THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

State and Local Coverage Changes under Full Implementation of the Affordable Care Act

July 2013

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The Urban Institute

Introduction

The Affordable Care Act (ACA) of 2010 includes a number of new policies intended to substantially reduce the number of people without health insurance. Key provisions to be implemented in 2014 include new health insurance exchanges, subsidies for coverage in those exchanges, health insurance market reforms, and an individual mandate. The ACA also includes an expansion of Medicaid coverage to individuals with incomes up to 138 percent of the Federal Poverty Level ($15,856 for an individual or $26,951 for family of three in 2013).[1] The Medicaid expansion under the ACA became a state option following the Supreme Court ruling in June of 2012. At this point, it is not clear how many states will elect to expand Medicaid coverage.[2] If all states were to do so, enrollment in Medicaid is projected to increase nationwide by about 18.1 million and the uninsured would decline by 23.1 million.[3]

This brief provides highlights from new state and sub-state estimates of how the number and composition of individuals enrolled in Medicaid/CHIP would change with full implementation of the ACA, including the Medicaid expansion (see kff.org/zooming-in-ACA). These estimates provide more detail on the projected coverage changes under the ACA at the state level than in prior research.[4] They also provide new information on the expected coverage changes resulting from the ACA at the local level in all states. This analysis demonstrates that there is substantial variation across and within states in the magnitude and composition of the population that is projected to gain Medicaid coverage under the ACA. These estimates also provide guidance on the areas that are likely to experience the largest declines in the uninsured and where the residual uninsured are likely to be concentrated.

Methods

The analysis uses the Urban Institute's American Community Survey - Health Insurance Policy Simulation Model (ACS-HIPSM). This model simulates decisions of individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms, using data from the American Community Survey (ACS). The estimates draw on a sample of approximately 7.5 million individuals from combined 2008, 2009, and 2010 ACS data. All three years of data were combined to achieve sufficient precision at both the state and local level. The data was reweighted so that the distribution of the population by age, race, and sex in the pooled file matches 2011 population estimates published by the Census Bureau. For more detail on the ACS-HIPSM model and the methods underlying this analysis, see the Methods Appendix. For further information, see http://www.urban.org/UploadedPDF/412841-American-Community-Survey-Health-Insurance-Policy-Simulation-Model.pdf.

Medicaid Enrollment Increases under the ACA

The demographic composition of Medicaid enrollees shifts under the ACA

Nationally, our model projects a 37.4 percent increase in Medicaid/CHIP enrollment under the ACA, with total enrollment rising from 48.3 million to 66.4 million.[5] This enrollment includes both people newly-eligible for Medicaid coverage and also new enrollment among adults and children currently eligible for Medicaid coverage but not enrolled. The composition of individuals gaining Medicaid enrollment is projected to differ from the current distribution of individuals covered by Medicaid/CHIP, primarily due to the increased coverage of nonelderly adults, particularly those without dependent children, who have historically been excluded from coverage.[6] For example, 78.0 percent of new enrollees are adults, compared to 39.3 percent of current enrollees (Exhibit 1). Children will represent a smaller share of Medicaid/CHIP beneficiaries than they currently do. Currently, children represent a majority of enrollees in 45 states, but after the ACA implementation, only 24 states will have more than half of their enrollees under the age of 19 (data not shown).

New Medicaid enrollees will also differ from current enrollees in terms of their race/ethnicity as well as language spoken at home. For example, 55.0 percent of new Medicaid/CHIP enrollees are white non-Hispanic, compared to 43.1 percent of current enrollees (Exhibit 1). With full implementation of the ACA, the share of the Medicaid/CHIP population that would be living in a Spanish-speaking household is expected to decline.[7] Specifically, 71.8 percent of new enrollees live in households in which all adults speak only English at home compared to 66.0 percent of current Medicaid/CHIP enrollees.

Exhibit 1: Demographic Composition of Medicaid/CHIP Enrollees (0 to 64), Pre and Post Affordable Care Act Implementation With All States Expanding Medicaid

	Pre-ACA Medicaid/ CHIP	Post-ACA Medicaid/ CHIP	New Medicaid/ CHIP
Total (in 1,000's)	**48,326**	**66,378**	**18,177**
		Share	
Age			
Age 0 to 18	60.7%	50.2%	22.0%
Age 19 to 24	6.1%	10.8%	23.2%
Age 25 to 44	17.8%	21.5%	31.2%
Age 45 to 64	15.4%	17.6%	23.5%
Race			
White	43.1%	46.3%	55.0%
Black	21.4%	20.2%	17.0%
Hispanic	27.6%	25.7%	20.5%
Other Race	7.9%	7.8%	7.5%
Gender			
Male	46.1%	47.5%	51.1%
Female	53.9%	52.5%	48.9%
Language Spoken at Home			
Only English Spoken at Home among Adult Household Members	66.0%	67.6%	71.8%
Only Spanish Spoken at Home among Adult Household Members	21.3%	19.6%	15.1%
English and Another Language Spoken at Home among Adult Household Members	5.2%	5.6%	6.5%
Other Languages Spoken at Home among Adult Household Members	7.4%	7.2%	6.5%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for definitions of each demographic group and details on data and methods.

Medicaid enrollment increases across and within states under the ACA

Our model projects that with full implementation of the Medicaid expansion under the ACA, Medicaid enrollment increases will vary substantially across states.[8] A total of 14 states are projected to experience enrollment increases in excess of 50 percent,[9] while seven states are projected to expand their Medicaid/CHIP enrollment by less than 20 percent under the ACA (Exhibit 2).[10] The current differences among states in the expansiveness of Medicaid/CHIP eligibility for adults are reflected in the varying projected changes in Medicaid/ CHIP growth among adults. Overall, Medicaid/CHIP enrollment is expected to increase among adults by 74.1 percent, ranging from under 15 percent in New York and Vermont to over 150 percent in Montana, Nevada and Idaho (Exhibit 2).[11] Exploratory multivariate analysis indicates that higher Medicaid/CHIP enrollment growth is projected in states with a smaller share of their population enrolled in Medicaid/CHIP at baseline and a higher proportion of individuals with incomes below 138 percent of the FPL (data now shown).[12]

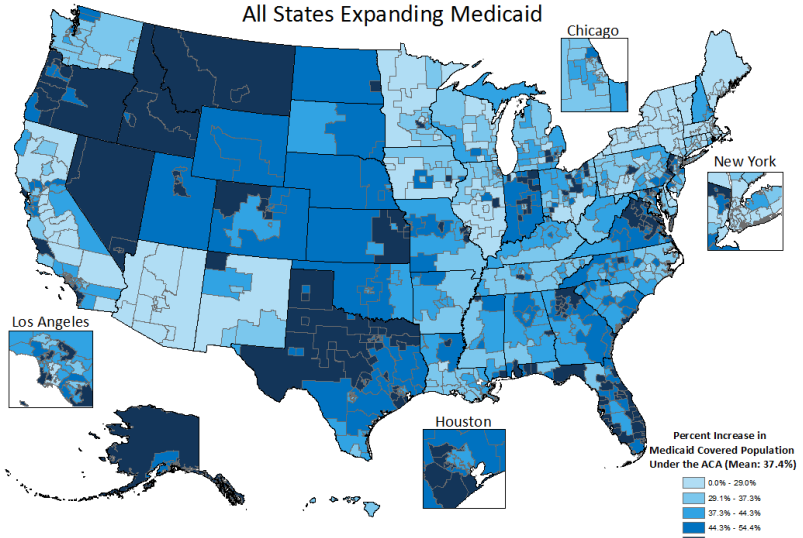
Exhibit 2: Increase in Number (0 to 64) with Medicaid/CHIP Coverage with All States Expanding Medicaid

State	Nonelderly (0-64)				Adults (19-64)
	Medicaid Enrollment at Baseline (1000's)	Medicaid Enrollment Under Reform (1000's)	Number Change (1000's)	Percent Change (%)	Percent Change (%)
United States	**48,326**	**66,378**	**18,052**	**37.4%**	**74.1%**
Nevada	254	445	191	75.4%	161.4%
Montana	119	204	85	71.2%	154.4%
Idaho	206	331	125	60.7%	172.1%
Oregon	497	787	290	58.4%	118.0%
North Dakota	57	89	32	57.4%	116.0%
Florida	2,475	3,875	1,400	56.5%	123.7%
Utah	306	475	169	55.5%	108.5%
Kansas	326	497	171	52.6%	125.6%
Alaska	99	151	52	52.2%	119.0%
Georgia	1,464	2,215	751	51.3%	141.6%
Virginia	783	1,185	401	51.2%	114.8%
Texas	3,876	5,841	1,965	50.7%	147.5%
Colorado	585	881	296	50.6%	102.8%
Wyoming	61	92	31	50.2%	131.4%
Nebraska	214	314	99	46.3%	118.3%
South Carolina	718	1,048	330	45.9%	99.6%
Indiana	939	1,369	430	45.8%	92.3%
Missouri	870	1,268	398	45.8%	95.5%
South Dakota	112	163	51	45.7%	128.8%
Alabama	784	1,136	352	44.9%	106.0%
New Hampshire	136	196	60	43.9%	89.1%
Oklahoma	596	857	260	43.7%	114.4%
North Carolina	1,485	2,096	611	41.1%	98.7%
Mississippi	614	859	245	40.0%	95.7%
Hawaii	171	239	68	39.8%	68.0%
Louisiana	858	1,196	338	39.4%	104.9%
West Virginia	316	439	123	39.1%	77.5%
Kentucky	749	1,039	290	38.7%	83.7%
Arkansas	555	766	211	38.0%	107.6%
Ohio	1,757	2,423	666	37.9%	71.7%
Tennessee	1,118	1,534	415	37.1%	74.1%
Maryland	697	953	256	36.8%	77.5%
California	6,747	9,208	2,461	36.5%	72.8%
Washington	1,020	1,386	366	35.9%	70.8%
Michigan	1,729	2,340	611	35.3%	68.3%
New Jersey	1,035	1,401	366	35.3%	61.0%
New Mexico	448	603	155	34.5%	76.8%
Pennsylvania	1,886	2,518	633	33.5%	60.0%
Illinois	2,099	2,794	696	33.2%	69.4%
Iowa	421	558	138	32.7%	61.9%
Wisconsin	858	1,120	262	30.5%	50.0%
Minnesota	716	923	206	28.8%	37.7%
Rhode Island	162	205	43	26.8%	41.4%
Connecticut	493	625	132	26.7%	43.7%
District of Columbia	143	170	28	19.4%	31.4%
Maine	273	323	50	18.4%	29.8%
Arizona	1,274	1,506	232	18.2%	22.8%
Delaware	148	171	23	15.4%	20.8%
New York	3,784	4,267	482	12.7%	13.9%
Vermont	135	139	4	2.7%	-1.0%
Massachusetts	1,159	1,159	0	0.0%	0.0%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for details on data and methods.

The increases in Medicaid/CHIP enrollment projected under the ACA relative to current levels vary not only by state, but also across areas within states (Exhibit 3). State boundaries can only account for approximately 60 percent of the total variation in Medicaid/CHIP enrollment growth seen across areas.[13] In many states, areas of both high and low Medicaid/CHIP enrollment growth are found. California, where the median area in terms of Medicaid/CHIP enrollment growth is 38.5 percent, contains one local area with 111.2 percent projected growth in enrollment and another with 21.1 percent projected growth, which is below the national median (Exhibit 4).

