

BACKGROUND

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2014 Health Insurance Enrollment: Increase Due Almost Entirely to Medicaid Expansion

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Abstract

Health insurance enrollment data for 2014 shows that the number of Americans with health insurance increased by 9.25 million during the year. However, the vast majority of the increase was the result of 8.99 million individuals being added to the Medicaid rolls. While enrollment in private individual-market plans increased by almost 4.79 million, most of that gain was offset by a reduction of 4.53 million in the number of people with employment-based group coverage. Thus, the net increase in private health insurance in 2014 was just 260,000 people.

Last year's changes in health insurance enrollment are of particular interest, as 2014 was the year in which key provisions of the Affordable Care Act (ACA, or Obamacare) took effect—most notably, the offering of subsidies for coverage purchased through the new government exchanges and the ACA's Medicaid expansion. Analysis of enrollment data for private health insurance plans and public programs finds that 9.25 million more Americans had health insurance coverage at the end of 2014 than at the end of 2013.¹ However, the data (see Figure 1) also show that the ACA's Medicaid expansion was responsible for almost all of the net increase in coverage.

Enrollment in individual-market policies increased by almost 4.8 million individuals during 2014. For the employer-group-coverage market, enrollment in fully insured plans dropped by 6.6 million individuals, while enrollment in self-insured plans increased by 2.1 million individuals.² The net effect of those changes was a decrease of 4.5 million in the number of individuals with employer-sponsored coverage in 2014.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3062>

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KEY POINTS

- 2014 is the year in which key provisions of the Affordable Care Act (ACA) first took effect—most notably, subsidies for coverage purchased through the new exchanges and the ACA's Medicaid expansion.
- In 2014, the number of people enrolled in individual-market health insurance plans increased by 4.8 million, enrollment in employer-group coverage declined by 4.5 million, and Medicaid enrollment grew by almost 9 million.
- The decline in employment-based coverage offset 95 percent of the increase in individual-market coverage, resulting in a net increase in private coverage of only 260,000 individuals.
- While the number of insured Americans increased by 9.25 million, growth in Medicaid accounted for 97 percent (8.99 million people) of that net gain.
- When it comes to increasing the number of people with health insurance, the net effect of the ACA in 2014 was almost entirely a simple expansion of Medicaid.

Because the reduction in employer-group coverage offset almost all of the increase in individual-market coverage, the net change in private-market coverage during 2014 was an increase of just 260,000 individuals.

In contrast, total Medicaid and Children's Health Insurance Program (CHIP) enrollment increased by almost 9 million individuals in 2014. Not surprisingly, Medicaid enrollment growth differed sharply between those states that adopted the ACA's Medicaid expansion and those that did not. States with the ACA's Medicaid expansion in effect experienced Medicaid enrollment growth of almost 8.3 million people, while the increase in Medicaid enrollment for the states without the expansion in effect was 725,000 people.

Enrollment Trends

The increased enrollment in individual-market plans in 2014 equates to 40.6 percent growth in a single year for that market segment. By comparison, during the previous three years, total enrollment in individual-market plans was nearly flat, fluctuating narrowly around 12 million individuals.

For the fully insured employer-group market, the 2014 enrollment decline of 6.6 million persons equates to a single-year drop of 11 percent relative to 2013 enrollment of 60.6 million individuals. Before implementation of the ACA, total enrollment in fully insured employer plans had been gradually declining by about 2 percent per year.

The 2.1 million enrollees added to employer self-insured plans in 2014 constitute a 2 percent increase over the 2013 enrollment figure of 100.6 million individuals. By comparison, the average annual growth rate for this market segment during the three years prior to the implementation of the ACA was 2.8 percent.

The nearly 9 million person increase during 2014 in enrollment in Medicaid and CHIP equated to single-year growth in those programs of 14.7 percent—compared to the preceding three years' aver-

age annual growth rate of 2.3 percent. However, as noted, Medicaid enrollment growth during 2014 occurred disproportionately in states that adopted the ACA Medicaid expansion. In the states with the Medicaid expansion in effect, enrollment grew by 23.2 percent; while in the states without the expansion in effect, enrollment increased by 2.9 percent—or just above the pre-ACA trend.

ACA Effects

The Department of Health and Human Services (HHS) reported that, as of the end of 2014, 6,337,860 people were covered by individual-market plans purchased through ACA exchanges. That figure is 1.5 million higher than the 4.7 million net enrollment increase for the total individual market (both on and off the exchanges). The difference most likely consists of people who already had individual-market coverage and purchased replacement plans through the exchanges. Some were likely forced to obtain new coverage by the discontinuation of prior plans that did not conform to the ACA insurance requirements, which also took effect in 2014, while others may have been induced to switch to exchange coverage by the availability of the new subsidies.

