

Measuring Medicaid/CHIP Enrollment Progress Under the Affordable Care Act

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AT A GLANCE:

- Nationally, as of April, 2014, Medicaid/CHIP programs had reached 47 percent of the Medicaid/CHIP enrollment increases projected to be obtained by the end of 2016, when the Affordable Care Act's coverage provisions implemented in 2014 are expected to reach their full effect, based on projections derived from the Urban Institute's Health Insurance Policy Simulation Model.¹
- Taking into account current state decisions on Medicaid expansion, Medicaid/CHIP enrollment is projected to increase by 12.8 million by 2016, of whom 9.9 million live in states expanding Medicaid and 2.9 million live in states not expanding Medicaid.
- Collectively, states that expanded Medicaid had reached 53 percent of the 2016 projected enrollment increases by April 2014 compared with a rate of 29 percent for states that did not expand Medicaid.²
- States vary tremendously in Medicaid/CHIP enrollment increases relative to projected increases, though reporting differences across states make interpretation of state-specific patterns within in each category challenging; it is anticipated that the quality and consistency of the enrollment statistics will improve over time.

INTRODUCTION

Recent news articles have called attention to an estimated 2.9 million Medicaid applications that have not yet been processed by states.³ As states work to clear these backlogs, it is useful to assess how well states have been doing in 2014 at enrolling people who are eligible for Medicaid and the Children's Health Insurance Program (CHIP). The Centers for Medicare and Medicaid Services has [released information](#) on how many additional people were enrolled in coverage through Medicaid and CHIP since October 1, 2013, when the first open-enrollment period for the new health insurance marketplaces was launched, through April 2014, the most recent information available.⁴

This brief assesses how reported changes in enrollment in Medicaid and CHIP during this period compare with changes in Medicaid/CHIP enrollment projected by the end of 2016 by the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). The projections from HIPSM take into account the size and characteristics of the eligible population under current state decisions regarding whether to expand Medicaid under the ACA and expectations about the share of Medicaid and CHIP eligibles who would enroll, based on factors such as health status and prior insurance status.

The Patient Protection and Affordable Care Act (ACA) includes a number of provisions aimed at expanding access to affordable health insurance coverage. To address high rates of uninsurance among poor and near-poor adults, the ACA included a Medicaid expansion to individuals with incomes at or below 138 percent of the federal poverty level (FPL). In addition, federal subsidies were made available for

coverage through the new marketplaces to individuals with incomes between 138 and 400 percent of the FPL who do not have access to employer-sponsored coverage defined as affordable under the law.⁵ Following the Supreme Court decision of June 2012, which de facto gave states the option of expanding eligibility for Medicaid under the ACA, 26 states, including the District of Columbia, expanded Medicaid by April 1, 2014. In states that do not expand Medicaid, individuals with incomes below the FPL are not eligible for subsidized coverage, while individuals with incomes between 100 and 138 percent of the FPL can qualify for subsidized private health insurance coverage through the new marketplaces in these states.

When all states were expected to expand Medicaid under the ACA, enrollment in Medicaid and CHIP was anticipated to increase by over a third by the end of 2016; with fewer states expanding, the projected increase in Medicaid/CHIP enrollment is significantly smaller.⁶ Increases in Medicaid and CHIP enrollment under the ACA are not limited to groups who are made newly eligible for Medicaid. New Medicaid and CHIP enrollment may also come from increased take-up among children and adults who were eligible under pre-ACA eligibility categories but not enrolled—the “woodwork” or “welcome mat” effect. Before 2014, an estimated 8 to 9 million uninsured adults and children appeared to be eligible for Medicaid or CHIP but not enrolled.⁷ Research from Massachusetts found that the health reform effort there, which contained many of the same features as the ACA, was associated with increased take-up of Medicaid coverage among already

eligible children and adults.⁸ In addition, prior expansions in Medicaid and CHIP have increased take-up among previously eligible groups; in particular, expansions in coverage to parents have been associated with increased participation among already eligible children.⁹

