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Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota

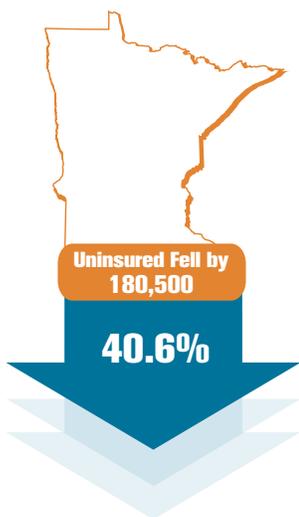
Executive Summary

With full implementation of the Affordable Care Act's (ACA's) health insurance coverage provisions on January 1, 2014, there has been great interest in assessing the law's early impact on health insurance coverage in Minnesota. At the request of Minnesota's State-Based Health Insurance Marketplace, MNsure, researchers from the University of Minnesota's State Health Access Data Assistance Center (SHADAC) compiled data from a variety of sources to analyze, at an aggregate level, the shifts in health insurance coverage that have taken place in Minnesota since the fall of 2013. Support for this work was provided through the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

To our knowledge, this report is the first assessment of early state-level impacts of the ACA on health insurance coverage. The major findings of this report include the following:

- Between September 30, 2013 and May 1, 2014, the number of uninsured Minnesotans fell by 180,500, a reduction of 40.6 percent. The number of uninsured in Minnesota fell from 445,000 (8.2 percent of the population) to about 264,500 (4.9 percent of the population).
- This increase in health insurance coverage was primarily driven by an increase in the number of Minnesotans enrolled in state health insurance programs, Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare. Enrollment increased by over 155,000 for these two programs combined.
- Coverage in the private health insurance market also increased. The total number of Minnesotans with private group coverage (primarily employer-sponsored coverage) was relatively stable with a decline of about 6,000 (a 0.2 percent change); growth in self-insured plans was balanced by a decline in fully-insured coverage. The nongroup market grew by almost 36,000 and included gains both inside and outside of MNsure.

Our findings on the change in the number of uninsured are consistent with national reports of early ACA impact, and with research on the impacts of Massachusetts reforms implemented in 2007 which are quite similar to the access expansion provisions included in the ACA. Further research and analysis are needed to answer questions such as what are the characteristics of Minnesotans who gained or lost coverage from different sources, how many Minnesotans who purchased coverage through MNsure were previously uninsured, and what are the characteristics of the remaining uninsured population in Minnesota.



Introduction

On January 1 2014, Minnesotans gained access to new health insurance coverage options through the Affordable Care Act (ACA). These options included an expansion of Medicaid coverage for adults with annual incomes of up to 138 percent of the federal poverty level and new premium tax credits and cost-sharing subsidies for the purchase of private coverage through MNsure.¹ MNsure is a new state-based health insurance marketplace with the goal of helping people shop and sign up for health insurance coverage. These new options, along with an individual mandate to have health insurance coverage or pay a tax penalty, have undoubtedly led to shifts in Minnesota's coverage landscape.

By the end of May, MNsure reported that more than 227,500 individuals had enrolled in health insurance coverage through MNsure.² This total included enrollment in both private and public health insurance plans. While this figure signals growth in some types of coverage, it doesn't provide an accurate picture of how many *uninsured* have gained coverage since open enrollment began and whether there have been significant shifts in where people are getting coverage. To understand the shifts in health insurance coverage and to more fully understand the impact of recent changes on rates of uninsurance, additional information is required to account for the potential shifts among all sources of coverage (for example, between employer-sponsored group coverage and MNsure or between nongroup coverage and public insurance).

The best way to assess coverage shifts would be through a population survey. Minnesota conducts a bi-annual household survey, the Minnesota Health Access Survey (MNHA), to understand state coverage rates and trends in health insurance coverage over time. However, the next MNHA is not scheduled to take place until the latter half of 2015, with results available in early 2016; similarly, 2014 estimates from national surveys that provide state-level health insurance estimates will not be available until the fall of 2015.

