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**The Changing Dynamics Of US Health Insurance And Implications For The Future Of The Affordable Care Act**

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**Abstract**

The introduction of Medicaid expansions and state Marketplaces under the Affordable Care Act (ACA) have reduced the uninsurance rate to historic lows, changing the choices Americans make about coverage. In this article we shed light on these changing dynamics. We drew upon multistate transition models fit to nationally representative longitudinal data to estimate coverage transition probabilities between major insurance types in the years leading up to and including 2014. We found that the ACA’s unprecedented coverage changes increased transitions to Medicaid and nongroup coverage among the uninsured, while strengthening the existing employer-sponsored insurance system and improving retention of public coverage. However, our results suggest possible weakness of state Marketplaces, since people gaining nongroup coverage were disproportionately older than other potential enrollees. We identified key opportunities for policy makers and insurers to improve underlying Marketplace risk pools by focusing on people transitioning from employer-sponsored coverage; these people are disproportionately younger and saw almost no change in their likelihood of becoming uninsured in 2014 compared to earlier years.

* [**Affordable Care Act**](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/search?fulltext=Affordable+Care+Act&sortspec=date&submit=Submit&andorexactfulltext=phrase)

* [**Insurance Coverage**](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/search?fulltext=Insurance+Coverage&sortspec=date&submit=Submit&andorexactfulltext=phrase)

* [**Insurance Marketplace**](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/search?fulltext=Insurance+Marketplace&sortspec=date&submit=Submit&andorexactfulltext=phrase)

The health insurance reforms brought about by the Affordable Care Act (ACA) have resulted in an estimated twenty million people obtaining insurance.[1](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-1) These coverage gains, according to the National Health Insurance Survey, contributed to a decline in the uninsurance rate from 16.0 percent (48.6 million people) in 2010 to 9.1 percent (28.4 million) by early 2016—the lowest recorded rate in the United States.[2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-2)

As the focus of policy makers now turns to the ultimate fate of the ACA, it will be important to understand the precise channels through which these coverage changes occurred. For example, survey evidence suggests that one-third of enrollees in the ACA’s state-based health insurance Marketplaces were previously uninsured.[3](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-3)[⇓](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-4)–[5](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-5) However, the uninsurance rate could also decline if Medicaid retention rates improved or if people transitioning from employer-sponsored insurance obtained Marketplace coverage or Medicaid in lieu of becoming uninsured.

Coverage rates also have increased since thirty-one states and the District of Columbia expanded their Medicaid programs to 138 percent of the federal poverty level. The degree to which recent Medicaid enrollment was concentrated among previously uninsured people compared to those with a private coverage option (that is, whether private insurance was “crowded out”) remains an important question that is at the heart of ongoing debates about the role of Medicaid in continuing to insure millions of low-income Americans.

This study’s primary objectives were to provide novel evidence on the frequency at which Americans experience changes in their primary source of insurance and to examine how these coverage dynamics changed under the ACA. By tracing the mechanisms through which the ACA’s unprecedented coverage changes occurred, we provide policy makers with key insights into how changes to or repeal of the law will affect the status and source of coverage for millions of Americans. Our study differed from prior studies of coverage transitions under the ACA in two key ways.[4](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-4) First, we considered the full set of transitions among all types of coverage and among the whole nonelderly adult population. Second, we drew upon multistate transition models fitted to nationally representative longitudinal data on 33,194 nonelderly adults surveyed between January 2011 and December 2014. We used these data to estimate coverage transition probabilities among major insurance types and to examine how these transition probabilities changed under the ACA. We used these estimates to inform discussion of the policy implications of coverage dynamics for the ACA and for policies to replace the ACA.

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**Study Data And Methods**

**Data**

Our data were drawn from three panels of the Medical Expenditure Panel Survey (MEPS), a nationally representative longitudinal survey of US households sponsored by the Agency for Healthcare Research and Quality.[6](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-6) MEPS uses an overlapping panel design that samples a new two-year panel each year. Responding households are surveyed in person five times, with interviews spaced five to six months apart. The first panel we used was sampled between January 2011 and December 2012, while the second panel spanned January 2012 to December 2013. The third panel surveyed households between January 2013 and December 2014; thus, for this panel we observed longitudinal data on individuals for twelve months prior to the beginning of the ACA’s expansions and for twelve months following those expansions.