Medicaid/CHIP enrollment can increase in states that do not expand Medicaid as people apply for coverage in the Marketplace and learn they or their children are eligible for Medicaid or CHIP. In addition, the individual requirement to have health insurance coverage and associated penalties for noncompliance can encourage enrollment in general, even among those not subject to penalties due to having low income. The adoption of the modified adjusted gross income (MAGI) standard and the addition of the standard income disregard of 5 percent of the FPL, which as of 2014 applies to most Medicaid eligible persons who are not elderly or disabled and all CHIP eligible persons, may also increase the number of Medicaid- and CHIP-eligible children and adults under pre-ACA eligibility categories, particularly in states not expanding Medicaid. Finally, all states, regardless of whether they chose to expand Medicaid, were required to modernize their eligibility determination and renewal processes by using a common application for

all insurance affordability programs, offering multiple options for applying, relying more on electronic data for verification, and moving to real-time eligibility determinations when possible. This modernization, which includes what is known as having “no wrong door” to coverage, should increase both enrollment and retention in Medicaid and CHIP when fully implemented.¹⁰

Medicaid and CHIP enrollment is likely to continue growing over the course of 2014. Unlike coverage in the new Marketplaces, Medicaid and CHIP enrollment for the remainder of the year is not dependent on the individual qualifying for a special enrollment period. Moreover, the reported backlog of pending applications could substantially affect Medicaid and CHIP enrollment numbers in some states.¹¹ In addition, many Medicaid and CHIP enrollees will go through their renewal for Medicaid or CHIP in the coming months, affecting caseloads as individuals and families move between eligibility for Medicaid and tax credits in the Marketplace.¹² Finally, the enrollment information reported by CMS for March and April are preliminary. Therefore, we will regularly update and compare the reported enrollment changes in Medicaid and CHIP to our projected changes in enrollment by 2016.

METHODS

This brief relies upon analysis of the Health Insurance Policy Simulation Model-American Community Survey version (HIPSM-ACS). The model is based upon ACS data from 2009, 2010, and 2011 to obtain representative samples of state populations and their pre-ACA implementation insurance coverage. We identify the eligible population for Medicaid and CHIP enrollment—the population that Medicaid and CHIP are designed to cover—as those who would be eligible for Medicaid or CHIP under the ACA. In the states that have expanded Medicaid coverage, this includes adults with incomes at or below 138 percent of the FPL who are newly eligible for Medicaid under the ACA coverage expansion, as well as adults and children who qualify under pre-ACA eligibility categories; for those not expanding, eligibility is limited to those eligible under prior state rules but taking into account changes to the measurement of income (i.e., the use of MAGI to define income and a standard income disregard). Undocumented immigrants and other immigrant groups are excluded from the target population as the ACA prohibits their enrollment in Medicaid and CHIP. State-level estimates of projected enrollment result from aggregating projected individual- and family-level enrollment for those residing in each state.

HIPSM simulates individual and family health insurance enrollment under the ACA based upon eligibility for programs and subsidies, health insurance coverage and options in the family, health status, socio-demographic characteristics, any applicable penalties for remaining uninsured, and other factors.¹³ The enrollment projections reflect the fact that different members of the Medicaid-eligible population are likely to enroll at different rates. For example, other things equal, individuals who are made newly eligible for Medicaid/CHIP are expected to enroll at higher rates than those who were eligible under prior rules but who had not yet enrolled (i.e. the residual eligibles who had not yet taken up Medicaid/CHIP coverage); likewise, higher take-up is expected among those with health problems and among those who lack coverage or have non-group coverage relative to those with employer-sponsored coverage.¹⁴

In projecting enrollment for 2016, we take into account Medicaid and CHIP eligibility standards for children and adults by state as of April 2014. At that point, 26 states (including the District of Columbia) had expanded Medicaid eligibility to adults up to 138 percent of the FPL. Among these states, all but Michigan had expanded Medicaid on

January 1, 2014, or before; Michigan's expansion was implemented on April 1, 2014. New Hampshire is grouped with the states that are not expanding Medicaid since its expansion will not be implemented until later in 2014.¹⁵