At the request of MNsure, we developed an alternative and more timely approach to assess the

early impact of the ACA on health insurance coverage in the state. We rely on the most current information on Minnesota's uninsured population along with administrative data from public and private health plans to estimate changes in health insurance coverage. We use this data to analyze shifts in the aggregate distribution of health insurance coverage in Minnesota across all segments of the health insurance market before and after MNsure's open enrollment period. The purpose of the report is to estimate the early impact of the ACA on the number of uninsured in the state, and to show how the distribution of health insurance coverage has changed.

Methods

SHADAC collected information from private and public payers on the number of Minnesota residents enrolled in their health plans at two points in time: September 30, 2013 and May 1, 2014.² These data provide a snapshot of coverage in Minnesota just before the MNsure open enrollment period began, and one month after it closed, allowing for processing of enrollments that had been started but not completed prior to the end of open enrollment.

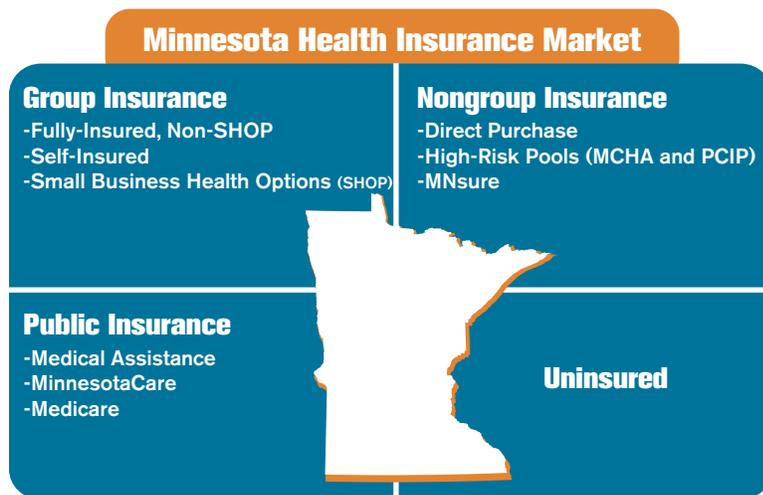
Figure 1 illustrates the categories of health insurance coverage in Minnesota. Within each major coverage type (group, nongroup, and public) there are several subtypes, as shown in the figure.

The methodology used in this analysis is similar to one that has been used by the State of Minnesota to estimate the distribution of health insurance coverage in Minnesota since the early 1990s.³ The data come from a variety of sources, including private health plans, MNsure, the Minnesota Department of Human Services (DHS), the U.S. Census Bureau, the Minnesota Health Access Survey, and other sources as detailed below. The analysis begins with the total population of the state, and then accounts for the number of people with each type of health insurance coverage, for which data are available. Since enrollment in self-insured plans is not subject to state regulation and is not reported publicly, this coverage type is calculated as a residual for September 2013.⁴ In other words, the estimated number of people

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covered by self-insured plans is the number that are “left over” after accounting for all other categories (including the uninsured); as a result, any errors or imprecision in the other coverage types are captured in this coverage category.

FIGURE 1. MINNESOTA HEALTH INSURANCE MARKET



Total population

According to the most recent estimates from the U.S. Census Bureau, Minnesota’s population was 5,420,380 as of July 1, 2013.⁵ SHADAC calculated an average monthly growth rate for the period from July 1, 2010 to July 1, 2013 and applied this growth rate to estimate Minnesota’s population on October 1, 2013 and on May 1, 2014.

Private group coverage

Enrollment counts as of September 30, 2013 and May 1, 2014 for Minnesota residents in fully-insured group coverage, outside of MNsure’s SHOP exchange, were provided to SHADAC by the Minnesota Council of Health Plans (MCHP) for its members.⁶ SHADAC adjusted this number upward to account for the market share held by plans that are not members of MCHP. Market share was calculated by using information on premiums and market shares in the fully-insured market as a whole⁷ and subtracting premiums for nongroup coverage.⁸ SHADAC estimated that the MCHP member plans account for 88.9 percent of the fully-insured group market, and adjusted the MCHP enrollment counts

accordingly to represent the total market.

Estimated enrollment in self-insured plans as of September 30, 2013 was calculated as a residual after accounting for all other coverage sources and subtracting it from the total population. To account for growth in this market over the time period in question, SHADAC used information provided by MCHP that indicates that enrollment in self-insured plans administered by MCHP members grew by 1.6 percent between September 30, 2013 and May 1, 2014. May 1 enrollment in self-insured plans was calculated by applying this growth rate to the September 30 estimated enrollment in self-insured plans.