Exhibit 3: Increase in Medicaid/CHIP Population (0 to 64) Under ACA with All States Expanding Medicaid



Source: Urban Institute Analysis, ACS- HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS).
Notes: See text for details on how geographies are defined and details on data and methods.

Outside of Massachusetts, Medicaid/CHIP enrollment is anticipated to increase in each area of the country under the ACA, particularly among adults who may not have been eligible in the past. Nearly 40 percent of all local areas are projected to experience a doubling of their adult Medicaid/CHIP population, while 20 areas across the nation are expected to experience a tripling of their adult Medicaid/CHIP population under the ACA (data not shown).[14] Most of the areas with large projected increases in their adult Medicaid/CHIP population are in states that are expected to experience well above average enrollment increases in Medicaid/CHIP.

Medicaid demographic composition changes on the local level

There is also local area variation in the composition of Medicaid enrollment after ACA implementation. For example, the share in Spanish-speaking households varies substantially across local areas, and areas in seven different states are expected to have at least half of their post-ACA Medicaid enrollees in households in which the adults speak only Spanish [Arizona (3 areas), California (22 areas), Florida (4 areas), New Jersey (2 areas), New York (2 areas), and Texas (10 areas)]. These areas face an increase in the number of Medicaid enrollees with potential linguistic barriers to both enrollment and care. For some areas with a large share of the projected Medicaid population in Spanish speaking households after ACA implementation, this will represent a major increase in the number of Medicaid enrollees with potential linguistic barriers. For example, in the Kendall/ Kendale Lakes/ Tamiami area of Florida, the Medicaid population in Spanish speaking households would be projected to increase by 60.4 percent (Exhibit 5).

Exhibit 4: Distribution of Percent Change of Area-level Medicaid/CHIP Coverage Under the ACA with All States Expanding Medicaid, by State

State	Nonelderly (0-64) Area with Largest Percentage Change in Medicaid/CHIP	Nonelderly (0-64) Area with Smallest Percentage Change in Medicaid/CHIP	**Median Medicaid/CHIP Increase Across the State**
United States	**111.2%**	**0.0%**	**40.8%**
Nevada	102.1%	62.1%	77.5%
North Dakota	98.2%	48.2%	73.2%
Montana	74.9%	65.7%	68.5%
Idaho	71.4%	45.9%	61.4%
Florida	89.0%	33.3%	57.6%
Oregon	67.3%	47.1%	55.3%
Texas	97.5%	34.1%	54.5%
Utah	65.2%	46.9%	54.3%
Alaska	56.2%	49.1%	52.6%
Georgia	76.4%	36.4%	51.0%
Wyoming	52.2%	48.5%	50.3%
Virginia	84.3%	40.3%	49.7%
Kansas	81.3%	41.2%	48.7%
Missouri	90.8%	31.9%	48.5%
Nebraska	59.3%	43.1%	48.2%
Indiana	92.9%	27.5%	48.1%
Colorado	86.2%	39.7%	47.7%
South Dakota	52.6%	38.8%	47.6%
South Carolina	61.9%	37.3%	46.7%
Oklahoma	49.1%	37.5%	44.5%
New Hampshire	46.4%	43.5%	43.7%
Alabama	74.1%	37.0%	43.2%
Mississippi	67.8%	32.3%	42.0%
West Virginia	42.4%	35.2%	41.9%
North Carolina	57.1%	26.6%	40.6%
Maryland	60.6%	25.9%	40.6%
Kentucky	54.2%	31.4%	40.3%
Ohio	71.3%	26.7%	39.8%
Louisiana	55.4%	22.1%	38.8%
Arkansas	50.7%	33.7%	38.7%
California	111.2%	21.1%	38.5%
Michigan	66.4%	22.7%	38.4%
New Jersey	82.1%	22.7%	38.1%
Tennessee	63.1%	31.6%	37.8%
Hawaii	49.5%	34.6%	35.7%
Washington	58.6%	22.7%	35.1%
Rhode Island	41.8%	23.3%	34.9%
Pennsylvania	59.0%	20.0%	33.3%
New Mexico	58.6%	28.5%	32.4%
Illinois	62.5%	25.3%	32.2%
Iowa	62.8%	26.3%	31.9%
Wisconsin	46.3%	21.5%	29.7%
Minnesota	57.4%	22.2%	29.1%
Connecticut	36.1%	18.6%	27.6%
District of Columbia	35.6%	11.6%	23.6%
Arizona	26.2%	12.4%	18.2%
Maine	22.3%	13.3%	15.6%
New York	42.2%	3.8%	15.5%
Delaware	16.9%	13.6%	13.7%
Vermont	3.1%	2.4%	2.8%
Massachusetts	0.0%	0.0%	0.0%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for details on data and methods.

Exhibit 5: Top 50 Areas by Share of Medicaid/ CHIP Population in a Spanish Speaking Household with All States Expanding Medicaid

Rank	Area Name	Total Number (1000's)	Share	Percent Increase	State	Share in State
1	Webb County	85	93.5%	38.5%	Texas	43.7%
2	Hidalgo County	275	90.9%	32.2%	Texas	43.7%
3	South Gate/ Florence-Graham/ Huntington Park Area	214	82.8%	27.2%	California	43.1%
4	El Paso County	208	82.4%	42.0%	Texas	43.7%
5	Kendall/ Kendale Lakes/ Tamiami Area	61	81.0%	60.4%	Florida	23.0%
6	Cameron County	131	78.6%	35.7%	Texas	43.7%
7	Kingsville/ Rio Grande City/ Raymondville Area	44	78.0%	38.6%	Texas	43.7%
8	Imperial County	49	78.0%	24.8%	California	43.1%
9	Yuma County	44	70.5%	16.5%	Arizona	32.9%
10	Miami/ Fountainebleau/ Doral Area	101	70.0%	53.7%	Florida	23.0%
11	Los Angeles/ Torrance Area	197	69.3%	20.6%	California	43.1%
12	Los Angeles/ Pasadena/ South Pasadena Area	139	67.4%	30.7%	California	43.1%
13	Los Angeles Area (Chatsworth, Granada Hills, Pacoima, North Hills)	106	65.4%	24.9%	California	43.1%
14	Salinas/ Hollister/ Seaside Area	78	63.9%	27.8%	California	43.1%
15	Del Rio/ Eagle Pass/ Kerrville Area	65	63.4%	42.5%	Texas	43.7%
16	New York Area (Tremont, Jerome Park, Morris Heights, Concourse,Woodstock)	251	62.8%	3.5%	New York	25.8%
17	Pasadena/ Houston/ Cloverleaf Area	117	60.8%	39.5%	Texas	43.7%
18	Los Angeles Area (Shadow Hills, North Hollywood, Van Nuys)	80	60.4%	24.5%	California	43.1%
19	San Diego/ National City/ Imperial Beach Area	98	60.3%	36.2%	California	43.1%
20	Phoenix/ Tolleson/ Glendale Area	107	59.7%	15.7%	Arizona	32.9%
21	Irvine/ Garden Grove/ Santa Ana Area	113	59.1%	29.4%	California	43.1%
22	Anaheim/ Orange Area	69	58.7%	24.1%	California	43.1%
23	East Los Angeles/ Whittier/ Pico Rivera Area	91	58.4%	32.2%	California	43.1%
24	New York Area (Fort George, Manhattanville, Harlem, East Harlem)	127	58.3%	4.4%	New York	25.8%
25	Dona Ana County	42	57.8%	27.3%	New Mexico	31.4%
26	Country Club/ Aventura/ Miami Lakes Area	62	57.8%	64.1%	Florida	23.0%
27	Madera County	31	57.6%	12.8%	California	43.1%
28	Los Angeles Area (Koreatown, Adams-Normandie, Baldwin Hills-Crenshaw, Westchester)	90	57.6%	34.4%	California	43.1%
29	Houston/ Aldine Area	89	56.5%	36.6%	Texas	43.7%
30	Downey/ Norwalk/ Bellflower Area	89	56.0%	33.1%	California	43.1%
31	San Antonio/ Kirby/ Windcrest Area	98	55.9%	32.0%	Texas	43.7%
32	Pomona/ Baldwin Park/ Azusa Area	69	53.3%	26.6%	California	43.1%
33	Santa Barbara County	53	53.0%	20.8%	California	43.1%
34	El Monte/ Diamond Bar/ Rowland Heights Area	84	52.7%	25.5%	California	43.1%
35	Tulare County	91	52.7%	20.9%	California	43.1%
36	Ventura County	83	52.2%	24.9%	California	43.1%
37	Murrieta/ Temecula/ Indio Area	94	51.4%	31.8%	California	43.1%
38	Irving/ Grand Prairie/ Dallas Area	62	51.2%	49.1%	Texas	43.7%
39	Kings County	21	51.1%	24.5%	California	43.1%
40	Passaic County	65	50.8%	20.5%	New Jersey	26.8%
41	Inglewood/ Santa Monica/ Gardena Area	85	50.8%	28.2%	California	43.1%
42	The Hammocks/ Richmond West/ Key West Area	66	50.1%	51.2%	Florida	23.0%
43	Hudson County	72	50.1%	19.7%	New Jersey	26.8%
44	Phoenix Area	69	50.0%	10.7%	Arizona	32.9%
45	Perris/ Eastvale/ Lake Elsinore Area	78	49.6%	29.9%	California	43.1%
46	Fontana/ Ontario/ Chino Area	91	49.5%	33.1%	California	43.1%
47	New York Area (Astoria-Ditmars Steinway, East Corona, Corona, Sunnyside)	99	49.4%	6.3%	New York	25.8%
48	Merced County	48	49.1%	17.6%	California	43.1%
49	Cicero/ Berwyn/ Oak Park Area	54	49.0%	19.2%	Illinois	19.9%
50	Yakima County	41	48.4%	28.6%	Washington	15.1%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for details on data and methods.