We restricted the sample to adults ages 18–63 as of their first interview month. This allowed us to focus on the population of nonelderly adults who did not age into the Medicare program while in the survey time frame. We also identified demographic characteristics (age, race, sex) as of the baseline month. In total, our study sample comprised 33,194 distinct individuals.

**Insurance Measures**

We measured each person’s monthly insurance status using a mutually exclusive hierarchy that classified the primary source of coverage based on whether the person was a policyholder of an employer-sponsored insurance plan, a dependent on a family member’s employer-sponsored insurance plan, covered by a nongroup or state insurance Marketplace plan (after 2014), covered by Medicaid or some other public coverage program (for example, the Children’s Health Insurance Program), or uninsured. People who reported multiple sources of coverage were classified according to the source that was highest on the above hierarchy.

We followed each respondent for up to twenty-four months and recorded transitions as their primary coverage source changed. These individual-level transitions served as the source of underlying variation for the multistate model described below. In total, 6.3 percent of respondents were right-censored (that is, the end of their initial insurance spell was not observed) because of temporary or permanent attrition from the survey sample. Additional demographic and socioeconomic features of our nationally representative sample are provided in online Appendix Table 1.[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7)

**Statistical Analysis**

Our statistical approach focused on two quantities of interest: first, the probability of transition from the initial coverage source (for example, employer-sponsored insurance) to a different coverage source (for example, nongroup coverage) within a given time frame (for example, within twelve months); and second, the change in that transition probability over time (for example, 2012–13 versus 2013–14).[8](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-8),[9](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full%22%20%5Cl%20%22ref-9)

As described in an example in the Limitations section below, our approach was distinct from previous studies because we captured transitions that would otherwise have been masked in a simple cross-tabulation of coverage at two points in time. In addition, our approach facilitated the construction of novel transition probability matrices that summarize overall turnover in the US health insurance system. Most previous work focused on transitions among people with a single coverage type (for example, the uninsured) or considered newly insured people and assessed whether those individuals were ever uninsured in the prior year and not what other types of coverage those people may have had.[4](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-4),[5](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-5) To our knowledge, no previous study has catalogued the full range of coverage transitions experienced by the nonelderly US population during a one- or two-year period; nor has any previous study assessed how these dynamics changed in the pre- versus post-ACA period.

Transition rates were estimated nonparametrically using a Kaplan-Meier-based multistate model that accounted for right-censoring that might occur because of temporary or permanent attrition from the survey or the end of the survey.[10](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-10)[⇓](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-11)[⇓](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-12)[⇓](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-13)–[14](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-14) Separate models were fitted for each baseline insurance category (employer-sponsored insurance—own, employer-sponsored insurance—dependent, nongroup, public, and uninsured) and each MEPS panel (2011–12, 2012–13, and 2013–14). The use of nonparametric methods and analyses stratified by population group and MEPS panel ensured that our analysis relied entirely on patterns observed in the raw data instead of on restrictive proportional hazards or proportional odds modeling assumptions.[9](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-9) We converted the transition rates estimated by the multistate models to transition probabilities using the nonparametric Aalen–Johansen estimator.[13](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-13),[14](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full%22%20%5Cl%20%22ref-14)

As noted above, our second quantity of interest considered changes in each transition probability over time. Comparisons of change from 2011 to 2012 versus from 2012 to 2013 allowed us to investigate whether rates of transition within and between coverage types were stable in the period leading up to the ACA’s coverage expansions, while comparisons of change from 2012–13 versus 2013–14 allowed us to quantify the extent to which the likelihood of transition changed by the end of 2014.

All statistical inferences and adjustments for the complex survey design were obtained using replicate survey weights provided in MEPS.

**Limitations**

Our study had some important limitations. First, our multistate models captured the first transition observed for a given individual. Consider an individual who initially had employer-sponsored insurance but lost that coverage before regaining it through a new job several months later. A simple cross-tabulation of coverage at baseline and after twenty-four months would reveal that the individual had stable employer-sponsored insurance coverage. By comparison, our multistate model captured the initial transition out of employer-sponsored insurance but did not model the subsequent transition back to employer-sponsored insurance.

While both of the above approaches would understate the total number of insurance transitions in the population, our multistate approach understated transitions only among individuals with more than one transition during a twenty-four-month period. This is particularly important to highlight because of the one-time nongroup plan cancellations at the end of 2013.[15](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-15) These cancellations occurred as issuers discontinued plans that were not compliant with the ACA’s essential health benefits requirements or as issuers otherwise consolidated their plan offerings in advance of the state Marketplaces beginning in 2014. For these individuals, we observed only the first coverage type they received after the plan cancellation. The impact of these cancellations on our overall transition estimates was small, however, because another limitation of our data was the relatively small number of individuals () who began with nongroup coverage.

