University of Kentucky

Gatton College of Business and Economics

Institute for the Study of Free Enterprise

How Did the ACA Affect Health Insurance Coverage in Kentucky?

- **This research suggests that the integrity of the Kentucky Medicaid program is at risk**
- **Following the Affordable Care Act expansion, Kentucky's Medicaid program exceeded new enrollment expectations**
- **However, it appears the program exceeded expectations because of people who were not actually allowed to be on Medicaid—38 percent of new enrollees were not eligible for the program, according to American Community Survey data**
- **ACA rules funneled ineligible people on to Medicaid by requiring them to estimate their future income—they evidently underestimated**

The Patient Protection and Affordable Care Act (ACA) is the most sweeping change to the health insurance landscape since the implementation of Medicare and Medicaid in the 1960s. The most important provisions impacted private, nongroup (individual) coverage and public Medicaid coverage. Provisions related to private insurance include the introduction of the Health Insurance Marketplace (i.e., the exchange), guaranteed issue and community rating reforms, and subsidies via the premium tax credit for individuals with incomes from 100 to 400 percent of the federal poverty level (FPL) ($23,850 to $95,400 for a family of four in 2014). In addition, states were given the option to expand Medicaid, and by the end of 2015, 29 states and the District of Columbia had done so in some form (Hu et al. 2016). Almost all individuals were compelled to obtain health insurance coverage due to the individual mandate or to pay a penalty.

With the passage of the ACA, Kentucky has stood out for a several reasons. As figure 1 shows, adoption of the Medicaid expansion was largely confined to the northeastern, midwestern, and western states—Kentucky was one of the few southern states to adopt the optional Medicaid

expansions in 2014. The Medicaid expansion, combined with a backdrop of relatively low per-capita income and low existing insurance coverage rates, left open the possibility for sizable gains in health insurance coverage in Kentucky.3 Indeed, Courtemanche, Marton, and Yelowitz (2016) find that Kentucky experienced the largest gain in coverage out of all the states, primarily from gains in Medicaid. Benitez, Creel, and Jennings (2016) find that gains in insurance coverage in Kentucky led to declines in "unmet medical needs."4 Sommers et al. (2016a) find that Kentucky's Medicaid program was associated with significant increases in outpatient utilization, preventive care, improved health care quality, reductions in emergency department use, and improved self-reported health. However, it is unclear whether Kentucky's experience with the ACA can be extrapolated to other states in the South that didn't expand Medicaid.

In 1994, Kentucky conducted an unsuccessful experiment with guaranteed issue and community rating in the individual market (Wachenheim and Leida 2012). As a consequence, more than 40 insurers left the individual market by January 1998 (Clark and Wilson 1998). In addition, Kentucky adopted Medicaid managed care in 1997 in the area surrounding Louisville (Marton, Yelowitz, and Talbert 2014; Marton and Yelowitz 2015; Marton et al. 2015), and the remainder of the state shifted to Medicaid managed care in 2011 (Marton, Yelowitz, and Talbert 2016).

Because of Kentucky's unique history, its recent experience has been examined by numerous commentators. Artiga, Tolbert, and Rudowitz (2016) argue that "Kentucky has had one of the most successful ACA implementation experiences among states." Rosenbaum, Schmucker, and Rothenberg (2016) note that "among states that have implemented the Affordable Care Act's Medicaid expansion, Kentucky has been singular in its success." Atkin and Israel (2015) call Kentucky "the nation's most unlikely Obamacare success story." This sentiment is echoed in other contexts, especially with respect to possible changes to the Medicaid program (Yetter 2015; Willard 2015; Goodnough 2016). Often front and center in commentary is a discussion of the large drop in the adult uninsured rate, the role of Medicaid, and the lack of access to insurance if the expansion were rolled back (Kaiser Family Foundation 2016). A Deloitte (2015) report showing that Medicaid enrollment exceeded expectations is typically cited. 5 Remarkably, the report notes that first-year Medicaid expansion enrollment in Kentucky exceeded estimates of the entire pool of potentially eligible enrollees.

One of the principal goals of this study is to analyze how this happened. Although some commentaries define "success" solely in terms of reducing the number of uninsured individuals, a more nuanced definition of success is whether the ACA was carried out in the way it was

intended. The intent of the ACA, as written, was clearly to provide different sources of health insurance coverage and different subsidies based on a person's economic circumstances. Lowerincome individuals were meant to get larger subsidies. Medicaid generally provides more heavily subsidized coverage in comparison to subsidies gained through the ACA marketplace and was targeted to those with incomes under 138 percent of the FPL in Medicaid expansion states (Joint Economic Committee 2016). Higher-income individuals were meant to get smaller subsidies. Private coverage, with less generous subsidies, was targeted to those with incomes at or above 138 percent of the FPL in both expansion and no expansion states.

The goals of this study are twofold. First, using credible, arms-length, publicly available data, I document how the ACA impacted insurance coverage in Kentucky and in several neighboring states that either adopted or did not adopt the Medicaid expansions in 2014. I find that the vast majority of the gains in coverage in Kentucky were for nonelderly adults, and the pathway for gaining coverage was through the new adult Medicaid expansions. Patterns in other states varied, depending on whether they implemented Medicaid expansions in 2014. Second, given the outsized role of Medicaid in expanding insurance coverage among adults in Kentucky, I examine whether such adults appear to be eligible for Medicaid. This examination addresses the issues of whether the targeting of (1) heavily subsidized Medicaid coverage to individuals with incomes under 138 percent of the FPL and (2) less generous private coverage to individuals with higher incomes was carried out in practice.

I find that 73,000 of the individuals who gained coverage appear to be ineligible for Medicaid based on their incomes and would have instead qualified for private, nongroup coverage with subsidies from the premium tax credit. This finding persists after the group is pared down based on Supplemental Security Income (SSI) participation, participation in other public assistance programs, and factors that proxy for instability or nonnuclear families. In short, the reason why Medicaid enrollment in Kentucky in 2014 vastly exceeded forecasts is that thousands of ineligible individuals signed up.

Finally, I discuss some possible reasons why ineligible individuals might be receiving Medicaid instead of private insurance. One plausible reason—echoed in longstanding literature on effective tax rates in welfare programs (Ziliak 2007)—is that the way the rules are implemented on the ground differs from the rules on the books. In practice, issues of prospectively forecasting income for the next calendar year (perhaps too conservatively) along with anticipating possible deductions (perhaps too aggressively) in order to compute modified adjusted gross income (MAGI) could lead to ineligible individuals receiving Medicaid instead of private coverage.