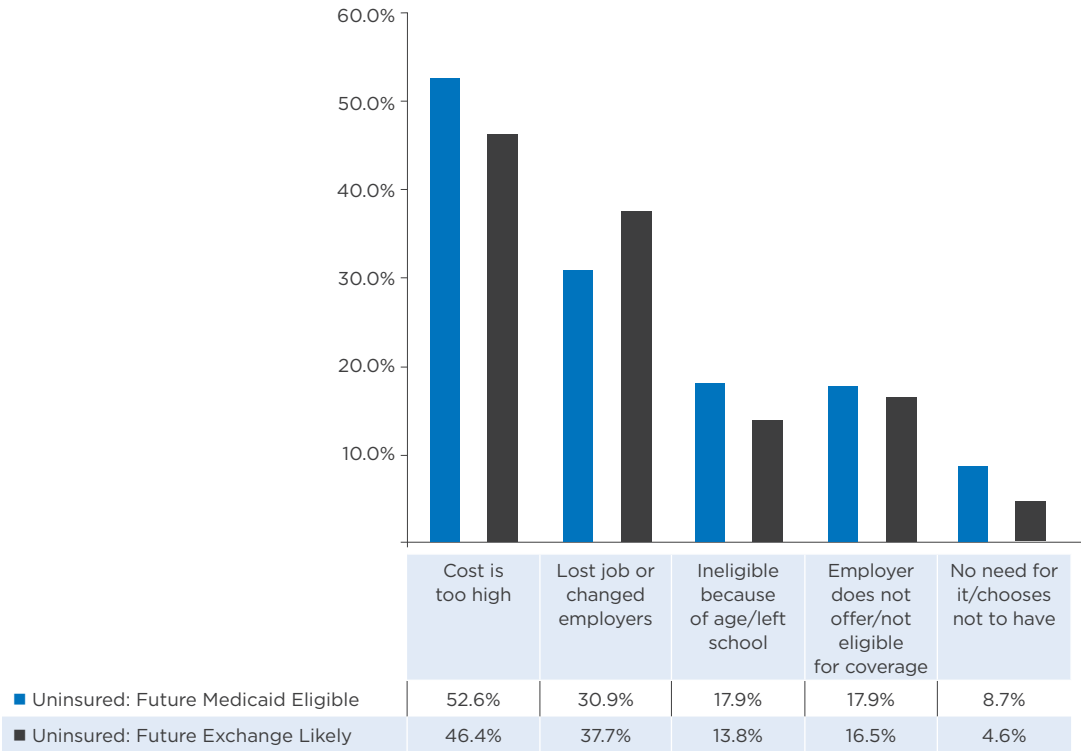
Figure 23: Insurance History Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