Enrollment in SHOP plans as of May 1 was provided by MNsure, using data from monthly reports related to advance payments of tax credits and cost sharing reductions that participating carriers submit to the federal government.⁹

Private nongroup coverage

Estimates for private nongroup coverage were calculated in a manner similar to the calculations for group coverage. MCHP provided counts of Minnesota residents enrolled in its members’ plans as of September 30, 2013 and May 1, 2014, and SHADAC adjusted the estimates to represent the entire private nongroup market. SHADAC estimated that the MCHP member plans accounted for 91.5 percent of covered lives in the private nongroup market,¹⁰ and this assumption was used to adjust the enrollment counts from MCHP to represent the complete private nongroup market outside of MNsure. SHADAC also obtained enrollment counts as of September 30, 2013 and April 30, 2014 from the Minnesota Comprehensive Health Association (MCHA), Minnesota’s state high-risk health insurance pool; to avoid double counting, these enrollment counts exclude Medicare Supplemental policies. In addition, SHADAC used enrollment data published by the Centers for Medicare and Medicaid Services (CMS) to account for enrollment in the temporary federal high-risk pool established by the ACA (Pre-Existing Condition Insurance Program, or PCIP).¹¹ Finally, MNsure provided counts of enrollment in nongroup Qualified Health Plans (QHPs) as of May 1, 2014, using data from the

monthly reports that participating carriers submit to the federal government.

Medical Assistance and MinnesotaCare

SHADAC obtained counts of enrollment in Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare (a separate state program with sliding-scale premiums based on income) as of September 30, 2013 and April 30, 2014 from DHS. To avoid double counting, the counts used in this analysis for Medical Assistance and MinnesotaCare excluded individuals who were dually eligible for Medicare and Medical Assistance or MinnesotaCare. Because the April 30 enrollment counts are still preliminary and final enrollment counts are typically higher, SHADAC's analysis used an adjustment factor recommended by DHS, based on historical experience, to estimate the complete enrollment counts for April 30.

Notably, the figures for Medical Assistance and MinnesotaCare reflect substantial shifts between these two programs. This is due in part to new requirements effective January 2014 that all income-eligible MinnesotaCare populations be shifted into Medical Assistance.¹²

Medicare

The most recent publicly available enrollment counts for Minnesota residents in Medicare are for July 1, 2012.¹³ SHADAC calculated average monthly enrollment growth rates in Medicare for Minnesota residents for July 2009 to July 2012, and applied this average monthly growth rate to the 2012 enrollment count to estimate enrollment of Minnesota residents in Medicare as of October 1, 2013 and May 1, 2014.

Uninsured

The estimated number of uninsured in September 2013 comes from the Minnesota Health Access Survey (MNHA), a bi-annual survey of Minnesota households that is conducted jointly by the Minnesota Department of Health and SHADAC. Approximately 445,000 Minnesotans were uninsured in the fall of 2013. This estimate reflects the most recent survey of nearly 12,000 Minnesota households conducted between mid-August and mid-November 2013.¹⁴

The estimated number of uninsured in Minnesota as of May 1, 2014 was calculated by starting with the total state population and subtracting all other coverage sources described above.

Results

Figures 2 and 3 present our results. We estimate that there were approximately 180,500 fewer Minnesotans who were uninsured on May 1, 2014 compared to the number of uninsured on October 1, 2013. In other words, the size of the uninsured population in Minnesota declined by 40.6 percent. While the private group market remained relatively stable (a decline of about 0.2 percent), the distribution of enrollment shifted slightly from fully-insured to self-insured plans. The nongroup market grew by 12.5 percent and was driven by enrollment in MNsure, but included enrollment growth in the nongroup market outside of MNsure (direct purchase). Not surprisingly, there were enrollment declines in two market segments: (1) the high-risk pools, MCHA and PCIP, where enrollees were widely expected to take advantage of lower premium rates available elsewhere through guaranteed issue of coverage with no premium rating based on health status (and the programs are slated to close), and (2) MinnesotaCare, which experienced a shift of enrollment to Medical Assistance as described above.¹⁵