Another limitation was that our study was observational; that is, our estimates relied on the abrupt change in the availability of insurance starting in January 2014, instead of on random assignment of insurance. Thus, while we found that coverage transition rates were remarkably stable in the months leading up to 2014, our reported changes for 2014 could also reflect the impact of some external factor other than the launch of the ACA, such as improvements in macroeconomic conditions that might have contributed to more people obtaining employer-sponsored insurance for reasons unrelated to ACA policies. We therefore present our estimates in terms of descriptive changes in the overall insurance landscape in 2014, relative to the immediately preceding period.

A third limitation was left-truncation, which is a well-known characteristic of prevalent cohorts (that is, cohorts of individuals who begin the survey already enrolled in a given insurance type).[16](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-16) Left-truncation occurs when observation of a given individual begins while a coverage spell is already under way. A statistical feature of left-truncated samples is that they may overrepresent people in long spells. That is, the individuals we identified as insured under a given coverage type in the first month they appeared in the survey are more representative of people in longer spells for that coverage category. In terms of our transition estimates, this could manifest in lower transition rates compared to if we were able to sample a nationally representative population of individuals as they began their initial coverage spell. However, our estimates of transition changes over time should net out any fixed impacts of left-truncation in the sample.

Finally, because the MEPS public data do not contain state identifiers, we were unable to assess differences across states or state groups based on Medicaid expansion status. The impact on the ACA’s coverage provisions on transitions likely varied with state Marketplace outreach efforts, Medicaid expansion decisions, and insurance market characteristics; the impact of these state-specific factors on insurance dynamics should be a focus of future work on this topic.

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**Study Results**

[Exhibit 1](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F1) plots cumulative transition rates in each month since the start of the survey for transitions from uninsured status to obtaining nongroup coverage. Separate lines are shown for the three MEPS panels; thus, the lines compare how transitions from uninsured status to nongroup coverage evolved during three distinct twenty-four-month periods: 2011–12, 2012–13, and 2013-14. For a given month (for example, month 12), higher values indicate that these transitions occurred more frequently in the population during that time period.

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**Exhibit 1**

Transition rates from uninsured to nongroup coverage among US adults, by Medical Expenditure Panel Survey (MEPS) panel year, 2011–14

SOURCE Authors’ analysis of 2011–14 MEPS data. NOTES Plot shows cumulative transition hazard rates for each MEPS panel. Higher numbers indicate that transitions occurred more frequently.  uninsured adults.

[Exhibit 1](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F1) also shows that the rate of transitioning from uninsured to nongroup coverage was stable during the time periods leading up to 2014. That is, the lines for the 2011–12 and 2012–13 panels overlap, indicating that the rate at which uninsured adults transitioned to nongroup insurance policies was nearly identical from January 2011 to December 2012 as compared to a similar twenty-four-month period between January 2012 and December 2013. In addition, the plotted line for the 2013–14 panel overlaps with the earlier panels for the first twelve months—again indicating that the transition rates were similar from January 2013 to December 2013 to what they were in the first twelve months in the earlier years.

Beginning in month 13 for individuals in the 2013–14 MEPS cohort, we found an abrupt and sustained increase in transitions from uninsured status to nongroup coverage. This increase in insurance transitions at month 13 coincided with the launch of the ACA’s insurance Marketplaces and subsidies for the purchase of Marketplace coverage in January 2014. Additional plots showing transitions for other coverage types are in Appendix Figures 2–6.[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7)

[Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1) takes the transition rates at the twenty-four-month mark from [Exhibit 1](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F1) (as well as analogous estimates for all other transition types) and converts these rates into twenty-four-month transition probabilities. That is, the estimates report on the probability that a person with a given coverage type at baseline transitioned to another coverage type at any point during a two-year period. In the Appendix version of this exhibit, laid out as a matrix, the probability that an individual remained in the same coverage category is provided in the diagonal elements (running from left to right) of this grid (see Appendix Figure 1).[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7)

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**Exhibit 2**

Probabilities of transitioning from one insurance type to another during twenty-four-month periods, 2012–13 and 2013–14

The left-hand section of [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1) shows the twenty-four-month transition probabilities for 2012–13. For example, it shows that 59.4 percent of uninsured adults experienced no transitions and remained uninsured, while 16.0 percent obtained employer-sponsored insurance coverage as the primary policyholder and 2.7 percent enrolled in a nongroup plan.

