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REALIZING HEALTH REFORM'S POTENTIAL

DECEMBER 2014

How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations

Sara Rosenbaum and Carla Hurt

Abstract In the wake of the Supreme Court's 2012 decision making state expansion of Medicaid to more adults optional under the Affordable Care Act, several states have received approval to combine such expansion with broader Medicaid reforms. They are doing so under Section 1115 of the Social Security Act, which authorizes Medicaid demonstrations that further program objectives. State demonstrations approved so far combine expanded adult coverage with changes in that coverage and in how the states deliver and pay for health care. These states have focused especially on expanding the use of private health insurance, requiring beneficiaries to pay premiums, and incentivizing them to choose cost-effective care. By enabling states to link wider program reforms to the adult expansion, Section 1115 has allowed them to better align Medicaid with local political conditions while extending insurance to more than 1 million adults who would otherwise lack a pathway to coverage.

OVERVIEW

The Supreme Court's decision allowing states to opt out of the Affordable Care Act's Medicaid expansion for adults has had enormous ramifications for the nation's poorest adults.[1] Under the act, federal subsidies for insurance premiums begin only when people cross the federal poverty level—$11,670 for an individual in 2014. In states that elect not to expand Medicaid, adults with incomes below that threshold lack a pathway to affordable health insurance. The most recent estimates from the Kaiser Family Foundation suggest that 4 million people fall into the coverage gap created by states' failure to expand Medicaid: 85 percent of these individuals reside in the South, half are African American or Hispanic, and less than half rate their health as very good to excellent.[2]

As of September 2014, 27 states plus the District of Columbia have expanded Medicaid for poor adults. Another 23 states have chosen

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not to do so. Four of the expanding states—Arkansas, Michigan, Iowa, and Pennsylvania—have implemented their expansion as part of a demonstration program authorized under Section 1115 of the Social Security Act. New Hampshire, whose expansion already is under way, has also submitted a demonstration proposal, and a proposal from Indiana to link the adult expansion with a demonstration is pending with the Department of Health and Human Services (HHS).[3]

Enacted in 1962, Section 1115 allows the secretary of HHS to waive requirements for Social Security Act programs tied to need, enabling states to test innovations.[4] The secretary can initiate the Section 1115 demonstration process by inviting states to propose such innovations. (The George W. Bush administration did so to interest states in expanding Medicaid eligibility for low-income adults.[5]) States also can submit demonstration proposals on their own initiative.

The HHS secretary must follow certain ground rules in approving Section 1115 demonstrations. First, the demonstrations must further program objectives. Second, they must test hypotheses and be evaluated. Third, both state and federal officials must allow public input before the secretary approves the demonstrations. Finally, the demonstrations must be "budget neutral": under longstanding policy of the Office of Management and Budget, the federal government must spend no more on benefits and services than it would have spent in the absence of a demonstration.[6] HHS enforces this "budget neutrality" requirement by estimating what states would have spent on their Medicaid programs over time in the absence of a demonstration and using that estimate to cap federal and state spending on a demonstration.[7]

The federal government and the states have a long tradition of using Section 1115 to reform Medicaid.[8] Over the decades, they have used it to expand and alter eligibility, encourage the growth of managed care, restructure the design of benefits, improve long-term care, and otherwise test broader changes in the health care system.[9]

Section 1115 demonstrations have sometimes led to permanent changes in the federal Medicaid statute. For example, demonstrations of Medicaid managed care during the 1990s paved the way for amendments allowing states to use such an approach to organize and deliver health care.[10] A Medicaid demonstration program provided a key basis for health reform in Massachusetts.[11] Medicaid demonstrations also allowed states to experiment with "benchmark coverage," the standard that now guides "alternative benefit plans" for adults under expanded state Medicaid programs.[12]

STANDARD MEDICAID VS. STATE DEMONSTRATION PROGRAMS

Medicaid demonstrations for expanding adult coverage have sought to embed reforms that address state lawmakers' concerns about adding thousands of people to what they perceive as a costly program in need of modernization. Although advocates of expansion have made effective counterarguments to concerns about adding new people to a broken and out-of-control program that exposes states to alarming new costs,[13] even the best marshaling of facts has not halted political pressure against expansion.

To find a way forward, lawmakers favoring coverage of poor adults have sought to reframe it as a part of a broader effort to restructure Medicaid to reflect updated approaches to program management. Elements of adult-expansion demonstrations approved so far provide important clues to the direction in which states want to move the program and underscore limits on the authority that Medicaid legislation gives the HHS secretary to approve changes that could move the program in some new directions.

To shed light on how the demonstrations depart from normal Medicaid policy, we will briefly explain how the "standard" Medicaid program is supposed to operate after expansion.

First, under standard Medicaid, states may offer private insurance as a coverage option. For adults eligible for coverage after expansion, the demonstrations anticipate that states will enroll most beneficiaries (other than those considered medically frail or otherwise exempt) in "alternative benefit plans." This coverage tracks the Affordable Care Act's "essential health benefit" but has been modified to ensure coverage of all Early and Periodic Screening Diagnosis and Treatment (EPSDT) program services for people under age 21, family planning services from the provider of choice, and nonemergency medical transportation.[14] HHS expects Medicaid managed care plans to provide this coverage, with benchmarks designed by each state. Federal officials expect state benchmark plans to differ from traditional coverage by offering more benefits for preventive care but only limited coverage for long-term care.

Second, standard postexpansion Medicaid bars states from forcing beneficiaries with incomes below 150 percent of the federal poverty level to pay premiums.[15] This provision applies even though people with incomes over 100 percent of the federal poverty level in states that have not expanded Medicaid can pay premiums for coverage through the health insurance exchanges equal to 2 percent of their modified adjusted gross income.

Third, standard Medicaid coverage allows states to ask beneficiaries to share the cost of care, chiefly through copayments at the time of care.

Fourth, standard coverage preserves retroactive eligibility, which begins up to three months before an adult applies for Medicaid.[16] This provision, which dates to the original Medicaid legislation, ensures continuity of care by recognizing that beneficiaries may enroll at a time of great medical need (perhaps the most fundamental difference between Medicaid and private insurance, which operates on traditional risk principles)—and even during a course of treatment. Retroactivity also incentivizes providers to care for indigent people who are sick.

Finally, standard Medicaid does not contain "consumer-driven" elements typical of the private market today, such as value-based cost-sharing, in which beneficiaries who use cost-effective providers and drugs have lower copays, as do beneficiaries who participate in wellness programs. The rationale has been that Medicaid beneficiaries are so indigent that such economic incentives would not be effective.

Section 1115 demonstrations for adult expansion depart from these standard Medicaid elements. Exhibit 1 presents an overview of the four demonstrations approved so far and the two pending proposals, one of which is still under development.[17] This information provides a roadmap to what states are testing or seeking to test in moving away from standard Medicaid, at least for newly eligible adults.

KEY FEATURES OF STATE DEMONSTRATION PROGRAMS FOR ADULTS

One key feature is the expanded use of Medicaid to purchase private insurance, most notably in Arkansas but also in Iowa. New Hampshire and Indiana similarly propose expanded reliance on private insurance to provide coverage to adults. Although Medicaid has always allowed states to offer private insurance as an option, Arkansas and Iowa mandate it for all or some newly eligible adults, with exceptions for those who are more medically vulnerable and perceived as needing Medicaid's traditional protections. Arkansas is relying heavily on private insurance because the state has no Medicaid

managed care market. New Hampshire, which has similarly lacked such a market, has begun to build one. Michigan and Pennsylvania—and Iowa, for its lowest-income newly eligible adults—plan to continue to rely on a Medicaid managed care market, although the former two have made certain modifications to their managed care programs. The core purpose of modifying Medicaid to emphasize public support for private insurance premiums is to test the impact on churn among low-income adults, who seem to move often between public and private insurance.[18] Another purpose is to test the impact of adding healthy adults to the private health insurance risk pool. Preliminary reports suggest that in doing so, Arkansas has helped hold down rate increases for private insurance in the state.[19]

Most of the six states with approved or pending proposals also seek to test the impact of requiring beneficiaries with modified adjusted gross incomes well below Medicaid's standard 150-percent-of-poverty threshold to pay monthly premiums. HHS has not allowed any states to ask beneficiaries to pay more for care than traditional Medicaid standards allow. However, states are expected to expand cost-sharing to more situations, especially nonemergency use of emergency departments, to spur beneficiaries to avoid care that is not cost-effective.