Two other data points are consistent with the explanation that a portion of 2014 exchange enrollments reflect a shift within the individual market from off-exchange plans to on-exchange plans.

First, the HHS data shows that 908,000 (or 14.3 percent) of individuals with exchange coverage did not qualify for subsidies. Because that means that they had relatively higher incomes, most of those individuals probably could have afforded pre-ACA individual-market coverage—particularly since those plans were generally less expensive than ACA-compliant ones—and it is likely that many of them had such prior coverage.

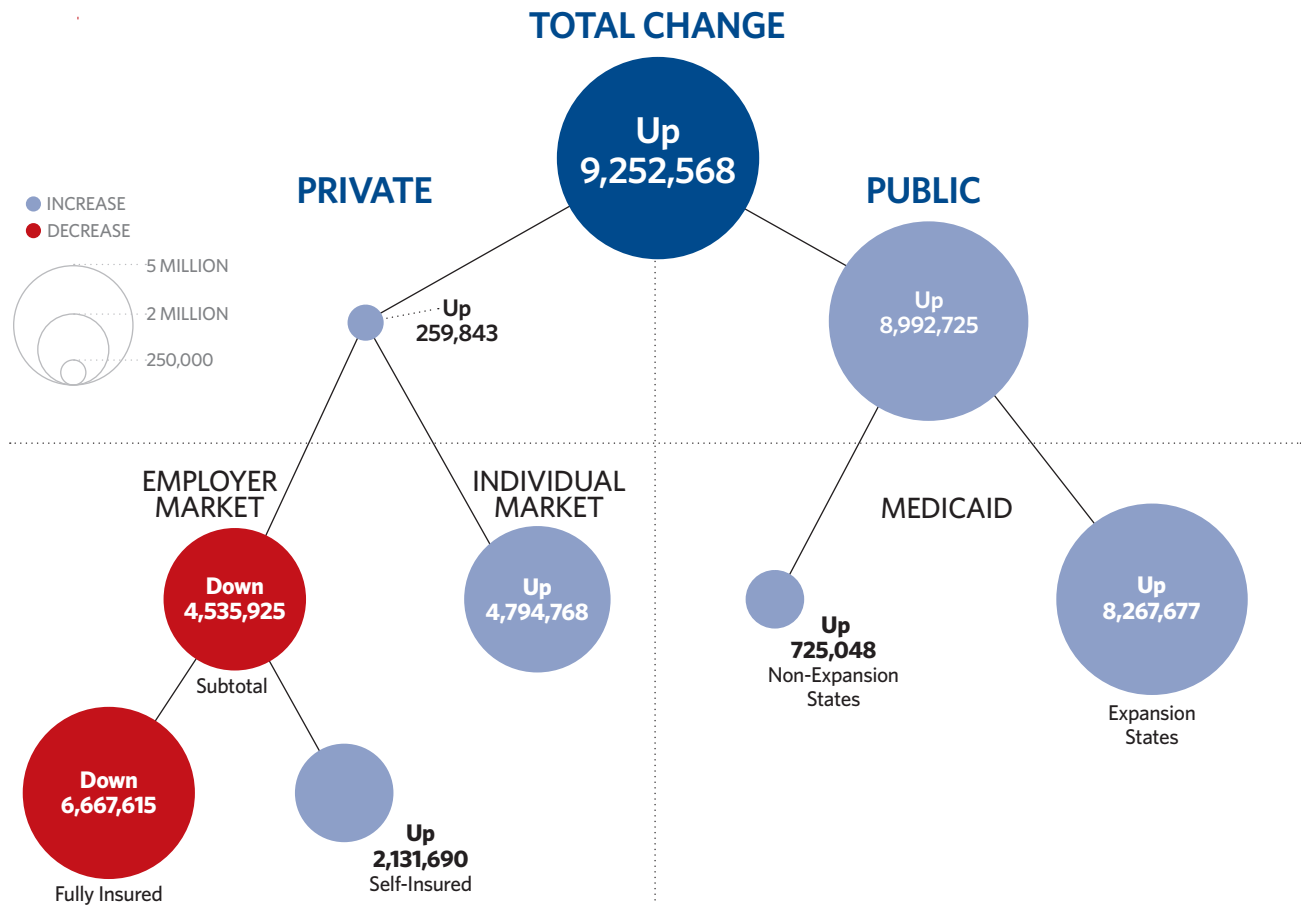
Second, for the individual market as a whole (both on and off the exchanges), enrollment increased by a net 4,795,768 individuals. But, for carriers offering coverage on the exchanges, enrollment increased by