In the results described below, we compare the latest Medicaid/CHIP enrollment statistics released by the CMS to enrollment projections derived for the end of 2016 based on HIPSM-ACS. The 2016 estimates represent expected levels of enrollment when the Affordable Care Act's coverage provisions implemented in 2014 are expected to reach their full effect. We focus on 2016 because it is expected that all early enrollment problems will have been overcome by then, the penalty for not having insurance coverage will be fully phased in, and knowledge and understanding of the law's coverage options and financial assistance mechanisms will have spread more widely than can be expected at the start of a new program. Relying on Medicaid and CHIP enrollment increases after October 1, 2013 excludes enrollment that occurred before this time in states that availed themselves of the option to expand Medicaid before January 2014 under the ACA.¹⁶

The CMS estimates of change are derived by comparing enrollment levels in March and April 2014 to each state's average monthly enrollment for the months of July–September 2013. We consider the reported enrollment increases as a reflection of net changes in full benefit Medicaid/CHIP enrollment since just before the first open-enrollment period, which began October 1, 2013. Importantly, changes in enrollment between the July–September period and other periods may reflect seasonal and other factors beyond changes related to the ACA, however, it provides an anchor for changes in enrollment. Moreover, states vary in the quality and consistency of the data reported: some states include enrollees with limited benefits or dual-eligibles, some states have not been able to submit consistent data, and the data are considered preliminary and will likely be revised over time in some states. Connecticut, North Dakota, and Maine are excluded from this analysis because enrollment information was not available from CMS. We assessed the state-specific estimates and flag some notable patterns but do not present the state-specific findings due to concerns about a lack of comparability across states in the enrollment statistics presented by CMS.

WHAT WE FOUND

Nationally, as of April, 2014, Medicaid/CHIP programs had reached 47 percent of the enrollment increases projected to occur by the end of 2016, when the full effects of the coverage provisions implemented in 2014 under the ACA are expected to be phased in. According to information released by the Centers for Medicare and Medicaid Services, the average monthly enrollment in Medicaid and CHIP increased on net by approximately 6.0 million between just before the first open-enrollment period, which began October 1, 2013, and April 2014 (Figure 1, bottom set of bars).¹⁷ This represents an increase in Medicaid/CHIP enrollment of 1.1 million between March and April 2014.

Overall, under current state decisions on the Medicaid expansion, the ACA coverage provisions are expected to increase Medicaid/CHIP enrollment by 12.8 million by 2016. Most (9.9 million) of that increased enrollment is expected in the states that are expanding Medicaid under the ACA (Figure 1, middle bars). Taken together, this implies that as of April 2014, Medicaid and CHIP programs were almost halfway—or 47 percent (i.e., 6.0 million divided by 12.8 million)—toward reaching the net enrollment increases expected by 2016 (Figure 2, first bars), up from 39 percent as of March 2014.

Collectively, as of April 2014, the states that expanded Medicaid coverage have been more successful in reaching the increases in Medicaid/CHIP enrollment that were projected by 2016 than have the states that had not expanded Medicaid. As a group, the states that expanded Medicaid reached 53 percent of their projected Medicaid/CHIP enrollment increase for 2016 by April 2014 (Figure 2, second bars), compared with 29 percent for states that did not expand Medicaid (third bars).¹⁸ Both expanding and non-expanding states experienced net increases in Medicaid/CHIP enrollment between March and April 2014. For expanding states, Medicaid/CHIP enrollment increases relative to projected enrollment increases grew from 43 percent in March to 53 percent in April; for non-expanding states, the share of the projected increase that was achieved grew from 22 percent in March 2014 to 29 percent in April 2014.

States vary tremendously in Medicaid/CHIP enrollment increases relative to projections, though reporting differences across states make interpretation of state-specific patterns within each category challenging. While states are expected to experience Medicaid/CHIP enrollment increases under the ACA whether they expand Medicaid or not, several states in the non-expanding category were

reported to have experienced a decline in Medicaid/CHIP enrollment over this period (see for example, an assessment of caseload declines in Missouri).¹⁹ Within the group of expanding states, states such as Maryland, Oregon, Rhode Island, Vermont, and West Virginia appeared to be very close to reaching the enrollment increases projected for 2016 in April 2014. In those states, it is likely that they will

surpass the projected enrollment increases, indicating that they are achieving higher Medicaid/CHIP participation rates than anticipated in our model. In contrast, within this group, states such as Illinois and New Jersey (both of which reportedly have accumulated a sizeable backlog of Medicaid applications) had smaller enrollment gains relative to the projected enrollment increases (data not shown).²⁰