Most of the demonstration programs also eliminate retroactive eligibility. However, states that have done so retain Medicaid's core provision allowing eligible adults to enroll at any time—a feature that the HHS secretary most likely lacks the power to waive, because restricting eligibility would run counter to Medicaid's safety net purpose. One testable question is whether there is any link between elimination of retroactive eligibility and earlier enrollment by beneficiaries.

States have not usually sought to relax Medicaid's benefit and coverage rules further, with two notable exceptions. The first is coverage of medical transportation for nonemergencies, which the HHS secretary waived for three demonstrations. The second is EPSDT benefits for Medicaid-eligible adults under 21, waived in Michigan. In effect, Michigan has sought to align its Medicaid coverage with health plans available through the federally run health insurance marketplace, which cease mandatory coverage of vision and dental care at age 18.

Finally, three of the four states with approved demonstrations are using or plan to use insurance coverage to incentivize healthy behavior. Indiana and New Hampshire use consumer-driven incentives. Arkansas is considering a similar approach, using health savings accounts to encourage healthy behaviors by allowing consumers to keep the money they save when they use less health care.

HHS did not approve Pennsylvania's proposal to condition adult eligibility for Medicaid on job search. Indiana has made a similar proposal. Because Medicaid's objective is to expand access to coverage, the secretary likely does not have the power to restrict eligibility in this fashion.

Exhibit 1. Provisions of Demonstration Programs for Adult Medicaid Expansion, as of September 2014

	Arkansas	Iowa	Michigan	Pennsylvania	Indiana (proposed)	New Hampshire (proposed)
Model	Enrolls newly eligible adults in private health plans, except for adults who are medically frail.	Enrolls newly eligible adults with incomes of 100%–138% of federal poverty level (FPL) in private health plans. Includes behavioral interventions and standard Medicaid managed care for newly eligible adults with incomes <100% FPL.	Requires newly eligible adults to pay premiums and have health savings accounts. Provides behavioral interventions and standard Medicaid managed care to newly eligible adults with incomes <100% FPL.	Relies on a "private coverage option" (PCO): private insurance plans modified to meet Medicaid managed care requirements. Newly eligible adults pay premiums and receive behavioral interventions.	Will eliminate enrollment caps now in effect under Healthy Indiana and reform the health care delivery system.	Extended Medicaid to low-income adults in August 2014. Expansion beyond 2016 contingent on approval of demonstration proposal. Temporarily uses Medicaid managed care; transitioning in 2016 to premium support for qualified health plans purchased in the marketplace. Includes reform of delivery system.
Premiums	None. State is considering requiring beneficiaries to have a health savings account.	No premium for first year. Adults with incomes 50%–100% of FPL or more pay premiums. Capped at $5/month for adults with incomes 50%–100% of FPL, and 2% of income for adults at 100%–133% of FPL.	No premium for first six months. Monthly premiums capped at 2% of household income for adults with incomes 100%–138% of FPL.	No premium for first year. Monthly premium capped at 2% of household income for adults with incomes 100%–138% of FPL.	No premium for first year. Optional defined contribution up to 5% of family monthly income into employer-sponsored insurance plans or individual coverage.	Two temporary programs: Mandatory Health Insurance Premium Program to help workers earning up to 138% of FPL pay employee premiums. Voluntary Bridge to Marketplace subsidizes managed care coverage for newly eligible adults.
Benefits	No changes to standard Medicaid alternative benefit plan.	Standard alternative benefit plan for managed care enrollees. Marketplace standard for beneficiaries enrolled in qualified health plans.	Standard alternative benefit plan for Medicaid managed care enrollees. Marketplace standard for beneficiaries enrolled in qualified health plans.	Standard alternative benefit plan for PCO enrollees. Additional benefits for newly eligible individuals with complex health needs.	Standard alternative benefit plan. Enrollees under 100% of FPL can choose between Basic or Plus plans.	Alternative benefit plan for individuals enrolling in the Bridge to Marketplace program.
Cost-sharing	Follows Medicaid requirements.	Follows Medicaid requirements.	Follows Medicaid requirements.	Follows Medicaid requirements.	Follows Medicaid requirements but will add health savings accounts and increase beneficiary cost-sharing for nonemergency use of emergency departments.	Not yet determined.
Retroactive eligibility	Waived for newly eligible adults.	Not waived.	Waived for newly eligible adults.	Waived for newly eligible adults.	Waived for newly eligible adults.	Not addressed.
Health and wellness plans	None.	Health and wellness initiative for beneficiaries with incomes <100% FPL, incentivized through reductions in cost-sharing and waived premiums.	Beneficiaries who attain benchmarks for healthy behaviors contribute less to their MI Health Account.	Beneficiaries who attain benchmarks for healthy behaviors see reductions in cost-sharing.	Managed care organizations may allow enrollees to earn funds for their POWER accounts if they attain benchmarks for healthy behavior.	Expanding programs under the New Hampshire Medicaid Wellness Incentive Program (InSHAPE).
Work search requirement	None.	None.	None.	Voluntary participation in Encouraging Employment program. Health coverage not contingent on participation.	Will require non-disabled adults unemployed or working fewer than 20 hours a week to search for work.	Not addressed.
Wraparound benefits	Provides all wraparound benefits required under Medicaid alternative benefit plan.	Eliminates nonemergency medical transportation for one year.	Eliminates nonemergency medical transportation. Waives EPSDT dental, vision, and hearing benefits for newly eligible 19-to-21-year-olds.	Eliminates nonemergency medical transportation for one year.	Eliminates nonemergency medical transportation for one year.	Provides all wraparound benefits for Bridge to Marketplace Program, including nonemergency medical transportation and EPSDT benefits.

Exhibit 2. Number and Share of Adults Gaining Coverage Through State Medicaid Demonstrations

	Arkansas	Iowa	Michigan	Pennsylvania	Indiana (proposed)	New Hampshire (proposed)
Number of uninsured adults	510,400	301,500	1,110,500	1,426,900	801,600	158,500
Number of adults gaining coverage under Section 1115 waivers	200,000	150,000	300,000–500,000	500,000	334,000–598,334	50,000
Share of uninsured adults	39.20%	49.80%	27.0%–45.0%	35.00%	41.67%–74.6%	31.50%

Sources: http://www.in.gov/fssa/hip/2445.htm#impact; http://www.commonwealthfund.org/~/media/images/blog/2014/mar/exhibit-1.jpg; http://www.nhfpi.org/new-hampshire-health-protection-program; and http://kff.org/other/state-indicator/nonelderly-0-64/.
Notes: In some cases, these estimates vary among the sources. Commonwealth Fund estimates obtained from Section 1115 demonstration waivers, supplemented with state data where numbers were missing.

Overall, the impact of a Section 1115 demonstration program on a state's uninsured population is considerable. Medicaid-eligible adults account for nearly one-third or more of the uninsured adults in each of the six states (Exhibit 2).

CONCLUSION: EVALUATING ADULT COVERAGE THROUGH SECTION 1115

For decades, Section 1115 has enabled states to evolve their Medicaid programs outside the federal legislative process, and in ways that address the program's uncommonly complex politics. Analysis of approved and pending demonstrations shows common movement toward private insurance, premium payments by even the poorest adults, more limited benefits, and an emphasis on Medicaid as subsidized health insurance for healthy adults rather than as a safety net for the sick.

Given that additional states, including Utah, Wyoming, and Tennessee, have come forward with their own preliminary plans to use Section 1115 to create Medicaid expansion alternatives, robust evaluation will be essential to answer these key questions: What is the impact of required premium payments on the poorest beneficiaries? Does reliance on private health plans sold in the marketplace work as well as a separate Medicaid managed care market? Is care equally accessible, and is beneficiary satisfaction comparable? What is the effect of subsidized premiums on the market for health insurance for individuals? How does eliminating retroactive eligibility affect hospitals and other safety net providers? What is the effect of eliminating vision and dental care for the poorest young adults? Can consumer-driven elements change health behaviors among low-income adults?

Section 1115 has enabled four states to find a pathway to coverage for more than 1 million low-income adults who otherwise would be left without one. Given that record and the likelihood that more states will follow this path, it is crucial that these questions be answered.

Notes

[1] *National Federation of Independent Businesses v Sebelius*, 132 S. Ct. 2566 (2012).