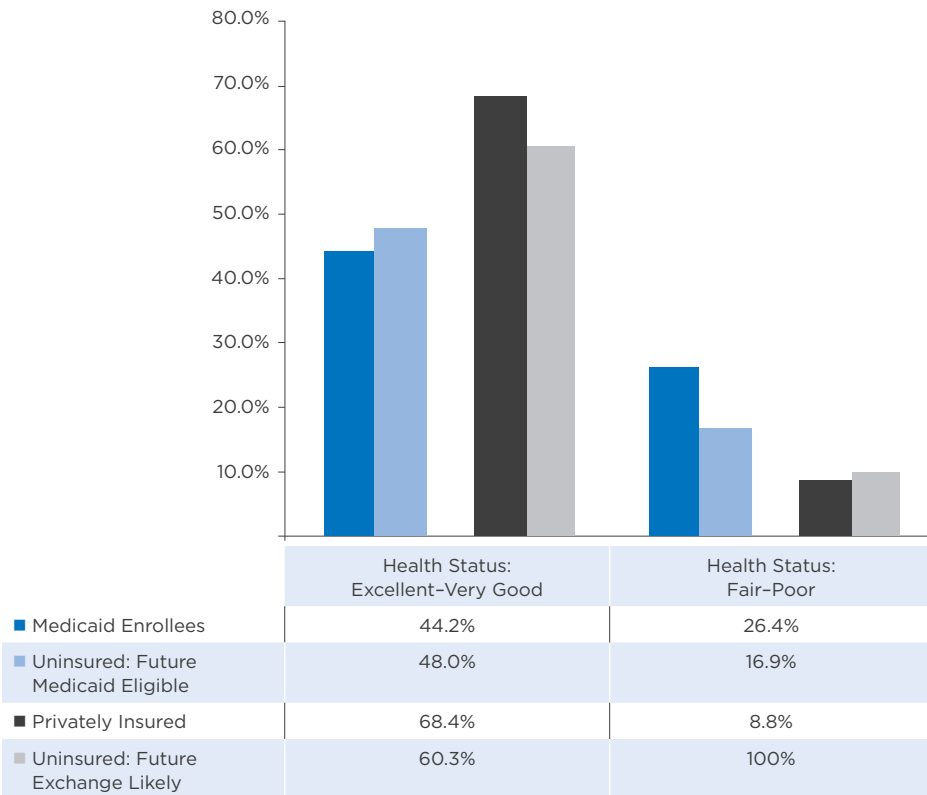
About 60 percent of the future Medicaid eligibles report being without insurance for 3+ years, or never having insurance (Figure 23). For future exchange likely adults that figure is about 50 percent. For both groups, cost is the dominant reason for uninsurance, followed by job loss or job change (Figure 24). A small percentage reports being uninsured because of a perceived lack of need.

Figure 24: Uninsurance Reasons Profile of the Newly Eligible



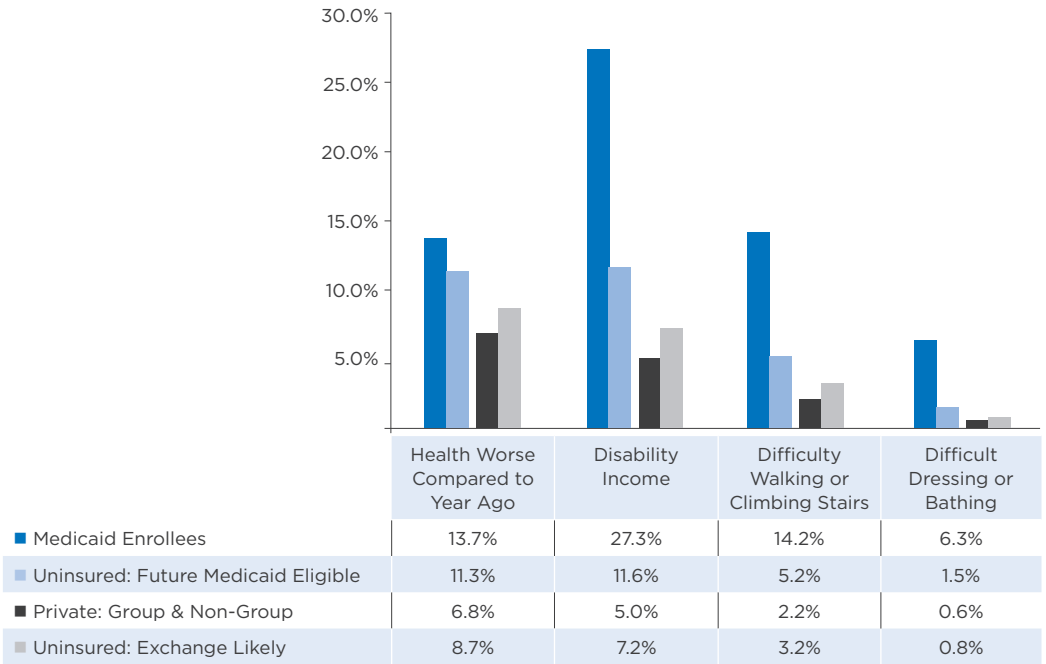
Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 25: Health Status Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