CONCLUSION

States, particularly those that expanded Medicaid under the ACA, have made considerable progress toward enrolling individuals and families eligible for Medicaid and CHIP compared to what enrollment is expected to look like by the end of 2016 under full implementation. By the end of April 2014, states had reached 47 percent of the projected 2016 enrollment increase, up from 39 percent at the end of March. This implies that as a whole, states are experiencing comparable enrollment progress in Medicaid as in the new marketplaces as of April 2014—both reaching between 45 and 50 percent of the projected change for 2016.²¹ However, with both marketplace and Medicaid enrollment progress, there is substantial variation across states.

States that have expanded Medicaid are doing much better than those who have not, achieving 53 percent of their projected Medicaid/CHIP enrollment increase compared with 29 percent for non-expanding states. A number of factors could contribute to the greater progress observed on average in states that expanded Medicaid including differences in the quality and extent of outreach and application assistance, the greater reliance on state based marketplaces, the higher level of support for the ACA and its goal of increasing coverage within the state, and the use of so-called “fast track” strategies that use data from the Supplemental Nutritional Assistance Program and from Medicaid and CHIP on parents of enrolled children to automatically enroll individuals and families.²² Progress in expanding states does appear to be highly variable however, with some states coming close to the 2016 expected increase. Understanding what is contributing to success in the high-achieving states and which policies are most effective will be important to making all states better equipped to meet their enrollment potential.

Recent reports indicate that 2.9 million Medicaid/CHIP applications are currently pending in state Medicaid programs.²³ If these applications contained one person each and most applicants complete the process and are found eligible, this would suggest that states received

enough applications to result in enrollment that reached more than two thirds of the expected 2016 increases. At the same time, states need to be ready to tackle the renewals for previously enrolled Medicaid beneficiaries as they come up in order to maintain these numbers; this will be challenging in some states.²⁴ We will monitor states’ progress as states revise their enrollment totals and the year goes on.

A full assessment of the impact of the ACA on Medicaid enrollment and the uninsured will come with time. In particular, it will be critical to measure the observed patterns of enrollment in Medicaid and CHIP against what would have happened if the ACA were not implemented, taking into account changes in the underlying macro-economy. Other analysts have shown that the increases in enrollment seen here far outpace those that occurred during the Great Recession, suggesting that the ACA is driving these results rather than a secular trend.²⁵ Similarly, it will be critical to understand what these increases in enrollment have meant for reductions in the uninsured in both expanding and non-expanding states.

