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The ACA and America's Cities: Fewer Uninsured and More Federal Dollars

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Timely Analysis of Immediate Health Policy Issues

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In-Brief

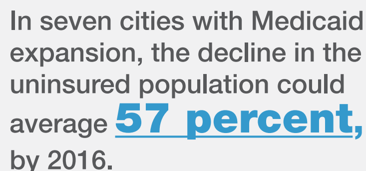
This report estimated the effect of the Affordable Care Act (ACA) on 14 large and diverse cities: Los Angeles, Chicago, Houston, Philadelphia, Phoenix, Indianapolis, Columbus, Charlotte, Detroit, Memphis, Seattle, Denver, Atlanta, and Miami.

Among the seven cities in states that have expanded Medicaid, the ACA will likely decrease the number of uninsured by an average of 57 percent. City by city, the reduction is projected to vary between 49 percent in Denver and 66 percent in Detroit by 2016. New federal spending on health care from 2014 to 2023 would range from $4.1 billion in Seattle to $27 billion in Los Angeles.

Among the seven cities in states not expanding Medicaid, the ACA will likely decrease the number of uninsured by an average of 30 percent. The decrease would range from 25 percent in Atlanta to 36 percent in Charlotte by 2016. New federal spending due to the ACA from 2014 to 2023 would increase by between $1.9 billion in Atlanta and $9.9 billion in Houston.

If Medicaid eligibility were expanded in these cities, the number of uninsured would fall by an average of 52 percent, ranging from 45 percent in Houston to 59 percent in Memphis. New federal spending would increase by between $4.8 billion in Atlanta and $16.4 billion in Houston from 2014 to 2023.

How Will State Decisions to Expand Medicaid Affect U.S. Cities?



In seven cities without Medicaid expansion, the decline in the uninsured population could average 30 percent, by 2016.

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Introduction

America's cities are very diverse in income, immigration status, and race and ethnicity. This diversity will likely affect the impact of the Patient Protection and Affordable Care Act (ACA) on each city. State decisions on ACA implementation—most notably whether or not to expand Medicaid eligibility—also have a large effect on cities, particularly because most cities have large low-income populations who stand to benefit from the law.

For our analysis, we chose 14 of the largest census designated places:[1] Los Angeles, California; Chicago, Illinois; Houston, Texas; Philadelphia, Pennsylvania; Phoenix, Arizona; Indianapolis, Indiana; Columbus, Ohio; Charlotte, North Carolina; Detroit, Michigan; Memphis, Tennessee; Seattle, Washington; Denver, Colorado; Atlanta, Georgia; and Miami, Florida. Some of these cities are in states that have expanded Medicaid and some are in those that have not. We included at most one city in each state to provide more regional diversity.

We used the Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) to estimate the effects of the ACA. The model uses ACS data from 2009, 2010, and 2011 to obtain representative samples of state populations and their pre-ACA implementation insurance coverage.[2] Our estimates of new federal spending are based on per capita spending from our earlier state-level report[3] combined with the specific numbers and characteristics of projected Medicaid, CHIP, and subsidized coverage enrollees in each city from the HIPSM-ACS data.

Characteristics of the Nonelderly Population

All 14 cities have large numbers of low-income people who would be eligible for Medicaid under the ACA expansion, but the share is noticeably larger in some. In particular, 61.6 percent of Detroit residents have incomes below 138 percent of the federal poverty level (FPL) (Table 1).

The ACA also provides assistance to low-income families through subsidized coverage in the health insurance marketplaces. In order to qualify, one must have a family income between 138 and 400 percent of FPL, be lawfully present, be ineligible for public coverage such as Medicaid, and not have a family member with an affordable offer of employer coverage. In each of the 14 cities, between 5 and 7 percent of the population would be eligible for subsidized coverage in the health insurance marketplaces under the ACA.

Under the ACA Medicaid expansion, more than half of the total population of four cities would become eligible for Medicaid, CHIP, or subsidized marketplace coverage: Detroit (66.5% would be eligible for assistance), Memphis (51.8%), Miami (51.2%), and Philadelphia (50.5%). But only Detroit is in a state that has expanded Medicaid, leaving many residents of the other cities ineligible for assistance with health coverage.