The right-hand section of [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1) shows the same transition probabilities for 2013–14. Recall that in [Exhibit 1](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F1) we found that the coverage transition rates from uninsured to nongroup insured were similar during the first twelve months when comparing the 2011–12, 2012–13, and 2013–14 panels. Thus, the differences in coverage transition probabilities for uninsured to nongroup insured in [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1) stemmed from changes in transition rates that occurred starting in January 2014. Here, we found that the probability that an uninsured person remained without coverage for twenty-four months was 49.1 percent in 2013–14—a decline of 10.3 percentage points from 59.4 percent in 2012–13.

[Exhibit 3](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F2) reports the change in probabilities between the two panels of [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1). We found that uninsured adults (24.7 percent of the baseline sample; see [Exhibit 1](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F1)) were 3.1 percent more likely to enroll in a nongroup (Marketplace) plan by the end of 2014 relative to the 2012–13 period (). Again, this estimate simply quantifies, in terms of a probability change, the difference in the cumulative transition rates observed at twenty-four months.

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**Exhibit 3**

Changes in insurance transition probabilities, 2012–13 to 2013–14

SOURCE Authors’ analyses of Medical Expenditure Panel Survey data. NOTES Plot shows the change in the twenty-four-month probability of retaining the original coverage type or transitioning to another insurance type from 2012–13 to 2013–14. ESI is employer-sponsored insurance. Sample sizes are in the Notes to [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1).

[Exhibit 3](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F2) shows clearly that the first year of the ACA’s coverage reforms was associated with large reductions in the probability of remaining uninsured among adults who lacked insurance at baseline. In addition to a higher likelihood of obtaining nongroup coverage, these adults also had a higher probability of obtaining employer-sponsored insurance (2.4 percent) or enrolling in Medicaid (4.8 percent).

There were meaningful changes also among adults with Medicaid and among adults with nongroup coverage in 2013. Among those with public coverage, we found that they were more likely to have retained public coverage (3.2 percent; standard error = 1.05) and less likely to have become uninsured (−3.0 percent; SE = 0.98). These adults were also less likely to obtain employer-sponsored insurance through a parent or spouse (−1.7 percent; SE = 0.36).

[Exhibit 3](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F2) also shows that adults with employer-sponsored insurance saw surprisingly little change in their probability of becoming uninsured in 2014. Moreover, the probability of switching from employer-sponsored insurance to nongroup coverage increased by less than 1 percent between 2013 and 2014. The change in transitions to public coverage is small and statistically insignificant, which suggests that, on average, few of those who qualified for both employer-sponsored insurance and Medicaid dropped employer-sponsored insurance coverage for public coverage.

Finally, we found that adults with nongroup coverage in 2013 were much more likely to transition from that coverage to obtain employer-sponsored insurance in 2014, compared to the similar sample of adults with nongroup coverage in 2012–13. This change may have been driven by the mass nongroup plan cancellations in 2013 or, alternatively, greater access to employer-sponsored coverage through overall improvements in the economy. Our results suggest that while some who lost nongroup coverage gained employer-sponsored insurance, the probability that they became uninsured also increased 3.7 percent, although this result was not statistically significant at conventional levels.

**Transitions By Age Group**

A key question facing health insurance plans and policy makers is the distribution of underlying health status in the population of individuals maintaining and enrolling in nongroup plans in the ACA’s newly reformed individual insurance markets. These concerns have been central to recent debates over the economic viability of the Marketplaces as premiums have increased and as major national insurance carriers have begun to exit from certain state Marketplaces.

Our results in [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1) set the stage for understanding the dynamics of insurance transitions by age group. [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1) findings indicate a higher likelihood of gaining nongroup coverage among those who were uninsured. We also found no evidence of change in the probability of obtaining nongroup coverage or becoming uninsured among those with employer-sponsored insurance. This suggests that the availability of subsidized Marketplace coverage might not have attracted individuals previously covered through their employer. Conversely, we found a 10-percentage-point decline in the probability that someone with nongroup coverage in 2013 maintained that plan into 2014.