Exhibit 6: Reduction in Number of Uninsured (0 to 64) Under the ACA with All States Expanding Medicaid

	Uninsured at Baseline		Uninsured Under Reform		Change	
State	**(1000's)**	**(%)**	**(1000's)**	**(%)**	**(1000's)**	**(%)**
United States	**48,971**	**18.1%**	**25,910**	**9.6%**	**-23,061**	**-47.1%**
West Virginia	272	17.4%	117	7.5%	-155	-57.0%
Montana	184	21.6%	80	9.4%	-104	-56.5%
Missouri	808	15.7%	354	6.9%	-454	-56.2%
Michigan	1,250	14.5%	557	6.5%	-693	-55.5%
South Dakota	106	15.2%	47	6.8%	-59	-55.5%
Louisiana	805	20.5%	361	9.2%	-445	-55.2%
Ohio	1,436	14.5%	646	6.5%	-790	-55.0%
Indiana	944	16.8%	428	7.6%	-516	-54.6%
North Dakota	68	12.1%	31	5.5%	-37	-54.6%
Wyoming	82	17.1%	37	7.8%	-44	-54.3%
Mississippi	544	21.1%	249	9.7%	-294	-54.1%
Kentucky	646	17.2%	296	7.9%	-349	-54.1%
Alaska	139	21.6%	64	9.9%	-75	-54.0%
Pennsylvania	1,300	12.1%	598	5.6%	-702	-54.0%
Arkansas	515	20.5%	241	9.6%	-274	-53.1%
Alabama	708	17.3%	333	8.1%	-375	-52.9%
Iowa	279	10.8%	132	5.1%	-148	-52.9%
Idaho	284	20.7%	134	9.7%	-150	-52.9%
New Hampshire	146	12.8%	70	6.1%	-76	-52.3%
Tennessee	931	16.9%	447	8.1%	-483	-51.9%
Maine	143	12.7%	69	6.1%	-74	-51.6%
Nebraska	219	13.9%	107	6.8%	-112	-51.1%
Kansas	380	15.4%	186	7.5%	-194	-51.1%
Oregon	684	20.6%	335	10.1%	-349	-51.1%
Hawaii	98	8.9%	48	4.4%	-50	-50.9%
Oklahoma	719	22.3%	355	11.0%	-364	-50.6%
Wisconsin	555	11.3%	277	5.6%	-278	-50.1%
South Carolina	816	20.5%	408	10.2%	-408	-50.0%
Virginia	993	14.3%	503	7.3%	-490	-49.3%
New Mexico	448	24.2%	228	12.3%	-220	-49.2%
Georgia	1,931	22.4%	983	11.4%	-949	-49.1%
Utah	434	17.0%	221	8.6%	-213	-49.1%
Florida	4,092	26.3%	2,117	13.6%	-1,975	-48.3%
North Carolina	1,610	19.5%	834	10.1%	-776	-48.2%
Washington	959	16.2%	500	8.4%	-459	-47.8%
Minnesota	485	10.4%	254	5.4%	-232	-47.7%
Texas	6,150	26.8%	3,270	14.3%	-2,880	-46.8%
District of Columbia	49	9.0%	27	4.9%	-22	-45.7%
Colorado	853	18.9%	464	10.2%	-389	-45.7%
Illinois	1,794	15.8%	980	8.6%	-814	-45.4%
Rhode Island	124	13.6%	68	7.5%	-56	-45.2%
California	7,177	21.2%	4,039	11.9%	-3,138	-43.7%
Connecticut	338	11.0%	191	6.2%	-147	-43.5%
Nevada	614	26.0%	348	14.7%	-266	-43.4%
Maryland	666	13.2%	382	7.6%	-284	-42.6%
New Jersey	1,172	15.3%	681	8.9%	-491	-41.9%
Delaware	96	12.5%	61	7.9%	-36	-37.1%
Arizona	1,190	20.9%	793	13.9%	-397	-33.4%
New York	2,373	13.9%	1,613	9.5%	-760	-32.0%
Vermont	54	10.0%	41	7.5%	-14	-25.0%
Massachusetts	307	5.4%	307	5.4%	0	0.0%

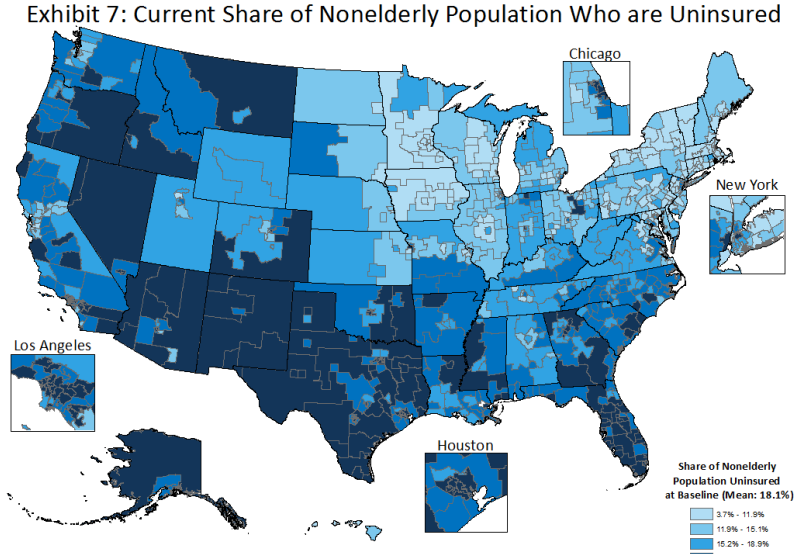
Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for details on data and methods.

Impact of the ACA on the Uninsured

Projected declines in the uninsured across and within states

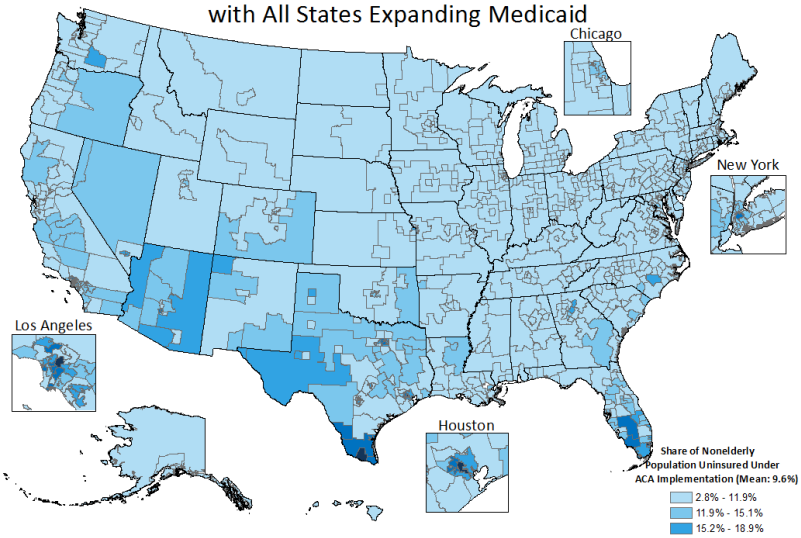
With full implementation of the ACA, the uninsured rate would decline by 47.1 percent nationally. Every state will experience a decrease in the uninsured of at least 25 percent, although it will vary as a consequence of different current uninsured rates and expected post-ACA uninsured rates.[15] Uninsured rates currently vary from under 10 percent in Massachusetts, Hawaii, and the District of Columbia, to over 25 percent in Texas and Nevada. They will vary less after reform, with every state below 15 percent, and 7 states below 6 percent (Exhibit 6).

Exhibit 7: Current Share of Nonelderly Population Who are Uninsured



Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS).
Notes: See text for details on how geographies are defined and details on data and methods.

Exhibit 8: Share of Nonelderly Population Uninsured Under ACA with All States Expanding Medicaid



Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS).
Notes: See text for details on how geographies are defined and details on data and methods.

The rates of uninsured also vary widely within certain states (Exhibit 7). Currently, 264 of the 781 local areas have an uninsured rate of 20 percent or higher. The ACA would greatly compress the distribution of uninsured rates across areas both within and between states (Exhibit 8). With the exception of MA, all areas are expected to experience a decrease in the number of uninsured under the ACA. Uninsured rates of over 20 percent are expected to persist in sixteen areas which are located in the four states of AZ, CA, FL, and TX (Exhibit 9). As would be expected, areas that are projected to experience larger declines in the number of uninsured are also projected to experience higher increases in Medicaid/CHIP enrollment.[16]

Characteristics of the uninsured under the ACA. The composition of the uninsured is also expected to change under the ACA. For example, proportionately fewer of the remaining uninsured will be between the ages of 19 and 24 nationwide. Additionally, a higher proportion of the remaining uninsured will be Hispanic and in Spanish-speaking households (Exhibit 10).

Exhibit 9: Share of Population (0 to 64) who would be Uninsured Under the ACA with All States Expanding Medicaid, Top 50 Areas

Rank	State	Area	Uninsurance Rate Pre-Implementation	**Uninsurance Rate Post-Implementation**	Percent Uninsurance Decline
1	Florida	Miami/ Fountainebleau/ Doral Area	40.6%	24.3%	40.1%
2	Texas	Pasadena/ Houston/ Cloverleaf Area	41.2%	24.3%	41.0%
3	Florida	Miami Beach/ North Miami/ West Little River Area	41.1%	24.2%	41.2%
4	Texas	Hidalgo County	39.8%	23.8%	40.1%
5	California	Los Angeles/ Pasadena/ South Pasadena Area	38.3%	23.1%	39.8%
6	Texas	Webb County	38.1%	21.9%	42.6%
7	Texas	Cameron County	39.5%	21.8%	44.7%
8	Arizona	Phoenix/ Tolleson/ Glendale Area	29.6%	21.8%	26.5%
9	Arizona	Phoenix Area	30.1%	21.6%	28.4%
10	Texas	Dallas/ Duncanville/ Cockrell Hill Area	38.4%	21.3%	44.5%
11	Texas	Houston/ Aldine Area	35.6%	21.2%	40.3%
12	California	South Gate/ Florence-Graham/ Huntington Park Area	35.2%	21.2%	39.9%
13	Florida	Country Club/ Aventura/ Miami Lakes Area	38.0%	21.1%	44.4%
14	California	Los Angeles/ Torrance Area	32.9%	21.0%	36.3%
15	California	Los Angeles Area (Koreatown, Adams-Normandie, Baldwin Hills-Crenshaw, Westchester)	34.1%	20.9%	38.8%
16	Texas	Kingsville/ Rio Grande City/ Raymondville Area	37.3%	20.0%	46.5%
17	Florida	Sebring/ Avon Park/ Arcadia Area	36.0%	19.8%	44.9%
18	New York	New York Area (Astoria-Ditmars Steinway, East Corona, Corona, Sunnyside)	28.0%	19.4%	30.8%
19	Texas	Houston Area	32.9%	19.3%	41.3%
20	Florida	Collier County	33.7%	19.2%	43.2%
21	Texas	Irving/ Grand Prairie/ Dallas Area	32.9%	19.2%	41.8%
22	California	Los Angeles Area (Shadow Hills, North Hollywood, Van Nuys)	31.5%	18.9%	39.9%
23	Texas	Dallas/ Mesquite/ University Park Area	33.7%	18.9%	44.0%
24	Nevada	Sunrise Manor/ Paradise/ Whitney Area	30.5%	18.2%	40.2%
25	Florida	West Palm Beach/ Jupiter/ Palm Beach Gardens Area	31.7%	17.8%	43.7%
26	Florida	The Hammocks/ Richmond West/ Key West Area	31.4%	17.8%	43.3%
27	Texas	Ector County	32.1%	17.4%	45.8%
28	Texas	Arlington/ Fort Worth/ Bedford Area	31.1%	17.3%	44.5%
29	Florida	Fort Lauderdale/ Plantation/ Lauderhill Area	30.9%	17.3%	44.1%
30	Texas	El Paso County	33.0%	17.2%	47.8%
31	North Carolir	Clinton/ Wallace/ Warsaw Area	29.0%	16.7%	42.4%
32	Florida	Vero Beach South/ Sebastian/ Florida Ridge Area	30.8%	16.6%	46.1%
33	Arizona	Tucson/ Drexel Heights/ Marana Area	23.9%	16.6%	30.7%
34	Washington	Yakima County	29.6%	16.6%	44.1%
35	California	East Los Angeles/ Whittier/ Pico Rivera Area	28.9%	16.5%	42.7%
36	New Mexico	San Juan County	36.6%	16.4%	55.2%
37	Texas	Houston/ South Houston/ Bellaire Area	29.6%	16.4%	44.6%
38	Nevada	Las Vegas/ Spring Valley/ Sunrise Manor Area	27.7%	16.4%	40.9%
39	Texas	Austin Area	28.1%	16.4%	41.8%
40	Florida	Deerfield Beach/ Margate/ Coconut Creek Area	28.8%	16.3%	43.2%
41	Kansas	Wyandotte County	28.9%	16.2%	43.7%
42	Texas	Dallas/ Garland/ DeSoto Area	28.7%	16.2%	43.6%
43	Texas	Potter County	31.6%	16.2%	48.7%
44	California	Irvine/ Garden Grove/ Santa Ana Area	26.7%	16.1%	39.9%
45	Georgia	Gwinnett County	26.2%	16.0%	38.8%
46	Texas	Baytown/ Houston/ Atascocita Area	28.9%	15.9%	45.2%
47	Georgia	Hall County	26.6%	15.8%	40.5%
48	Texas	San Antonio/ Kirby/ Windcrest Area	30.2%	15.8%	47.8%
49	Florida	Kendall/ Kendale Lakes/ Tamiami Area	27.1%	15.6%	42.2%
50	California	Los Angeles/ Beverly Hills Area	26.3%	15.5%	41.0%

