

## Coverage Impacts of Early Medicaid Expansions under Health Reform: A Policy Brief for State and Federal Leaders

Benjamin D. Sommers,<sup>a</sup> Juliana Stone,<sup>a</sup> Genevieve Kenney,<sup>b</sup> and Arnold Epstein<sup>a</sup>  
*<sup>a</sup>Harvard School of Public Health, Boston, MA; <sup>b</sup>The Urban Institute, Washington, DC*

The Affordable Care Act expands Medicaid in 2014 in states that choose to participate. We analyzed four states – Connecticut, the District of Columbia (D.C.),<sup>1</sup> California, and Minnesota – that chose to expand Medicaid eligibility even earlier, in 2010-2011, to uninsured individuals targeted by the ACA. Using administrative and survey data, we examined the impact of these expansions on several key questions: How quickly did enrollment occur? Which newly-eligible adults enrolled? Did the expansion crowd-out private coverage? And were there any spillover effects on previously-eligible adults? Our findings may prove useful to policymakers who are preparing for the 2014 expansion and officials in states still deciding whether to expand.

### Background on the expansions

With an April 1, 2010 expansion date, Connecticut targeted adults with income levels up to 56% or 68% of the Federal Poverty Level (FPL), depending on the region. D.C.'s expansion began on July 1, 2010 and targeted adults with income levels up to 200% FPL. Minnesota's expansion began on March 1, 2011, targeting adults with incomes up to 75% FPL. Finally, California expanded on July 1, 2011, targeting those with incomes up to 133% or 200% FPL, varying by county. All four of these early expander states transferred previous enrollees from pre-existing state or local programs and also enrolled new individuals in Medicaid.<sup>2</sup>

### How quickly did enrollment occur?

Figure 1 shows administrative data on Medicaid enrollment in each state's expansion, excluding individuals transferred from pre-existing programs. In all four states, enrollment proceeded gradually. In D.C. and Connecticut, the two earliest expansions, enrollment has steadily increased for over three years without slowing. California shows a similar pattern over the past 2 years. Minnesota – which had the smallest number of new enrollees – experienced more month-to-month volatility, especially early in the expansion.

This gradual ramp-up is important context to bear in mind when interpreting the initial enrollment reports that will

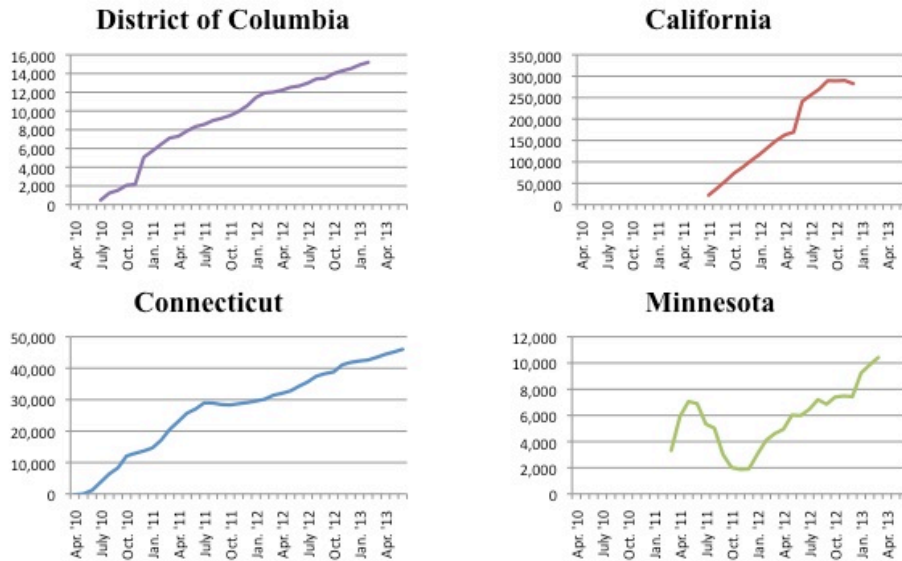
emerge in 2014. Our findings indicate these reports should not be taken as strong indications of the law's ultimate success at expanding coverage. Policymakers should also expect considerable variance in the speed of enrollment across states.

### Which newly eligible adults enrolled?

Using survey data from the Census Bureau's American Community Survey, we compared insurance coverage for adults before and after the two 2010 expansions; data are not yet available on the more recent 2011 expansions. We compared adults eligible for the expansion in Connecticut versus similar adults in other Northeastern states.<sup>3</sup> We compared adults eligible for the expansion in Washington D.C. to similar adults in Virginia. In both cases, we studied so-called "childless adults," adults without dependent children in the home, who were targeted by the expansion.

In Connecticut, we found a significant 4.9 percentage-point increase in Medicaid coverage among eligible childless adults. Among this group, the greatest increase in Medicaid enrollment occurred among those with health-related limitations (a 14.4 percentage-point increase), consistent with prior research on Medicaid participation.<sup>4</sup> This finding has important implications for cost and care delivery planning, suggesting that the initial enrollment in the 2014 expansion may disproportionately occur among those in worse health.