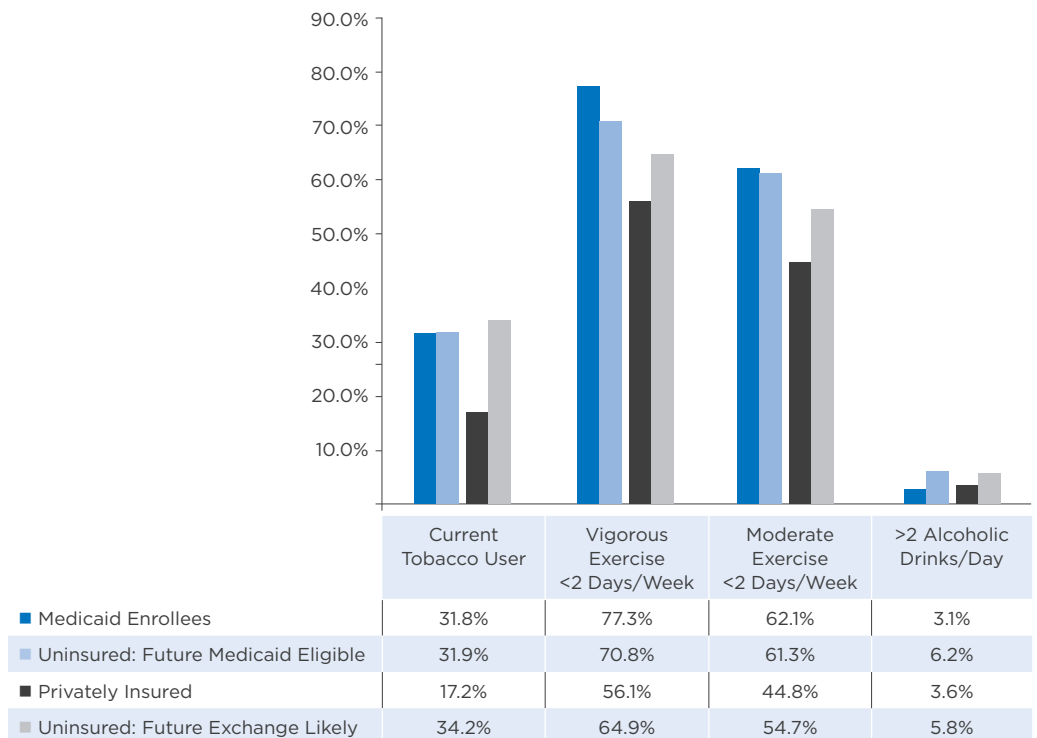
Figure 26: Disability/ADL Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Future Medicaid eligibles report lower levels of fair or poor health status than do future Medicaid eligibles, while future exchange likely adults report higher levels in comparison to privately insured adults (Figure 25). Current Medicaid enrollees report higher levels of disability (aliased by presence of disability income) and issues with activities of daily living (ADLs) than do future Medicaid eligibles (Figure 26). Future exchange likely adults report slightly higher levels of disability and ADL issues than those privately insured.

