Assessing the Coverage Effects of the Affordable Care Act: A Comparison of Estimates from Recent Studies

Doug Badger

MERCATUS CENTER
George Mason University

3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201
www.mercatus.org

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ABSTRACT

The Affordable Care Act (ACA) has substantially increased the number of Americans with public and private health insurance coverage. The Assistant Secretary for Planning and Evaluation (ASPE) at the US Department of Health and Human Services estimates that the ACA has resulted in 20 million additional nonelderly adults gaining coverage between the law's enactment and February 2016. This estimate is likely overstated. Government surveys' estimates of the number of people who gained coverage between December 2013 and December 2015 vary by 20 percent. Moreover, while the ASPE estimates that the ACA increased the number of young adult dependents with insurance coverage between 2010 and 2013 by 2.3 million, data from government surveys indicate that 1.2 million fewer dependent children had private coverage in 2013 than in 2010, offsetting half the gain in coverage among older dependents. Coverage gains have nonetheless been significant, with most of the increase coming from enrollment surges in Medicaid and the Children's Health Insurance programs. But a substantial proportion of those who have enrolled in these public programs since 2014 met eligibility standards that predated the ACA. This increase in public coverage may have crowded out private coverage, although further study is needed to determine the existence and magnitude of this effect.

JEL codes: I180, I130

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The Affordable Care Act (ACA) has substantially increased the number of Americans with public and private health insurance coverage. The law was enacted in March 2010 and fully implemented in January 2014.[1] During the period from 2010 to 2013, the uninsurance rate returned to prerecession levels, according to the National Health Interview Survey (NHIS), although the percentage of people under age 65 with private health insurance coverage hovered at historic lows.[2]

The law's major coverage provisions took effect in January 2014. From that point, government surveys report substantial declines in the uninsurance rate among the nonelderly population. Major government surveys agree that more than 90 percent of Americans had health insurance coverage in 2015, the highest total ever reported in those surveys.[3] The bulk of these coverage gains occurred beginning in 2014.

The ACA set out to increase coverage by making millions of individuals and families eligible for Medicaid, providing premium subsidies and cost-sharing subsidies to millions more, and levying a tax penalty on individuals who fail to purchase coverage and on businesses that do not sponsor insurance for their workers.

In addition to this system of subsidies and penalties, the ACA erected a federal regulatory framework on private individual and group health insurance. These regulations require insurers to issue policies to all applicants during annual enrollment and special enrollment periods. Applicants may not be

1. The Affordable Care Act is the result of two laws: Pub. L. No. 111-148, 124 Stat. 119 (2010) (the Patient Protection and Affordable Care Act) and Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the Health Care and Education Reconciliation Act of 2010).
2. Michael E. Martinez, Robin A. Cohen, and Emily P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2015* (Washington, DC: National Center for Health Statistics, 2016), A3, table III.
3. The NHIS estimated that 28.6 million people were uninsured in 2015. The Census Bureau estimated the total at 29 million. These estimates are the lowest recorded numbers of uninsured people in either survey.

medically underwritten—that is, their premiums cannot be increased due to their medical conditions—and policies must cover preexisting medical conditions.

Estimating the coverage gains attributable to the ACA and the sources of that increased coverage is a difficult undertaking. There are no precise headcounts on the number of people who have health insurance or the number who gained it after the ACA's enactment. Government surveys provide different estimates on the number of newly insured people.[4]

"There are no precise headcounts on the number of people who have health insurance or the number who gained it after the ACA's enactment."

Even if precise headcounts existed, they would not reveal whether a particular law or regulation caused a particular individual to acquire coverage. Uninsurance rates are influenced by factors unrelated to public policy. Labor market fluctuations and medical cost trends are among the factors that have been associated with an increase or reduction in the percentage of people with coverage.[5]

The most widely cited estimate of the ACA's effect on the uninsurance rate was prepared by the Assistant Secretary for Planning and Evaluation (ASPE) at the US Department of Health and Human Services (HHS) in March 2016.[6] The ASPE estimates that the ACA has resulted in 20 million additional adults gaining public or private coverage between the law's enactment in 2010 and the end of the open enrollment season in February 2016. This figure of 20 million has gained wide currency.

This paper will examine that estimate using more recent data from the NHIS and survey data from the Census

4. NHIS data on health insurance can be found at National Center for Health Statistics, Centers for Disease Control and Prevention, "The National Health Interview Survey Early Release Program," February 23, 2017. Census Bureau data are available at US Census Bureau, "Health Insurance Historical Tables: HIC Series," October 24, 2016.
5. See, for example, Sherry Glied and Kathrine Jack, "Macroeconomic Conditions, Health Care Costs, and the Distribution of Health Insurance" (NBER Working Paper No. 10029, National Bureau of Economic Research, Cambridge, MA, October 2003).
6. Namrata Uberoi, Kenneth Finegold, and Emily Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016* (Washington, DC: ASPE, Department of Health and Human Services, March 3, 2016).

Bureau's American Community Survey (ACS), as well as insurance company regulatory data and government Medicaid enrollment data.

It will also look at the sources of this coverage expansion, examining studies that explore the extent to which coverage gains are attributable to premium subsidies, Medicaid expansions, and other major ACA provisions. Finally, it will review estimates of "crowd-out"—the extent to which ACA coverage under public programs substituted for preexisting private insurance.

This study concludes the following:

- The estimate that the ACA has increased coverage by 20 million people is likely overstated.
- Most of the increase in coverage appears to be owing to surges in Medicaid and Children's Health Insurance Program (CHIP) enrollment.
- A substantial proportion of people who have enrolled in these public programs since 2014 met eligibility standards that predated the ACA.
- This increase in public coverage may have crowded out private coverage, although further study is needed to determine the existence and magnitude of this effect.