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1. Unless otherwise noted in the appendix, figures for private coverage in this report are derived from data compiled by Mark Farrah Associates, which is available by subscription (<http://www.markfarrah.com>). The Mark Farrah Associates dataset consists primarily of data from annual and quarterly insurer regulatory filings, supplemented by data on self-insured plans compiled by the firm from those and other public and private sources.
 2. In a "fully insured" plan, the employer purchases a group coverage policy from an insurer. In a "self-insured" plan the employer retains the risk but contracts with an insurer, or other third party, to perform administrative tasks, such as enrollment, provider contracting, claims adjudication, and claims payment.
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FIGURE 1

New 2014 Health Insurance Enrollment: Increase Mostly Due to Medicaid

The number of Americans with health insurance increased by 9.25 million in 2014. However, the vast majority of that increase was the result of nearly 9 million individuals being added to Medicaid, while the net enrollment increase in private health insurance was just 260,000 people. Shown below are changes in health care enrollment from December 2013 to December 2014.



Source: Authors' calculations based on data from Mark Farrah Associates and the Centers for Medicare and Medicaid Services. See appendix for details.

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5,270,318 individuals, while for carriers not offering exchange coverage, enrollment decreased by 474,550 individuals.³ That also suggests that some individuals who previously had individual-market policies purchased replacement plans through the exchanges.

As noted, the enrollment decline in employer-sponsored coverage offset almost all (94 percent) of the net gain in individual-market coverage for the

year. That indicates that much of the enrollment gain in the individual market can be attributed to a shift from employer-group coverage to individual-market coverage. That shift can be explained by employers discontinuing coverage for some or all of their workers, or, in some cases, individuals losing access to such coverage due to employment changes.

While it is not possible to determine from the data the subsequent coverage status of individu-

3. Figures derived by assigning state-level carrier enrollment according to carrier exchange participation in each state.

als who lost group coverage, there are four possibilities: (1) some obtained replacement individual-market coverage (either on or off the exchanges); (2) some enrolled in Medicaid; (3) some enrolled in other coverage for which they are eligible (such as a plan offered by their new employer, a spouse's plan, a parent's policy, or Medicare); and (4) some became uninsured.

If individuals lost group coverage, but obtained new coverage under either another employer-group plan or one in the individual market, they would then be counted in the enrollment figures for those submarkets. Similarly, if individuals transitioned to Medicaid, they would be counted in the Medicaid enrollment figures reported by the Centers for Medicare and Medicaid Services (CMS).

Because the ACA's "essential benefit" requirements apply to fully insured small-group plans, but not to large-group plans, nor to self-insured plans of any size, the law effectively creates a marginal incentive for more employers to shift to self-insured plans. Yet, the data do not indicate any significant such shift occurring during 2014. That said, the ACA definition of "small group" to which the essential benefit requirements apply is scheduled to increase in January 2016 from 50 workers to 100 workers, possibly inducing more employers to shift to self-insured plans.

As noted, the growth in Medicaid enrollment over the course of the year occurred disproportionately in states with the ACA Medicaid expansion in effect. Indeed, the expansion states accounted for 92 percent of total Medicaid enrollment growth in 2014.

Conclusion

The implementation of the ACA appears to have had three effects on insurance coverage in 2014: (1) a modest shift among enrollees with prior individual-market coverage from "off-exchange" to "on-exchange" plans; (2) a substantial increase in individual-market enrollment that was matched by a nearly equivalent decline in employer-group plan enrollment (particularly among fully insured group plans); and (3) a significant increase in Medicaid enrollment, particularly in the states that had the ACA Medicaid expansion in effect during the year.

In sum, when it comes to increasing the number of individuals with health insurance coverage, the net effect of the ACA in 2014 was almost entirely a simple expansion of Medicaid.

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Appendix: Data Sources and Adjustments

We used the Mark Farrah Associates dataset, derived from insurer regulatory filings, for private-market enrollment by market segment. We excluded, as not relevant to our analysis, enrollments in: Federal Employees Health Benefits plans, Medicare Advantage plans, and supplemental coverage products (such as dental, vision, prescription drug, Medicare supplemental, and single disease).

For enrollment in self-insured employer plans we used the data reported by Mark Farrah Associates for plans administered by an insurance carrier. Mark Farrah compiles that data from insurer regulatory filings, supplemented by other public and private sources, such as Securities and Exchange Commission filings. While the firm's data on the self-insured market is the most comprehensive available, there are no reliable figures for enrollment in self-insured plans that are administered by independent third-party administrators (TPAs)—that is, TPAs that are not a subsidiary of an insurance carrier. However, based on its research, Mark Farrah Associates believes that truly independent TPAs likely account for no more than 5 percent of the total self-insured market.⁴