Race and ethnicity also vary considerably between cities. The cities with the largest Hispanic populations are Miami (70.8%), Los Angeles (54%), Houston (48.1%), and Phoenix (45.6%). Cities with a large share of Hispanics also have a large share of immigrants who are not lawfully present in the United States: Miami (18%), Houston (12.9%), Los Angeles (12.6%), and Phoenix (10.8%). This has implications for the ACA because immigrants without legal status are not eligible for coverage under either Medicaid or federal subsidy programs.

Cities such as Seattle, Columbus, and Indianapolis have majority white, non-Hispanic populations (64.8%, 64.2 percent and 57.7%, respectively). By contrast, Detroit (7.1%) and Miami (11.6%) have relatively few whites. Some cities have very large black, non-Hispanic populations, including Detroit (81.4%), Memphis (63.9%), and Atlanta (50.0%). Seattle has a large Asian/Pacific Islanderpopulation (15.7%).

Characteristics of the Uninsured

In each of the 14 cities, nearly 40 percent or more of the uninsured population has income below 138 percent of FPL (Table 2). In over half of the cities (Columbus, Seattle, Denver, Philadelphia, Indianapolis, Charlotte, Memphis, and Atlanta), those with incomes below 138 percent of FPL—thus gaining access to Medicaid in states that expand eligibility—make up a noticeably larger share of the uninsured than of the population in general. Detroit has the largest uninsured population with income below 138 percent of FPL: 64.8 percent. Columbus, Philadelphia, Memphis, and Atlanta have more than 50 percent of their uninsured populations within this income range.

In Seattle, just over 22 percent of the uninsured will be eligible for subsidized marketplace coverage under the ACA. In Atlanta, Indianapolis and Philadelphia, 18 to 20 percent of the uninsured will be eligible for subsidized coverage. On the other end of the spectrum, the uninsured in Miami are much less likely to be within this range and subsidy-eligible (11%).

Miami, Phoenix, and Los Angeles have large shares of the uninsured with incomes above 400 percent of FPL. Medicaid expansion and subsidized coverage do not affect this population. The large majority would be required to purchase coverage or face a penalty.

The race and ethnicity of the uninsured generally reflects the race and ethnicity of the overall city population, but there are exceptions. Hispanics are overrepresented among the uninsured in all 14 cities. They make up about two-thirds or more of the uninsured populations in Miami, Phoenix, Houston and Los Angeles. This is in part because immigrants who are not lawfully present compose 30 percent or more of the uninsured populations in these four cities.

In Seattle, Columbus, and Indianapolis, the majority of the uninsured population is white. The uninsured are disproportionately black in Atlanta (61.8

More tables available here

percent, while blacks constitute only 50 percent of the nonelderly population of the city). Most of the uninsured are black in Detroit, Philadelphia, and Memphis, though they make up similar shares of the overall population.

Changes in Coverage Under the ACA

We projected how the ACA would change all kinds of health coverage in each city: employer-sponsored coverage, nongroup private health coverage, Medicaid/CHIP coverage, and those without health coverage.