ASPE (2016)

In March 2016, the ASPE estimated that the ACA had resulted in gains in health insurance coverage of 20 million adults between its enactment in March 2010 and February 22, 2016, when open enrollment for the 2016 benefit year concluded. The ASPE further found that this gain in coverage among nonelderly adults was shared widely across racial and ethnic groups, although coverage gains were higher among women than men.

In preparing its estimates, the ASPE relied largely on data from the NHIS. The ASPE regards the NHIS as "the most reliable source of estimates of current coverage."[7] At the time of the report, NHIS data were available only through the third quarter of 2015. The ASPE therefore supplemented the NHIS figures with data from the Gallup-Healthways Well-Being Index for coverage estimates between October 2015 and February 22, 2016. This private survey tracks the current rate of health insurance coverage.[8] It adjusts changes in the uninsured rate

7. Ibid., 7.
8. More information on the Gallup-Healthways survey can be found at http://www.well-beingindex.com/topic/uninsured-rate.

to account for changes in employment status, geographic location, demographics, and other secular trends.

The ASPE's estimate is divided into two major components:

- Coverage gains of 17.7 million people among nonelderly adults between October 2013 and the conclusion of open enrollment in February 2016; and
- Coverage gains of 2.3 million adults age 19–25 between enactment of the ACA in 2010 and the October 2013 open enrollment.

Estimate of Coverage Gains between October 2013 and February 2016

When the ASPE estimated coverage gains of 17.7 million through February 2016, NHIS data were not available for the fourth quarter of 2015 or the first half of 2016. Since publication of the study, the NHIS has published data through June 2016, obviating the need to substitute the Gallup-Healthways numbers for that period.

This 17.7 million figure is not directly comparable to those used in the ASPE study, since the ASPE adjusts the NHIS data for various factors. Those adjustments, however, appear to have produced very small deviations from the raw NHIS data. For example, the ASPE estimated that uninsurance rates among nonelderly adult males had declined to 15 percent—and to 10.8 percent among females—between the third quarter of 2013 and the end of 2015.[9] Those figures were almost identical to NHIS estimates of a 14.9 percent uninsurance rate among males age 18–64 and a 10.8 percent uninsurance rate among women in the same age bracket.[10]

In essence, the reduction in uninsurance rates among nonelderly adults between the third quarter of 2013 and the end of 2015 that the ASPE attributes to the ACA is nearly indistinguishable from the reduction in rates reported in the NHIS survey. That being the case, we substitute the NHIS data for the first half of 2016 for the Gallup-Healthways report.[11] Those data indicate that

9. Martinez, Cohen, and Zammitti, *Health Insurance Coverage January–September 2015*, A7, table VII.
10. Ibid.
11. Data from the first half, rather than the first quarter, are used both because they are current and because the data from the second quarter more accurately capture the number of people actually enrolled in coverage. The Department of Health and Human Services (HHS), for example, reported that 12.7 million people had "selected plans" during the 2016 open enrollment period that concluded February 22, 2016. Later in the year, they reported that "effectuated enrollment"—the number of people who actually had coverage through exchange-based plans—was 10.5 million, a decline of 17.3 percent over a period of only a few months.

coverage gains among nonelderly adults totaled nearly 17.1 million over that period.[12]

Through the end of 2015, that figure was 16.5 million.[13] Using December 2015 (rather than sometime in 2016) as an endpoint allows us to compare the NHIS estimate with that of other government surveys. The ACS estimates that 15.8 million nonelderly adults gained coverage over the first two years of the ACA's full implementation.[14] The Census Bureau also estimates the number of uninsured in its Current Population Survey (CPS), its longest-running series of estimates. The CPS estimates that 13.7 million people age 18–64 gained coverage between 2013 and 2015.[15]

The NHIS is thus at the high end of estimates in coverage increases among nonelderly adults between 2013 and 2015. As table 1 shows, its estimate is 0.7 million (4.4 percent) higher than the ACS and 2.8 million (20.4 percent) higher than the CPS. Estimates from these surveys are not yet available for the first half of 2016. Table 1 therefore focuses on the 2013–2015 period to illustrate the range of estimates among government surveys.

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12. Author's calculations are based on tables II and III of Martinez, Cohen, and Zammitti, *Health Insurance Coverage January–September 2015*, and Emily P. Zammitti, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2016* (Washington, DC: National Center for Health Statistics, 2016). Table II of the 2015 document reports that 39.6 million people age 18–64 were uninsured during 2013. Table III reports that they represented 20.4 percent of that age group. That implies that 154,517,600 people had public or private health coverage in 2013. Data from the 2016 study suggest that the number of insured nonelderly adults had risen to 171,587,100 by June 2016 (24.4 million 18- to 64-year-olds, representing 12.4 percent of that age group, lacked coverage). That computes to an increase of 17,069,500 people with coverage in that age group between 2013 and June 2016.

13. Author's calculations are based on tables II and III of Martinez, Cohen, and Zammitti, *Health Insurance Coverage January–September 2015*. Table II reports that 39.6 million people age 18–64 were uninsured during 2013. Table III reports that they represented 20.4 percent of that age group. That implies that 154,517,600 people had public or private health coverage in 2013. The comparable number for 2015 was 170,993,800 (25.1 million 18- to 64-year-olds, representing 12.8 percent of that age group). That computes to an increase of 16,476,200 individuals with coverage during that period.

14. For 2013, the ACS estimates that 39,500,682 people age 18–64 were uninsured in 2013, out of a population of 194,358,411. That means that 154,857,729 nonelderly adults had coverage in that year. For 2015, the number of nonelderly adults with coverage had risen to 170,690,058, representing an increase of 15,832,329 over the two-year period.

15. Table 3 of a 2013 Census Bureau report estimates that 159.0 million people age 18–64 had coverage in that year. Jessica C. Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2013* (Washington, DC: US Census Bureau, 2014), table 3. Table A2 of the Census Bureau's 2015 report estimates that the number had risen to 172.7 million by 2015, an increase of 13.7 million people with coverage. Jessica C. Barnett and Marina S. Vornovitsky, *Health Insurance Coverage in the United States: 2015* (Washington, DC: US Census Bureau, 2016), table A2. Unlike respondents to the NHIS and ACS surveys, respondents to the Census survey were asked whether they had had coverage for the entire prior year rather than whether they were insured at the time of the survey.

