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The ACA and the States

Andrew J. Rettenmaier and Thomas R. Saving

States have responded quite differently in implementing provisions of the Affordable Care Act (ACA), to say the least. They differ in terms of whether they developed their own insurance marketplace or participated in expanding Medicaid to adults under the age of 65 whose incomes are less than 138% of the poverty level. The marketplaces and Medicaid expansion are the two primary means by which the framers of the ACA intended to reduce the number of the uninsured in the United States.

Fifteen states, including the District of Columbia, set up their own state-based marketplace with the remaining thirty-six relying on federally facilitated marketplaces. So far, twenty-seven states have expanded Medicaid and more are expected to follow. Of the states that have not expanded Medicaid, none set up their own marketplace.

As of April 2014, over 8 million Americans had enrolled in a health insurance plan though the Affordable Care Act's new marketplaces. And between the summer of 2013 and October of 2014, Medicaid enrollment grew by about 9.7 million for a 17% increase. Medicaid enrollment now totals 68.5 million or almost 22% of the population. So, in its first year, the expansion of Medicaid resulted in greater new Medicaid enrollment than the insurance exchanges.

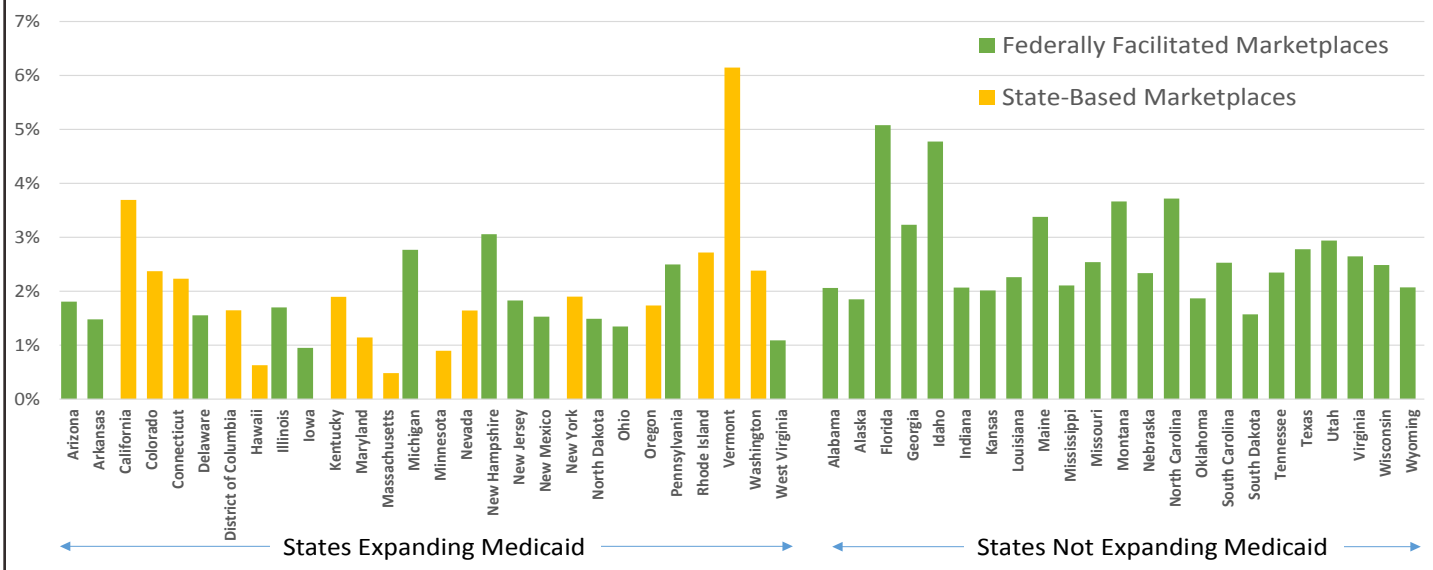
The disparate implementation of the ACA across the states is a function of the legislation's famously cumbersome language and the legal and political challenges this has engendered. In May of 2010, the Supreme Court determined that the ACA's provision requiring states to expand Medicaid, or lose funding, was unconstitutional. However, the fact that the federal government will initially fund 100% of the cost of expansion and only trim its share to 90% by 2020 makes expansion attractive to all states. This percentage is well above the federal government's share of other Medicaid spending which ranges from a low of 50% in high income states to 73% in Mississippi – the state with the lowest per capita income.