Previous MNsure releases of enrollment counts have included the number of people who selected a plan and payment method,¹⁶ while the counts used in this analysis include only those with coverage in effect on May 1. The difference between these figures reflects the fact that some people may have never paid their first month's premium or may have dropped coverage between January and May (for example, if they obtained a job with health benefits or stopped paying premiums due to affordability issues or other reasons). These types of changes are common for people with nongroup insurance coverage – for example, one recent study found that over one-third of people with nongroup coverage in May 2008 no longer had nongroup coverage four months later.¹⁷

The fastest enrollment growth occurred in public health insurance coverage through Medical Assistance and MinnesotaCare. Combined, these programs

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exhibited an enrollment growth rate of 20.6 percent from the end of September 2013 to the beginning of May 2014. Given that two-thirds of Minnesotans who were uninsured in 2013 were estimated to be eligible for public health insurance coverage, this rapid growth in state public program coverage is not surprising.¹⁸

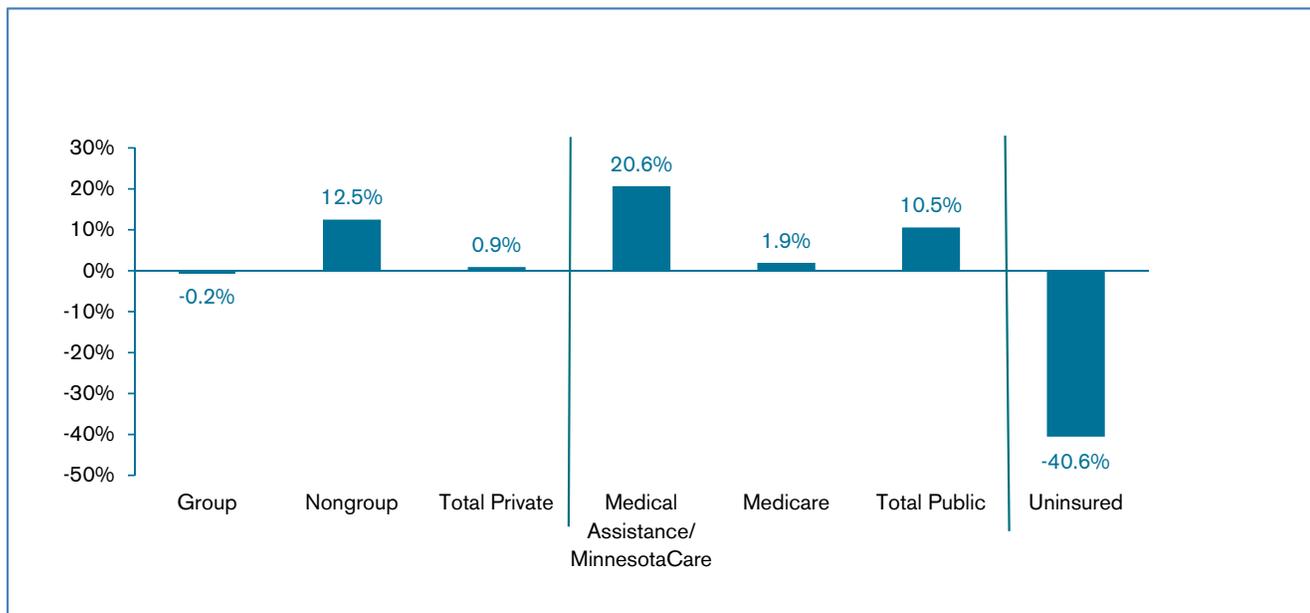
Although nearly all of the information that we relied on for this study was reported to us directly from the entities that provide health insurance coverage in the state of Minnesota, we did make some assumptions about portions of the market for which we couldn't collect data. For example, we assumed that

enrollment in MCHP members' plans represented 88.9 percent and 91.5 percent of the group and nongroup markets, respectively, at both the start and the conclusion of the open enrollment period. We performed a sensitivity analysis to determine how much our results would change under different assumptions for changes in enrollment in portions of the market for which we did not collect enrollment data directly from payers. This assumption had little impact on our conclusion about the size of the reduction in Minnesota's uninsured population.¹⁹ In addition, we assumed that total enrollment in self-insured plans grew at the same rate reported to us by members of MCHP for their self-insured enrollment.