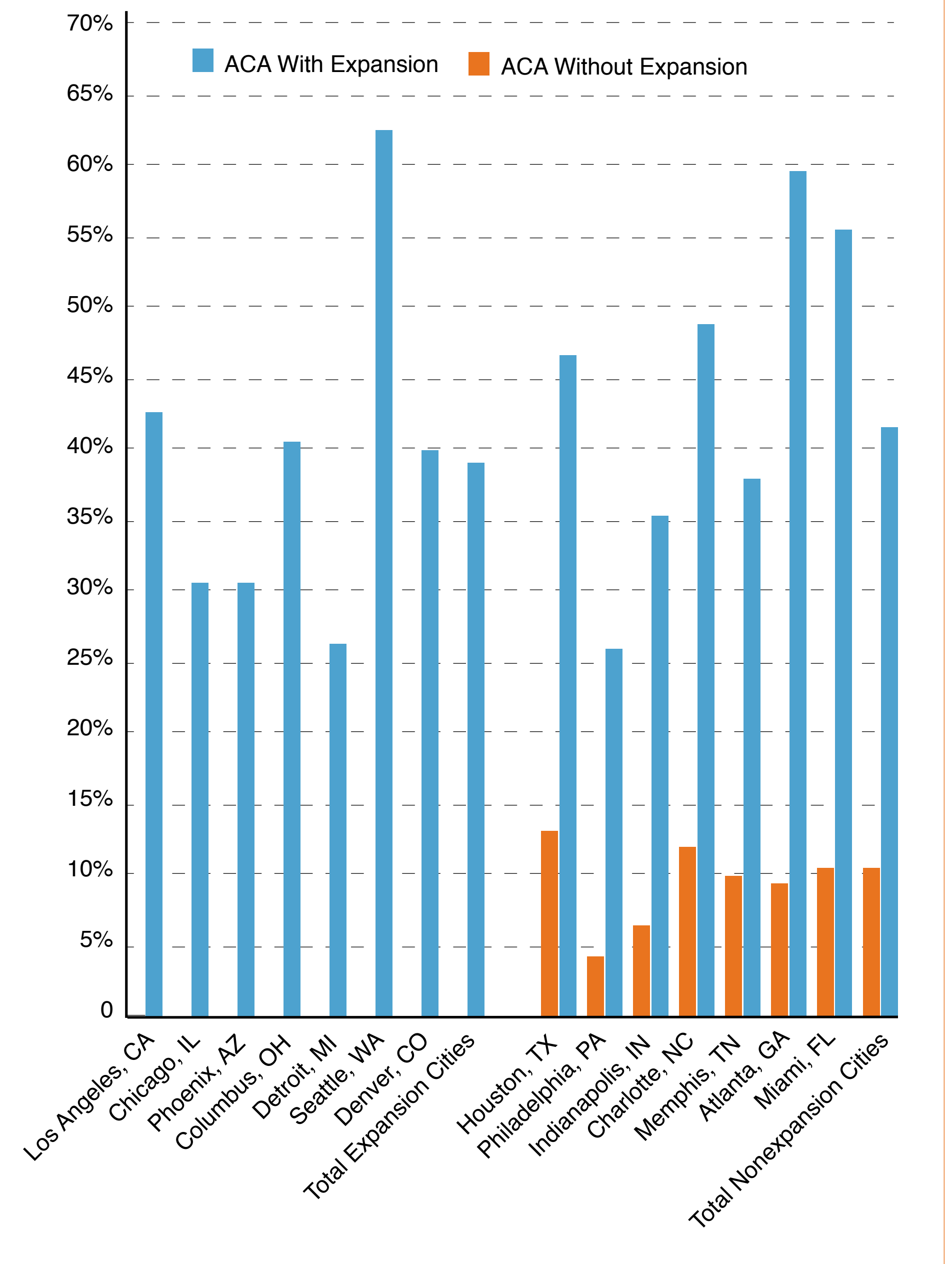
Employer-Sponsored Health Insurance

About 56 percent of nonelderly adults in the United States have health coverage through an employer.[4] In most of the cities we considered, the share of adults with employer-sponsored insurance is noticeably lower. Only five cities have more than half of their populations covered by employer plans: Seattle (66.5%), Columbus (58.4%), Charlotte (55.5%), Denver (51.3%), and Indianapolis (50.7%). The remaining nine cities have less than 50 percent of their populations covered by employers. Miami and Detroit have the lowest rates with 29.2 percent and 28.3 percent, respectively. Under the ACA, we project that employer coverage would increase by 4.4 percent (from 46.4% of the nonelderly to 48.2%) in Medicaid expansion cities and 2.5 percent (from 45.9% to 46.9%) in nonexpansion cities (Table 3). Employer-sponsored health insurance increases primarily because the ACA's individual coverage requirement would increase take-up of coverage more than the availability of subsidized marketplace coverage and Medicaid would decrease it.[5]

Private Nongroup Health Insurance

Currently, private nongroup plans cover about 5 percent of the population or less in most cities (Table 4). The exceptions are Seattle (7.4%), Atlanta, (6%), Los Angeles (5.8%) and Denver (5.6%). Nongroup coverage will increase with reform, largely due to the introduction of subsidies in the marketplaces and the requirement for insurance coverage under the ACA. Nongroup enrollment will grow the most in Detroit, but that city also starts out with the lowest share covered by nongroup policies (1.3%). Such a large share of that city's population is low-income that subsidies are necessary to increase take-up of nongroup coverage to levels closer to those in other cities.

