How Will Health Care Reform Affect Costs and Coverage?

Examples from Five States

The Patient Protection and Affordable Care Act (ACA) contains substantial new requirements aimed at increasing rates of health insurance coverage. These include

- mandatory expansion of Medicaid programs to cover individuals in households with incomes below 133 percent of the federal poverty level ($14,484 for a single person and $29,726 for a family of four in 2010)
- a requirement that states develop and run health insurance exchanges through which individuals and small businesses can purchase health care coverage
- a provision that large and mid-sized employers—including state governments—must provide qualifying coverage to employees or face the possibility of penalties
- a requirement that most individuals purchase or otherwise obtain coverage.[1]

Because many of these provisions impose additional costs on state governments, officials need reliable estimates of the likely impact of the ACA in their state.

Decisionmakers often use models, which are simplified mathematical representations of systems, to help them understand the effects of policy choices. To demonstrate the usefulness of modeling for state-level decisionmaking, RAND researchers undertook a preliminary analysis

[1] The act also involves substantial changes to Medicare, insurance regulation, and other aspects of health care that could substantially impact state and private-sector costs and coverage. These factors were not included in the RAND analysis.

Key findings:

- The percentage of the state population with health care coverage will increase significantly in all five example states.

- The percentage of employees offered insurance will not change substantially, but a small number of employees in small firms (defined as those with under 100 employees in 2016) will obtain employer-sponsored insurance through the state insurance exchanges.

- Substantial numbers of the nonelderly will choose to buy coverage through the exchanges.

- In most cases, the majority of new Medicaid enrollees will be newly eligible, but increased enrollment of those previously eligible will cost the states more because the federal government heavily subsidizes newly eligible enrollees.

- Total state government health care spending will increase in four of the states. Spending will decrease in Connecticut because some low-income individuals previously covered under the state's own insurance plan will now be covered under Medicaid, and the federal government will pay a large portion of their costs.

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of how the ACA's key coverage-related provisions would affect insurance coverage and state government health care spending in five states—California, Connecticut, Illinois, Montana, and Texas. These states were chosen because they provide a good geographical distribution. They range in size from the two largest states (California and Texas) to one of the smaller ones (Montana).

The analysis used a microsimulation model developed by RAND for the COMPARE (*Comp*rehensive *A*ssessment of *R*eform *Ef*forts) initiative. The model uses publicly available data to estimate how various coverage-expansion policies affect the number of people who newly obtain and/or change sources of health insurance, the types of plans in which they enroll, and changes in private- and public-sector spending. The model is designed to help elected officials and policymakers at the federal and state levels anticipate the choices that will likely be made by individuals, employers, insurance companies, and governments as various provisions of the ACA are implemented.

The table summarizes the state-specific estimates resulting from the modeling effort. Results were estimated for each year from 2011 to 2020. Most of the estimates in the table are for 2016, the year in which all of the provisions in the ACA related to coverage expansion will be fully implemented. The projections of increases and decreases shown in the table are all relative to what would be the case in the absence of the ACA. ∎

Coverage and Cost Effects of the Affordable Care Act: Summary of State-Specific Estimates

All estimates of change are relative to what would have been the case in the absence of the ACA.

	Estimate	California[a]	Connecticut	Illinois	Montana	Texas[a]
1	Increase in the percentage of the state population with insurance, 2016	From 80% to 96%	From 89% to 95%	From 85% to 97%	From 82% to 97%	From 72% to 94%
2	Increase in the number of the state population newly insured, 2016	6 million	170,000	1.3 million	125,000	5 million
3	Change in the percentage of employees offered employer-sponsored insurance, 2020	2% decrease	No substantial change	No substantial change	No substantial change	No substantial change
4	Number of employees obtaining employer-provided coverage through the state health insurance exchange, 2020	500,000	40,000	60,000	20,000	190,000
5	Percentage of the insured, nonelderly population obtaining coverage through the state health insurance exchange, 2016	17% (6 million)	10% (310,000)	11% (1.1 million)	20% (140,000)	18% (4 million)
6	Percentage increase in enrollment in Medicaid, 2016	58% (3.6 million)	31% (130,000)	49% (770,000)	51% (58,000)	80% (2.7 million)
7	Percentage change in cumulative state government health care spending, 2011–2020	7% increase	10% decrease	10% increase	3% increase	10% increase
8	Change in annual total state government health care spending, 2016 and 2020	2016: $2 billion increase; 2020: $4 billion increase	2016: $300 million decrease; 2020: $290 million decrease	2016: $700 million increase; 2020: $1.3 billion increase	2016: $10 million increase; 2020: $40 million increase	2016: $600 million increase; 2020: $2.5 billion increase
9	Additional state government health care spending per newly insured person in state, 2016	$333	None	$540	$83	$120