Notes: Number of areas by state: TX(19), FL(11), CA(8), AZ(3), NV(2), GA(2), KS(1), NM(1), NY(1), NC(1), and WA(1).
Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for how geographies are defined and details on data and methods.

Exhibit 10: Demographic Composition of the Uninsured (0 to 64), Pre and Post ACA Implementation with All States Expanding Medicaid

	Pre-ACA Uninsured	Post-ACA Uninsured
Total (in 1,000's)	**48,971**	**25,910**
	Share	
Age		
Age 0 to 18	14.5%	14.8%
Age 19 to 24	17.0%	15.8%
Age 25 to 44	42.2%	43.1%
Age 45 to 64	26.3%	26.3%
Race		
White	45.4%	40.2%
Black	14.1%	12.7%
Hispanic	32.5%	38.8%
Other Race	8.0%	8.3%
Gender		
Male	53.9%	53.7%
Female	46.1%	46.3%
Language Spoken at Home		
Only English Spoken at Home among Adult Household Members	58.0%	50.8%
Only Spanish Spoken at Home among Adult Household Members	27.2%	33.6%
English and Another Language Spoken at Home among Adult Household Members	6.4%	6.4%
Other Languages Spoken at Home among Adult Household Members	8.4%	9.3%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for definitions of each demographic group and details on data and methods.

Example: Projected Changes in Texas and Illinois

The data permit detailed estimates to be constructed for each state. As an example of how these estimates can be used to understand variation within states, we analyze results from two states, Texas and Illinois. Both states show wide variation in the effects of the ACA among local areas. Texas has 59 different local areas within the state, and Illinois has 29 local areas.

Texas

With full implementation of the Medicaid expansion in Texas, Medicaid/CHIP enrollment is projected to increase by 50.7 percent (from 3.9 million to 5.8 million), with 76.1 percent of the new enrollment occurring among adults ages 19 to 64. On average, the Texas Medicaid/CHIP population under full ACA implementation is projected to be more likely to be white non-Hispanic and to speak English relative to the pre-implementation Medicaid population (Exhibit 11).

In Texas, under full implementation of the ACA, Medicaid/CHIP growth rates are expected to vary between 34.1 and 97.5 percent across local areas (Exhibit 12). The areas within Texas that would experience the largest growth in Medicaid/CHIP enrollment under the ACA include Collin, Randall, Fort Bend, and Brazos Counties, each in very different parts of the state. Growth in Medicaid coverage of adults drives most growth in total enrollment in local areas with large increases. Overall, Medicaid enrollment among nonelderly adults would grow by 147.5 percent in Texas under the ACA , with growth rates between 82.3 and 324.8 percent for areas within Texas (Exhibit 13).

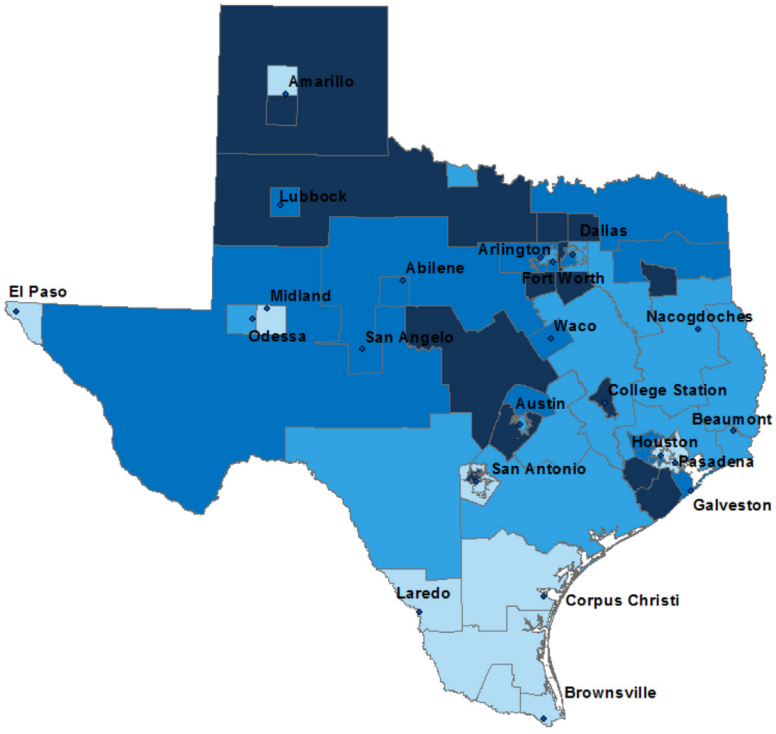
With full implementation of the ACA, the uninsured rate is projected to fall by 46.8% percent in Texas. Each of the 59 local areas within Texas are expected to see a decline of 40 percent or greater in their uninsured rate, and 22 areas would see their uninsured rate decline by more than 50 percent (Exhibit 14). Fully 35.4 percent of the total expected decline in the uninsured would occur in the counties containing Texas' three largest cities of Houston (Harris County), Dallas (Dallas County), and San Antonio (Bexar County), which together account for 1.0 million of the expected 2.9 million expected to gain coverage in Texas under the ACA (data not shown). With ACA implementation that includes the expansion of Medicaid, the uninsured rate in the state of Texas would be 14.3 percent, higher than the expected national rate of 9.6 percent, but a marked decline compared to the pre-reform rate in Texas of 26.8 percent (Exhibit 14).

Exhibit 11: Demographics of Medicaid/CHIP Enrollees (0 to 64) in Texas, Pre and Post ACA Implementation with the Medicaid Expansion

	Pre-ACA Medicaid/ CHIP	Post-ACA Medicaid/ CHIP	New Medicaid/ CHIP
Total (in 1,000's)	**3,875**	**5,841**	**1,965**
Age			
Age 0 to 18	73.8%	57.0%	23.9%
Age 19 to 24	4.0%	9.8%	21.4%
Age 25 to 44	10.9%	18.4%	33.4%
Age 45 to 64	11.3%	14.7%	21.4%
Race			
White	22.0%	25.5%	32.6%
Black	15.9%	15.2%	13.7%
Hispanic	58.4%	55.3%	49.1%
Other Race	3.7%	4.0%	4.7%
Gender			
Male	47.6%	47.6%	47.7%
Female	52.4%	52.4%	52.3%
Language Spoken at Home			
Only English Spoken at Home among Adult Household Members	42.6%	44.7%	48.9%
Only Spanish Spoken at Home among Adult Household Members	46.6%	43.7%	37.7%
English and Another Language Spoken at Home among Adult Household Members	7.2%	7.8%	8.9%
Other Languages Spoken at Home among Adult Household Members	3.5%	3.8%	4.4%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for definitions of each demographic group and details on data and methods.

Exhibit 12: Increase in Medicaid/CHIP Population in Texas with ACA Medicaid Expansion



Percent Change in Medicaid/CHIP Coverage Under the ACA (Mean: 50.7%)

- 34.1% - 46.6%
- 47.4% - 53.9%
- 54.5% - 58.2%
- 58.3% - 97.5%

Source: Urban Institute Analysis, ACS- HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS).
Notes: See text for details on how geographies are defined and details on data and methods.

Exhibit 13: Increase in Medicaid/ CHIP Population (0-64) Across Areas in Texas Under the ACA with the Medicaid Expansion

Area Name	Total Change (1000's)	Percent Nonelderly Enrollment Increase	Percent Adult Enrollment Increase	Share of Post-Reform Population In a Household Speaking Only Spanish
Full State	**1,965**	**50.7%**	**147.5%**	**43.7%**
Collin County	41	97.5%	324.8%	22.6%
Randall County	9	95.3%	187.1%	8.1%
Fort Bend County	38	87.2%	281.6%	30.6%
Brazos County	16	72.4%	212.9%	22.8%
Pflugerville/ San Marcos/ Austin Area	43	66.6%	192.9%	36.0%
Denton County	31	63.9%	188.1%	27.1%
Ellis County	11	62.8%	185.5%	27.2%
Smith County	18	62.8%	173.4%	21.1%
Brazoria County	18	61.1%	176.3%	28.0%
Pampa/ Hereford/ Dumas Area	15	61.0%	184.4%	47.1%
Johnson County	13	60.9%	179.0%	19.2%
Irving/ Grand Prairie/ Dallas Area	46	59.6%	212.7%	51.2%
San Antonio/ Shavano Park Area	42	58.4%	164.6%	40.1%
Plainview/ Levelland/ Vernon Area	24	58.3%	151.6%	30.4%
Copperas Cove/ Fort Hood/ Harker Heights Area	35	58.3%	140.0%	11.7%
San Angelo/ Stephenville/ Mineral Wells Area	32	58.2%	140.5%	24.5%
Sherman/ Texarkana/ Greenville Area	49	57.4%	148.4%	12.7%
Lubbock County	24	57.2%	165.9%	28.2%
Galveston County	20	56.9%	149.1%	18.0%
Taylor County	11	56.8%	185.5%	17.1%
Grapevine/ Haltom City/ North Richland Hills Area	46	56.7%	173.6%	32.4%
Longview/ Marshall/ Kilgore Area	30	56.3%	144.3%	12.9%
Williamson County	20	56.3%	163.3%	23.1%
Mission Bend/ Katy/ Jersey Village Area	44	55.7%	185.7%	42.0%
Houston Area	46	55.3%	139.4%	45.0%
Mansfield/ Grand Prairie/ Benbrook Area	41	55.2%	154.6%	22.6%
Spring/ Atascocita/ Houston Area	35	55.1%	149.9%	29.1%
Dallas/ Duncanville/ Cockrell Hill Area	65	54.9%	162.3%	47.3%
McLennan County	21	54.6%	141.0%	22.9%
Big Spring/ Andrews/ Lamesa Area	18	54.5%	148.3%	44.6%
The Woodlands/ Liberty/ Cleveland Area	37	53.9%	155.8%	27.6%
Dallas/ Garland/ DeSoto Area	58	53.6%	151.3%	41.4%
Rockwall/ Palestine/ Terrell Area	21	53.1%	135.3%	18.0%
Wichita County	9	52.7%	130.0%	14.4%
Arlington/ Fort Worth/ Bedford Area	49	52.0%	170.4%	40.4%
Huntsville/ Lufkin/ Nacogdoches Area	35	51.5%	112.9%	16.4%
Victoria/ New Braunfels/ Schertz Area	45	51.1%	145.9%	33.5%
Dallas/ Mesquite/ University Park Area	47	50.2%	162.7%	46.1%
Austin Area	42	50.1%	114.7%	45.1%
Lockhart/ Elgin/ Bastrop Area	14	49.9%	151.1%	32.1%
Corsicana/ Brenham/ Hillsboro Area	21	48.5%	113.6%	21.1%
Ector County	12	47.7%	120.5%	46.7%
Del Rio/ Eagle Pass/ Kerrville Area	33	47.6%	152.3%	63.4%
Orange/ Lumberton/ Vidor Area	20	47.6%	130.4%	5.4%
Jefferson County	19	47.4%	115.3%	15.3%
Houston/ South Houston/ Bellaire Area	46	46.6%	124.5%	37.5%
Corpus Christi/ Alice/ Portland Area	48	45.4%	118.5%	44.8%
Midland County	8	44.9%	117.3%	39.4%
Potter County	12	44.9%	123.0%	35.5%
El Paso County	77	44.1%	156.7%	82.4%
Kingsville/ Rio Grande City/ Raymondville Area	17	43.8%	130.3%	78.0%
Baytown/ Houston/ Atascocita Area	48	43.3%	120.7%	46.9%
Cameron County	50	43.0%	169.8%	78.6%
Houston/ Aldine Area	48	43.0%	121.2%	56.5%
Pasadena/ Houston/ Cloverleaf Area	56	40.8%	105.8%	60.8%
San Antonio/ Universal City/ Converse Area	47	40.6%	113.2%	46.3%
Webb County	26	40.1%	219.4%	93.5%
San Antonio/ Kirby/ Windcrest Area	45	34.4%	82.3%	55.9%
Hidalgo County	77	34.1%	167.1%	90.9%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for how geographies are defined and details on data and methods.