Figure 1. Percent Change in Medicaid and CHIP Enrollment Under the ACA, by 2016



Enrollment in the nongroup market is projected to increase 56.7 percent among the seven Medicaid expansion cities and 110.2 percent among seven nonexpansion cities. Without Medicaid expansion, more people would be eligible for subsidized marketplace coverage, so more would enroll.[6] However, differences in nongroup coverage are not entirely caused by the expansion. Other factors, such as the availability of insurance through an employer, are also important.

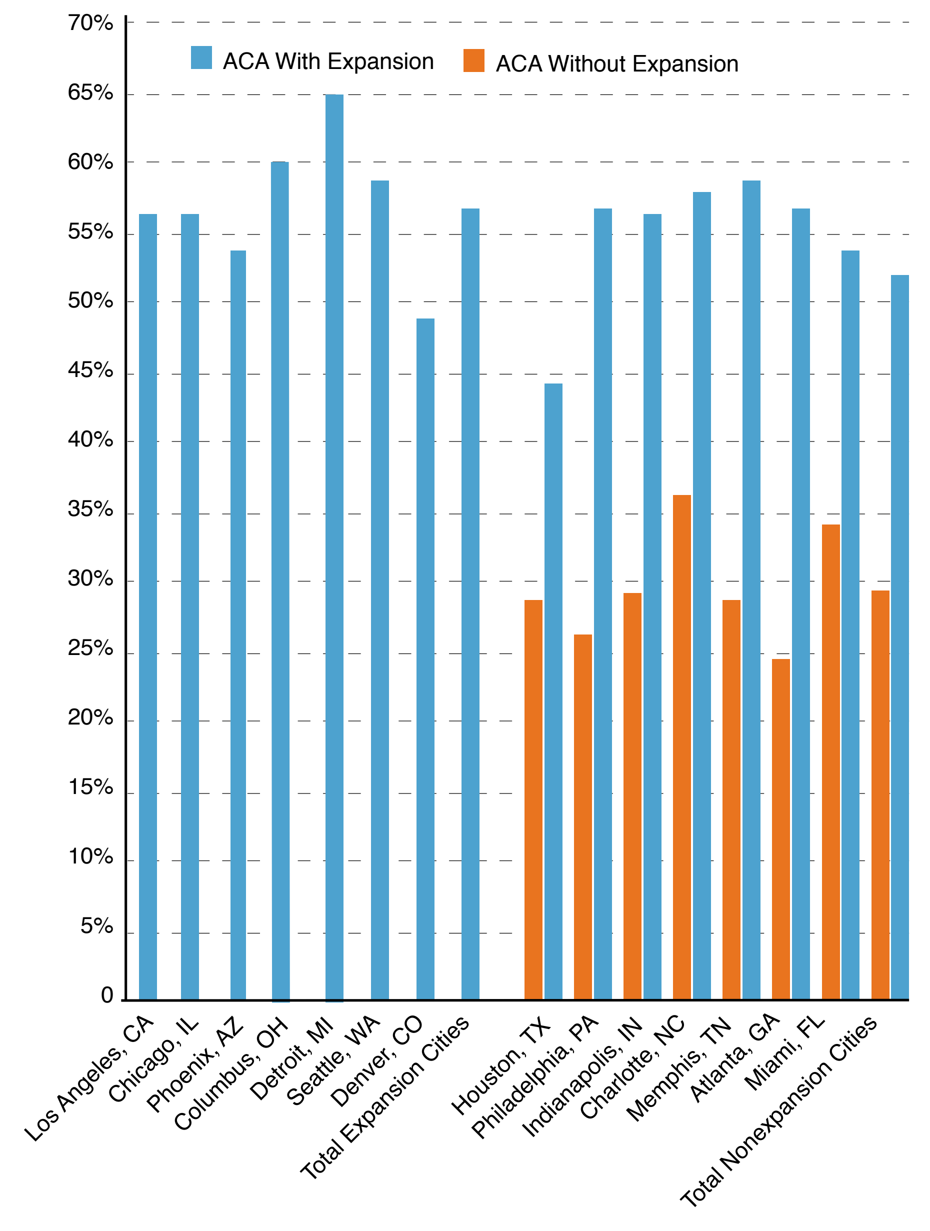
Medicaid and CHIP

We estimate that Medicaid and CHIP enrollment will increase under the ACA by an average of 38.5 percent in the seven Medicaid expansion cities and 10.7 percent in the seven nonexpansion cities (Figure 1 and Table 5). There would be notable variation in new Medicaid and CHIP enrollment rates even among Medicaid expansion cities. The largest increase would be in Seattle (63%). The three expansion cities with the lowest percent increases are in states that expanded Medicaid eligibility for adults before the ACA: Detroit (27%), Chicago (31%) and Phoenix (31%).