**FIGURE 2. SHIFTS IN MINNESOTA HEALTH INSURANCE COVERAGE
SEPTEMBER 30, 2013 - MAY 1, 2014**

Type of insurance	Number of people			Percent of population		
	September 30, 2013	May 1, 2014	Difference	September 30, 2013	May 1, 2014	Difference
Private insurance						
Group insurance						
Fully-insured (non-SHOP)	948,925	908,984	(39,941)	17.5%	16.7%	-0.8%
Self-insured	2,113,828	2,146,982	33,154	38.9%	39.4%	0.5%
SHOP	-	761	761	0.0%	0.0%	0.0%
Total, group insurance	3,062,753	3,056,726	(6,027)	56.4%	56.1%	-0.3%
Nongroup insurance						
Direct purchase	262,301	273,555	11,254	4.8%	5.0%	0.2%
MCHA	25,506	8,690	(16,816)	0.5%	0.2%	-0.3%
Federal high-risk pool (PCIP)	733	-	(733)	0.0%	0.0%	0.0%
MNsure	-	42,265	42,265	0.0%	0.8%	0.8%
Total, nongroup insurance	288,540	324,510	35,970	5.3%	6.0%	0.6%
Total, private insurance	3,351,293	3,381,236	29,943	61.7%	62.0%	0.3%
Public insurance						
Medical Assistance	622,044	834,140	212,096	11.5%	15.3%	3.8%
MinnesotaCare	131,926	75,345	(56,581)	2.4%	1.4%	-1.0%
Medicare	879,389	896,150	16,760	16.2%	16.4%	0.2%
Total, state programs	753,970	909,485	155,515	13.9%	16.7%	2.8%
Total, public insurance	1,633,359	1,805,634	172,275	30.1%	33.1%	3.0%
Uninsured						
Uninsured	445,000	264,480	(180,520)	8.2%	4.9%	-3.3%
Total population	5,429,653	5,451,350	21,698	100.0%	100.0%	

FIGURE 3. PERCENT CHANGE BY TYPE OF INSURANCE
SEPTEMBER 30, 2013 - MAY 1, 2014



Discussion

Aggregating enrollment in public and private health plans in Minnesota over the initial months of implementation of the ACA (October 1 – May 1) we found substantial gains in health insurance coverage leading to a significant drop in rates of uninsurance. Enrollment in the total private market grew slightly, and was driven by gains in the nongroup market which were slightly offset by a modest decline in the group market. We found the largest enrollment growth in Medical Assistance due in part to the Medicaid expansion provisions of the ACA but also due to the fact that more than two-thirds of uninsured Minnesotans were already eligible for public coverage.

To our knowledge, this analysis provides the first state-level estimate of the ACA's early impacts on the number of people without health insurance coverage. This analysis was possible due to Minnesota's strong data infrastructure and voluntary participation in this study by the Minnesota Council of Health Plans (MCHP) and its members, MNsure, Minnesota's Department of Human Services (DHS) and the Minnesota Comprehensive Health Association

(MCHA). Their willingness to provide enrollment data to support this effort was critical to our ability to estimate total enrollment in a timely manner. In addition, the availability and timing of the 2013 Minnesota Health Access Survey provided a high quality, well-established baseline for the number of uninsured in Minnesota. The methods that we used are fairly straightforward, and could be readily replicated in other states if the appropriate data are available and if both public and private payers are willing to provide enrollment counts.

Our findings are consistent with early national analysis of the ACA's impacts on the share of the population without health insurance coverage. For example, the Urban Institute's Health Reform Monitoring Survey (HRMS) showed a drop of 2.7 percentage points in the share of nonelderly adults without health insurance between September 2013 and March 2014; states that implemented the law's expansion of Medicaid coverage saw a decline of 4 percentage points, compared to 1.5 percentage points in states that did not expand Medicaid.²⁰ Similarly, results from the RAND Corporation's Health Reform Opinion Study indicate a 4.7 percentage point drop in the share of nonelderly adults without

We found increases in private coverage as well as public program enrollment.