TABLE 1. ESTIMATES OF COVERAGE GAINS AMONG NONELDERLY ADULTS, 2013–2015

NHIS	ACS	CPS	Haislmaier and Gonshorowski
16.5 million	15.8 million	13.7 million	14.0 million

The table also includes in the fourth column data from a Heritage Foundation study by Edmund F. Haislmaier and Drew Gonshorowski.[16] That study uses data derived from insurer regulatory filings and Medicaid and CHIP reports to the Centers for Medicare and Medicaid Services to estimate a net increase of just over 14 million among the under-65 population over the 2014–2015 time period. The NHIS estimated coverage gains are 2.5 million (17.9 percent) higher than those found by Haislmaier and Gonshorowski.

Table 1 illustrates that there is a range of estimates of the number of people who gained coverage over the first two years of the ACA's implementation. There is a more than 20 percent variation between the low (13.7 million) and the high (16.5 million) estimates, illustrating the dangers of relying on a single government source as the authoritative estimate of coverage gains. It is essential that policy analysts bear in mind that precise estimates are not possible. Each survey methodology has its own strengths and weaknesses, and the regulatory and governmental data on which the Heritage study relies are not without shortcomings and omissions.[17]

Estimate of Coverage Gains between 2010 and 2013

The ASPE's estimate that coverage gains among young adults totaled 2.3 million between 2010 and 2013 overlooks substantial private coverage losses among nonelderly adults in other age groups over that period.

The ASPE arrives at the 2.3 million estimate by comparing the uninsurance rate among 19- to 25-year-olds in 2010 (34.1 percent) to the same rate in October

16. Edmund F. Haislmaier and Drew Gonshorowski, "2015 Health Insurance Enrollment: Net Increase of 4.8 Million, Trends Slowing" (Issue Brief No. 4620, Heritage Foundation, October 31, 2016), 2, table 1. The figures from this table are for the entire nonelderly population, including children. The net increase in coverage among adults age 18–64 is consequently lower than the 14 million estimate. CHIP provides coverage to children in families whose incomes are too high to qualify for Medicaid.

17. The data used by Haislmaier and Gonshorowski, for example, do not include information about self-funded plans that are administered by an entity that is not an insurance company. The authors note that these plans represent fewer than 5 percent of self-insured plans.

TABLE 2. PERCENTAGE OF PEOPLE UNDER AGE 65 WITH PUBLIC AND PRIVATE COVERAGE, 2008–2013

Year	Public coverage	Private coverage
2008	19.3	65.4
2009	21.0	62.9
2010	22.0	61.2
2011	23.0	61.2
2012	23.5	61.0
2013	23.8	61.0

Note: Numbers do not add to 100 percent in any year because the remainder of the population was uninsured and consequently had neither public nor private coverage.

2013 (26.7 percent), when the ACA's first open enrollment season kicked off. These uninsurance rates, once again, are virtually identical to those reported in the NHIS.[18] The ASPE study concludes that this reduction in the uninsured was entirely "due to the ACA's provision allowing young adults to stay on a parent's plan until the age of 26."[19]

The decline in the uninsurance rate for this age group between 2010 and 2013 is undeniable. But private coverage rates among the nonelderly population fell to historic lows over this same period. The net coverage increase among the under-65 population between 2010 and 2013 was because of increases in public coverage, as table 2 shows.

This unexpected trend remains unexplained in the ASPE report. The drop in private coverage was most pronounced between 2008 and 2009, at the trough of the Great Recession. But private coverage among the nonelderly continued to fall throughout the recovery, despite significant employment gains. It bottomed out at 61 percent in 2012 and remained there in 2013, 4.4 percentage points below its prerecession level. Public coverage was 1.8 percentage points higher in 2013 than in 2010, while private coverage declined by 0.2 percentage points over that period.

Table 3 displays the nonelderly data by broad age classifications. It shows that the percentage of people age 19–25 with private coverage rose substantially between 2010 and 2013, buttressing the ASPE's conclusion that the ACA helped people in this age group. In 2013, 58.1 percent of young adults were enrolled in private coverage, 2.4 percentage points more than in 2008.

18. NHIS data show that the uninsurance rate among this age group declined from 33.9 percent in 2010 to 26.5 percent in 2013. Robin A. Cohen and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2013* (Washington, DC: National Center for Health Statistics, 2014), table 3.
19. Uberoi, Finegold, and Gee, *Health Insurance Coverage and the Affordable Care Act*, 7.

TABLE 3. PERCENTAGE OF NONELDERLY PEOPLE WITH PUBLIC AND PRIVATE COVERAGE BY AGE GROUP, 2008–2013

	18–64		19–25		Under 18	
Year	Public	Private	Public	Private	Public	Private
2008	13.4	68.1	14.0	55.7	34.2	58.3
2009	14.4	65.8	15.0	52.6	37.7	55.7
2010	15.0	64.1	15.7	51.0	39.8	53.8
2011	15.9	64.2	16.8	56.2	41.0	53.3
2012	16.4	64.1	17.5	57.2	42.1	52.8
2013	16.7	64.2	16.1	58.1	42.2	52.6

TABLE 4. PERCENTAGE OF CHILDREN WITH PRIVATE COVERAGE AFTER THE RECESSIONS OF 2001 AND 2008–2009

	Recession of 2001	Recession of 2008–2009
Prerecession year	67.1	59.9
Last year of recession	66.7	55.7
First year of recovery	63.9	53.8
Second year of recovery	62.6	53.3
Third year of recovery	63.1	52.8
Percentage point change	−4.0	−7.1
Percentage change	−6.0	−11.9

Source: National Bureau of Economic Research, "US Business Cycle Expansions and Contractions," April 23, 2012.