All seven cities in states that have not expanded Medicaid would see increases in Medicaid and CHIP enrollment of 14 percent or less. ACA provisions such as the individual coverage requirement will lead to increased enrollment in Medicaid and CHIP among those who were already eligible.

If Medicaid eligibility were to be expanded in these cities, Medicaid and CHIP enrollment would increase by an average of 42.4 percent. As we saw with cities in Medicaid expansion states, the magnitude of the increase varies with the current levels of coverage. In Atlanta, Charlotte, Miami, and Houston, where there is very limited Medicaid eligibility for adults, enrollment would increase by 47 percent or more. Pennsylvania and Indiana have broader Medicaid eligibility, so there would be smaller increases in Medicaid enrollment for Philadelphia (26.3%) and Indianapolis (35.6%).

Figure 2. Percent Decline in the Uninsured Under the ACA, by 2016



Overall Gains in Health Coverage

The net result of these gains in health coverage under the ACA is shown in Figure 2 and Table 6. In the seven cities with the Medicaid expansion, the number of uninsured will drop by an average of 56.5 percent, ranging from 48.8 percent in Denver to 65.8 percent in Detroit. Except for Denver, the number of uninsured is expected to be reduced by more than half in every Medicaid expansion city we analyzed.

The uninsured rate would be reduced by an average of 29.7 percent in the nonexpansion cities. City by city, the reduction in the uninsured is projected to range from 26.6 percent in Philadelphia to 36.4 percent in Charlotte.

Were Medicaid eligibility in these seven cities to be expanded, the uninsured rates would fall by more than 50 percent in every city except Houston, which would see a reduction of 44.8 percent. Cities with relatively large populations of immigrants who are not legally present—such as Houston, Miami, and Los Angeles—would have higher uninsured rates under the ACA than other cities.

Immigration Status of the Remaining Uninsured

In general, a large percentage of those remaining uninsured under the ACA are immigrants not lawfully present. Among the seven cities that are in states with the Medicaid expansion, the remaining uninsured population is heavily not-

lawfully-present in Los Angeles (46.6%), Phoenix (49.7%), and Denver (48.8%) (Table 7). In contrast, only 18.6 percent of the remaining uninsured population in Detroit is not lawfully present. In several cities located in states not expanding Medicaid, a large percentage of those remaining uninsured are not lawfully present—41.4 percent in Houston, 28.4 percent in Charlotte, and 35.2 percent in Miami. If these states did adopt the Medicaid expansion, more individuals would be covered, but this would not affect the number of uninsured undocumented immigrants. As a result, the percentage of the uninsured that are undocumented would increase, reaching 42 percent in Charlotte and over 50 percent in Houston and Miami.