[2] R. Garfield, A. Damico, J. Stephens, and S. Rouhani, *The Coverage Gap: The Uninsured Poor in States that Do Not Expand Medicaid* (Washington D.C.: Kaiser Family Foundation, Nov. 12, 2014), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

[3] New Hampshire expanded adult Medicaid coverage in August 2014, before HHS approved the state's demonstration proposal. Continuation of the expansion beyond 2016 is conditioned on approval.

[4] Title I, Pub. L. 87-543 (87th Cong. 2d sess.). See B. Vladeck, "Medicaid Section 1115 Demonstrations: Progress Through Partnership," *Health Affairs*, Feb. 1995 14(1):217–20.

[5] See N. Owcharenko, *How States Can Expand Private Coverage with HIFA Waivers*, executive memorandum no. 846 (Washington, D.C.: Heritage Foundation), http://www.heritage.org/research/reports/2002/12/how-states-can-expand-private-coverage-with-hifa-waivers.

[6] A recent study by the Government Accountability Office (GAO) found that Arkansas's Medicaid demonstration, which subsidizes insurance premiums for low-income adults, is expected to exceed the state's spending, absent the demonstration, by as much as $778 million, chiefly because the Centers for Medicare & Medicaid Services (CMS) allowed the state to make unsubstantiated assumptions about what it otherwise would have spent. According to the GAO, HHS has also allowed other states to exceed budget neutrality. See *Medicaid Demonstrations: HHS' Approval Process for Arkansas' Medicaid Expansion Waiver Raises Cost Concerns* (Washington, D.C.: GAO, September 2014), http://www.gao.gov/assets/670/665265.pdf.

[7] R. Rudowitz, S. Artiga, and M. Musumeci, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers* (Washington, D.C.: Kaiser Family Foundation, Feb. 2014), http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-1115-medicaid-demonstration-waivers/.

[8] See J. Holahan et al., "Insuring the Poor Through Section 1115 Demonstration Waivers," *Health Affairs*, Feb. 1995 14(1):195–216.

[9] Vladeck, "Progress Through Partnership," 1995.

[10] Balanced Budget Act of 1997, Pub. L. 105-33 (105th Cong., 1st sess.).

[11] For a discussion of why the Oregon Medicaid demonstration failed to serve as a basis for broader health system reform while the Massachusetts demonstration succeeded, see J. Oberlander, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan," *Health Affairs*, Jan. 2007 26(1):w95-w105.

[12] Kaiser Family Foundation, *The Deficit Reduction Act of 2005: Implications for Medicaid* (Washington, D.C.: KFF), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7465.pdf. See also 42 U.S.C. §1396u-7 and 13960-1.

[13] See, for example, S. Dorn, M. McGrath, and J. Holahan, *What Is the Result of States Not Expanding Medicaid?* (Washington, D.C.: Urban Institute, Aug. 2014), http://www.urban.org/publications/413192.html.

[14] 42 U.S.C. §1397u-7.

[15] 42 U.S.C. §1396o(c)(2).

[16] 42 U.S.C. §1396a(a)(34).

[17] Agreements between states and HHS describe in detail how a state can modify the standard Medicaid approach. CMS has no single website with details on all approved and pending Medicaid demonstrations of adult expansion. An online search usually reveals CMS approval letters for such programs.

[18] See B. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, Feb. 2011 30:228–36.

[19] Health Insurance Marketplace Premiums Projected to Drop Two Percent in Arkansas in 2015, http://governor.arkansas.gov/newsroom/index.php?do:newsDetail=1&news_id=4592

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Medicaid and the Uninsured

REPORT

The Uninsured: A Primer

December 2014

KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN AMERICA

Prepared by:

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Introduction

Millions of people in the United States go without health insurance each year. Because nearly all of the elderly are insured by Medicare, most uninsured Americans are nonelderly (below age 65). A majority of the nonelderly receive their health insurance as a job benefit, but not everyone has access to or can afford this type of coverage. Together, Medicaid and the Children's Health Insurance Program (CHIP) fill in gaps in the availability of coverage for millions of low-income people, in particular, children. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage on their own without financial assistance.

The gaps in our health insurance system affect people of all ages, races and ethnicities, and income levels; however, those with the lowest incomes face the greatest risk of being uninsured. Being uninsured affects people's access to needed medical care and their financial security. The access barriers facing uninsured people mean they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact also can be severe. Uninsured families struggle financially to meet basic needs, and medical bills can quickly lead to medical debt.

A major goal of the Affordable Care Act (ACA), which was passed in 2010, was to expand coverage to millions of Americans who were previously uninsured. The ACA has filled existing gaps in coverage by providing for an expansion of Medicaid for adults with incomes at or below 138% of poverty in states that chose to expand, building on employer-based coverage, and providing premium tax credits to make private insurance more affordable for many with incomes between 100-400% of poverty.[1] Most of the major coverage provisions of the ACA went into effect in 2014, and millions of people have enrolled in coverage under the law.

The Uninsured: A Primer is structured in two parts. The first presents basic information about health coverage and the uninsured population leading up to and after the implementation of the Affordable Care Act, who the uninsured are and why they do not have health coverage. The second presents information on the impact lack of insurance can have on health outcomes and personal finances, and provides an understanding of the difference health insurance makes in people's lives.

What Was Happening to Insurance Coverage Leading up to the ACA?

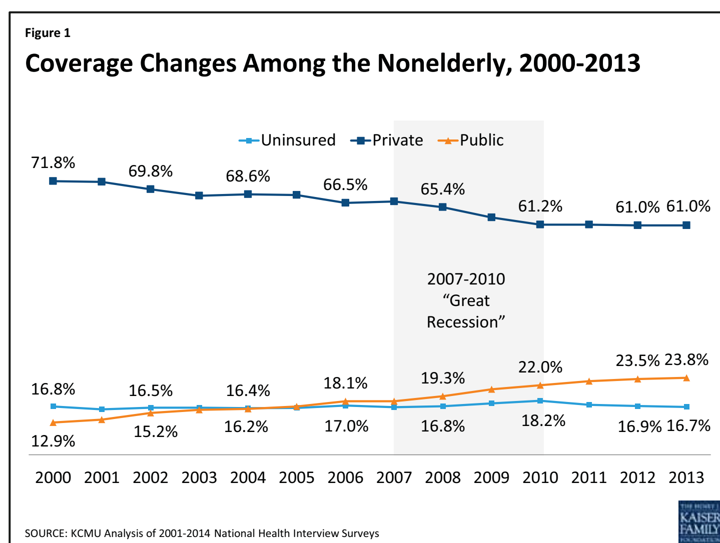
The coverage provisions in the ACA built on a piecemeal insurance system that left many without affordable coverage. Historically, most people in the United States obtained health insurance coverage as a fringe benefit through a job. However, many people were left out of the employer-based system, and the availability of employer-based coverage has eroded over time. Some people purchased coverage on their own, but this type of coverage could be costly or difficult to obtain. Medicaid and the Children's Health Insurance Program (CHIP) have expanded over time to cover more low-income individuals (primarily children) and have been an important source of coverage during economic downturns. However, the gaps in our private and public health insurance systems still left over 41 million nonelderly people in the country—15% of those under age 65—without health coverage in 2013.[2]

EMPLOYER- SPONSORED HEALTH INSURANCE COVERAGE

Historically, the majority of employers offered group health insurance policies to their employees and to their employees' families. In 2013, 57% of firms offered coverage to their employees, and most firms offering coverage also covered spouses and dependents.[3] When offered coverage, roughly 80% of employees participated in their employer's health plan.[4] Among individuals with employer-sponsored coverage, half were covered by their own employer and half were covered as an employee's dependent.[5]

Not all workers had access to employer-sponsored insurance. In 2013, two-thirds of uninsured adult workers were not offered health insurance by their employer.[6] Some worked in firms that did not offer coverage: small firms were less likely to offer coverage than large firms, and firms with more low-wage workers were less likely to offer coverage than firms with fewer low-wage workers.[7] Some people worked in firms that covered some employees but were not themselves eligible for coverage, often because they had not worked for their employer for a sufficient amount of time or because they had not worked enough hours.

Cost was a barrier to expanding employer-sponsored coverage. Cost was the most common reason employers cited for not offering health coverage.[8] In addition, when offered coverage, many low- and moderate-income workers found their share of the cost unaffordable, especially for non-working dependents.[9] In 2013, annual employer-sponsored premiums averaged $5,884 for individual coverage and $16,351 for family coverage, with workers contributing $380 per month for family coverage and $83 for individual coverage.[10] Total family premiums, as well as the employee's share of those premiums rose by over 70% in the ten years leading up to 2013.