Exhibit 14: Reduction in Uninsurance (0 to 64) Across Areas in Texas Under the ACA with the Medicaid Expansion

Rank	Area	Total Change (1000's)	**Percent Uninsurance Decline**	Uninsurance Rate Pre-Implementation	Uninsurance Rate Post-Implementation
	Texas	**2,880**	**46.8%**	**26.8%**	**14.3%**
1	Taylor County	13	55.9%	21.4%	9.5%
2	Corpus Christi/ Alice/ Portland Area	66	55.2%	25.3%	11.3%
3	Lubbock County	29	54.7%	21.5%	9.7%
4	Orange/ Lumberton/ Vidor Area	30	54.5%	25.6%	11.7%
5	McLennan County	26	54.2%	22.4%	10.2%
6	Smith County	26	53.9%	26.8%	12.3%
7	Midland County	16	53.9%	24.0%	11.1%
8	Johnson County	20	53.8%	26.6%	12.3%
9	San Angelo/ Stephenville/ Mineral Wells Area	44	53.4%	26.0%	12.1%
10	San Antonio/ Shavano Park Area	56	52.9%	21.0%	9.9%
11	Victoria/ New Braunfels/ Schertz Area	66	51.9%	23.4%	11.3%
12	Wichita County	12	51.8%	21.6%	10.4%
13	Copperas Cove/ Fort Hood/ Harker Heights Area	45	51.6%	19.8%	9.6%
14	Randall County	10	51.4%	18.7%	9.1%
15	San Antonio/ Universal City/ Converse Area	64	50.9%	20.3%	9.9%
16	Lockhart/ Elgin/ Bastrop Area	19	50.9%	24.2%	11.9%
17	Sherman/ Texarkana/ Greenville Area	66	50.6%	27.4%	13.5%
18	Del Rio/ Eagle Pass/ Kerrville Area	46	50.6%	29.4%	14.6%
19	Williamson County	31	50.6%	16.1%	8.0%
20	Jefferson County	29	50.5%	27.6%	13.7%
21	Plainview/ Levelland/ Vernon Area	33	50.4%	27.4%	13.6%
22	Collin County	67	50.3%	18.1%	9.0%
23	Huntsville/ Lufkin/ Nacogdoches Area	47	50.0%	25.6%	12.8%
24	Galveston County	28	49.3%	21.7%	11.0%
25	Rockwall/ Palestine/ Terrell Area	31	49.2%	22.9%	11.6%
26	Spring/ Atascocita/ Houston Area	56	49.0%	18.0%	9.2%
27	Pampa/ Hereford/ Dumas Area	22	49.0%	28.4%	14.5%
28	Brazoria County	30	48.9%	22.4%	11.5%
29	Potter County	17	48.7%	31.6%	16.2%
30	The Woodlands/ Liberty/ Cleveland Area	60	48.5%	22.8%	11.7%
31	Longview/ Marshall/ Kilgore Area	41	48.5%	27.8%	14.3%
32	Mansfield/ Grand Prairie/ Benbrook Area	62	48.4%	22.4%	11.6%
33	Big Spring/ Andrews/ Lamesa Area	25	48.1%	29.3%	15.2%
34	Denton County	53	48.0%	17.9%	9.3%
35	Ellis County	15	48.0%	22.0%	11.5%
36	El Paso County	114	47.8%	33.0%	17.2%
37	San Antonio/ Kirby/ Windcrest Area	62	47.8%	30.2%	15.8%
38	Brazos County	14	47.6%	17.2%	9.0%
39	Fort Bend County	52	47.2%	20.4%	10.8%
40	Corsicana/ Brenham/ Hillsboro Area	28	47.1%	24.6%	13.0%
41	Grapevine/ Haltom City/ North Richland Hills Area	67	47.0%	21.0%	11.1%
42	Kingsville/ Rio Grande City/ Raymondville Area	23	46.5%	37.3%	20.0%
43	Mission Bend/ Katy/ Jersey Village Area	71	46.3%	26.4%	14.2%
44	Pflugerville/ San Marcos/ Austin Area	58	46.0%	20.6%	11.1%
45	Ector County	19	45.8%	32.1%	17.4%
46	Baytown/ Houston/ Atascocita Area	76	45.2%	28.9%	15.9%
47	Cameron County	69	44.7%	39.5%	21.8%
48	Houston/ South Houston/ Bellaire Area	70	44.6%	29.6%	16.4%
49	Dallas/ Duncanville/ Cockrell Hill Area	93	44.5%	38.4%	21.3%
50	Arlington/ Fort Worth/ Bedford Area	73	44.5%	31.1%	17.3%
51	Dallas/ Mesquite/ University Park Area	72	44.0%	33.7%	18.9%
52	Dallas/ Garland/ DeSoto Area	91	43.6%	28.7%	16.2%
53	Webb County	39	42.6%	38.1%	21.9%
54	Austin Area	60	41.8%	28.1%	16.4%
55	Irving/ Grand Prairie/ Dallas Area	73	41.8%	32.9%	19.2%
56	Houston Area	70	41.3%	32.9%	19.3%
57	Pasadena/ Houston/ Cloverleaf Area	88	41.0%	41.2%	24.3%
58	Houston/ Aldine Area	77	40.3%	35.6%	21.2%
59	Hidalgo County	118	40.1%	39.8%	23.8%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for how geographies are defined and details on data and methods.

Illinois

In Illinois, with full implementation of the ACA and the Medicaid expansion, Medicaid/CHIP enrollment is expected to increase by over 33 percent, or by about 696,000 new enrollees. Among nonelderly adults 19-64, enrollment is expected to increase by 69.4 percent. Total Medicaid enrollment post-ACA is estimated to be almost 2.8 million individuals, with the large majority of new enrollees expected to be white, non-Hispanic and adult. Unlike in Texas, the majority of new enrollees are projected to reside in households where everyone speaks English (Exhibit 15).

With full implementation of the ACA in Illinois, Medicaid/CHIP growth rates are expected to vary between 25.3 and 62.5 percent (Exhibit 16). The area in Illinois with the largest projected increase in Medicaid/CHIP enrollment under the ACA is Champaign County. Other than McLean County in the central part of the state, the remaining top five areas are all part of the greater-Chicago region. More so than in Texas where, with several exceptions, most areas can anticipate a high share of post-reform Medicaid enrollees to come from Spanish speaking households, the language distribution in Illinois is much more varied across areas. Some areas, especially in the greater-Chicago region, are projected to have a high share of Medicaid enrollees in Spanish speaking households. The Cicero/ Berwyn/ Oak Park Area slightly west of Chicago would have almost half their Medicaid enrollees in such households, whereas 9 areas are projected to have less than 5 percent of their enrollees in such households (Exhibit 17).

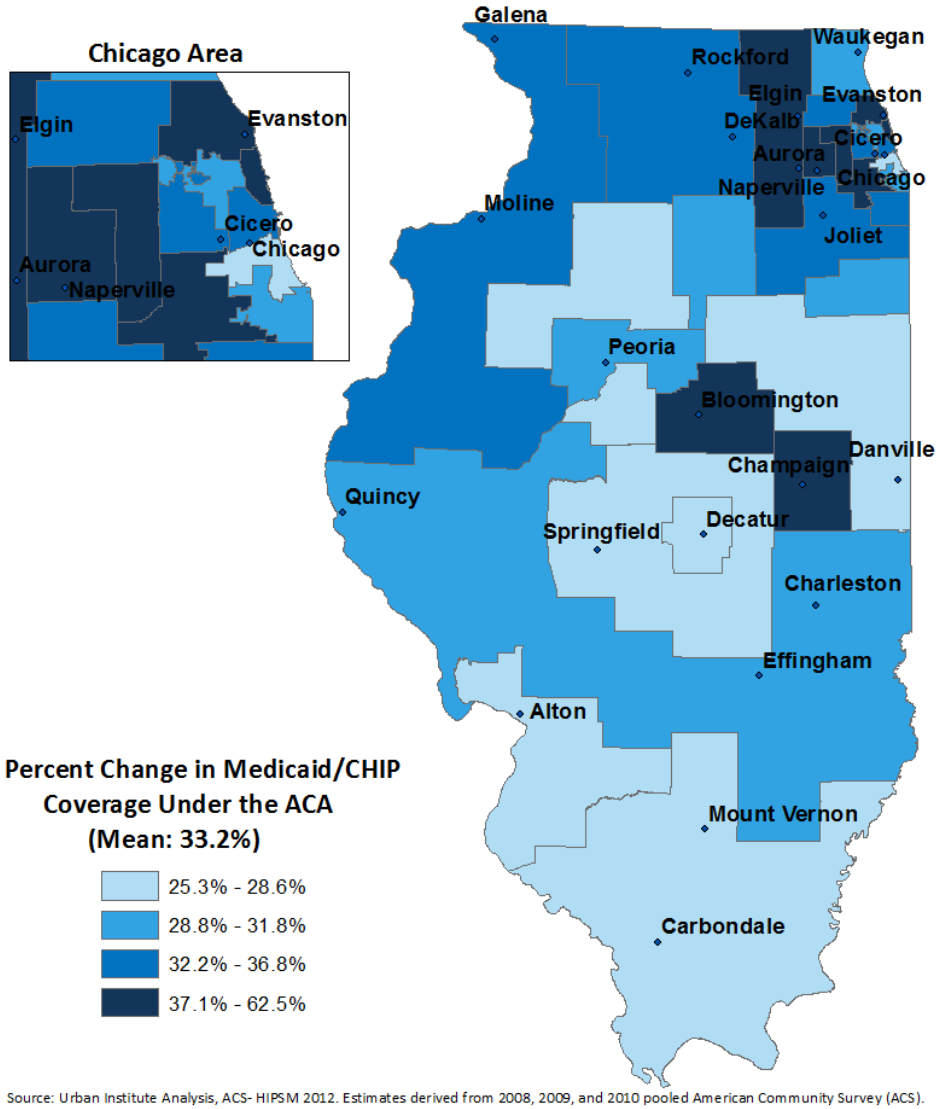
The uninsured rate in Illinois is projected to decrease 45.4 percent, or by about 814,000 individuals, with the full implementation of the ACA. Every area is expected to experience a decrease in their uninsured rate greater than 35 percent. In over 10 areas, the decline is projected to exceed 50 percent. The post-reform rate of uninsured is not expected to be uniform across areas. Three areas within Chicago are expected to have uninsured rates persisting above 14 percent, whereas two counties in the central part of the state, Tazewell and McLean County, are projected to have rates below 5 percent (Exhibit 18).