[Exhibit 4](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#F3) examines how these dynamics may have played into the Marketplace risk pools. We did so by decomposing the observed changes in uninsured status to nongroup coverage and employer-sponsored insurance coverage to uninsured status by age group. Panel A shows that starting in January 2014, the sudden increase in take-up of nongroup insurance coverage among the uninsured was predominantly driven by higher take-up among the oldest age group, ages 45–63. The youngest age group, 18–34, also had an increased likelihood of enrolling in nongroup plans; however, the change in the rate was nearly five times higher by twenty-four months among those in the oldest group. Moreover, increased take-up of nongroup coverage among the young uninsured was driven almost exclusively by females, while young males saw little to no change (see Appendix Figures 2–8, particularly 7 and 8).[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7) This dynamic played out despite the fact that young adults—particularly young males—were more likely than older adults to be uninsured at baseline (see Appendix Table 1).[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7)

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**Exhibit 4**

Insurance transition rates, by age group, 2012–13 and 2013–14

SOURCE Authors’ analysis of 2011–14 Medical Expenditure Panel Survey (MEPS) data. NOTES Plot shows cumulative transition hazard rates for each MEPS panel. Higher numbers indicate that transitions occurred more frequently. ESI is employer-sponsored insurance. Sample sizes are in the Notes to [Exhibit 2](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#T1).

Panel B shows a very different story for transitions from employer-sponsored insurance coverage to uninsured status. There, we found that young adults were considerably more likely than older adults to lose employer-sponsored insurance and become uninsured—but that the rate at which these transitions happened was virtually unchanged when comparing 2012–13 to 2013–14; this finding was similar across both young males and females (see Appendix Figure 3).[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7) In other words, the availability of subsidized Marketplace plans in 2014 did not seem to attract young (or older) people losing employer-sponsored insurance to the state insurance Marketplaces in 2014; instead, they remained just as likely to become uninsured.

[Previous Section](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#sec-6)[Next Section](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#sec-9)

**Discussion**

Results from our study demonstrate clear and meaningful changes in coverage dynamics following the implementation of the ACA’s major coverage reforms in 2014. We found that coverage transitions were concentrated among the uninsured, who saw increased probabilities of obtaining private coverage or enrolling in public coverage relative to the historical norm from 2011 to 2013. We also found modestly improved retention in public insurance as twenty-six states and the District of Columbia expanded their Medicaid programs to 138 percent of poverty as of the end of 2014.

Our study can provide answers to several important questions facing policy makers as they debate the future of the ACA. For example, state-level debates about whether to expand Medicaid have focused on the question of whether the expansion would lead to crowd-out of private insurance. Here, our results add to existing estimates suggesting little crowd-out overall.[17](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-17) Crowd-out could manifest in two ways: People who are currently covered by private insurance but also become eligible for Medicaid might drop private for public coverage; alternatively, those who are currently uninsured might choose to obtain public coverage instead of private coverage. Our results show little evidence that either form of crowd-out occurred after 2014.

Another question is whether the ACA has eroded the existing employer-sponsored system of health insurance.[18](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-18) We found little evidence that this occurred. In fact, transitions to employer-sponsored insurance plans accelerated after 2014—a dynamic also seen in similar Massachusetts reforms that presaged the ACA.[19](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-19) The uninsured, those with nongroup coverage, and dependents on employer-sponsored insurance plans were all more likely to obtain employer-sponsored insurance by the end of 2014, compared to a similar nationally representative population of adults observed in 2012–13.

A third question is whether the ACA would destabilize the nongroup market, as low enrollment combined with higher demand among sick people would result in adverse selection.[20](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-20) Similar to those of another recent study,[4](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full%22%20%5Cl%20%22ref-4) our results show that nongroup enrollment rates among the previously uninsured were concentrated among older adults—validating a claim made often by Marketplace insurers.[21](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-21) This is notable considering that young adults constituted the largest fraction of the uninsured population at baseline (see Appendix Table 1).[7](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-7)

Our results also highlight an enormous missed opportunity. We found that young adults were disproportionately more likely to transition from employer-sponsored insurance to uninsured status. Yet despite the availability of subsidized Marketplace coverage in 2014, the rates at which adults at all ages with employer coverage became uninsured did not change between 2012 and 2014.