But the gains among adults age 19–25 contrast sharply with a decline in the percentage of people with private coverage among the rest of the nonelderly population. Over this period, the number of adults age 26–64 grew by more than 2.8 million, but the number with private coverage was slightly less in 2013 than in 2010.

And while private coverage increased among young adult dependents, it fell sharply among child dependents, declining by 5.7 percentage points (from 58.3 percent in 2008 to 52.6 percent in 2013). This reduction in rate is more than double the private coverage gains among young adults. This is an especially curious development, since children with private insurance, like young adults, are typically covered under their parents' policies.

Table 4 shows that this private coverage decline among children was far greater during the first three years after the Great Recession than it was during the first three years of recovery after the 2001 recession.

While private coverage among children fell during and after both recessions, the decline was much more pronounced after the recession of 2008–2009.

Nearly 12 percent fewer children had coverage during the third year of recovery after the Great Recession, compared with 6 percent fewer after the recession of 2001. That discrepancy suggests that a greater proportion of working-age adults lost their private insurance during the latter period. Paradoxically, while more workers (and consequently more children) lost employer-sponsored coverage during and after the most recent recession, a greater percentage of young adults were able to remain on their parents' plans.

The effects of the ACA on private coverage during the period before 2014 are thus complex. The ASPE study seizes on the one inarguably positive effect: an increase in the number of young adults with private coverage. But outside that population, there was a substantial decline in the proportion of people with private coverage. In all, while the population of children and of workers age 26–64 increased by more than 2.3 million between 2010 and 2013, the number with private coverage declined by nearly 1.2 million.[20]

It could be argued, of course, that the ACA stood as a bastion against a broad secular decline in coverage, at least for a small segment of the nonelderly population. But perhaps other regulations imposed by the ACA on the individual and small-group markets before 2014 made the decline in coverage worse than it would otherwise have been. The ACA imposed new requirements on group health plans renewed after September 23, 2010. For example, these plans could no longer impose annual and lifetime limits on medical claims. They were also required to cover preventive services at no charge at the point of service. And they were mandated to cover the preexisting conditions of newly enrolled children. All of these new requirements increased the costs of group coverage and may have contributed to declines in that coverage among workers and their children. In addition, medical loss ratio requirements also influenced the cost of coverage.

"Perhaps . . . regulations imposed by the ACA on the individual and small-group markets before 2014 made the decline in coverage worse than it would otherwise have been."

20. Had coverage rates remained at 2010 levels, the number of adults age 26–64 and children with private insurance would have been more than 2.8 million higher in 2013.

Most importantly, the mandate that group health plans cover dependents up to age 26 affected those costs. Gopi Shah Goda, Monica Farid, and Jay Bhattacharya find that workers with employer-based coverage—whether or not they have dependent children—experience an annual reduction in wages of approximately $1,200 as a result of this mandate.[21] The wage effect was larger in firms with fewer than 100 workers. It is hardly unreasonable to infer that some employers might have chosen to avoid these effects by dropping coverage. The dependent coverage mandate itself may thus have contributed to declines in the percentage of workers and children with private coverage during this period.

Additionally, public coverage of children increased during and after both recessions, suggesting that public coverage may to some extent have crowded out private coverage. It is worth noting, in that regard, that the CHIP program, which provides enhanced federal matching funds to states for public coverage of children whose parents earn too much to qualify for Medicaid, was created shortly before the recession of 2001. It was reauthorized and expanded in 2009, the year before the ACA was enacted.[22]

While it is beyond the scope of this paper to examine these effects in detail, it is incumbent upon the ASPE to account for these anomalies. The study seems instead to claim that the ACA increased coverage, ignoring the fact that overall coverage increased for one small group, while all other groups had unexplained declines in their rates of private coverage. This is especially troubling since one obvious potential factor in those declines is the increased costs imposed on group health plans by ACA regulations, including the dependent care mandate itself.

The 20 million figure is consequently problematic. It is much more accurate to say that the number of nonelderly adults with health coverage increased by 13.7 million for a total of 16.5 million during the ACA's first two years of full implementation.[23] One could add that 2.3 million young adults also gained coverage in

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21. Gopi Shah Goda, Monica Farid, and Jay Bhattacharya, "The Incidence of Mandated Health Insurance: Evidence from The Affordable Care Act Dependent Care Mandate" (NBER Working Paper No. 21846, National Bureau of Economic Research, Cambridge, MA, January 2016).
22. Pub. L. No. 111-3, 123 Stat. 8 (2009). The ACA also increased the federal match for CHIP by 23 percentage points beginning in fiscal year 2016. Several studies have attempted to assess the effect of CHIP on crowding out private health coverage. See, for example, Carol Roan Gresenz et al., "Take-Up of Public Insurance and Crowd-Out of Private Insurance under Recent CHIP Expansions to Higher Income Children" (NBER Working Paper No. 17658, National Bureau of Economic Research, Cambridge, MA, December 2011).
23. While data from all government survey sources for 2016 are not yet available, Haislmaier has presented an update of his study to the House Budget Committee. Using preliminary figures through September 2016, he estimates coverage gains of 16.5 million, with Medicaid and CHIP accounting for 13.8 million of the additional enrollees. Edmund F. Haislmaier, "The Real Changes in Health

the 2010–2013 period, with the caveat that the rate of private coverage declined among children and among workers age 26–64. At the very least, it should be noted that 1.2 million fewer people in these age groups had private coverage in 2013 than in 2010, offsetting more than half the gain among those age 19–25.