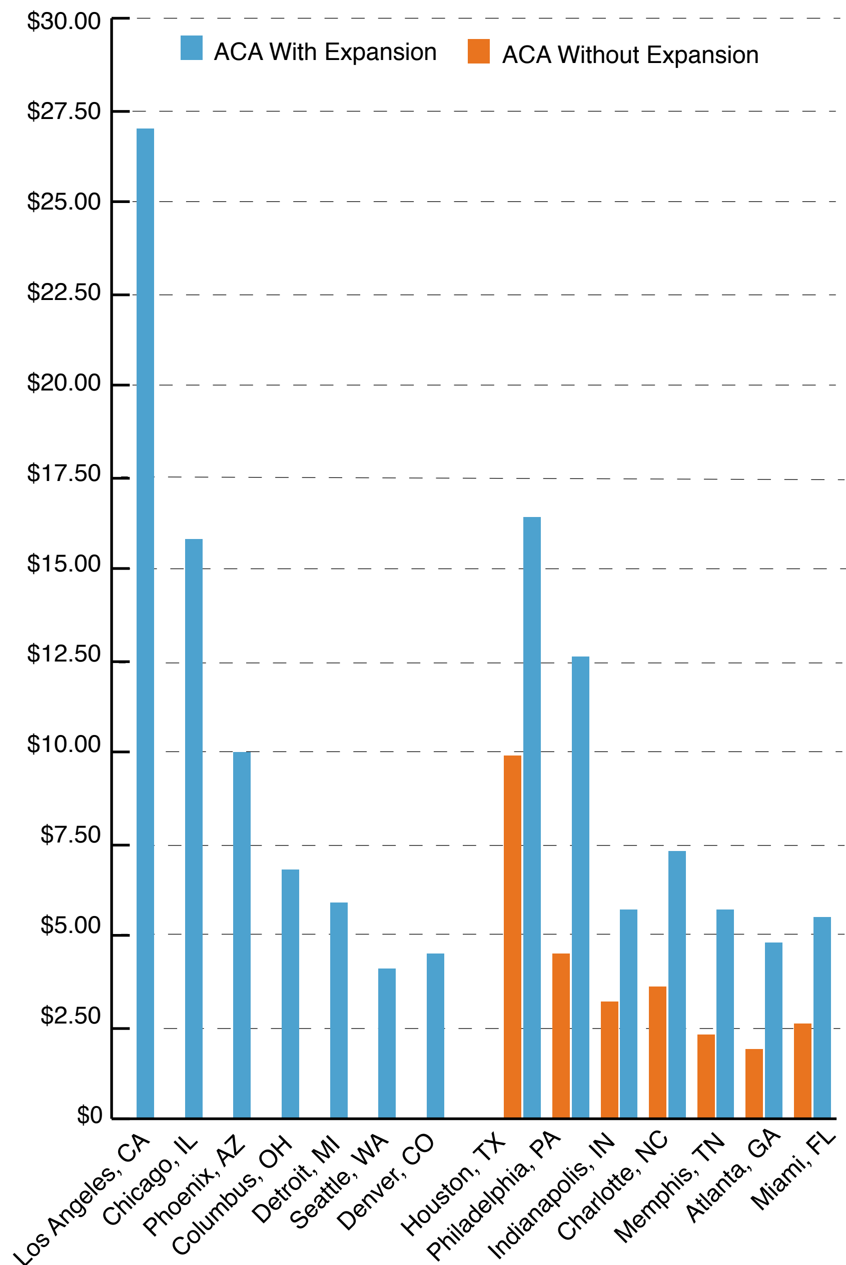
Changes in Federal and State Health Care Spending

The ACA will bring a large amount of new federal funding into all 14 cities. How much depends largely on Medicaid expansion decisions. In all cases, the increase in federal dollars going into cities is much larger than the increases in state and local expenditures that are required as matching funds. In addition to spending on Medicaid, there will also be a substantial amount of federal subsidy funding, depending on the size of the population entering marketplaces. The enrollment in marketplaces and therefore federal subsidy funding will be smaller in the seven nonexpansion states if they were to expand. This is simply because the subsidies will only be available to those with incomes above 138 percent of FPL if the Medicaid expansion is passed. This decline would partially offset the increase in Medicaid spending noted above, but federal spending would still be higher with Medicaid expansion.[7]

Estimates of new federal Medicaid spending between 2014 and 2023 are shown in Table 8 and Figure 3. The amount of federal dollars coming into Los Angeles would be $27 billion over this period and $4.1 billion in Seattle. Total spending, federal and state, would be $30.3 billion in Los Angeles and $4.6 billion in Seattle. The amount of federal dollars in cities in states not expanding Medicaid would vary from $1.9 billion in Atlanta to $9.9 billion in Houston. But if the states adopted the Medicaid expansion, the federal dollars over the ten-year period would increase to $4.8 billion in Atlanta and $16.4 billion in Houston. Total spending increases would be $5.1 billion and $17.5 billion in Atlanta and Houston, respectively.