The availability of employer-sponsored coverage has eroded over time, and declines in employer coverage accelerated during the economic downturn. The share of the nonelderly population with employer-sponsored coverage has

declined steadily since 2000 even during years when the economy was strong and growth in health insurance premiums was slowing.[11] However, during the Great Recession, there was a substantial decline in employer coverage (Figure 1). Because health coverage is linked to employment, when people lose their jobs they frequently lose coverage. As unemployment spiked between 2007 and 2010, the uninsured rate for adults increased, resulting in 5.8 million more nonelderly adults without coverage.[12] As the economy began to recover starting in 2011, employer-sponsored coverage stabilized, and the uninsured rate did as well. However, rates of employer coverage in 2013 were still below pre-recession levels.

Non- Group Health Insurance Coverage

Very few people were covered by non-group health insurance policies prior to the ACA. Private policies directly purchased in the non-group or individual market (i.e., outside of employer-sponsored benefits) covered only 5% of people under age 65 in 2013.[13]

In the past, non-group insurance premiums could be more expensive for the enrollee than group plans purchased by employers. Though, on average, non-group insurance premiums were lower than those for employer-sponsored coverage, enrollees paid 100% of the cost because they could not share that premium expense with an employer. Nationwide, the average monthly premium per person in the non-group market in 2013 was $236, with substantial variation by state.[14] In addition, deductibles and other cost sharing in non-group plans were often higher than in employer-sponsored coverage.

Obtaining coverage in the individual market could be difficult, particularly for those who were older or had had health problems. Historically, premiums in the non-group market could vary by age or health status, and people with health problems or at risk for health problems could be charged high rates, offered only limited coverage, or denied coverage altogether. In 2013, 41% of adults who previously tried to purchase non-group insurance said that the policy offered to them was too expensive to purchase, and nearly 6% said that no insurance company would sell them a policy at any price.[15] Those who were in fair or poor health were twice as likely to be denied.

Public Health Insurance Coverage

In the past, Medicaid and CHIP provided coverage to some, but not all, nonelderly low-income individuals and people with disabilities. In 2013, Medicaid and CHIP covered just under a fifth (19%) of the nonelderly population by primarily covering four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities.

Medicaid and CHIP were and continue to be particularly important sources of coverage for children. Even before the ACA, federal law required state Medicaid programs to cover school age children up to 100% of the poverty level (133% for preschool children), and states had expanded coverage for children in families with slightly higher incomes through the Children's Health Insurance Program (CHIP). As a result, Medicaid and CHIP remain the largest source of health insurance for children in the U.S., covering 78% of poor children and over half (56%) of near-poor children in 2013. Still, as of 2011, over half (53%) of uninsured children were eligible for Medicaid or CHIP but not enrolled.[16] Some families may not have been aware of the availability of the programs or their eligibility. For others, burdensome enrollment and renewal requirements may have posed major obstacles to participation, despite major improvements made over the past decade.

In contrast to coverage for children, the role of Medicaid for nonelderly adults was more limited prior to the ACA. In the past, state Medicaid programs were only required to cover parents below states' 1996 welfare eligibility levels (often below 50% of the federal poverty level). Most states had much lower income eligibility for parents than for children. As of January 2013, a total of 33 states limited parent eligibility for Medicaid to less than the federal poverty level, including 16 states that limited eligibility to parents earning less than 50% of the federal poverty level.[17] In addition, although Medicaid covered some parents and low-income individuals with disabilities, most adults without dependent children—regardless of how poor—have traditionally been ineligible for Medicaid. As of January 2013, just nine states (including the District of Columbia) provided Medicaid or Medicaid-comparable coverage to non-disabled adults without dependent children.[18] As a result of limited eligibility, over a third (35%) of poor parents and 38% of poor adults without children were uninsured in 2013.[19]

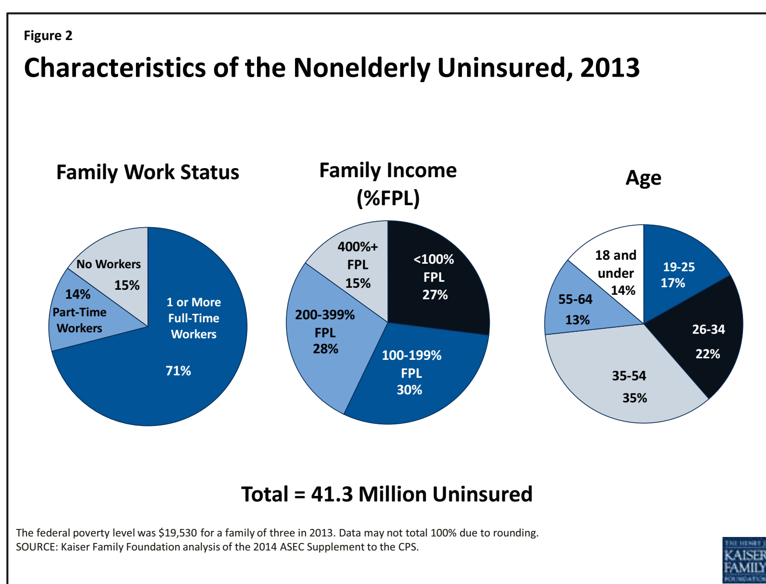
Increases in Medicaid and CHIP enrollment helped to offset declines in private coverage during the recent economic downturn and slow recovery, particularly for children. During the recent economic recession and slow recovery (2007-2012), the share of children who were uninsured actually declined slightly despite a decrease in the share of children with employer-sponsored coverage. As parents lost employment and related health coverage, incomes dropped and more children became eligible for Medicaid or CHIP. The uninsured rate among children continued to decline during the recovery that began in 2010. In comparison, because Medicaid eligibility for adults was more limited than for children, public coverage did not offset the recession-related decline in employer-sponsored coverage and uninsured rates increased considerably among non-elderly adults.

The Uninsured

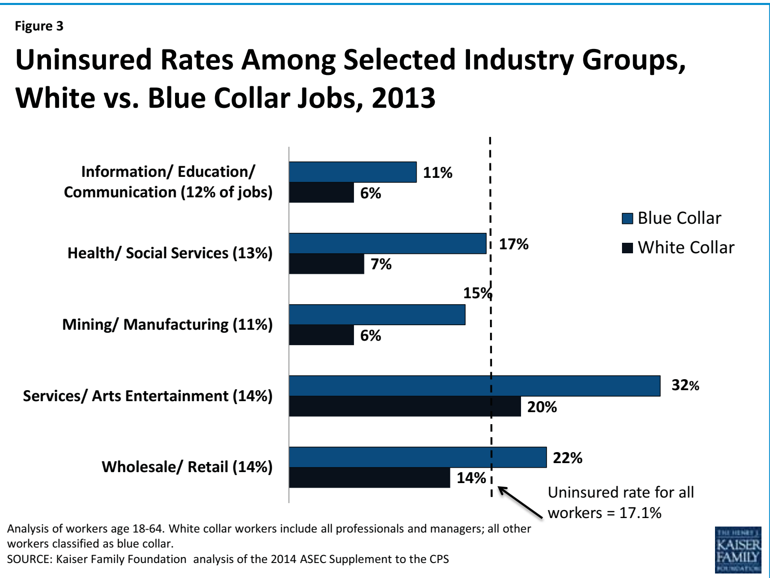
The historical gaps in the insurance system left many without an affordable source of coverage. In 2013, 41.3 million nonelderly people in the U.S. lacked health insurance.[20] The main reason that people gave for being uninsured is that they could not afford coverage.[21]

Adults were more likely to be uninsured than children. In 2013, adults made up 71% of the nonelderly population but 86% of people without health coverage (Figure 2). This pattern reflects historical exclusions or restrictions on public coverage for adults.

The vast majority of uninsured people were in low- or moderate-income families (Figure 2). Individuals below poverty are at the highest risk of being uninsured, and this group comprised 27% of the uninsured population in 2013 (the poverty level for a family of three in 2013 was $19,530[22]). In total, 85% of uninsured people were in low- or moderate-income families, meaning they were below 400% of poverty.