HAISLMAIER AND GONSHOROWSKI (2015 AND 2016)

This range of estimates is corroborated by studies written by Edmund Haislmaier and Drew Gonshorowski, who find that the number of people under age 65 who gained coverage in 2014 and 2015 was just over 14 million (see table 1).[24]

Unlike other studies that rely on survey data, Haislmaier and Gonshorowski base their analyses of private health coverage on a Mark Farrah Associates (MFA) dataset. The MFA data are derived from insurer regulatory filings compiled by the National Association of Insurance Commissioners. For self-insured plans administered by insurers, MFA supplements information from insurer regulatory filings with other public and private sources, including filings with the Securities and Exchange Commission.[25] For Medicaid and CHIP enrollment, the authors use figures from CMS state-level monthly enrollment reports. Since CMS did not include enrollment data for December 2013, the authors use figures from the Kaiser Commission on Medicaid and the Uninsured for their baseline estimates.[26] The results are reported in table 5.

The study finds that the number of people with individual coverage grew by nearly 5.9 million people over the first two years of full ACA implementation. At the end of 2015, 17.7 million people had such coverage, a 50 percent increase over the 11.8 million people who had nongroup coverage in December 2013. According to HHS data,[27] 8.8 million people—roughly half the 2015 market—were enrolled through the exchanges at the end of December 2015, of whom nearly

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Insurance Enrollment under the Affordable Care Act" (Testimony before the House Budget Committee, Heritage Foundation, Washington, DC, January 24, 2017).

24. Edmund F. Haislmaier and Drew Gonshorowski, "2014 Health Insurance Enrollment: Increase Due Almost Entirely to Medicaid Expansion" (Backgrounder No. 3062, Heritage Foundation, October 15, 2015); Haislmaier and Gonshorowski, "2015 Health Insurance Enrollment."

25. The data from Mark Farrah exclude information about enrollment in self-insured plans administered by entities other than insurance companies. MFA believes such plans account for no more than 5 percent of the self-insured market. Haislmaier and Gonshorowski exclude enrollment in the Federal Employees Health Benefit plans, Medicare Advantage plans, and supplemental coverage products (e.g., dental, vision, prescription drug) from their analysis.

26. Laura Snyder et al., "Medicaid Enrollment Snapshot: December 2013" (Issue Brief, Kaiser Commission on Medicaid and the Uninsured, Menlo Park, CA, June 2014), table A-1.

27. Centers for Medicare and Medicaid Services, "December 31, 2015 Effectuated Enrollment Snapshot," March 11, 2016.

TABLE 5. CHANGE IN COVERAGE BY MARKET SEGMENT, 2014–2015

	2014	2015	TOTAL
Private coverage change			
Individual market change	4,738,257	1,124,702	5,862,959
Group market change			
Fully insured change	−6,654,985	−932,263	−7,587,248
Self-insured change	2,131,690	1,858,189	3,989,879
Total group market change	−4,523,295	925,926	−3,597,369
Total private market change	214,962	2,050,628	2,265,590
Public coverage change			
Medicaid and CHIP change			
Medicaid expansion states	8,267,677	2,127,220	10,394,897
Medicaid nonexpansion states	725,048	639,089	1,364,137
Total Medicaid and CHIP change	8,992,725	2,766,309	11,759,034
TOTAL PUBLIC AND PRIVATE CHANGE	9,207,687	4,816,937	14,024,624

7.4 million were receiving subsidies. The number of people receiving subsidies thus exceeds the net growth in nongroup coverage (5.9 million), confirming the powerful effect that these subsidies had on the individual market.

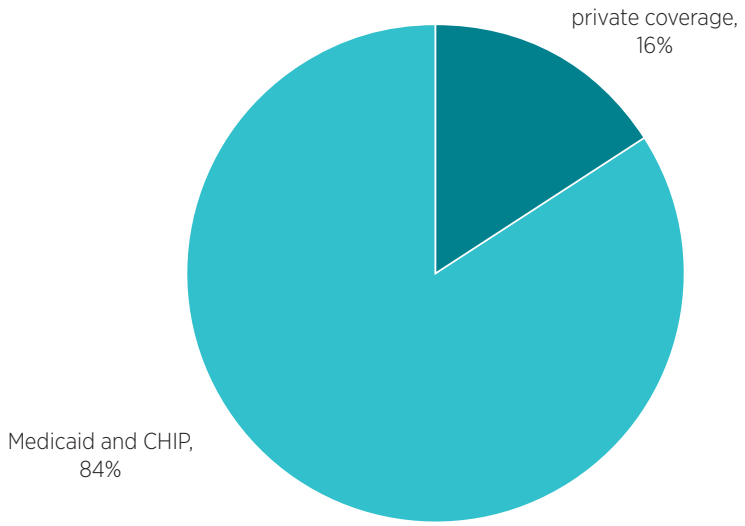
Haislmaier and Gonshorowski's most consequential finding is that this increase in nongroup coverage was to a large extent offset by a contraction in the group market. That contraction was greatest in the fully insured employer market, which covered 7.6 million fewer people in December 2015 than in December 2013. The self-insured group market grew by nearly 4 million people over the same period of time, limiting net losses in the group market to 3.6 million people.

Medicaid and CHIP enrollment increases far exceeded gains in private coverage in 2014 and 2015, the study finds. An estimated 60.9 million individuals had Medicaid or CHIP coverage in December 2013, according to the Kaiser Commission on Medicaid and the Uninsured. That figure had grown to 72.7 million at the end of 2015, an increase of nearly 11.8 million.

Figure 1 illustrates the study's finding that Medicaid and CHIP enrollment was responsible for the lion's share of coverage increases in 2014 and 2015.

The strength of the Haislmaier and Gonshorowski study lies in its reliance on data from insurance company regulatory filings and the federal government. This allows for precision and a level of detail that survey data do not supply. It distinguishes, for example, between individual and group insurance and between

FIGURE 1. NET COVERAGE GAINS, 2014–2015



Source: Edmund F. Haislmaier and Drew Gonshorowski, "2015 Health Insurance Enrollment: Net Increase of 4.8 Million, Trends Slowing" (Issue Brief No. 4620, Heritage Foundation, October 31, 2016).

fully insured and self-insured plans, something that surveys cannot do. In addition, by using Medicaid and CHIP enrollment data from government sources, it avoids Medicaid undercounts that are characteristic of government surveys.[28] The study, however, does not analyze the extent to which the ACA is responsible for changes in coverage. Medicaid enrollment, for example, grew annually even before enactment of the ACA. Private health coverage was declining in the period immediately preceding the law's full implementation, as discussed above. The study does not attempt to assess the extent to which increases in public and private coverage can be ascribed to the ACA.