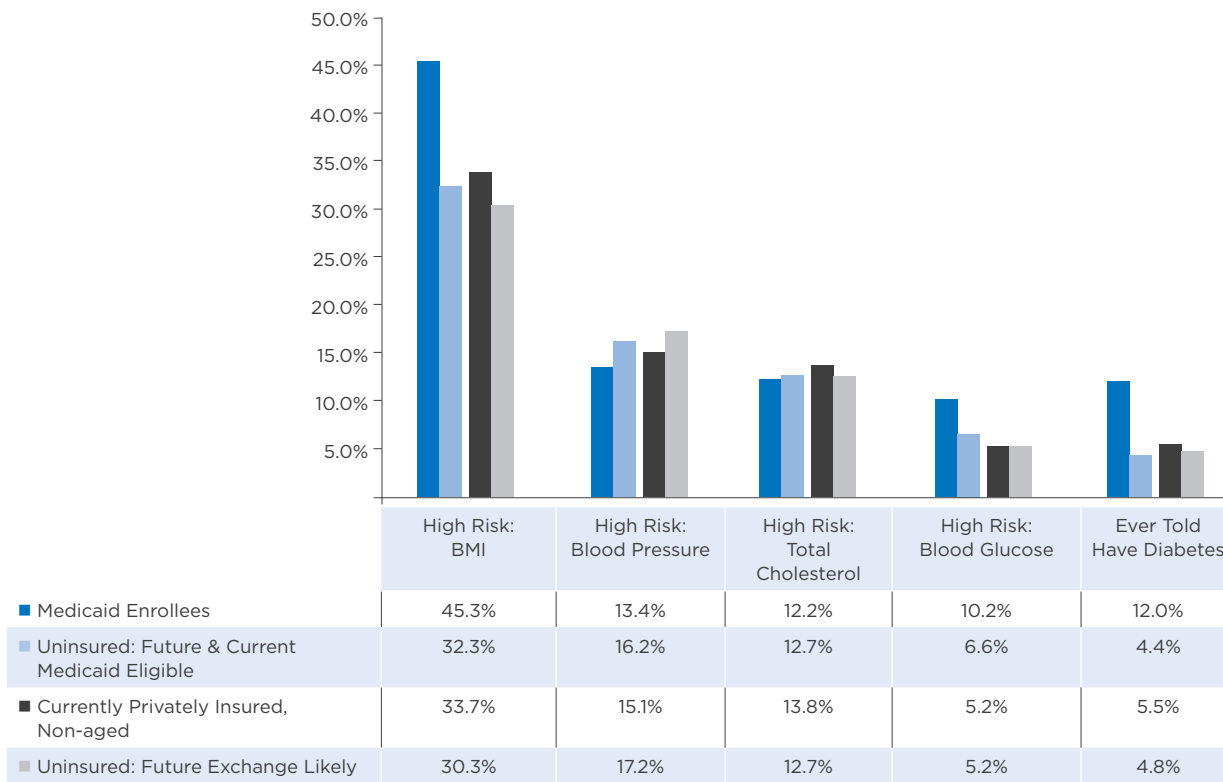
Figure 27: Health-Risk Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

From the perspective of behavioral health risks, future exchange likely adults are much more likely to use tobacco and are less likely to exercise regularly than those privately insured (Figure 27). Future Medicaid eligibles and current Medicaid enrollees have similar risk profiles. The levels of tobacco use and lack of exercise are high for both Medicaid groups compared to all U.S. non-elderly adults.