**Figure 1: Administrative Totals of Monthly Enrollment in Medicaid Expansions, Excluding Transfers from Previous State/Local Programs**



**Notes:** Enrollment figures came directly from each state’s administrative data, excluding the estimated number of individuals transferring from previous state/local insurance programs. California’s figures only include those counties that expanded in June 2011; several additional counties expanded in 2012, but those data are not included here to preserve a consistent frame of reference for enrollment.

In D.C., we found a smaller 3.7 percentage-point increase in coverage, which was of borderline statistical significance. The gains may have been less pronounced than in Connecticut, since most new Medicaid enrollees in D.C. were already in the District’s local insurance program. Similarly, nearly a dozen states expanding in 2014 will be building on previous state-funded or waiver programs for childless adults.<sup>5,6</sup>

In D.C., expansion of Medicaid was greater among higher income adults (133-200% FPL). While the 2014 Medicaid expansion will not cover this income group, this group will be eligible for tax credits for coverage through the insurance Marketplaces. The higher take-up rate in this group is also promising for states considering creating a Basic Health Program under the ACA for those in this income range.<sup>7</sup>

**Did expansions enroll uninsured adults, or did they ‘crowd-out’ private coverage?**

Connecticut experienced significant declines in both private coverage and the uninsured rate. 40% of Medicaid gains were from private insurance, while 60% were from uninsured

individuals gaining coverage. Crowd-out occurred predominantly among young adults, and much less so among individuals with health-related limitations. While crowd-out increases public spending, Medicaid may provide better financial protection than private coverage and reduce the risk of underinsurance for poor adults.<sup>8</sup>

Meanwhile, both the changes in uninsured rates and private coverage rates were not statistically significant in D.C., making it difficult to draw firm conclusions on crowd-out in D.C.’s expansion.

**The Woodwork Effect**

In Connecticut, we found a significant 2.7 percentage-point increase in coverage among previously eligible low-income parents, suggesting a positive spillover effect from the Medicaid expansion to childless adults – sometimes called “the woodwork effect.” In D.C., we found no such spillover effect. However, D.C. already had one of the highest Medicaid participation rates in the country; there simply may not have been room for

improvement.<sup>9</sup> Policymakers may expect an even larger spillover effect in 2014, when the individual mandate for insurance begins and Marketplace coverage becomes available.

### Conclusions

Our analysis of four states that expanded Medicaid eligibility to low-income childless adults in 2010 and 2011 reveals several important lessons. We found gradual growth in coverage over time; high enrollment among

those with health-related limitations; evidence of moderate private insurance crowd-out; and positive spillover effects on previously-eligible parents.

While a supportive political climate and the existence of prior state- or locally-funded insurance programs may make these states somewhat unique, these insights into who is likely to enroll and when may inform expectations among policymakers working to implement the 2014 expansion.

---

**Funding:** This research was supported by grants from the Agency for Healthcare Research and Quality and the National Institute of Health Care Management Foundation.

**Not for Distribution:** The current memo is preliminary and not yet for publication. Please contact the authors directly at [bsommers@hsph.harvard.edu](mailto:bsommers@hsph.harvard.edu) before circulating or citing these results.

---

### Notes/References:

<sup>1</sup> For brevity, we refer to the District of Columbia as a state.

<sup>2</sup> While New Jersey and Washington also enacted Medicaid expansions since 2010, those two states exclusively transferred individuals from pre-existing state-funded programs and did not enroll any new individuals, so we excluded them from this analysis.

<sup>3</sup> The Northeastern states of comparison were Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, New York, Pennsylvania, and New Jersey.

<sup>4</sup> Sommers BD, Tomasi MR, Swartz K, Epstein AM. Reasons for the wide variation in medicaid participation rates among States hold lessons for coverage expansion in 2014. *Health Aff (Millwood)* 2012;31:909-19.

<sup>5</sup> Status of State Action on the Medicaid Expansion Decision, as of July 1, 2013. Kaiser Family Foundation, 2013. (Accessed at <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.)

<sup>6</sup> Kaiser. Where are states today? Medicaid and state-funded coverage eligibility levels for low-income adults. Washington, D.C.: Kaiser Family Foundation; 2012.

<sup>7</sup> Dorn S. The Basic Health Program option under Federal Health Reform: Issues for Consumers and States. Washington, D.C.: Urban Institute, 2011. (Accessed at: <http://www.urban.org/publications/412322.html>).

<sup>8</sup> Magge H, Cabral HJ, Kazis LE, Sommers BD. Prevalence and Predictors of Underinsurance Among Low-Income Adults. *J Gen Intern Med* 2013.

<sup>9</sup> Kenney GM, Lynch V, Haley J, Huntress M. Variation in Medicaid eligibility and participation among adults: implications for the Affordable Care Act. *Inquiry* 2012;49:231-53.