For Medicaid and CHIP enrollment, we used the figures from CMS state-level monthly enrollment reports as they include enrollment under both Medicaid fee-for-service and Medicaid managed-care plans and are “point-in-time” counts, which makes them consistent with the “point-in-time” counts of private-market coverage in insurer regulatory filings.⁵ The CMS reports do not include enrollment data for December 2013, but we were able to obtain those figures from a report by the Kaiser Commission on Medicaid and the Uninsured and used them as the basis for calculating enrollment growth during 2014.⁶

We made several adjustments to the Mark Farrah Associates private-market data to make it as complete and accurate as possible. Specifically:

1. Arkansas implemented the Medicaid expansion through a so-called private-option design. Under that approach, qualified individuals are enrolled in the state's Medicaid program, and then, at the beginning of the month following enrollment, select (or are assigned) coverage through a Silver-level plan offered in the exchange, with Medicaid paying almost all of the premiums. This arrangement could result in double counting those individuals in our analysis. The CMS Medicaid enrollment reports include private-option enrollees in Arkansas' Medicaid enrollment figures. However, the regulatory filings by carriers offering exchange coverage in Arkansas include private-option enrollees in their enrollment counts for individual-market coverage—which, from the carrier perspective, would be appropriate. Separately, the Arkansas Department of Human Services (DHS) reported that the number of individuals with completed private-option enrollment at the end of 2014 was 186,769.⁷

Consequently, to avoid counting private-option enrollees twice, we subtracted the Arkansas DHS figures from the figures for total individual-market enrollment for Arkansas derived from the insurer regulatory filings. Thus, our analysis counts Arkansas private-option enrollees as Medicaid enrollees.

2. Similar to Arkansas, Iowa implemented part of its Medicaid expansion through a “premium support” program, called Iowa Marketplace Choice.

4. Author conversation with LuAnne Farrah, president of Mark Farrah Associates.

5. Centers for Medicare and Medicaid Services, “Medicaid and CHIP Application, Eligibility Determination, and Enrollment Data,” <http://www.medicare.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html> (accessed August 19, 2015).

6. Laura Snyder et al., “Medicaid Enrollment: December 2013 Data Snapshot,” The Kaiser Commission on Medicaid and the Uninsured, June 2014, Table A-1, <http://files.kff.org/attachment/medicaid-enrollment-snapshot-december-2013-issue-brief-download> (accessed August 2, 2015).

7. Arkansas Department of Human Services, “Arkansas Private Option 1115 Demonstration Waiver Quarterly Report October 1, 2014 to December 31, 2014,” <https://www.medicare.state.ar.us/Download/general/publicdata/POQrtlyRptOct-Dec.pdf> (accessed August 2, 2015).

Under that arrangement, the state's Medicaid program pays the premiums for Silver-level plans offered through the exchange—but only for individuals who qualify for the expansion and have incomes between 100 percent and 138 percent of the federal poverty level. Again, Iowa carriers include those enrollees in their enrollment counts for individual-market coverage, while the CMS includes them in the state's Medicaid enrollment figures. Separately, the Iowa Department of Human Services (DHS) reported that the number of individuals enrolled in Iowa Marketplace Choice was 27,734 at the end of December 2014.⁸ To avoid counting Iowa Marketplace Choice enrollees twice, we subtracted the Iowa DHS figures from the figures for total individual-market enrollment for Iowa derived from the insurer regulatory filings. Thus, our analysis counts Iowa Marketplace Choice enrollees as Medicaid enrollees.

3. Data for two California carriers was missing from the Mark Farrah Associates dataset, but we were able to obtain their enrollment figures directly from the reports that they filed with the California Department of Managed Health Care.

4. Four New York carriers that offered coverage through the exchange are Medicaid managed-care plans that had not offered coverage in the individual or group markets prior to 2014, and do not file National Association of Insurance Commissioners (NAIC) reports, as they are regulated by the New York State Department of Health. For those carriers, we used the figures from the 2014 enrollment report published by the state exchange.⁹
5. Finally, CoOpportunity Health, which offered coverage in Iowa and Nebraska, did not file NAIC reports for the fourth quarter, as it was put into receivership in December 2014 and ordered into liquidation in March 2015. Consequently, we used the enrollment figures it reported for the third quarter on the presumption that most, if not all, of those enrollees still had their coverage in force through the end of 2014.

The net effects of the foregoing adjustments to the enrollment figures derived from the Mark Farrah Associates dataset were a decrease of 7,745 for the individual market, and an increase of 46,799 for the fully insured group market.

8. Iowa Department of Human Services, "Overall Iowa Marketplace Choice Plan Enrollment: As of December 26, 2014," http://dhs.iowa.gov/sites/default/files/IHAWPEnrollmentMaps_December2014.pdf (accessed August 2, 2015).

9. NY State of Health, "2014 Open Enrollment Report," June 2014, http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf (accessed August 2, 2015).