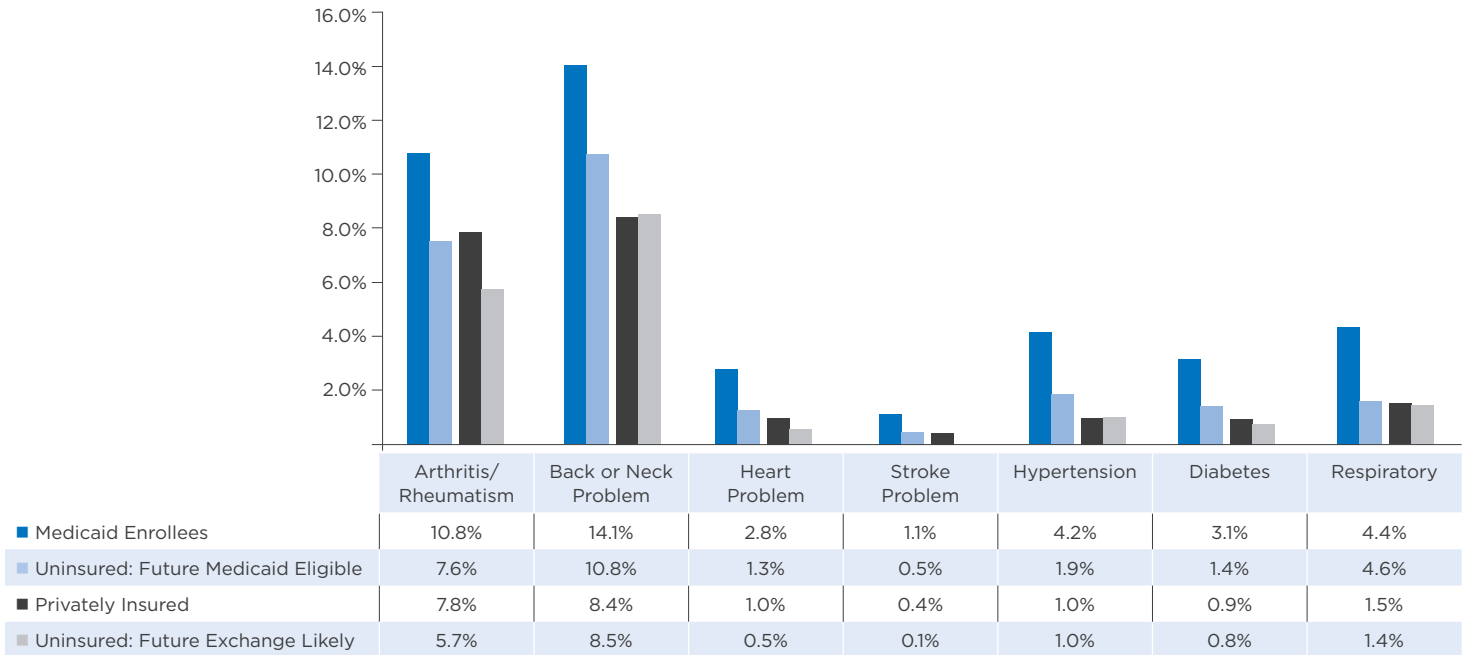
Figure 28: Biometric Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Turning to biometric risks, future Medicaid eligibles have lower rates of obesity, blood glucose, and self-reported diabetes than do current Medicaid enrollees (Figure 28). The biometric profiles for those privately insured and future exchange likely are similar.

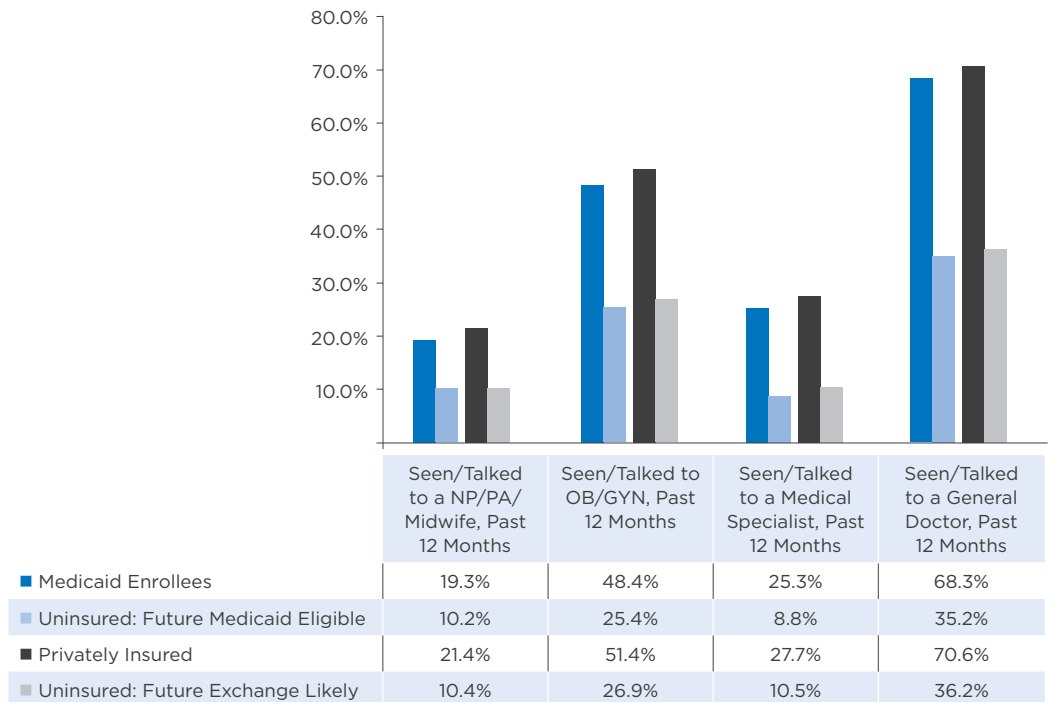
Figure 29: Condition Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Future Medicaid eligibles are much less likely to report chronic conditions than current enrollees (Figure 29). Future exchange likely adults report lower levels of arthritis and heart disease than those currently privately insured, perhaps reflecting the slightly younger age of the future exchange likely group.