Pennsylvania expanded Medicaid as of the turn of the year and expansion is currently receiving consideration in other states that have not yet expanded.

The ACA's legal challenges continue. The Supreme Court will decide in June whether the insurance subsidies received by individuals who purchase insurance on one of the federally facilitated marketplaces will continue. The legal challenge argues the subsidies were only intended for lower income enrollees in states that had established their own marketplace. If the legal challenge prevails, then individuals who received subsidies in states that relied on the federally-facilitated marketplace may lose the subsidy. About 85 percent of the purchases in the federal marketplaces had some financial assistance.

Figure 1 presents the percent of each state's population that was covered by insurance purchased either through a state-based or federally fa-

Figure 1. Percent of Population with Insurance Purchased through State-Based and Federally Facilitated Marketplaces as of April 2014



Sources and Notes: Enrollment from Appendix Table A2, ASPE Issue Brief, May 1, 2014, and population from Current Population Survey, 2014 Annual Social and Economic Supplement, BLS.

cilitated marketplace. The states are also distinguished by their decision to expand Medicaid. Vermont had the highest percentage of new enrollees at just over 6% of the population. Florida had the second highest increase with new enrollees accounting for about 5% of the population. Massachusetts and Hawaii had the lowest number of new enrollees as a percent of their population, but this is expected as these states had the lowest percentages of uninsured prior to the implementation of the ACA.

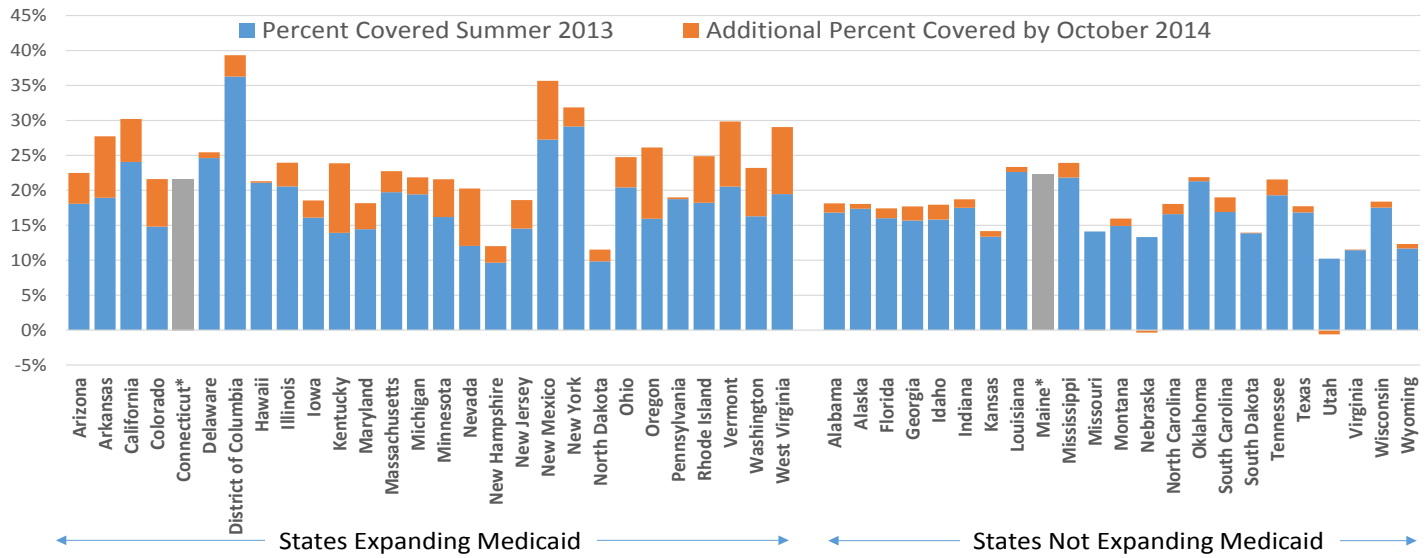
Also apparent from the figure is the higher enrollment percentages among the states that did not expand Medicaid. New enrollees accounted for 2.2% of the population in the states that expanded Medicaid and in the states that did not expand they accounted for 3%. Again, this difference results from lower percentages of uninsured individuals in the states that expanded Medicaid and, as will be seen in the next figure, the higher reliance on Medicaid in those states.