Our results for Minnesota are consistent with early national analysis, and also consistent with early results from implementation of a comprehensive set of health reforms in Massachusetts in 2007.

insurance between September 2013 and March 2014.²¹ The Gallup Corporation has also published survey findings showing a drop in the share of U.S. adults who lack health insurance, from 17.1 percent in the fourth quarter of 2013 to 13.4 percent in April 2014,²² with larger declines in states that have implemented the ACA's Medicaid expansion than in those that have not.²³

Our results for Minnesota are also consistent with early results from implementation of a comprehensive set of health reforms in Massachusetts in 2007; the Massachusetts coverage reforms were very similar to those in the ACA. Between the fall of 2006 and fall of 2007, the share of working-age adults who were uninsured in Massachusetts fell from 13.0 percent to 7.1 percent, a 45 percent decline.²⁴ Further research comparing changes in Massachusetts to other states during the same period found that the uninsurance rate in Massachusetts fell by over half.²⁵

This report provides a snapshot of insurance coverage in Minnesota at two distinct points in time. However, it is important to recognize that insurance coverage is dynamic and many people experience changes in their coverage over time – through the gain or loss of a job, changes in family income or the cost of health insurance, and decisions about whether to apply for coverage through public programs. As a result, the picture of insurance coverage and the composition of the population without health insurance also will shift over time. Additional monitoring and research will be needed to understand the ACA's medium-and longer-term impacts on coverage in Minnesota.

Because the analysis in this report relies on aggregated data gathered from payers, there are many important questions that we cannot yet answer. For example, what are the characteristics of people who gained and lost coverage? How many people who purchased coverage through MNsure were previously uninsured? What are the characteristics of the remaining uninsured in Minnesota?

To provide additional information on the impact of the ACA on Minnesota, SHADAC is collaborating with the Minnesota Department of Health's Health Economics Program to conduct a survey of individuals who responded to the 2013

Minnesota Health Access Survey. This study will survey individuals who were most likely directly affected by the insurance coverage provisions of the ACA: respondents who in the fall of 2013 reported being uninsured, purchased nongroup coverage or received insurance through the state's high-risk pool (MCHA). The goal of the survey is to find out if previously uninsured Minnesotans gained coverage; whether people with individual or MCHA coverage experienced changes in coverage; and to what extent survey respondents had remaining barriers to obtaining care. The survey will also determine whether individuals used MNsure to access coverage. Results from this survey are expected to be available in the fall/winter of 2014.

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We are grateful for the assistance of several people who helped us obtain access to the information that we used in this analysis: Eileen Smith and Julie Brunner at the Minnesota Council of Health Plans and staff at private insurers who helped to assemble the information; Katie Burns at MNsure; Shawn Welch at the Minnesota Department of Human Services, and Peggy Zimmerman-Belbeck at the Minnesota Comprehensive Health Association.

ENDNOTES

¹The federal poverty guideline for a family of four in 2014 is \$23,850. <http://aspe.hhs.gov/poverty/14poverty.cfm>, accessed May 30, 2014.

²Some estimates vary from these dates by one day – for example, the estimate that we used for total population is as of October 1, 2013, and estimates for some types of insurance coverage represent enrollment counts as of April 30, 2014. This one-day variation is unlikely to have much impact on the results of our analysis.

³See, for example, Minnesota Department of Health, Health Economics Program Chartbook, “Trends and Variation in Health Insurance Coverage.” Accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section2.pdf>

⁴There are two types of private coverage: fully-insured and self-insured. In a fully-insured plan, the purchaser pays a premium to an insurance carrier, which is then financially responsible for all claims costs. In a self-insured (or self-funded) plan, the purchaser retains the financial risk associated with claims costs but often contracts with a third party administrator to administer the plan. Many large employers self-insure their employee health benefit plans.

⁵U.S. Census Bureau, Population Division. “Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013 (NST-EST2013-01). December 2013. Accessed May 21, 2014 at <http://www.census.gov/popest/data/state/totals/2013/index.html>

⁶Excluding dental-only plans.

⁷Minnesota Department of Health, Health Economics Program Chartbook, “Health Plans.” Accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section7.pdf>

⁸Minnesota Department of Commerce, “Report of 2012 Loss Ratio Experience in the Individual and Small Employer Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations, and Health Maintenance Organizations.” May 2013. Accessed May 21, 2014 at <http://mn.gov/commerce/insurance/images/LossRatioReport.pdf>

⁹These reports include all enrollees, not just those receiving financial assistance.