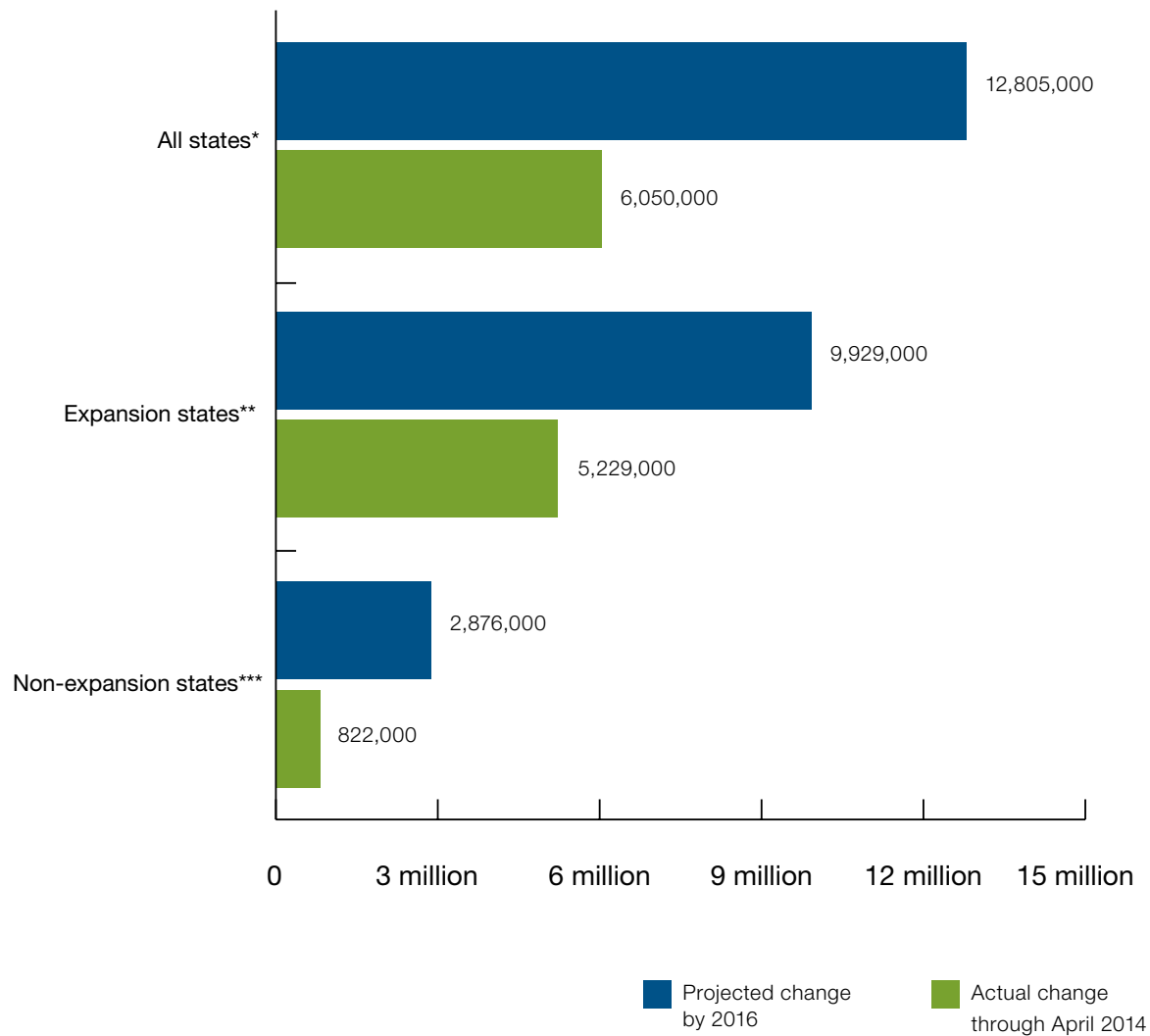
The findings presented here suggest that the rate of uninsurance will tend to decline faster in states that have expanded the Medicaid program—not only because more uninsured qualify for financial assistance for health insurance coverage in those states, but also because they appear to be enrolling the population who is eligible for Medicaid at higher rates compared with the non-expanding states. This finding is consistent with other work that indicates that the uninsurance rate declined 4 percentage points in states that expanded Medicaid and 1.5 percentage points in non-expanding states between early September 2013 and early March 2014.²⁶ Unlike enrollment in the Marketplace that ended for 2014 in the middle of April (except for those with specific changes in family or financial circumstances), Medicaid enrollment continues uninterrupted over the course of the year, potentially further driving down the uninsurance rate, particularly in states that expanded their programs.