Exhibit 15: Demographics of Medicaid/CHIP Enrollees (0 to 64) in Illinois, Pre and Post ACA Implementation with the Medicaid Expansion

	Pre-ACA Medicaid/ CHIP	Post-ACA Medicaid/ CHIP	New Medicaid/ CHIP
Total (in 1,000's)	**2,099**	**2,794**	**696**
Age			
Age 0 to 18	61.7%	51.3%	19.9%
Age 19 to 24	5.7%	10.6%	25.5%
Age 25 to 44	19.7%	22.4%	30.5%
Age 45 to 64	12.9%	15.7%	24.1%
Race			
White	39.4%	43.0%	54.0%
Black	28.2%	27.1%	23.8%
Hispanic	27.3%	24.6%	16.5%
Other Race	5.1%	5.3%	5.7%
Gender			
Male	44.7%	47.1%	54.3%
Female	55.3%	52.9%	45.7%
Language Spoken at Home			
Only English Spoken at Home among Adult Household Members	66.8%	68.6%	74.1%
Only Spanish Spoken at Home among Adult Household Members	22.5%	19.9%	12.0%
English and Another Language Spoken at Home among Adult Household Members	4.4%	4.8%	6.1%
Other Languages Spoken at Home among Adult Household Members	6.3%	6.7%	7.8%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for definitions of each demographic group and details on data and methods.

Exhibit 16: Increase in Medicaid/CHIP Population in Illinois with ACA Medicaid Expansion



Source: Urban Institute Analysis, ACS- HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS).
Notes: See text for details on how geographies are defined and details on data and methods.

Exhibit 17: Increase in Medicaid/ CHIP Population (0-64) Across Areas in Illinois Under the ACA with the Medicaid Expansion

Area Name	Total Change (1000's)	Percent Nonelderly Enrollment Increase	Percent Adult Enrollment Increase	Share of Post-Reform Population In a Household Speaking Only Spanish
Full State	**696**	**33.2%**	**69.4%**	**19.9%**
Champaign County	15	62.5%	148.7%	6.8%
Chicago Area (Edgewater, Lake View, Lincoln Square)	30	57.5%	114.8%	18.1%
Evanston/ Skokie/ Des Plaines Area	19	54.1%	100.9%	15.6%
McLean County	11	53.2%	106.4%	4.4%
Wheaton/ Aurora/ West Chicago Area	16	42.5%	85.4%	20.4%
Oak Lawn/ Orland Park/ Tinley Park Area	25	40.6%	84.2%	20.2%
Addison/ Glendale Heights/ Westmont Area	18	37.4%	93.7%	25.3%
Carpentersville/ St. Charles/ Oswego Area	42	37.1%	87.7%	35.4%
Bolingbrook/ Naperville/ Plainfield Area	32	36.8%	69.3%	20.2%
Calumet City/ Chicago Heights/ Oak Forest Area	31	34.9%	70.1%	13.8%
Cicero/ Berwyn/ Oak Park Area	28	34.0%	85.1%	49.0%
DeKalb/ Freeport/ Belvidere Area	35	33.9%	71.9%	11.8%
Chicago Area (Humboldt Park, Logan Square, Near West Side, South Lawndale)	50	32.6%	72.4%	39.8%
Mount Prospect/ Streamwood/ Wheeling Area	19	32.5%	84.1%	32.7%
Rock Island/ Macomb/ East Moline Area	22	32.2%	61.0%	7.0%
La Salle County	6	31.8%	68.5%	5.7%
Lake County	27	30.8%	80.8%	38.0%
Chicago/ Park Ridge Area	35	30.4%	72.3%	39.3%
Bartonville/ Peoria Heights/ Chillicothe Area	11	30.2%	59.7%	2.9%
Kankakee County	7	29.3%	52.5%	8.7%
Chicago Area (Auburn Gresham, Beverly, Pullman, South Deering)	40	29.1%	59.6%	10.1%
Quincy/ Charleston/ Jacksonville Area	30	28.8%	50.8%	0.9%
Tazewell County	6	28.6%	57.0%	0.9%
Macon County	6	28.6%	48.7%	2.0%
Granite City/ East St. Louis/ Alton Area	31	28.2%	53.2%	2.1%
Lincoln/ Chatham/ Taylorville Area	16	28.1%	50.1%	0.5%
Danville/ Galesburg/ Pontiac Area	15	27.2%	51.3%	2.5%
Chicago Area (McKinley Park, West Lawn, Hyde Park, Greater Grand Crossing)	49	27.0%	65.4%	30.2%
Carbondale/ Marion/ Mount Vernon Area	26	25.3%	44.1%	0.9%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for how geographies are defined and details on data and methods.

Exhibit 18: Reduction in Uninsurance (0 to 64) Across Areas in Illinois Under the ACA with the Medicaid Expansion

Rank	Area	Total Change (1000's)	Percent Uninsurance Decline	Uninsurance Rate Pre-Implementation	Uninsurance Rate Post-Implementation
	Illinois	**814**	**45.4%**	**15.8%**	**8.6%**
1	Kankakee County	9	57.8%	15.8%	6.7%
2	Tazewell County	7	57.0%	10.4%	4.5%
3	Quincy/ Charleston/ Jacksonville Area	33	55.7%	13.5%	6.0%
4	McLean County	8	54.1%	10.4%	4.8%
5	Granite City/ East St. Louis/ Alton Area	35	54.0%	12.2%	5.6%
6	Danville/ Galesburg/ Pontiac Area	16	53.8%	13.4%	6.2%
7	Carbondale/ Marion/ Mount Vernon Area	29	53.6%	14.4%	6.7%
8	Lincoln/ Chatham/ Taylorville Area	17	53.4%	11.4%	5.3%
9	Rock Island/ Macomb/ East Moline Area	23	52.5%	12.5%	6.0%
10	Macon County	7	50.9%	16.2%	8.0%
11	Bartonville/ Peoria Heights/ Chillicothe Area	12	49.9%	12.6%	6.3%
12	DeKalb/ Freeport/ Belvidere Area	35	49.5%	13.6%	6.9%
13	Chicago Area (Auburn Gresham, Beverly, Pullman, South Deering)	42	49.0%	20.7%	10.6%
14	La Salle County	6	48.3%	12.4%	6.4%
15	Calumet City/ Chicago Heights/ Oak Forest Area	36	48.3%	19.0%	9.8%
16	Champaign County	11	45.6%	13.1%	7.1%
17	Bolingbrook/ Naperville/ Plainfield Area	37	44.6%	12.4%	6.9%
18	Oak Lawn/ Orland Park/ Tinley Park Area	29	44.3%	14.9%	8.3%
19	Cicero/ Berwyn/ Oak Park Area	40	42.8%	21.2%	12.1%
20	Carpentersville/ St. Charles/ Oswego Area	51	42.8%	14.1%	8.0%
21	Chicago Area (Edgewater, Lake View, Lincoln Square)	36	42.4%	19.2%	11.0%
22	Chicago Area (McKinley Park, West Lawn, Hyde Park, Greater Grand Crossing)	62	42.4%	24.6%	14.2%
23	Addison/ Glendale Heights/ Westmont Area	22	42.3%	12.7%	7.3%
24	Chicago Area (Humboldt Park, Logan Square, Near West Side, South Lawndale)	62	41.9%	24.1%	14.0%
25	Chicago/ Park Ridge Area	50	41.8%	24.2%	14.1%
26	Evanston/ Skokie/ Des Plaines Area	20	41.5%	12.8%	7.5%
27	Lake County	36	40.9%	13.8%	8.2%
28	Wheaton/ Aurora/ West Chicago Area	16	40.4%	9.8%	5.8%
29	Mount Prospect/ Streamwood/ Wheeling Area	26	35.5%	14.2%	9.1%

Source: Urban Institute Analysis, ACS-HIPSM 2012. Estimates derived from 2008, 2009, and 2010 pooled American Community Survey (ACS). See text for how geographies are defined and details on data and methods.

Policy Implications

Health systems will need to prepare for coverage expansions and changes in the composition of the Medicaid population

We find substantial variation within states in the projected size of Medicaid enrollment gains under the ACA and in the composition of the population that would be newly covered by Medicaid/CHIP. Particular attention will be needed to assess whether Medicaid provider networks are sufficient to meet the needs of the new populations who would be served under the ACA. Most of those gaining Medicaid are expected to be adults, whose service needs likely differ substantially from those of the children who currently predominate in many state Medicaid programs.

Our analysis suggests that health care networks in certain areas may face greater linguistic complexity with respect to the Medicaid/CHIP enrollees they would be serving under the ACA. Given that prior research has shown that language barriers can have a significant negative impact on access and use of care, it will be important to consider the geographic concentration of certain language groups in designing provider networks and services.[17]

Increases in Medicaid, as well as private insurance gains anticipated under the ACA, may put pressure on local health care systems to provide adequate access to care.[18] Many of those newly insured under Medicaid may have primary care needs that had not been well addressed in the prior period when they were uninsured.[19] Our estimates show substantial local variation in both the number of new Medicaid enrollees and their characteristics. With the growth in the Medicaid population that is expected under the ACA, it will be important to track the extent to which supply of services keeps pace with demand. While the ACA includes provisions to address provider capacity within Medicaid, such as increased financing for federally qualified health centers and increases in primary care reimbursement rates, other policy changes may be needed to meet the health care needs of Medicaid enrollees.