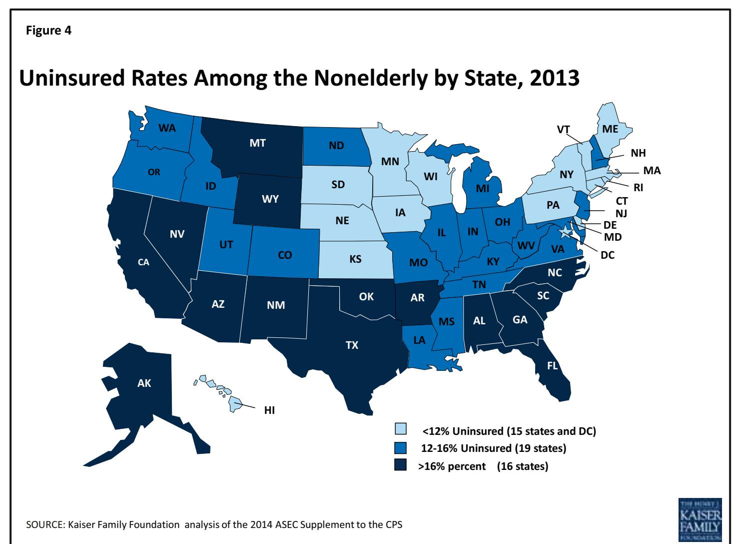
Most of the uninsured were in working families but did not have access to or could not afford employer-sponsored coverage. In 2013, more than three-quarters of the uninsured population was in working families, with 71% in families with one or more full-time workers and 14% in families with part-time workers (Figure 2). Health coverage varied both by industry and by type of occupation. For example, in agriculture, uninsured rates for workers were 37% compared to just 4% in public administration.[23] But even in industries where uninsured rates are lower, the gap in health coverage between blue and white-collar workers is often two-fold or greater (Figure 3). Almost 80% of uninsured workers are in blue-collar jobs.



Minorities were much more likely to be uninsured than whites. A quarter (26%) of Hispanics and 17% of Black Americans were uninsured in 2013 compared to 12% of non-Hispanic Whites. Medicaid and CHIP are important sources of coverage for racial and ethnic minorities, covering around one-third of Hispanic and Black Americans.

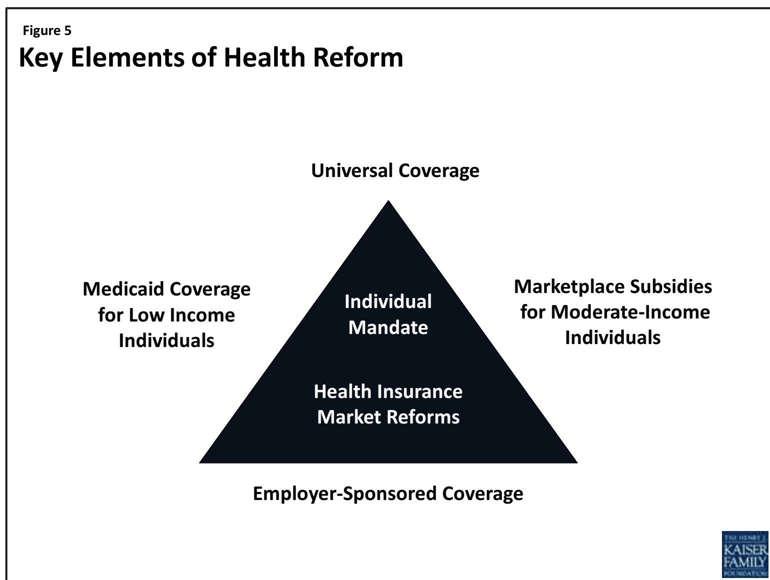
The majority of uninsured people (80%) were native or naturalized U.S. citizens. Although non-citizens (legal and undocumented) are about three times more likely to be uninsured than citizens, they accounted for only roughly 20% of the uninsured population in 2013.[24] Non-citizens have poor access to employer coverage because they are disproportionately likely to have low wage jobs or work in industries that are less likely to offer insurance.[25,26] Further, in most cases, lawfully present immigrants who have been in the U.S. less than five years are ineligible for Medicaid or CHIP, though some states cover lawfully-residing immigrant children or pregnant women who have been in the United States for less than five years.[27]

Insurance coverage varied by state depending on the income distribution in the state, the nature of employment in the state, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influence the insurance rate in each state.[28] Massachusetts has near universal coverage, with an uninsured rate of 4% due in part to health reform legislation enacted in 2006. In 2013, sixteen states had uninsured rates over 16% (Figure 4). Among these are states such as Nevada, Florida, and Texas with uninsured rates that are 20% or higher.

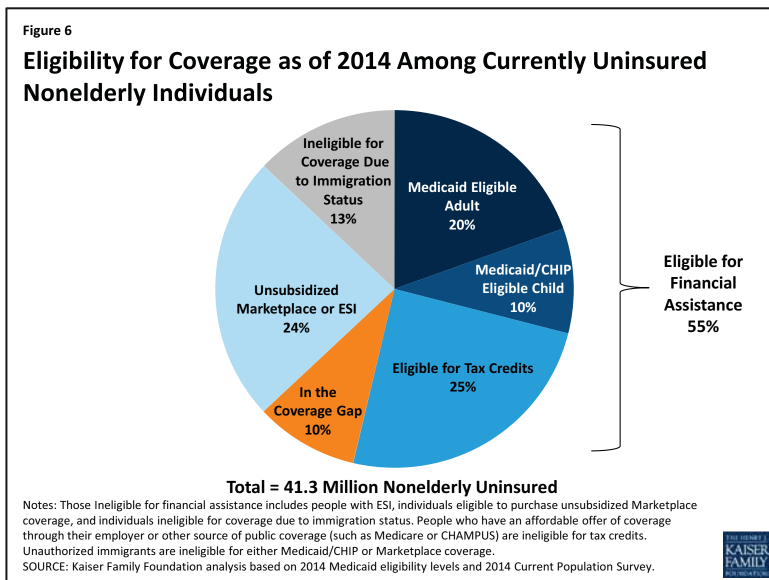


How Did Health Coverage Change Under The ACA?

A primary goal of the Affordable Care Act of 2010 (ACA) was reducing the number of uninsured people and increasing the affordability and availability of health insurance coverage. The ACA fills in existing gaps in coverage by expanding the Medicaid program, building on employer-based coverage, and providing premium subsidies to make private insurance more affordable (Figure 5). It also introduced new requirements for almost all individuals to obtain insurance coverage or pay a penalty and for insurance companies to be prohibited from denying coverage for any reason. Some of the ACA provisions went into effect as early as 2010 and others will not go into effect until 2018, but the major coverage expansions were implemented January 1, 2014.



Nationally, over half (55%) of uninsured nonelderly people are eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces (Figure 6). One-quarter (25%) of uninsured individuals are eligible for premium tax credits to help them purchase coverage in the Marketplace, and approximately three in ten uninsured individuals (30%) are eligible for either Medicaid or CHIP.[29] However, not all uninsured individuals are eligible for assistance under the ACA. Some (24%) have incomes above the limit for tax credits or have access to coverage through a job. Others (13%) are ineligible because they are undocumented immigrants. And one in ten fall into a "coverage gap" because they are living below poverty but their state has not expanded Medicaid. Even with the ACA, many will remain uninsured. Nationally, an estimated 29 million people are expected to remain uninsured in 2018.[30]

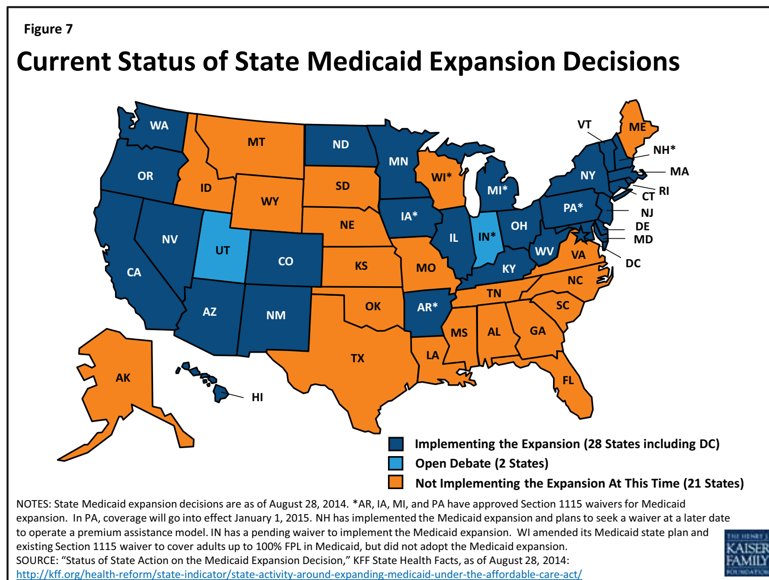


Early estimates indicate that the uninsured rate has dropped under the ACA. Data from the first quarter (January through March) of 2014 indicates that the uninsured rate dropped for nonelderly individuals in the first quarter of 2014 by a full percentage point relative to the first quarter of the previous year.[31] Several private polls and surveys also indicate that the uninsured rate has been decreasing since the period prior to ACA open enrollment. While these surveys have different methodologies and often have high error margins that make point estimates unreliable, they are all in agreement that the uninsured rate has dropped in 2014.