Thus, the ACA offers a substantial amount of money for these cities. The new revenue to the cities does not include the reductions that hospitals in these cities will see because of reductions in Medicare and Medicaid disproportionate share hospital payments or Medicare provider payment rate cuts. These reductions will occur with or without Medicaid expansion, though the reduction in disproportionate share hospital payments will take into account the decline in a state's uninsured rate as

Figure 3. Total New Federal Spending on Health Care Under the ACA, Between 2014-2023 (Billions of Dollars)



one of several factors. The new federal dollars are expected to substantially exceed those payment reductions in states expanding Medicaid.

Our estimates show new state spending on acute care for nonelderly Medicaid and CHIP enrollees under the ACA, but that does not give a complete picture of the effect on state budgets. Medicaid expansion requires the states to cover part of the costs of new Medicaid enrollees, but there are other important fiscal impacts of Medicaid expansion, many of which would be savings to the state.[8]

CONCLUSION

Medicaid expansion is increasingly seen as an important issue for cities.[9] As we have shown, over 50 percent of the uninsured population in all but one of the cities we studied will be potentially eligible for either Medicaid or income-related subsidies, assuming the Medicaid expansion. This means substantial revenue will flow into these cities and the economies of these cities should benefit greatly.

Cities in states not expanding Medicaid would face other challenges in addition to having more uninsured residents and foregoing additional revenue. There will be reductions in Medicare reimbursement and Medicare and Medicaid disproportionate share hospital payments under the ACA, which could be particularly difficult for urban safety-net providers serving uninsured people across a wider region. Also, many states require counties to maintain indigent care programs or pay part of the costs of Medicaid.

Differences in the impact of the ACA on cities also reflect a wide diversity in income, immigration status, and race and ethnicity. For example, nearly two-thirds of the uninsured in Detroit have incomes below 138 percent of the federal poverty level, compared with only 38 percent in Phoenix. Nearly 80 percent of the uninsured in Miami are Hispanic, while more than three-quarters of the uninsured in Detroit are non-Hispanic blacks.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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Notes

1. For more on Census Designated Places, see Bureau of the Census. "Places." In Geographic Areas Reference Manual. Washington, DC: US Department of Commerce, 1994, http://www.census.gov/geo/reference/pdfs/GARM/Ch9GARM.pdf.
2. More information about methodology can be found at "Further Methodological Information for 'Tax Preparers Could Help Most Uninsured Get Covered,'" accessed May 7, 2014, http://www.urban.org/health_policy/health_care_reform/taxfilingmethodology.cfm and Urban Institute. "The Urban Institute's Health Microsimulation Capabilities," Washington, DC: Urban Institute, 2010, http://www.urban.org/publications/412154.html.
3. Holahan J, Buettgens M and Dorn S. "The Cost of Not Expanding Medicaid." Washington, DC: Urban Institute, 2013, http://kff.org/medicaid/report/the-cost-of-not-expanding-medicaid/.
4. Calculation from HIPSM based on American Community Survey data.
5. For more information on how the ACA is likely to affect employer-sponsored health insurance, see Blumberg LJ, Buettgens M, Feder J, Holahan J (2012) Implications of the Affordable Care Act for American Business. Washington, DC. The Urban Institute. http://www.urban.org/health_policy/url.cfm?ID=412675.
6. The lower income threshold for subsidy eligibility is 138 percent of the federal poverty level in expansion states and 100 percent of the federal poverty level in nonexpansion states. In both expansion and nonexpansion states, documented immigrant adults who have been resident fewer than five years can be eligible for subsidies even with incomes below these levels.
7. Note that those with incomes between 100 and 138 percent of the federal poverty level in nonexpansion states are ineligible for subsidies if a family member is offered single coverage through an employer for which the premium is less than 9.5 percent of family income. There is no similar requirement for Medicaid eligibility. Therefore, Medicaid expansion would increase the number of people eligible for assistance with incomes between 100 and 138 percent of the federal poverty level.
8. Holahan J, Buettgens M and Dorn S. "The Cost of Not Expanding Medicaid." Washington, DC: Urban Institute, 2013, http://kff.org/medicaid/report/the-cost-of-not-expanding-medicaid/.
9. Dubay L, Kenney G and Zuckerman S, "Why Mayors Want States To Expand Medicaid: New Local 'Coverage Gap' Estimates," Health Affairs Blog, February 4, 2014, http://healthaffairs.org/blog/2014/02/04/why-mayors-want-states-to-expand-medicaid-new-local-coverage-gap-estimates/