FREAN, GRUBER, AND SOMMERS (APRIL 2016)

Molly Frean, Jonathan Gruber, and Benjamin D. Sommers attempt to make this assessment.[29] Using ACS data, the authors construct a model whose policy parameterization explains roughly 60 percent of the increase in coverage

28. See footnote 33 for more about the Medicaid undercount.
29. Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act" (NBER Working Paper No. 22213, National Bureau of Economic Research, Cambridge, MA, April 2016).

between 2012–2013 and 2014–2015.[30] They attribute the remainder to the general social effect of the individual mandate and to the economic recovery.[31] Figure 2 illustrates their findings.

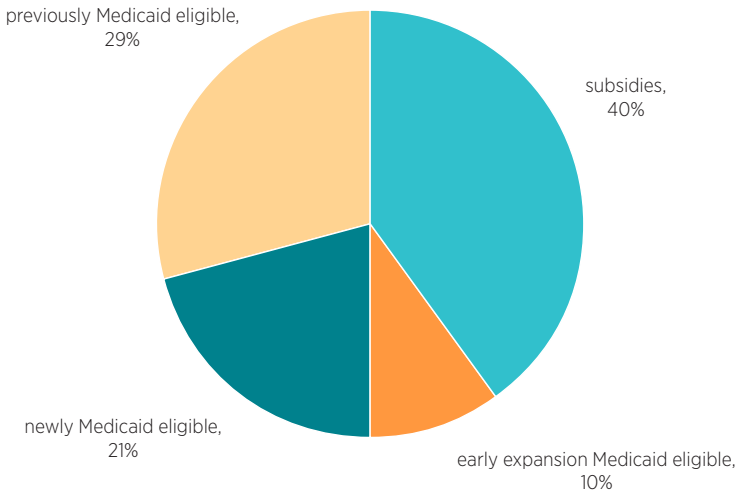
The authors find that subsidies available to people who bought insurance through the exchanges had a powerful effect on increased enrollment. Specifically, they find that each 10 percent increase in subsidies reduced the uninsurance rate by 0.5 percent in 2014 and by 0.9 percent in 2015.[32] These subsidies accounted for 40 percent of coverage gains in both 2014 and 2015.[33]

Medicaid was a far more significant source of increased coverage, accounting for 60 percent of the reduction in the number of uninsured over the two years. Of that 60 percent, a little more than half (31 percent of the total reduction) were made eligible for Medicaid under new criteria established by the ACA. Of these, about one-third (10 percent of the total reduction) lived in six states that expanded Medicaid eligibility prior to January 2014. The remainder (21 percent of the total reduction) lived in states that expanded Medicaid eligibility standards beginning in 2014 or 2015.

The other half of the 60 percent who signed up for Medicaid after the expansion (29 percent of the total reduction in the number of uninsured) would have been eligible for coverage under standards that predated the ACA. This "woodworking" or "welcome mat" effect is quite large. The authors note that the enrollment of previously eligible people in the program may be the indirect result of other ACA provisions. They cite the law's creation of a streamlined application process and its elimination of asset tests as factors. The ability of

30. Ibid., 4.
31. Ibid., 5.
32. Ibid.
33. Ibid. While the study finds that Medicaid was responsible for the majority of coverage gains, their 60 percent estimate is lower than what Haislmaier and Gonshorowski find. Part of this discrepancy may have to do with differences between survey data and CMS enrollment figures. Government surveys consistently undercount the number of people with Medicaid coverage. The NHIS, for example, estimates that 17.8 percent of the population was enrolled in Medicaid or CHIP in 2015. The ACS, on which Frean and her coauthors based their study, estimate the population enrolled in Medicaid or CHIP in 2015 at 15.3 percent. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), which collected enrollment data from CMS, the correct figure is 22.8 percent. See *MACStats: Medicaid and CHIP Data Book* (Washington, DC: MACPAC, December 2016), 3, exhibit 1. That exhibit also contains the NHIS estimate. The ACS 2015 estimate of Medicaid enrollment can be found at US Census Bureau, "Public Health Insurance Coverage by Type: 2015 American Community Survey 1-Year Estimates," American FactFinder, accessed February 24, 2017, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S2704&prodType=table.

FIGURE 2. EFFECT OF ACA ON COVERAGE EXPANSIONS, 2015



Source: Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act" (NBER Working Paper No. 22213, National Bureau of Economic Research, Cambridge, MA, April 2016), 42, table 4.

healthcare providers to enroll patients in Medicaid and CHIP may also have contributed to this enrollment surge.[34]

Regardless of the causes of woodworking, the study confirms that increases in public coverage account for much of the ACA's effect on uninsurance rates and that roughly half that growth in public coverage was among people who met pre-ACA eligibility standards.

CROWD-OUT

Frean, Gruber, and Sommers find no evidence of "crowd-out"—the substitution of Medicaid or CHIP coverage for private insurance. Their finding is at variance with studies conducted by other researchers.

Robert Kaestner et al. examine the effect of ACA Medicaid expansions on health insurance coverage and labor supply.[35] Using Census Bureau data (both the

34. Medicaid.gov, "Presumptive Eligibility for Medicaid and CHIP Coverage," accessed February 24, 2017, https://www.medicaid.gov/medicaid/outreach-and-enrollment/presumptive-eligibility/index.html.
35. Robert Kaestner et al., "Effects of ACA Medicaid Expansion on Health Insurance Coverage and Labor Supply" (NBER Working Paper No. 21836, National Bureau of Economic Research, Cambridge, MA, December 2015).