Figure 2 presents Medicaid and CHIP enrollment, as of the summer 2013 and then the marginal increase over the subsequent year, as a percent of each state's population. There are several noteworthy characteristics of the distinction between the states that have and have not expanded Medicaid.

As of the summer 2013, 20.5% of the population was already covered by Medicaid in the states that expanded coverage, (excluding Connecticut). In contrast, only 16.4% of the population was already covered by Medicaid in the states that did not expand coverage (excluding Maine). By October of 2014 the percentages were 25.0% and 17.6% in the states that did and did not expand coverage, respectively. Between the summer of 2013 and October 2014, states that expanded coverage saw a 4.6 percentage point increase in the percent of their population covered by Medicaid while in the states that did not expand coverage saw a 1.1 percentage point increase (for states reporting data in both periods).

As means-tested programs, Medicaid and the ACA's marketplace subsidies produce high implicit taxes on lower income families. As their incomes rise their marketplace subsidies decline and above certain income thresholds, that differ by state and situation, Medicaid coverage ends. These incentives suppress labor supply and reduce economic

Figure 2. Medicaid and CHIP Enrollment as a Percent of States' Populations



Sources and Notes: Enrollment from Table 1 in "Medicaid and CHIP: October 2014 Monthly Applications, Eligibility Determinations ad Enrollment Report," CMS, December 18, 2014, and population from Current Population Survey, 2014 Annual Social and Economic Supplement, BLS. *Summer 2013 enrollment NA.

mobility.

The state-to-state variation in how states interact with the federal government through Medicaid and now the ACA illustrate how the programs lead to higher federal spending. A given state has the incentive to take additional federal funds because taxpayers in other states pay for some of the spending on behalf of the residents in the given state. While state-to-state flexibility in Medicaid can be important to fostering innovation, expanding generosity in one state should be internalized by that state.

Health care reform begins with tax reform. The reform would limit the tax preference afforded health care insurance purchased through the employer and would provide a tax credit for workers who buy health insurance and are not covered by an employer provided plan.

Our tax sytem - federal, state and local - produces all kinds of distortions that affect relative prices and impact investment and labor supply decisions. Limiting the tax preference for health care consumption is just one possibility in reforming the tax system to make it less distorionary.

To reduce the incentives for states to expand their Medicaid program at the expense of taxpayers in other states, each state's federal funding level could continue to be determined based on the federal medical assistance percentage but that funding would only be available for enrollees who meet eligibility requirements that are common across the states. States should have the freedom to have more generous eligibility thresholds, but should bear the entirety of the additional expense.

Sources:

Medicaid and CHIP: October 2014 Monthly Applications, Eligibility Determinations and Enrollment Report, CMS, December 18, 2014.
ASPE Issue Brief, Assistant Secretary for Planning and Evaluation, HHS, May 1, 2014.
Current Population Survey, Annual Social and Economic Supplement, BLS, 2014, http://www.census.gov/hhes/www/cpstables/032014/pov/pov46_001.htm

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4231 TAMU
College Station, TX 77843-4231

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Private Enterprise Research Center
Texas A&M University
4231 TAMU
College Station, TX 77843-4231
(979) 845-7722
perc@tamu.edu