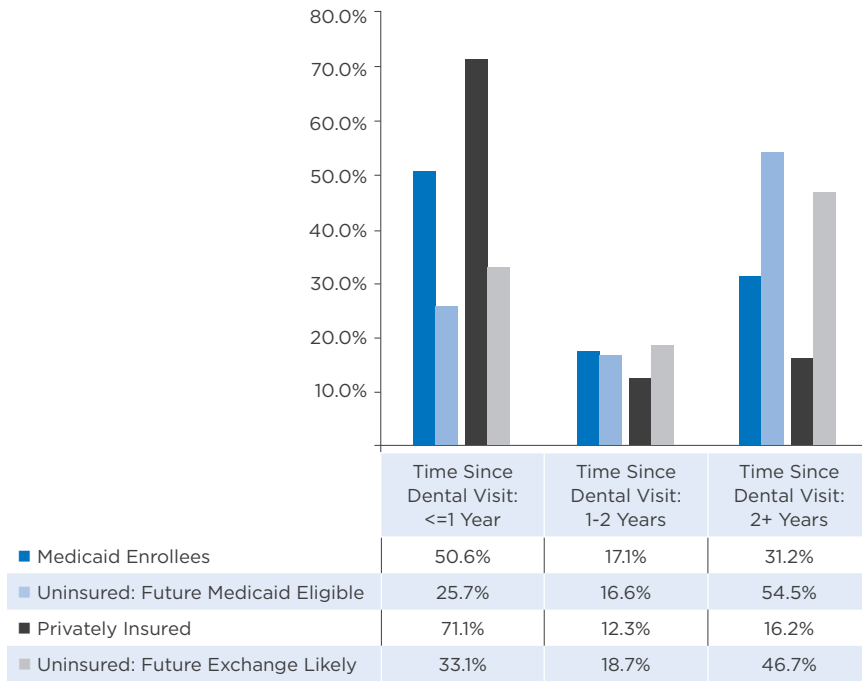
Figure 30: Medical Services Utilization Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

