Opinion: Love it or hate it, Obamacare has expanded coverage for millions

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The most significant pieces of the Affordable Care Act (ACA), or "Obamacare," were implemented in 2014. These include expanding Medicaid in many states, the establishment of insurance exchanges with subsidized coverage and the individual mandate, which requires individuals to purchase health insurance.

One aim of the law was to expand coverage to the very poor. That was to be done by expanding Medicaid, a joint federal-state insurance program for the poor and disabled. Medicaid is generally funded by the federal government with matching grants to the states, which administer the plan.

Under the ACA, the federal government offered money to states to expand Medicaid to those at or below 138 percent of the federal poverty line. The expansion became politicized, however, and many states chose to forgo the federal money and not expand. As of today, 19 states have not expanded Medicaid. As a result, about three million poor people across the country did not gain the coverage that the law originally intended.

Even so, several studies have since documented large gains in insurance coverage between 2013 and 2014 for other groups of uninsured people. One natural question is: How much of these gains in coverage came from the ACA? Could the higher number of insured people have come from other factors, notably a better economy?

In a recently released National Bureau of Economic Research working paper, we use data from the American Community Survey (ACS) to answer this question. We find that the ACA led to a 5.9 percentage point gain in insurance coverage in Medicaid expansion states and a 3.0 percentage point gain in coverage in nonexpansion states.

President Obama himself cited our work as supporting the claim that the ACA is the primary cause of recent national gains in coverage in his much-publicized article about the ACA in the *Journal of the American Medical Association* (*JAMA*).

With the election only weeks away, the ACA is going into its fourth open enrollment period. With some insurers having exited the ACA marketplace, causing premiums to rise, many Americans are asking whether the law is in peril.

If you look at our numbers, however, it is hard to escape the fact that it has helped 20 million people over three years gain insurance coverage – one of the law's primary objectives.

Disentangling the Medicaid numbers

One of the major contributions of our NBER working paper is to separately evaluate the impact of the Medicaid expansion from the other components of the ACA.

We accomplish this by taking advantage of both the fact that some states expanded their Medicaid programs under the ACA while others did not. Also, within a given state one would have expected larger gains in coverage to come from areas with larger pre-ACA uninsured rates. This analysis allows us to disentangle the causal effect of the ACA from the underlying time trend in insurance coverage.

For example, we estimate that the ACA including the Medicaid expansion increased insurance coverage by 5.9 percentage points. This is calculated using the average local area pre-ACA uninsured rate. The effect reached as high as 15.4 percentage points in the area with the highest uninsured rate.

The effect of the other components of the ACA without the Medicaid expansion was only 3.0 percentage points at the average uninsured rate, reaching as high as 7.8 percentage points.

A look at employer plans and individual plans

We also examine gains by type of coverage, finding that coverage gains in non-Medicaid expansion states came entirely from private insurance, divided evenly between gains in employer-sponsored insurance (ESI) and non-group coverage.

This result is unexpected and interesting for two reasons.

First, the ACA was not designed to alter the employer-provided insurance market. Also, the employer mandate had not yet been implemented in 2014. Because of that, we might have expected a smaller effect on ESI.

These gains in work-related coverage may represent employees, their spouses or their dependents responding to the individual mandate by increasing their take-up of ESI.

Second, because eight million people enrolled in the exchanges in 2014, we might have expected a larger effect on non-group coverage.

Our back-of-the-envelope calculations suggest that only 27 percent of people who purchased a plan through the exchanges were newly covered.

That being said, even if individuals with exchange plans already had some form of pre-ACA coverage, the quality of their coverage may have improved along several dimensions, such as the range of services covered.

Coverage gains from the Medicaid expansion can be attributed solely to increased Medicaid coverage. We find no evidence that individuals dropped their private coverage in order to enroll in newly offered public coverage.

Who was signing up?

Finally, we estimate how gains in coverage differed by different demographic groups.

The increases in coverage from the ACA with the Medicaid expansion were largest for those without a college degree, nonwhites, 19-34-year-olds, unmarried individuals and those without children in the home.

These subgroup findings have important implications with respect to disparities in coverage. For instance, our estimates imply that the fully implemented ACA reduced the coverage gap between the lowest and highest education groups by 11.4 percent. Without the Medicaid expansion, this gap is lowered by only 6.7 percent.

The ACA with the Medicaid expansion reduced the coverage gap between whites and nonwhites by 2.0 percentage points (14 percent). The ACA without the Medicaid expansion actually increased this gap in coverage.

New data will show trends

One limitation of our paper is that we estimate only the effects in the first year of full ACA implementation, due to data availability.

It would certainly be valuable to revise our estimates as additional waves of the ACS become available. The number of people who purchased an exchange plan increased from 8 million in 2014 to 8.8 million in 2015, and 12.7 million have selected an exchange plan in 2016.

Large increases in the maximum size of the individual mandate penalty in both 2015 and 2016 may lead to increases in the impact of the ACA on individually purchased and overall coverage.

Additionally, several states (Pennsylvania, Indiana, Alaska and Montana) have elected to expand their Medicaid program in 2015 or 2016. The employer mandate will come into play in the future as well.

Though these subsequent changes may lead to further coverage increases, higher-than-expected exchange premiums and insurer exits from the exchange market could actually reduce coverage.

The motivation for this work was to provide crucial evidence about the early effects of the ACA that may potentially inform ongoing debates regarding health policy.

More information: Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States (DOI): 10.3386/w22182

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