ENDNOTES

1. The information released by CMS includes information for July-September 2013 and March and April 2014 on Medicaid enrollment for all states and the District of Columbia except Connecticut, North Dakota, and Maine.
2. The states included in the Medicaid expansion category for this analysis are AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV.
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4. The CMS report presents changes based on an average monthly enrollment for July, August, and September 2013; we use this average as a proxy for the baseline period before October 1, 2013. See Sommers BD, GM Kenney, and AM Epstein, "New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions." *Health Affairs*, 33(1): 78–87, 2014. <http://content.healthaffairs.org/content/33/1/78.abstract>.
5. Specifically, if one family member is offered employer coverage for which the worker contribution of the single premium is less than 9.5 percent of the family income, then the entire family is ineligible for subsidies.
6. Kenney GM, M Huntress, M Buettgens, V Lynch and D Resnick, "State and Local Coverage Changes under Full Implementation of the Affordable Care Act," Kaiser Family Foundation, July 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8443-state-and-local-coverage-changes-under-full-implementation.pdf>; Holahan J, M Buettgens, C Carroll, and S Dorn, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Family Foundation, November 2012, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf>.
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11. See "How Many Americans Are Waiting for Decisions on Medicaid Coverage," available at <http://media.cq.com/pub/2014/medicaid/?pos=adps> for a summary on the extent of the backlog as of May 2014.
12. See "Lessons from California: Medi-Cal Renewals," available at <http://www.healthlaw.org/component/jfsfsubmit/showAttachment?tmpl=raw&id=00Pd000000B9fLyFAJ> for a discussion of renewal problems in California.
13. See "The Urban Institute's Health Microsimulation Capabilities," available at <http://www.urban.org/publications/412154.html>, for an overview of HIPSIM. For a more detailed description of the model, see "Health Insurance Policy Simulation Model (HIPSIM) Methodology Documentation: 2011 National Version," available at <http://www.urban.org/publications/412471.html>. In our projections, we assumed that about three-quarters of uninsured people who gain eligibility for Medicaid due to the expansion would eventually enroll. These take-up rates are higher than pre-ACA rates for adults, reflecting such ACA provisions as the individual coverage requirement. But they could be even higher in states where outreach is particularly effective. For example, participation rates for children's coverage are well above 75 percent: Kenney G, N Anderson, and V Lynch, "Medicaid/CHIP Participation Rates Among Children: An Update," Urban Institute, September 2013, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407769.
14. The take-up assumptions used are derived from empirical studies of Medicaid and CHIP take-up behavior under prior expansions.
15. See Sommers BD, GM Kenney, and AM Epstein, "New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions." *Health Affairs*, 33(1): 78–87, 2014. <http://content.healthaffairs.org/content/33/1/78.abstract> and Sommers BD, E Arnston, GM Kenney, and AM Epstein. "Lessons from Early Medicaid Expansions Under Health Reform: Interviews with Medicaid Officials." *Medicare & Medicaid Research Review*, 3(4), 2013. http://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a02.pdf for more detail on the states that expanded Medicaid early under the ACA. See "Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL), January 2013," available at <http://kff.org/medicaid/state-indicator/income-eligibility-low-income-adults/#note-22> for information on state Medicaid eligibility thresholds before 2014.
16. Sommers BD, GM Kenney, and AM Epstein, "New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions." *Health Affairs*, 33(1): 78–87, 2014. <http://content.healthaffairs.org/content/33/1/78.abstract>.
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18. We find that the differential between expanding and non-expanding states is robust to the inclusion or exclusion of states such as California, Florida, Alabama, and Nevada where there are more concerns about the enrollment information released by CMS (data not shown).
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22. State based marketplaces may have more effective processes in place to coordinate application processing seamlessly across marketplace and Medicaid/CHIP agencies. For more information about different experiences of the FFM and state-based marketplaces with regard to the coordination of application processing and eligibility determination across the marketplace and Medicaid/CHIP agencies see: Courtot B, T Coughlin, and D Upadhyay, "The Launch of the Affordable Care Act in Selected States: Building ACA-Compliant Eligibility and Enrollment Systems" Urban Institute, March 2014, <http://www.urban.org/UploadedPDF/413038-The-Launch-of-the-Affordable-Care-Act-in-Selected-States-Building-ACA-Compliant-Eligibility-and-Enrollment-Systems.pdf>. For strategies to facilitate enrollment see "Target Enrollment Strategies," Centers for Medicare and Medicaid Services, Last accessed 10 June 2014, <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html>; and Guyer J, T Schwartz, and S Artiga, "Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion," Kaiser Family Foundation, November 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf>.
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24. See "Lessons from California: Medi-Cal Renewals," available at <http://www.healthlaw.org/component/jfssubmit/showAttachment?tmpl=raw&id=00Pd000000B9fLyEAJ> for a discussion of renewal problems in California.
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Figure 1: Reported 2013–2014 Medicaid/CHIP Enrollment Increases and Projected Medicaid/CHIP Enrollment Increases By the End of 2016: Overall and for Medicaid Expansion and Non-Expansion States



Sources: Medicaid/CHIP enrollment increases between July and September 2013 and March/April 2014 are from CMS, Medicaid and CHIP: April 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, June 4, 2014. Projected Medicaid/CHIP increases by the end of 2016 are based on Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSIM-ACS) 2014.