¹⁰Ibid.

¹¹Centers for Medicare and Medicaid Services. “State by State Enrollment in the Pre-Existing Condition Insurance Plan.” Accessed June 5, 2014 at: <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/pcip-enrollment.html>

¹²Minnesota Department of Human Services. February 2014 Forecast. Accessed May 21, 2014 at http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_181293.pdf

¹³Centers for Medicare & Medicaid Services. “Medicare Enrollment Reports, Medicare Enrollment as of July 1, 2012.” Accessed May 12, 2014 at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/index.html?redirect=/medicareenrpts/>

¹⁴Minnesota Department of Health, Health Economics Program. “Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey.” Fact Sheet Update May 2014, accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013primary.pdf>

¹⁵PCIP was scheduled to end on December 31, 2013, but benefits for existing members were extended for up to four months. Benefits were not extended to May, so we assumed zero enrollment on May 1, 2014.

ENDNOTES (CONTINUED)

¹⁶See, for example, MNsure Dashboard, <https://www.mnsure.org/images/bd-2014-05-14-dashboard.pdf>, accessed May 21, 2014.

¹⁷Benjamin D. Sommers. Insurance Cancellations in Context: Stability of Coverage In The Nongroup Market Prior to Health Reform. *Health Affairs* 33, no. 5 (2014): 887-894.

¹⁸Minnesota Department of Health, Health Economics Program. "Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey." Fact Sheet Update May 2014, accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013primary.pdf>

¹⁹Under an alternative assumption of no change in enrollment in the portion of the market for which we do not have data, our estimated enrollment in private group coverage on May 1, 2014 would be higher by about 4,400 people. Similarly, estimated nongroup market enrollment on May 1, 2014 would be lower by about 960 people.

²⁰Long SK, Kenney GM, Zuckerman S, Wissoker D, Goin D, Hempstead K, Karpman M, Anderson N. Early Estimates Indicate Rapid Increase in Health Insurance Coverage Under the ACA: A Promising Start. April 15, 2014. Accessed May 27, 2014 at <http://hrms.urban.org/briefs/early-estimates-indicate-rapid-increase.html>

²¹Carman KG, Eibner C. Changes in Health Insurance Enrollment Since 2013: Evidence from the RAND Health Reform Opinion Study. 2014. Accessed May 27, 2014 at http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf

²²Levy J. U.S. Uninsured Rate Drops to 13.4%. May 5, 2014. Accessed May 27, 2014 at <http://www.gallup.com/poll/168821/uninsured-rate-drops.aspx>

²³Witters D. Uninsured Rate Drops More in States Embracing Health Law. April 16, 2014. Accessed May 27, 2014 at <http://www.gallup.com/poll/168539/uninsured-rates-drop-states-embracing-health-law.aspx>

²⁴Long SK. On the Road to Universal Coverage: Impacts of Reform in Massachusetts At One Year. 2008. *Health Affairs* 27(4):w270-w284.

²⁵Long SK, Stockley K, Yemane A. Another Look at the Impacts of Health Reform in Massachusetts: Evidence Using New Data and a Stronger Model. 2009. *American Economic Review: Papers & Proceedings* 99(2), 508-511.



State Health Access Data Assistance Center (SHADAC)

SHADAC is a health policy research center within the University of Minnesota School of Public Health whose faculty and staff are recognized as national experts on the collection and use of health policy data. SHADAC health economists and policy analysts cover the full range of technical, research and policy expertise involved in using federal and state data to inform health policy, while leveraging hands-on experience working in state government. SHADAC specializes in issues related to health insurance access, use, cost and quality with a particular focus on state implementation of health reform. Work includes providing technical assistance to many agencies and individuals across the country, at both the federal and state government levels. In addition, SHADAC contributes to general health policy literature and debate by conducting timely health policy research, which is translated into issue briefs, reports and peer-reviewed journal articles.

For more information, visit www.shadac.org. SHADAC is funded by the Robert Wood Johnson Foundation.

For more information, please contact us at shadac@umn.edu, or call 612-624-4802.

The State Health Reform Assistance Network

The State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org. For more information, visit www.rwjf.org.

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