Medicaid Expansion

The ACA extended Medicaid eligibility to many individuals at or below 138% of poverty as of January 2014. The Medicaid expansion eliminates the historical exclusion of adults outside of traditional eligibility groups, such as those without dependent children. Overall, the median eligibility limit for parents in the 28 states (including DC) implementing the Medicaid expansion rose from 106% FPL to 138% FPL for parents and from 0% to 138% FPL for childless adults between January 2013 and July 2014. Overall, eligibility levels increased for parents in 20 states and for childless adults in 26 states (including Pennsylvania, which implemented the Medicaid expansion in August 2014 to begin January 2015).[32] Among the 41.3 million nonelderly uninsured people in 2013, 19% are Medicaid-eligible adults and 9% are children who are eligible for either Medicaid or CHIP.[33]

However, not all states are expanding their Medicaid programs. The 2012 Supreme Court decision effectively made the Medicaid expansion optional for states, and as of November 2014, 23 states have indicated they are not expanding Medicaid (Figure 7).[34] In these states, eligibility for adults is generally still very limited. There is no deadline on state decisions about whether to expand Medicaid, and some states are still debating whether and how to expand their programs.[35]



In states that do not expand Medicaid, millions fall into a "coverage gap" of earning too much to qualify for traditional Medicaid coverage but not enough to qualify for other ACA coverage provisions. The median Medicaid eligibility levels for parents in states not implementing the ACA Medicaid expansion is just 50% of poverty, or about $9,400 a year for a family of three, and only one of those states (Wisconsin[36]) covers adults without dependent children. State decisions not to expand their programs will leave nearly four million people without an affordable coverage option.[37]

Even in states that do expand Medicaid, undocumented immigrants and many recent lawfully present immigrants will remain ineligible. Because many uninsured non-citizens are in low-income working families, many are in the income range to qualify for the ACA Medicaid expansion. However, under federal rules, undocumented immigrants may not enroll in Medicaid. Many lawfully present non-citizens who would otherwise be eligible for Medicaid remain subject to a five-year waiting period before they may enroll, and some groups of lawfully present immigrants remain ineligible regardless of their length of time in the country.

Medicaid enrollment has grown under the ACA. Enrollment data show that as of July 2014, Medicaid enrollment has grown by 8 million since the period before open enrollment (which started in October 2013). This growth is an increase of 14% in monthly Medicaid enrollment. Enrollment increases were higher (20%) among states that chose to expand Medicaid eligibility under the ACA. These data suggest that Medicaid

enrollment growth is related to ACA expansions. However, some who are eligible remain unenrolled due to limited awareness about the Medicaid program and their eligibility or other enrollment challenges.

The ACA includes several provisions to streamline Medicaid enrollment. The ACA has addressed past barriers to enrollment by requiring states to implement new streamlined Medicaid application and enrollment processes by 2014. These processes allow individuals to apply online, by phone, by mail, or in-person, use new simplified income standards, and rely on electronic data matches to the greatest extent possible to verify eligibility criteria. To implement these processes, states built new eligibility and enrollment systems and are replacing or making major upgrades to their Medicaid systems, with the federal government providing significant funding for these efforts.[38] Even with these new streamlined enrollment processes in place, effective outreach and enrollment efforts are fundamentally important for translating the new coverage opportunities into increased coverage.

Health Insurance Marketplaces and Non- Group Coverage

The ACA establishes Health Insurance Marketplaces, also known as Marketplaces, where individuals and small employers can purchase insurance as of January 1, 2014. These new Marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to enable them to choose among plans.

Health Insurance Marketplaces are established in each state, but only some states will run their own Marketplace. Sixteen states and DC have received approval to run their own health insurance Marketplaces, and 27 states have opted to have their Marketplace run by the federal government. The remaining 7 states use a hybrid approach and partner with the federal government to run certain aspects of their Marketplace.[39]

Marketplaces provide insurance options to millions of uninsured individuals. Over 10 million uninsured individuals are estimated to be eligible for tax credits through the Marketplace.[40] Around 7 million additional individuals who were enrolled in other (primarily non-group) coverage prior to the ACA are estimated to be eligible for tax credits through the ACA Marketplace.[41] The Department of Health and Human Services indicated that approximately 8 million people had selected a plan on the Marketplace as of the end of the open enrollment period (which extended through mid-April in most states).[42] A survey of people with private non-group plans after open enrollment found that nearly six in ten (57%) of those with Marketplace coverage were uninsured prior to purchasing their current plan.[43]

Premium tax credits help reduce the cost of non-group coverage premiums purchased in the Marketplace. To help ensure that coverage purchased in these new Marketplaces is affordable, the federal government provides tax credits for individuals and families with incomes between 100% of the federal poverty level (FPL) ($11,670 for an individual or $19,790 for a family of three in 2014) and 400% FPL ($46,680 for an individual or $79,160 for a family of three in 2014).[44] These tax credits limit the cost of the premium to a share of income and are offered on a sliding scale basis. As of the end of the first open enrollment period in April 2014, the vast majority of Marketplace enrollees (85%) qualified for premium subsidies.[45] In addition to the premium tax credits, the federal government also makes available cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty will have to pay out-of-pocket to access health services. The cost-sharing subsidies are also available on a sliding scale based on income. The pending

Supreme Court decision in King vs. Burwell could result in the denial of such subsidies to over 13 million Americans residing in states with federally-facilitated marketplaces.[46]

Lawfully present immigrants may receive tax credits for Marketplace coverage; however, undocumented immigrants are prohibited from purchasing such coverage. Lawfully present immigrants are eligible for tax credits on coverage purchased through a Marketplace without a waiting period.[47] In addition, lawfully present immigrants who would be eligible for Medicaid but are in a five-year waiting period are also eligible for tax credits for Marketplace coverage. Undocumented immigrants are not eligible for premium tax credits and are prohibited from purchasing insurance in the Marketplace at full cost.

Some people continue to purchase non-group coverage outside the Marketplace. Among the entire non-group market in Spring 2014, about half of individuals (48%) report having coverage obtained from a state or federal Marketplace, 16% have ACA-compliant coverage purchased outside of the Marketplace, and three in ten (31%) have non-ACA-compliant plans (those that have been in effect since before January 1, 2014).[48] People purchasing coverage outside the Marketplace are not eligible for ACA premium tax credits.

Employer Sponsored Insurance under the ACA

The ACA includes provisions to promote coverage in small firms. Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the ACA offers tax credits to small employers with no more than 25 full-time equivalent employees and average annual wages of less than $50,000. To access the tax credit, eligible employers must purchase insurance through the Small Business Health Options Program (or SHOP Marketplace).[49] Employers may take the tax credits for a maximum of two years.[50]

The ACA also extends dependent coverage. As of 2010, young adults may remain on their parents' private plans (including non-group plans or plans through an employer) until age 26. This provision has expanded coverage among young adults, even during a time when private coverage for other age groups was eroding.[51]

Starting next year, large employers will face penalties for not providing affordable coverage to full-time employees. Beginning in 2015, employers with 50 or more employees will be assessed a fee up to $2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and if they have at least one employee who receives a premium tax credit through a Marketplace. To avoid penalties, employers must offer insurance that pays for at least 60% of covered health care expenses, and the employee share of the premium must not exceed 9.5% of family income.[52] This requirement does not apply to employers with fewer than 50 workers. While the employer requirements may help many uninsured individuals with a worker in their family, the majority of uninsured workers work in small firms that are not required to provide insurance coverage.