ACS and the Current Population Survey), they find little effect on labor supply but substantial switching from private insurance to Medicaid among some groups.[36]

Crowd-out was most pronounced among unmarried parents living in states that had previously expanded their Medicaid eligibility criteria. Among those groups, the authors find a crowd-out rate of 69 percent.[37] They find lower crowd-out rates in other populations. Among parents in expansion states with less than a high school education, they find a crowd-out rate of 25 percent.[38] They find a slightly higher crowd-out rate (35 percent) among low-income parents in expansion states.

Charles Courtemanche et al. also find some evidence of crowd-out.[39] Using ACS data, they conclude that, for adults with incomes below 138 percent of the federal poverty level, Medicaid expansion increased coverage by 8 percentage points while decreasing private coverage by 1.8 percentage points.[40] This 23 percent crowd-out rate, the authors note, is similar to that found among certain populations by Kaestner et al. Unlike Kaestner et al., however, Courtemanche et al. find that "the effects in both studies are statistically insignificant and therefore should be deemed inconclusive."[41]

The differences among these various studies point yo the difficulty of determining the extent to which increases in public coverage come at the expense of private coverage. The matter warrants further study.

CONCLUSION AND POLICY IMPLICATIONS

The ACA's system of regulation, subsidies, penalties, and public program expansions has resulted in a substantial reduction in the rate of uninsurance. These coverage gains have been especially prevalent among nonelderly adults with incomes below 200 percent of the federal poverty level. Estimating the magnitude and sources of these coverage gains is an uncertain enterprise. This paper has tried to identify some of the factors that complicate these estimates. It concludes the following:

36. Ibid., 7.
37. Ibid., 18.
38. Ibid., 17.
39. Charles Courtemanche et al., "Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States" (NBER Working Paper No. 22182, National Bureau of Economic Research, Cambridge, MA, April 2016).
40. Ibid., 31.
41. Ibid.

- The claim that the ACA has resulted in coverage increases of 20 million nonelderly adults since its enactment in 2010 is likely overstated. The ACA's greatest effects on coverage occurred in 2014 and 2015, when its major provisions took effect. According to the NHIS, the number of adults age 18–64 with public or private coverage increased by 16.5 million over that period. This is slightly higher than the ACS estimate of a 15.8 million increase and substantially greater than the CPS estimate of a 13.7 million increase. Data from insurance company regulatory filings place the net number of newly insured individuals under the age of 65 (including children) at just over 14 million.

  Attempts to credit the ACA with a 2010–2013 coverage increase of 2.3 million among young adults are clouded by a decline of 1.2 million in the number of people with private coverage among the rest of the nonelderly population, including younger dependents, over the same period. New federal regulations imposed on private plans during that period, including the dependent care mandate, may have contributed to this decline in private coverage by increasing its cost. Until the potential effects of the ACA on the reduction in private coverage during that period are assessed, one should be cautious in crediting the law with private coverage increases before 2014 that occurred only for a single group.

- Medicaid and CHIP are by far the largest source of insurance for newly covered adults. Most of the debate about the ACA concerns its effect on individual health insurance markets. But the largest source of its net increase is public insurance. Higher Medicaid and CHIP enrollment accounts for 84 percent of the net coverage gains among the under-65 population, according to Haislmaier and Gonshorowski. Frean, Gruber, and Sommers estimate that 60 percent of coverage gains attributable to the ACA were through public programs.

- Much of the public program expansion is due to a "woodworking" or "welcome mat" effect. Frean, Gruber, and Sommers estimate that roughly half the Medicaid/CHIP growth attributable to the ACA was among those who were eligible under pre-ACA standards. The number of adults on Medicaid in the 19 states that have not expanded eligibility increased by 1.36 million. In states that expanded coverage of childless, nondisabled adults, many who have been added to the Medicaid rolls would have qualified under preexisting eligibility standards.

"Despite tens of billions in public spending on individual and corporate subsidies, the financial performance of insurance companies that participated in the exchanges in 2014 was poor."

- Researchers have reached conflicting conclusions on the extent to which this public program expansion has crowded out private coverage. Given the substantial increase in public coverage, it is not unreasonable to suspect that some crowd-out may be occurring. The evidence of crowd-out is inconclusive, however, and the issue warrants further inquiry.
- Private coverage has shown less impressive gains. The Haislmaier and Gonshorowski study finds that while subsidies have helped enlarge the nongroup market, that increase has to a large extent been offset by a decline in group coverage. This finding is perplexing and may have a variety of causes. Given that the NHIS data show an erosion in private coverage in the period between the ACA's enactment and its full implementation, this decline in the group market may have begun during the 2010–2013 period, when the percentage of Americans with private coverage plummeted to historic lows. The increase in nongroup coverage appears to be concentrated among those with incomes between 138 and 200 percent of the federal poverty level (100–200 percent in states that have not expanded Medicaid).[42] Given the richness of premium subsidies and cost-sharing subsidies received by these enrollees, this private coverage might reasonably be characterized as quasi-public.

If assessing the coverage effects of the ACA is vexing and uncertain, assessing the effects of its hypothetical repeal are more difficult still. First, most who advocate the ACA's repeal have said they want to replace it with something else. Replacement plans advanced by congressional

42. At the conclusion of the 2016 ACA open enrollment period, CMS reported that 66 percent of those who had selected plans had incomes of 200 percent of the federal poverty level or less. *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report* (Washington, DC: ASPE, Department of Health and Human Services, March 11, 2016), 29.

Republicans vary in approach. Until such legislation is written, it is impossible to fairly assess its potential effects on coverage.