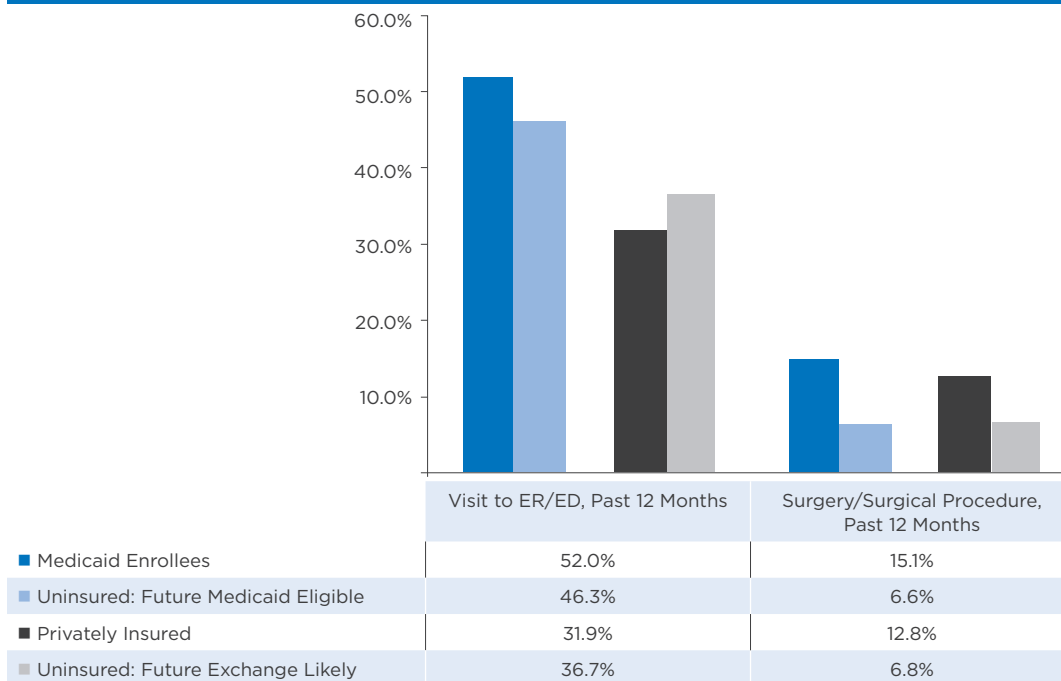
Future Medicaid eligibles and future exchange likely adults use medical professional services at much lower rates than their comparison groups (Figure 30). The same two groups also use dental professional services at lower rates than their insured counterparts (Figure 31). Interestingly, future Medicaid eligibles and future exchange likely adults use hospital emergency department services at roughly the same rates as their insured counterparts (Figure 32). However, they have lower rates of surgical procedures.

Figure 31: Dental Services Utilization Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Figure 32: Hospital Services Utilization Profile of the Newly Eligible



Source: Truven Health AnalyticsSM Insurance Coverage Estimates

Discussion

What should we conclude about planning for care of the newly insured? Reasonable estimates of coverage-volume changes can be produced and modified over time as implementation of the ACA plays out. The main unknown factor from our viewpoint is how the behavior of those newly eligible will change when they gain coverage. While we observe some favorable differences in the health profiles of the newly eligible compared to those under coverage today, these differences are due to a combination of underlying differences in health status/morbidity, undiagnosed or untreated ailments, and access barriers.

Research is scarce on the utilization impacts of newly acquired insurance coverage, but that which exists suggests some increase in utilization when (subsidized) coverage is available. Baicker et al reported that Medicaid coverage (versus lack of insurance) increases the use of outpatient care by 35 percent, prescription drugs by 15 percent, and hospital inpatient care by 30 percent, based on findings from the Oregon Medicaid lottery of 2008.¹⁵ Note that individuals receiving coverage under the lottery had actively sought Medicaid coverage and were on a waiting list. In a study of previously uninsured adults who obtain Medicare coverage, McWilliams et al found that coverage increased doctor visits by 13 percent, hospitalizations by 20 percent, and total medical expenditures by 51 percent.¹⁶ These findings held for beneficiaries with hypertension, diabetes, heart disease, or stroke. There were no significant differences for all other patients.

When we analyze health status and disability information for the newly insured, we find a complex picture. Future Medicaid eligibles appear to be somewhat healthier than current Medicaid enrollees, while future exchange likely adults appear to be somewhat less healthy. Yet both newly eligible groups use services at much lower rates than currently enrolled adults.

In addition, we found that at least half of future eligible adults had been without coverage for significant periods of time. Cost of insurance was by far the dominant reason for lack of coverage. Moreover, among the least frequently cited reasons for uninsurance was perceived lack of need for coverage. This suggests that the newly eligible may have deferred care or may have health issues that have been undiagnosed due in part to low rates of encounters with medical professionals, which in turn may be related to access barriers associated with lack of insurance. Thus, while the population profiles of the newly eligible portray some characteristics of enrollees or patients with lower costs of care, this advantage is likely overstated.

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