Leading into the open enrollment period for 2014, outreach efforts were understandably focused on identifying and enrolling those who were already uninsured. Much less attention was paid to an estimated ten million people (annually) who become eligible for a special enrollment period when they lose insurance because their work or family circumstances change.[22](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-22) Our findings are consistent with this figure and show further that those who lost employer-sponsored insurance were disproportionately younger—precisely the demographic that policy makers and issuers need to keep risk pools stable and Marketplace premiums low. Yet, at least in 2014, the large population of young adults transitioning off employer-sponsored insurance was missed by insurers in the state insurance Marketplaces.

This finding is important for the ongoing debate over alternatives to the ACA. Several ACA replacement plans put forth in Congress eliminate the ACA’s individual mandate in favor of other approaches to stabilizing nongroup risk pools. Most prominent among these approaches is guarantees of coverage without restrictions on preexisting conditions for people who maintain a continuous source of insurance (the so-called continuous insurance provisions).[23](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-23)This approach will undoubtedly incentivize people with preexisting conditions to maintain insurance but does not explicitly incentivize young, healthy people to do so. To capture these people, further carrots (for example, premium subsidies) or sticks (for example, premium surcharges) will be necessary. Yet we found that the presence of large premium and cost-sharing subsidies for people up to 400 percent of the federal poverty level under the ACA did not materially change the probability that young adults transitioning from employer-sponsored insurance enrolled in Marketplace coverage in lieu of becoming uninsured.

Another possible reason for lack of enrollment among those who recently left employer-sponsored insurance is the general unease among insurers regarding the health of people who enroll under a special enrollment period. Fearing adverse selection, issuers have discouraged this type of enrollment by lowering or even eliminating broker commissions for special enrollment period enrollees.[24](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-24)Others have targeted the temporarily uninsured by offering low-cost, short-term plans outside of the state insurance Marketplaces. These plans do not cover preexisting conditions and often do not cover other services, such as prenatal care.[25](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-25) Thus, not only are these plans noncompliant as qualified health plans under the ACA, they also would not be compliant with requirements for covering preexisting conditions under a continuous coverage provision offered as an alternative to the ACA.

Further efforts are needed to bring people who lose employer-sponsored insurance benefits into nongroup plans, as Americans will be increasingly reliant on such plans as either a temporary or permanent source of insurance in the coming years, regardless of what happens to the ACA.[8](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-8) One option is outreach and education to employers—particularly in the services sector, where loss of employer-sponsored insurance benefits among young adults is most frequent.[8](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-8)More generally, making consumers aware of their option to select a lower-cost nongroup Marketplace plan over insurance through the Consolidated Omnibus Budget Reconciliation Act (COBRA) when they change jobs could also facilitate further enrollment. Notice of potential eligibility for subsidized Marketplace coverage based on wage data and provided in the required notification letter for COBRA benefits is another option for raising consumers’ awareness of special enrollment periods. Optional language on the availability of Marketplace plans has been included in updated model COBRA election notices since 2014; however, a June 2016 “frequently asked questions” fact sheet from the Department of Labor makes clear that adoption of this language remains uneven.[26](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-26)

Finally, catastrophic health plans are currently available on the state Marketplaces for people younger than age thirty or people who qualify for a hardship exemption for the individual mandate. Expansion of catastrophic-plan eligibility to those eligible under a special enrollment period, including the ability to apply premium tax credits and cost-sharing subsidies toward the cost of those plans, is not currently permitted but could be incorporated into future ACA replacement or reform efforts. This could also facilitate the inclusion of people who might only need a few months of low-cost transitional insurance. As with COBRA, policy makers could similarly limit participation in transitional catastrophic plans to eighteen months, and they could also limit eligibility for subsidies to those who remain continuously insured through such plans.

[Previous Section](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#sec-8)[Next Section](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ack-1)

**Conclusion**

Our study provides clear evidence that along certain dimensions, the ACA had success in moving uninsured people into coverage and in improving retention in existing coverage programs. As policy makers grapple with options to keep or remove parts of the ACA, or repeal it altogether,[27](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full%22%20%5Cl%20%22ref-27) our work highlights strengths and weaknesses of the law. While the ACA’s Medicaid expansion did not result in significant amounts of crowd-out or further erosion of the employer-sponsored insurance system, more work needs to be done to promote the long-term stability of nongroup coverage and further reduction of the uninsured population. Moving forward, policy makers should focus on new strategies to enroll the millions of Americans who might not be uninsured today but who could lose their coverage over the next few years.

[Previous Section](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#sec-9)[Next Section](http://content.healthaffairs.org.proxy.libraries.rutgers.edu/content/36/2/297.full#ref-list-1)

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