[a] The model does not account for undocumented immigrants living in California and Texas. Some, but not all, undocumented immigrants were included in the microsimulation model. Most of these individuals will be prevented from obtaining Medicaid or subsidized exchange coverage. To the extent that the model estimated that these individuals *would* obtain coverage and therefore engender additional state Medicaid costs, estimates of the increased rate of coverage and associated costs to the state governments in California and Texas will be high (by as much as 23 percent for California and 17 percent for Texas), relative to a model that was able to accurately distinguish undocumented immigrants from legal residents.

Guide to the Table

Rows 1 and 2: The percentage of the nonelderly population who will have health insurance will increase substantially in all five states, with associated large increases in the number of newly insured.

Rows 3 and 4: The ACA will have only a slight effect on the overall percentage of employees offered employer-sponsored insurance, but a small number of employees in small firms will obtain their employer-sponsored insurance through the state insurance exchanges.

Row 5: Substantial numbers of the nonelderly will choose to buy coverage through the state insurance exchanges.

Rows 6 and 7: The expansion in Medicaid enrollment has two sources: individuals who are newly eligible under the ACA and those who were previously eligible but enrolled only after implementation of the ACA, possibly because of the law's individual mandate. Although the newly eligible group is typically the larger of the two, the previously eligible enrollees are more costly to the states because the federal government pays a substantial portion of the costs for newly eligible enrollees (100 percent in 2014, decreasing gradually to 90 percent in 2020 and beyond) but only the regular share for the previously eligible (between 62 and 78 percent in these five states in 2010).

Connecticut is the exception to this pattern. Its total health care spending will decrease under the ACA because some low-income individuals previously covered under the state's own insurance plan (State-Administered General Assistance) will, under the ACA, be covered by Medicaid. Since new enrollees are heavily subsidized by the federal government, their enrollment in Medicaid will save the state government money.

Row 8: Total state government health care spending will increase in four of the states. Spending will decrease in Connecticut because some low-income individuals previously covered under the state's own insurance plan will now be covered under Medicaid, and the federal government will pay a large portion of their costs.

Row 9: This row shows the net change in state costs in 2016 (reported in row 8) divided by the additional number of insured individuals (row 2). The main reason that these numbers vary substantially by state is the differing proportions of new Medicaid enrollees who will be newly eligible versus those who were previously eligible.

This research highlight summarizes RAND Health research reported in the following publications:

Auerbach D, Nowak S, Ringel JS, Girosi F, Eibner C, McGlynn EA, and Wasserman J, *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut: An Analysis from RAND COMPARE*, Santa Monica, Calif.: RAND Corporation, TR-973/1-CSG, 2011, available at http://www.rand.org/pubs/technical_reports/TR973.1.html.

Auerbach D, Nowak S, Ringel JS, Girosi F, Eibner C, McGlynn EA, and Wasserman J, *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Montana: An Analysis from RAND COMPARE*, Santa Monica, Calif.: RAND Corporation, TR-973/2-CSG, 2011, available at http://www.rand.org/pubs/technical_reports/TR973.2.html.

Auerbach D, Nowak S, Ringel JS, Girosi F, Eibner C, McGlynn EA, and Wasserman J, *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in California: An Analysis from RAND COMPARE*, Santa Monica, Calif.: RAND Corporation, TR-973/3-CSG, 2011, available at http://www.rand.org/pubs/technical_reports/TR973.3.html.

Auerbach D, Nowak S, Ringel JS, Girosi F, Eibner C, McGlynn EA, and Wasserman J, *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Texas: An Analysis from RAND COMPARE*, Santa Monica, Calif.: RAND Corporation, TR-973/4-CSG, 2011, available at http://www.rand.org/pubs/technical_reports/TR973.4.html.

Auerbach D, Nowak S, Ringel JS, Girosi F, Eibner C, McGlynn EA, and Wasserman J, *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Illinois: An Analysis from RAND COMPARE*, Santa Monica, Calif.: RAND Corporation, TR-973/5-CSG, 2011, available at http://www.rand.org/pubs/technical_reports/TR973.5.html.

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