Medicaid/CHIP Enrollment Gains have Potential to Expand Access to Care

Almost 73 percent of the new Medicaid coverage expected under the ACA draws from the ranks of the uninsured (data not shown). Currently, these groups go without needed care at much higher rates than those who have Medicaid coverage. Therefore, the acquisition of Medicaid coverage under the ACA should reduce the extent of unmet health needs and financial health burdens experienced by the low-income population and increase the extent to which they receive preventive and other types of needed care. However, the declines in the uninsured that are estimated here depend on full implementation of the ACA. The states that choose not to expand Medicaid will experience much smaller increases in Medicaid enrollment and associated declines in the uninsured than reflected in these estimates, which will place greater demands on the safety net. Moreover, this analysis shows that even with full implementation of the ACA, local areas in AZ, CA, FL, and TX can still expect to have one in every five people without health insurance coverage. The adequacy of the safety net will remain an important policy concern, particularly in local areas where high rates of the uninsured persist.

Conclusion

Our ACS-based simulation projects that an additional 18.1 million would enroll in Medicaid/CHIP coverage under full implementation of the ACA, assuming all states expand Medicaid eligibility to 138 percent FPL. Our analysis provides new information on the extent to which these gains would vary across the country and show how the demographic and socioeconomic characteristics of the population covered by Medicaid/CHIP could change under the ACA. This analysis also highlights the extent to which uninsured rates could decline across states and in all local areas. Capacity and access issues will be important on the local levels as individuals who were previously uninsured now have coverage, and their needs may differ based on the changing demographic of enrollees. Without full implementation of the ACA, many states and local areas will continue to see higher uninsured rates.

Methods Appendix

Data Sources

The American Community Survey. Pooled American Community Survey (ACS) data from 2008, 2009, and 2010 form the core data set for this model and the resultant estimates. The ACS is an annual survey fielded by the United States Census Bureau with a reported response rate of 98.0 percent in 2009.[20] The estimates presented here are derived from the data that were collected from approximately 2.5 million non-elderly sample respondents (ages 0 to 64) in the civilian non-institutionalized population each year, yielding a total sample of approximately 7.5 million. The ACS is a mixed mode survey that includes households with and without telephones (landline or cellular.) The ACS is designed to be state-representative, including samples from each county in the country.

Since 2008, the ACS has asked respondents about the health insurance coverage status at the time of the survey of each individual in the household. In an effort to correct for potential measurement errors in the ACS coverage data and to define coverage as including only comprehensive health insurance as opposed to single-service plans (e.g., dental coverage), we apply a set of logical coverage edits in the cases where other information collected in the ACS implies that coverage for a sample case likely has been misclassified.[21] The edits target under-reported Medicaid/CHIP coverage among children and over-reported non-group coverage among both adults and children, which in turn, affect other coverage types. We draw from approaches that have been applied to other surveys[22] and build on ACS edit rules used by the Census Bureau.[23]

American Community Survey-Health Insurance Policy Simulation Model. We use the Urban Institute's American Community Survey - Health Insurance Policy Simulation Model (ACS-HIPSM) to estimate the effects of the ACA on the non-elderly at the state and local level.[24] The ACS-HIPSM model builds off of HIPSM, which uses the Current Population Survey (CPS) as its core data source, matched to several others, including the Medical Expenditure Panel Survey-Household Component (MEPS-HC). We apply the micro-simulation approach developed in HIPSM/CPS to model decisions of individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms with data from the ACS. With the large ACS sample, we are able to produce more precise estimates for state and sub-state areas than available from models based on other data sources. Under our model, eligibility for Medicaid/CHIP and exchange subsidies are simulated using ACS data from 2008, 2009, and 2010 based on state-level eligibility guidelines for Medicaid and CHIP in 2010 and available information on the regulations for implementing the ACA.

We combine three years of ACS data to achieve sufficient precision at the state and local level. This process involves adjusting all dollar amounts such as income and wages to 2011 levels using the Consumer Price Index (CPI-U) and reweighting the combined file so that the distributions of demographic, employment, income, and health insurance coverage in the merged file match those of the 2011 ACS.

We simulate the main coverage provisions of the ACA as if they were fully implemented and the impacts were fully realized and compare the results to the model's pre-reform baseline results. The HIPSM models use a micro-simulation approach based on the relative desirability of the health insurance options available to each individual and family under reform, taking into account a number of factors such as premiums and out-of-pocket health care costs for available insurance products, health care risk, whether or not the individual mandate would apply to them, and family disposable income.

Medicaid/CHIP Eligibility Simulation Model. We use The Urban Institute Health Policy Center's *ACS Medicaid/CHIP Eligibility Simulation Model* to simulate pre-ACA eligibility for Medicaid/CHIP by comparing family income and other characteristics to the Medicaid and CHIP rules in each sample person's state of residence.[25] The model uses available information on eligibility guidelines, including income thresholds for the appropriate family size,[26] asset tests, parent/family status, and the amount and extent of income disregards for each program and state in place as of the middle of each year.[27] The model takes into account disregards for child care expenses, work expenses, and earnings in determining eligibility, but does not take into account child support disregards. For non-citizens, the model also takes into account length of U.S. residency in states where term of residency is a factor in eligibility.[28] Because the ACS does not contain sufficient information to determine whether an individual is an authorized immigrant and therefore potentially eligible for Medicaid/CHIP coverage, we impute documentation status for non-citizens based on a model developed using CPS ASEC data.[29]

Estimates from our ACS models of pre-ACA eligibility have been extensively benchmarked to assess their validity and have been found to line up with those from other sources; for instance, despite the differences between the ACS and the CPS ASEC, the models from the two surveys produce fairly comparable results in terms of participation rates and the number of uninsured children who are eligible for Medicaid/CHIP but not enrolled for the same time frame.[30] The number and characteristics of individuals according to their eligibility for Medicaid/CHIP and their eligibility pathway (Medicaid vs. CHIP, etc.) are also quite similar across the two models.

Projections of Eligibility Under the ACA. Under the ACA, income eligibility will be based on the Internal Revenue Service tax definition of modified adjusted gross income (MAGI) and will include the following types of income for everyone who is not a tax-dependent child: wages, business income, retirement income, Social Security, investment income, alimony, unemployment compensation, and financial and educational assistance. The ACS asks only indirectly about unemployment compensation, alimony, and financial and educational assistance when it asks about "other income" so we imputed income from other sources using a model developed for the CPS which has more detail on income sources than the ACS.

To compute family income as a ratio of the poverty level, we sum the person-level MAGI across the tax unit.[31] In situations where a dependent child is away at school, the ACS does not contain data on the family income and other family information on the child's record or the presence of the dependent child on the records of family members, so we assign some college students to families before beginning the simulation. Eligibility for Medicaid or subsidies under the ACA also depends on immigration status; HIPSM uses documentation status imputations described above.

We simulate ACA eligibility for adults and children for the eligibility pathways which correspond roughly to the order in which we expect eligibility to be determined. For children, we check for disability (SSI or Aged/Blind/Disabled eligibility under current rules), new Medicaid eligibility (family income up to 138 percent of FPL and meets immigration requirements), CHIP eligibility under current rules, and other eligibility under current rules, otherwise known as maintenance-of-eligibility. For adults, we check for disability (SSI or Aged/Blind/Disabled eligibility under current rules), Title IV-E/foster care, new Medicaid eligibility, and maintenance-of-eligibility.[32]

We model subsidy eligibility, which depends on whether the family was offered affordable health insurance benefits, based on imputations of the presence of an insurance offer in the family and the value of the employee's contribution towards the cost of the insurance premium among those with ESI. We impute offer status using regression models estimated from CPS data collected in 2005, the last year that the CPS included information on ESI offers in its February supplement. We first impute firm size on the ACS because offers are highly dependent on firm size. Similarly, we impute policyholder status to people in families with ESI because the ACS does not ask whose job offered the ESI.

Projections of Health Insurance Coverage Under the ACA. Once we have modeled eligibility status for Medicaid/CHIP and subsidized coverage in the exchanges, we use HIPSM to simulate the decisions of employers, families, and individuals to offer and enroll in health insurance coverage. To calculate the impacts of reform options, HIPSM uses a micro-simulation approach based on the relative desirability of the health insurance options available to each individual and family under reform.[33] The approach (known as a "utility-based framework") allows new coverage options to be assessed without simply extrapolating from historical data, as in previous models. The health insurance coverage decisions of individuals and families in the model take into account a number of factors such as premiums and out-of-pocket health care costs for available insurance products, health care risk, whether or not the individual mandate would apply to them, and family disposable income. Our utility model takes into account people's current choices as reported on the survey data. We use such preferences to customize individual utility functions so that their current choices score the highest, and this in turn affects behavior under the ACA. The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature, such as price elasticities for employer-sponsored and non-group coverage.

The first stage in the simulation process is to estimate additional enrollment in Medicaid and CHIP, both by those gaining eligibility under the ACA and those who are currently eligible, but not enrolled. Many characteristics are used to determine take-up, but the two most important are new eligible status and current insurance coverage, if any. The ACA includes a number of policies aimed at promoting enrollment, including a "no wrong door" enrollment policy whereby children and families will be screened and evaluated for Medicaid, CHIP, and subsidy eligibility no matter whether they apply for coverage (through Medicaid, CHIP or an exchange); new outreach funding; and procedures that minimize application and enrollment barriers. As a consequence, the model projects that Medicaid/CHIP participation rates will rise under the ACA for children and nonelderly adults who are eligible for Medicaid under current rules (see Holahan, Buettgens et al. 2012 for more on this issue.) While the HIPSM model projects that participation among children and non-elderly adults will increase with full implementation of the ACA, it projects that some individuals will remain uninsured despite being eligible for Medicaid/CHIP coverage. In subsequent stages, we model the following sequentially: enrollment in the non-group exchange, additional enrollment of the uninsured in employer-sponsored coverage, additional enrollment of the uninsured in non-group coverage outside of the exchange, transitions from single to family ESI and transition from non-group to ESI.

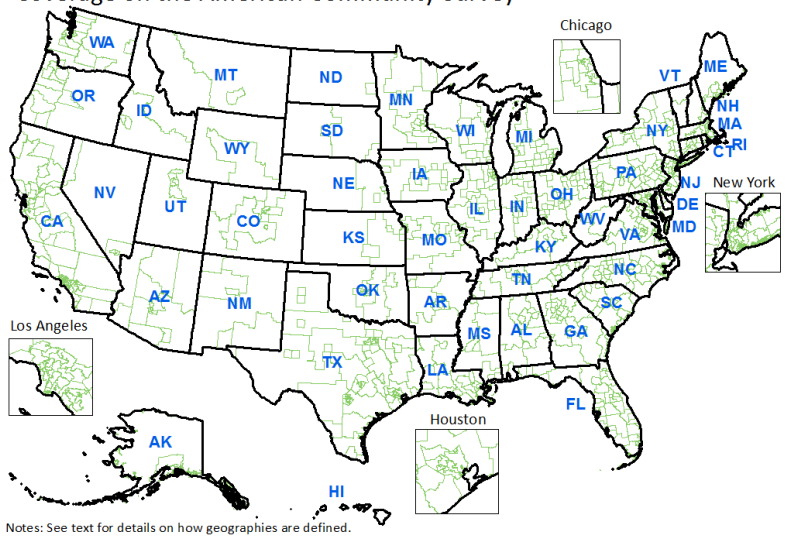
Geographies Used for Local Estimates.