Second, estimates of changes in coverage have to date been consistently erroneous. The Congressional Budget Office (CBO) overestimated the number of people who would gain nongroup coverage in 2016 by more than 100 percent.[43] Medicaid enrollment in expansion states exceeds CBO projections by roughly 50 percent.[44] More recently, CBO has estimated that 18 million people would immediately lose coverage were Congress to repeal the individual mandate.[45] The consequences would be especially devastating in the nongroup market, where 10 million people would drop or decide not to renew their policies and premiums would rise by 20 to 25 percent, according to the report. That would mean the individual market would immediately shrink by more than half: from 18 million to 8 million.[46] The resulting market would be nearly 50 percent smaller than the pre-ACA market.[47] Disruptions of this magnitude and suddenness are, of course, not inconceivable. But they appear to be out of line with other estimates.[48] Given CBO's track record on the coverage effects of the ACA's enactment, there is little reason to place confidence in the agency's estimate of the coverage effects of its repeal.

Third, these estimates all assume that insurers will continue to participate in the health insurance exchanges if the status quo prevails. This is by no means a safe assumption. Despite tens of billions in public spending on individual and corporate subsidies, the financial performance of insurance companies that

43. In May 2013, CBO forecast that 22 million people would be enrolled in exchange-based coverage in 2016. See Congressional Budget Office, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," accessed February 24, 2007, https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf. HHS reported that in June 2016, exchange-based enrollment stood at 10.5 million people. CMS, "First Half of 2016 Effectuated Enrollment Snapshot," October 19, 2016.

44. Brian Blase, "Learning from CBO's History of Incorrect Obamacare Projections," *Forbes*, January 2, 2017.

45. Congressional Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums*, January 2017.

46. Haislmaier and Gonshorowski estimate that approximately 18 million people were enrolled in individual health insurance policies in 2015. Haislmaier and Gonshorowski, "2015 Health Insurance Enrollment."

47. Haislmaier and Gonsorowski estimate that 11.7 million people had individual health insurance coverage in December 2013. Haislmaier and Gonshorowski, "2015 Health Insurance Enrollment."

48. A Rand Corporation study, for example, found that repealing the individual mandate would reduce enrollment by 20 percent and "cause modest increases in premiums." "Premiums and Stability in the Individual Health Insurance Market" (Research Highlight, Rand Corporation, Santa Monica, CA, 2014). The full study can be found at Christine Eibner and Evan Saltzman, *Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage* (Santa Monica, CA: Rand Corporation, 2014).

participated in the exchanges in 2014 was poor.[49] These losses were especially pronounced in the nongroup market.[50]

CMS data on risk corridors released in November 2016 indicate that these losses deepened in 2015.[51] Under the risk corridor program, CMS transfers money from insurers that overestimated their costs by more than 3 percent to those that underestimated their costs by more than 3 percent. It thus serves as a proxy for "excess" gains and losses made by insurers. In 2014, aggregate excess losses reported by insurers selling ACA-compliant individual policies surpassed excess gains by $2.2 billion. In 2015, that number rose to $5.2 billion.

The individual insurance market remains unstable. At the conclusion of the 2016 open enrollment season, CMS reported that nearly half those who selected plans were age 45 or older. The Kaiser Family Foundation has laid out a general rule of thumb for a stable risk pool in which premiums can vary only by age: enroll young adults in approximately the same proportion that they represent in the pool of potential individual market enrollees.[52] Using that rule, the number of 18- to 34-year-old enrollees should be more than double the number of enrollees age 55–64. At the conclusion of the 2016 open season, there were 3.3 million plan selections among people age 55–64, compared with 3.5 million among people age 18–34.[53] These age imbalances have now persisted through three open enrollment periods, suggesting that the instability may have become permanent.

This instability has caused numerous insurers to withdraw from the individual exchanges in 2017.[54] CMS estimates that 21 percent of Americans now live in areas that will have only one insurer offering exchange-based individual coverage.[55]

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49. Brian Blase, Doug Badger, and Edmund M. Haislmaier, "The Affordable Care Act in 2014: Significant Insurer Losses despite Substantial Subsidies" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, April 2016).
50. Brian Blase et al., "Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, June 2016).
51. CMS, Center for Consumer Information and Insurance Oversight, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year*, November 18, 2016.
52. Larry Levitt, Gary Claxton, and Anthony Damico, "The Numbers behind 'Young Invincibles' and the Affordable Care Act," Kaiser Family Foundation, December 17, 2013.
53. *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report* (Washington, DC: ASPE, Department of Health and Human Services, March 11, 2016), 24–25, appendix table A1. CMS reported that 12.7 million people had chosen plans as of February 22, 2016. By June, the number enrolled in such coverage had fallen to 10.5 million. CMS, "First Half of 2016 Effectuated Enrollment Snapshot."
54. Alison Kodjak, "Aetna Joins Other Major Insurers in Pulling Back from Obamacare," *All Things Considered*, National Public Radio, August 16, 2016.
55. Cynthia Cox and Ashley Semanskee, "Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces," Kaiser Family Foundation, August 2016.

Many of those that remain have reported substantial premium increases, making their product less attractive to young and relatively healthy people.[56]

Given this continued turmoil, it is quite likely that there will be further insurer withdrawals in 2018 even if the status quo is maintained, and that some areas—and potentially entire states—will have no exchange-based coverage. It is no small irony that the task of preserving these markets falls on an administration and a Congress that have vowed to repeal the law.

Finally, as this study has demonstrated, analysts have not yet arrived at a complete understanding of the ACA's coverage effects. Different government surveys provide different estimates of the increase in the number of people with insurance coverage. Data derived from insurer regulatory filings and government Medicaid and CHIP headcounts suggest still different numbers. Researchers take divergent views on whether and to what extent public coverage expansions may have crowded out private insurance, and millions who have qualified for public coverage would have done so under pre-ACA eligibility standards.

Until these and other ACA effects are better understood, predictions that its repeal would increase the number of uninsured by 20–30 million lack credibility.

56. Amy Goldstein, "Average Premiums for Popular ACA Plans Rising 25 Percent," *Washington Post,* October 24, 2016.

ABOUT THE AUTHOR

Doug Badger is a senior fellow at the Galen Institute. His career in public policy spans more than three decades and includes stints as a policy advisor to the White House, the US Senate, the Department of Health and Human Services, and the Social Security Administration.

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