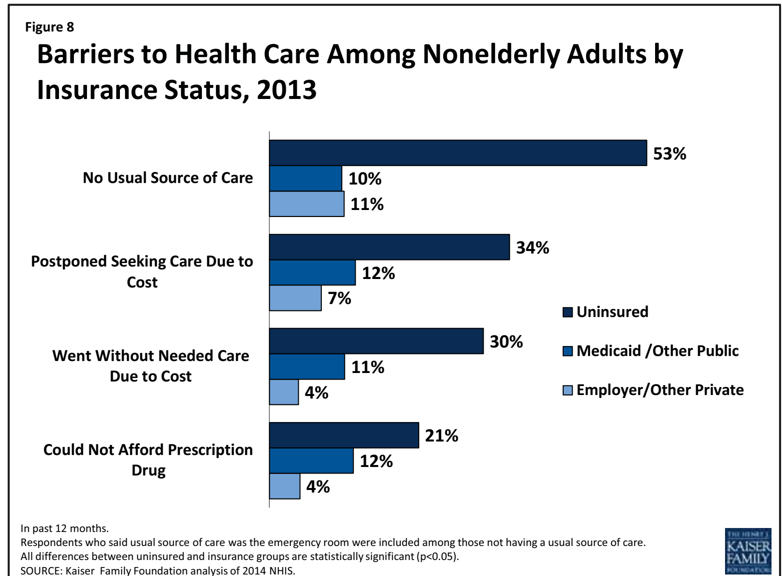
Some employer-sponsored plans will have new requirements for benefits and cost sharing. As of January 2014, all non-grandfathered plans offered by small employers must include, at a minimum, all of the benefits and consumer protections outlined in the Essential Health Benefits (EHBs) package. These benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services,

laboratory services, preventive and wellness care, chronic disease management, and pediatric dental and vision care.[53] The cost-sharing under an individual plan in 2014 is not to exceed $5,000; the limit for a family is twice the dollar amount set for an individual in any given year. These requirements do not apply to large employers or to firms that self-insure; however, these employers generally offer more comprehensive coverage that already meets these standards.

Some employers will continue to offer grandfathered health plans, which are not required to include the Essential Health Benefits package. Grandfathered plans are those that were established prior to March 23, 2010 and that have not undergone significant changes in cost-sharing, premium contributions or covered benefits. Unlike other plans under the ACA, grandfathered plans are not required to cover Essential Health Benefits or preventive services without cost-sharing; provide for an internal and external appeals process for contesting coverage decisions; or allow direct access to an OB/GYN without referral.[54] Businesses wishing to keep their grandfathered plans may even change insurance carriers if benefits and cost to employees remain largely the same; however, because benefits and costs tend to change from year to year, most plans have already lost grandfather status or will lose it over time.[55]

How Does Lack of Insurance Affect Access to Health Care?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.



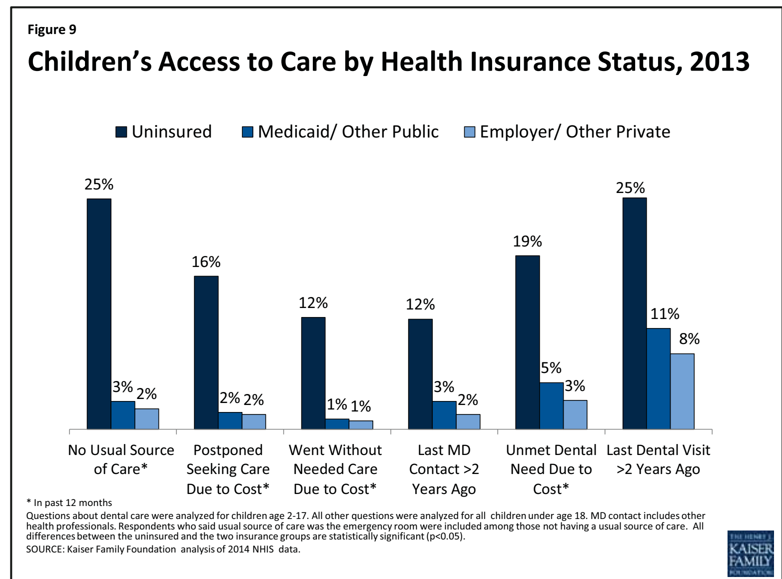
Uninsured people are far more likely than those with insurance to report problems getting needed medical care. Thirty percent of adults without coverage say that they went without care in the past year because of its cost compared to 4% of adults with private coverage. Part of the reason for poor access among the uninsured is that most (53%) do not have a regular place to go when they are sick or need medical advice (Figure 8).

Uninsured people are less likely than those with coverage to receive timely preventive care. Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. In 2013, only 1 in 3 uninsured adults (33%) reported a preventive visit with a physician in the last year, compared to 74% of adults with employer coverage and 67% of adults with Medicaid.[56] Uninsured patients are also less likely to receive necessary follow-up screenings after abnormal cancer tests.[57] Consequently, uninsured patients have an increased risk of being diagnosed in later stages of diseases, including cancer, and have higher mortality rates than those with insurance.[58,59,60]

Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2010, nearly a quarter of uninsured adults said they did not take a prescribed drug in the past year because they could not afford it.[61] Also, while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.[62]

Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[63,64,65,66]

Uninsured children also face problems getting needed care. Uninsured children are significantly more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 9).[67] Further, uninsured children with common childhood illnesses and injuries do not receive the same level of care as others. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[68] Among children with special needs, those without health insurance have less access to care, including specialist care, than those with insurance.[69]



Lack of health coverage, even for short periods of time, results in decreased access to care. Research has shown that adults who experienced gaps in their health insurance coverage in the previous year were less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.[70] Further, research indicates that children who are uninsured for part of the year have more access problems than those with full-year public or private coverage.[71] One study found that, on a number of different measures, those lacking coverage for 12 continuous months had poorer access to care compared with either those lacking coverage for 6-11 months or 1-5 months, suggesting that even short periods of coverage results in greater access to care than no coverage at all.[72]

Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of the impact of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care from a hospital or doctor than their counterparts who did not gain coverage.[73] Gaining Medicaid increased the likelihood of having an outpatient visit by approximately 35% and the likelihood prescription drug utilization by 15%. Findings two years out from the expansion showed significant improvements in access, utilization, and self-reported health, and virtual elimination of catastrophic out-of-pocket medical spending among the adults who gained coverage.[74] A separate study of Medicaid expansions for adults in three other states (New York, Maine, and Arizona) found that coverage gains were associated with reduced mortality, as well as improvements in access to care and self-reported health status.[75]

Public hospitals, community clinics, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people; however, the safety net does not close the access gap for the uninsured. Safety net providers, such as public hospitals, community health centers, rural health centers, and local health departments, provide care to many people without health coverage. In addition, nearly all other hospitals and some private, office-based physicians provide some charity care. However, the safety net has limited capacity and geographic reach. In addition, available services may not be comprehensive, and not all uninsured people have access to safety net providers.[76][77]

Increased demand and limited capacity means safety net providers are unable to meet all of the health needs of the uninsured population. The ability of health centers to serve uninsured people has been threatened in recent years due to increased demand and eroding financing[78], and many clinics report that they are at full capacity and cannot accept new patients.[79] Further, increasing financial pressures and changing physician practice patterns have contributed to a decline in charity care provided by physicians.[80]

The ACA made a large investment in community health centers (CHCs), which provide a primary care safety-net for millions of uninsured people. However, not all underserved communities have CHCs, and, especially in states not expanding Medicaid, health centers may not have sufficient resources to serve the uninsured population. To help meet the increasing demand for health care as coverage expands, the ACA established a five-year $11 billion dedicated trust fund to provide support for additional CHCs and expanded capacity in existing ones. In addition, the ACA Medicaid expansion was expected to generate increased patient revenues for CHCs in all states as low-income uninsured individuals, including both current and new CHC patients, gained coverage under the program.[81] The trust fund, which augments annual federal appropriations for CHCs, has fueled substantial growth in health centers and their patient capacity and enabled CHCs to provide more comprehensive primary care services.[82] However, in states not currently implementing the Medicaid expansion, millions of uninsured adults who could qualify for Medicaid remain uninsured, and by extension, the CHCs serving them are not receiving the associated increase in Medicaid revenues, reducing their potential resources for operations and expansion. Going forward, health centers' capacity to bridge the large gaps in access to primary care for the uninsured is likely to be affected by both state Medicaid expansion decisions and the expiration of the health center trust fund after September 30, 2015.