The geographies used for this analysis are constructed from available county-level information and Super Public Use Microdata Area (SuperPUMA) definitions on the 2008, 2009, and 2010 pooled American Community Survey. The 531 SuperPUMAs are made up of combinations of the more than 2,000 PUMAs. PUMAs and SuperPUMAs have been defined by Census in conjunction with state and local governments to reflect areas that generally follow the boundaries of county groups, single counties, or census-defined "places," constrained by the necessity to have a minimum population size (100,000 for PUMAs, 400,000 for SuperPUMAs). County of residence is available on the public-use files for residents of 374 counties, which together account for about 60% of the US population. Identifiable counties all have a population of at least 100,000, and include many of the nation's largest counties, but do not include all such counties.

In defining local geographies, our methodology uses the county of residence to define a sub-state area unless the county is larger than one of its constituent SuperPUMAs, in which case the SuperPUMA is assigned as the geographic unit instead. When a SuperPUMA is partially composed of an identifiable county according to the rules above, a "Rest of SuperPUMA" area is assigned to individuals in the SuperPUMA who do not reside in the identifiable county. In five small states that are composed of just one SuperPUMA (AK, DC, SD, VT, and WY), we constructed two sub-state areas in each state based on the PUMA definitions for the state.

The result is that each individual is assigned to either a county or an "other area" which could be either: a full SuperPUMA, a "Rest of SuperPUMA," or a specially constructed area. No resulting area is smaller than 100,000, and none is larger than the largest SuperPUMA of approximately 400,000 people. This yields 781 mutually exclusive geographies which span the entire US (Exhibit 19). Of those, 316 are counties, and 465 are "other areas," either full SuperPUMAs, "Rest of SuperPUMA areas", or specially constructed areas.

Exhibit 19: Substate Areas Defined for Assessing Health Insurance Coverage on the American Community Survey



Notes: See text for details on how geographies are defined.

Five states have just two areas, six have three areas, but over half have twelve or more areas (Exhibit 20). The states with the largest number of local geographies are California, for which we have defined 78 sub-state areas using the above described methods, followed by Texas and Florida, with 59 and 48 sub-state areas, respectively. We assigned non-county geographies names based on the cities/towns/etc. that are located in the area. We also separately provide estimates for all 374 counties that are identifiable in the ACS.

Exhibit 20: Number of Constructed Areas in Each State

22 Areas or More	California (75), Texas (59), Florida (48), New York (46), Pennsylvania (37), Ohio (34), Illinois (29), Michigan (29), North Carolina (28), Georgia (23), New Jersey (23), Virginia (22)
12 to 19 Areas	Indiana (19), Tennessee (17), Wisconsin (17), Maryland (16), South Carolina (16), Washington (16), Louisiana (15), Minnesota (14), Missouri (14), Alabama (13), Arizona (13), Massachusetts (13), Oregon (12)
4 to 11 Areas	Iowa (11), Colorado (10), Connecticut (10), Mississippi (10), Kentucky (9), Arkansas (8), Kansas (7), New Mexico (6), Oklahoma (6), Utah (6), Nebraska (5), Nevada (5), Idaho (4)
4 Areas or Less	Maine (4), Rhode Island (4), Delaware (3), Hawaii (3), Montana (3), New Hampshire (3), South Dakota (3), West Virginia (3), Alaska (2), District of Columbia (2), North Dakota (2), Vermont (2), Wyoming (2)

Notes: See text for details on how geographies are defined and details on data and methods.

Individual and Family Characteristics.

The estimates that are available on kff.org/zooming-in-ACA explore the composition of 1) individuals with Medicaid coverage/who were uninsured before implementation of the major coverage provisions of the ACA, 2) individuals who are projected to gain Medicaid under the ACA, and 3) individuals with Medicaid/who were uninsured after implementation of the ACA with respect to the following characteristics:

- Age—Reported age of individual defined categorically (between 0-18, 19-24, 25-44, or 44-64).
- Race—Reported race of individual. We define anyone who reported being "Hispanic" or "Latino" as Hispanic, and define single race-only for self-identified white or black respondents. Other ethnicities or those identifying multiple ethnicities are classified as "Other" race or ethnicity.
- Gender—Reported gender of individual.
- Language spoken at home—Reported language spoken at home by residents of the household aged 19 to 64. We define households where only English is spoken, only Spanish is spoken, English and some other language are spoken, or no English and not exclusively Spanish are spoken.

In this brief, we present estimates for all states; estimates are also presented for Texas and Illinois to spotlight the local variation in ACA impacts within a particular state. We also provide estimates of the share of Medicaid/CHIP enrollees who live in Spanish-speaking households to highlight the variation in the demographic and socio-economic composition of enrollees within states. We report estimates for all geographies with sufficient sample size to provide reliable estimates along these socio-demographic dimensions. Additional dimensions were modeled for this population but the data was not published. Our sample size cutoff for estimate suppression was 150 respondents in that cell in the geographic area. Only estimates of those newly gaining Medicaid under reform (between 5 and 10 percent of all geographies) were suppressed by this rule.

Limitations.

Both the baseline and the ACA estimates presented here have a number of limitations, including measurement error in reported health insurance coverage on the ACS, which may not be fully addressed by the edits that were implemented and in the Medicaid and CHIP eligibility simulation model. Efforts to simulate eligibility for public coverage based on survey data are inherently challenging, particularly for adults. Challenges include misreporting of income, insurance coverage, or other information used to model eligibility and lack of specific information needed to simulate all the pathways to eligibility. The ACS, like many other surveys, does not contain information on such factors as pregnancy status, legal disability status,[34] child support amounts, whether custodial parents meet child support cooperation requirements, medical spending (which would be used to calculate spend-down for medically needy eligibility), and duration of Medicaid enrollment or income history to determine Transitional Medical Assistance (TMA) and related eligibility. Finally, there is additional uncertainty in any projection of ACA coverage impacts related to difficulties associated with predicting take up of different types of coverage under the ACA, federal and state actions that could number of implementation issues related to state and federal actions and guidance and a host of behavioral responses that are difficult to predict.

Endnotes

[1] Based on the IRS tax definition of modified adjusted gross income (MAGI)—for more details on MAGI income definition, see: Buettgens, M., D. Resnick, V. Lynch, and C. Carroll. 2013. Documentation on the Urban Institute's American Community Survey Health Insurance Policy Microsimulation Model (ACS-HIPSM.) The Urban Institute. Washington DC.

[2] Sommers, B.D. and A.M. Epstein. 2010. "U.S. Governors and the Medicaid Expansion — No Quick Resolution in Sight." *New England Journal of Medicine* 368(6): 496-499.

[3] Holahan, J., M. Buettgens, C. Carroll, and S. Dorn. 2012. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Washington, DC: Kaiser Family Foundation.

[4] Clemans-Cope, C., G. Kenney, M. Buettgens, C. Carroll, and F. Blavin. 2012. The Affordable Care Act's Coverage Expansions Will Reduce Differences In Uninsurance Rates By Race And Ethnicity. Health Affairs, 31(5): 920-930; Holahan, Buettgens et al. 2012; Holahan, J. and I. Headen. 2010. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.; Dorn, S. and M. Buettgens. 2011. "Net Effects of the Affordable Care Act on State Budgets" Washington, DC: The Urban Institute.

[5] These national estimates are consistent with other models of Medicaid enrollment increases under the ACA: Blavin F., M. Buettgens, and J Roth. 2011. "State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain." Washington, DC: The Urban Institute; Holahan, Buettgens et al. 2012.

[6] While pathways through which childless adults can gain access to Medicaid coverage have existed, they've been limited to special categories of individuals and in most states income-based eligibility for childless adults has been very limited or nonexistent.

[7] Spanish-speaking households are defined as households in which all the non-elderly adults speak Spanish.

[8] This excludes Massachusetts, which we model as experiencing no change in Medicaid enrollment as a result of the ACA.

[9] Alaska, Colorado, Florida, Georgia, Idaho, Kansas, Montana, Nevada, North Dakota, Oregon, Texas, Utah, Virginia, Wyoming.

[10] Total includes Massachusetts.

[11] Excluding Massachusetts.

[12] The results of an exploratory OLS regression model indicates a positive and statistically significant relationship (p-value less than 0.05) in a given state, between share of the population below 138 percent FPL and percent increase in Medicaid , controlling for the baseline differences in Medicaid coverage (data not shown).

[13] When we partition the total variation in area-level Medicaid/CHIP percent increases between within and across state variation, we find that variation within states accounts for 40.4 percent of the total. The rest (59.6 percent) is attributed to across state variance.

[14] The areas with large percentage increases in their Medicaid/CHIP population do not correspond perfectly to the areas with the largest absolute Medicaid/CHIP population increases because of variation in reliance on Medicaid at baseline.

[15] Except in Massachusetts, which, as indicated above, we model as exhibiting no change due to reform.

[16] Nationally, we find a linear correlation between the projected changes in Medicaid enrollment and the uninsured of -0.4593 for the nonelderly.

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[26] Family-level characteristics used in determining pre-ACA eligibility, such as income, are based on the family groupings that states define during the process of determining eligibility under pre-ACA rules. However, indicators for "family" characteristics discussed in this paper refer to the family unit that is generally eligible for the same private plan, known as the health insurance unit (HIU). Eligibility for CHIP coverage is defined according to whether the child meets the income, asset, and documentation requirements for coverage and does not take into account whether the child might be subject to a waiting period.

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[29] Documentation status is imputed to immigrants in two stages using individual and family characteristics, based on an imputation methodology that was originally developed by Passel (Passel and Cohen, 2008). The approach is designed to produce imputations that match, in the aggregate, published summary estimates of the U.S. undocumented population, nationally and in a subset of large states.

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[31] We use "tax unit" and "HIU" or "health insurance unit" interchangeably in this report.

[32] Based on the most recent regulations as of this analysis, we assume maintenance-of-eligibility for children and for adults not above 138% FPL in an 1115 waiver or limited benefit program (federally- or state-funded programs that offer substantially more limited medical services, higher cost sharing, or other limitations).

[33] We apply this simulation approach to all individuals except those in Massachusetts, whom we assume will experience no change in health insurance status due to ACA implementation.

[34] States' determinations of disability-related eligibility use additional criteria than the indicators of functional limitations available on the ACS. Thus, some of the sample people who appear in our model to be eligible through the disability pathway might not qualify when the more detailed information on their characteristics is taken into account.

This research draws on work completed for the Kaiser Commission on Medicaid and the Uninsured. The authors gratefully acknowledge the funding of the Robert Wood Johnson Foundation for contributing to the development of the Urban Institute's Health Policy Center's American Community Center (ACS) Health Insurance Policy Simulation Model (ACS-HIPSM). The authors appreciate the research contributions and advice of Fredric Blavin, Linda Blumberg, John Holahan, Jennifer Haley, Caitlin Carroll, and Nathaniel Anderson to the development of the ACS-HIPSM simulation model and the construction of geographic areas on the ACS and the helpful advice of Rachel Garfield and Rachel Licata in developing the estimates for the website.

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This publication (#8443) is available on the Kaiser Family Foundation's website at www.kff.org.

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