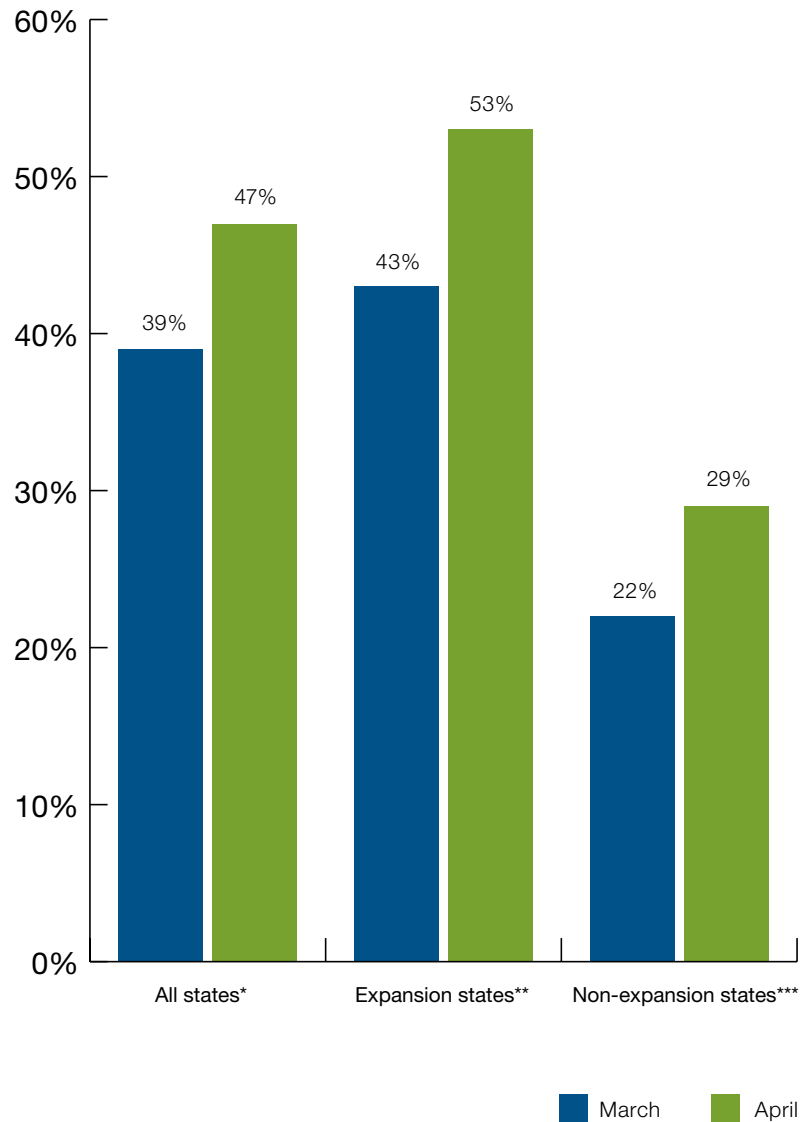
Note: Numbers are rounded to the nearest thousand.

* Connecticut, North Dakota, and Maine are excluded from these estimates owing to lack of enrollment information from CMS.

** Includes Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

*** Includes Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

Figure 2: Reported 2013–2014 Medicaid/CHIP Enrollment Increases Relative to Projected Medicaid/CHIP Enrollment Increases By the End of 2016: Overall and for Medicaid Expansion and Non-Expansion States



Source: Medicaid/CHIP enrollment increases between July-September 2013 and March/April 2014 are from CMS, Medicaid and CHIP: April 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, June 4, 2014. Projected Medicaid/CHIP increases by the end of 2016 are based on Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSIM-ACS) 2014.

Note: Medicaid enrollment increase is measured as the change between July-September 2013 and March/April 2014.

* Connecticut, North Dakota, and Maine are excluded from these estimates owing to lack of enrollment information from CMS.

** Includes Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

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