What Are The Financial Implications of Uninsurance?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs. When people without health coverage do receive health care, they may be charged for the full cost of that care, which can strain family finances and lead to medical debt. Uninsured people are more likely to report problems with high medical bills than those with insurance. Uninsured adults and those on Medicaid are three times more likely than those with higher incomes to report having difficulty paying basic monthly expenses such as rent, food, and utilities.[83]

Most uninsured people do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[84] In 2013, only 38% of uninsured adults who received health care services report receiving free or reduced cost care.[85]

Uninsured people often must pay "up front" before services will be rendered. When people without health coverage are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away.[86] Among uninsured adults who received health care, nearly a third (31%) were asked to pay for the full cost of medical care before they could see a doctor.[87]

People without health coverage spend half of what those with coverage spend on health care, but they pay for a much larger portion of their care out-of-pocket. Compared to nonelderly people who had insurance for a full year and average per capita medical expenditures of $4,876 in 2013, nonelderly people who were without insurance for a full year used health care services valued at about half that amount, or just $2,443 per capita per year. Nonelderly people who were uninsured for part of the year had annual medical expenditures about 30% lower than people who were insured for the full year, spending an average of $3,439 annually per capita. Part-year uninsured individuals spent more per capita than full-year uninsured individuals largely due to higher spending in the months that they had coverage. Despite lower overall spending, people without insurance pay nearly as much out-of-pocket as insured people for their care.[88] In aggregate, the uninsured pay for almost a third (30%) of their care out-of-pocket, totaling $25.8 billion in 2013. This total included the health care costs for those uninsured all year and the costs incurred during the months the part-year uninsured have no health coverage.[89]

The remaining costs of their care, the uncompensated costs for the uninsured, amounted to about $84.9 billion in 2013. Providers do not bear the full cost of their uncompensated care. Rather, funding is available through a wide variety of sources to help providers defray the costs associated with uncompensated care. Analysis indicates that in 2013, $53.3 billion was paid to help providers offset uncompensated care costs. Most of these funds (62%) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, the Community Health Centers block grant, and the Ryan White CARE Act. States and localities provided $19.8 billion, and the private sector provided $0.7 billion. While substantial, these dollars amount to a small slice of total health care spending in the U.S.[90]

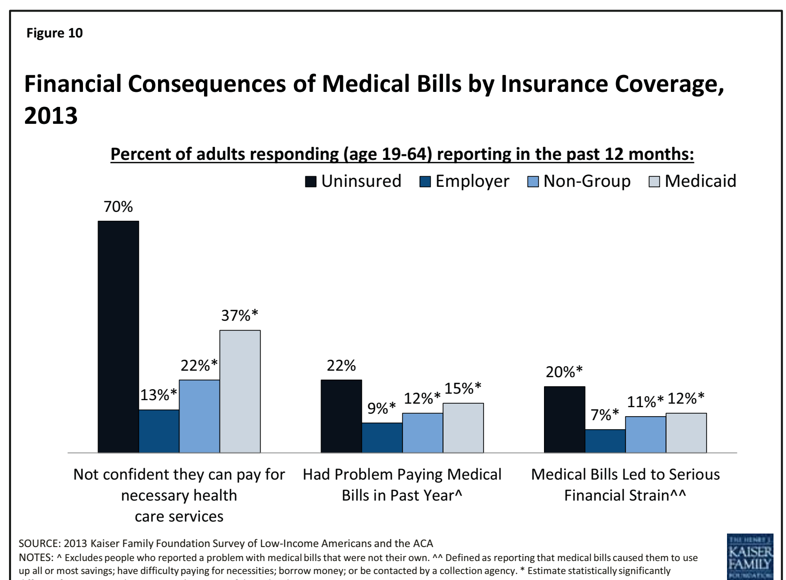
The burden of uncompensated care varies across providers. Hospitals, community providers (such as clinics and health centers), and office-based physicians all provide care to the uninsured. Given the high cost

of hospital-based care, the majority (60%) of uncompensated care is provided by hospitals. Community-based providers that receive public funds provide a little over a quarter (26%) of uncompensated care and the remainder of uncompensated care, 14%, is provided by office-based physicians.[91]

Safety net hospitals that serve a large number of uninsured individuals will receive a reduction in federal disproportionate share (DSH) Medicaid payments beginning in FY2016.[92] DSH payments are federal Medicaid payments intended to cover the extra cost incurred by hospitals serving a large number of low-income and uninsured patients. Unlike other Medicaid payments, federal DSH funds are capped at a state's annual allotted amount, determined by statutory formula, and states have two years to claim their allotments. DSH allotments currently vary considerably across states and total about $11.6 billion a year.[93] Anticipating fewer uninsured and lower levels of uncompensated care, the ACA reduces federal Medicaid DSH. Cuts were originally scheduled to begin in 2014, but other legislation delayed reductions which are now scheduled to begin in 2016 with a reduction of $1.2 billion. DSH cuts phase up to $5.6 billion in 2019, drop to $4 billion in 2020 and then increase by inflation until 2023. The legislation requires the Secretary of HHS to develop a methodology to allocate the reductions that must take into account factors outlined in the law.[94] For those states which have elected not to expand Medicaid eligibility, uninsured residents are left with few low-cost coverage options, and the hospitals that serve these individuals will receive less federal DSH funding.

Being uninsured leaves individuals at an increased risk of amassing unaffordable medical bills. Uninsured people are more likely (22%) than those with employer sponsored insurance (9%) or those with Medicaid (15%) to report having trouble paying medical bills in the past year (Figure 10). Medical bills may also force uninsured adults into serious financial strain. In 2013, 20% of uninsured adults reported that medical bills either caused them to use up all or most of their savings; caused them to have difficulties paying for medical necessities; caused them to borrow money; or caused them to be contacted by a collection agency. In contrast, only 7% among those with employer coverage and 12% among those with Medicaid experienced this type of financial strain due to medical bills.[95]

Most uninsured people have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured families living below 200% of poverty have no savings at all,[96] and the average uninsured household has no net assets.[97] Uninsured people also have far fewer financial assets than those with insurance coverage. A recent survey found that almost three-quarters (70%) of the uninsured are not confident that they can pay for the health care services they think they need, compared to 13% of those with employer sponsored coverage and 37% with Medicaid (Figure 10).



Unprotected from medical costs and with few assets, uninsured people are at risk of having difficulty paying off debt. Like any bill, when medical bills are not paid or paid off too slowly, they are

turned over to a collection agency, and a person's ability to get further credit is significantly limited. In 2013, over half (57%) of uninsured adults reported having difficulty paying off debt due to medical expenses, compared to 30% of those with employer sponsored insurance.[98] Medical debts contribute to almost half of the bankruptcies in the United States, and uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[99]

Conclusion

In the wake of the ACA's major coverage expansions, millions of Americans now have affordable health insurance for the very first time, allowing them to access the health care they need while protecting them against catastrophic medical costs. Historically, the options for the uninsured population were limited in the individual market, which was often expensive and under which many were denied coverage. Medicaid and CHIP have provided coverage to many families, but pre-2014 eligibility levels were low for parents and few states provided coverage to adults without dependent children. The ACA fills in many of these gaps by expanding Medicaid to low-income adults and providing subsidized coverage to people with incomes below 400% of poverty in the Marketplaces. Nonetheless, even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage, including low-wage workers who do not qualify for Medicaid or Marketplace subsidies, because they do not meet the income threshold or because they reside in a state that has not expanded Medicaid. Further, undocumented immigrants are excluded from Medicaid and the Marketplace regardless of their income. In addition, many uninsured people live in health professional shortage areas and may continue to do so even if they gain insurance under the ACA, underscoring the need to continue to develop and support safety-net providers and community health clinics.[100] Even so, the ACA has the potential to provide coverage to those who need it, ensuring that fewer individuals and families will face the health and financial consequences of not having health insurance.

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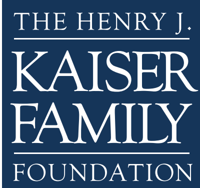

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ASPE RESEARCH BRIEF

HEALTH PLAN CHOICE AND PREMIUMS IN THE 2015 HEALTH INSURANCE MARKETPLACE

Updated January 8, 2015

Since open enrollment began on November 15, 2014, millions of Americans can once again shop for high-quality, affordable health care coverage in the Health Insurance Marketplace established by the Affordable Care Act.[1] Our research indicates that the Affordable Care Act is working to enhance competition, expand choice and promote affordability among Marketplace health insurance plans in 2015.[2]

This year, the Marketplace is welcoming new consumers as well as encouraging those who enrolled last year to come back, update their information and select the plan that best meets their needs. All plans in the Marketplace cover essential health benefits and recommended preventive care, and do not exclude people based on preexisting conditions. Consumers can see detailed information about each health insurance plan offered in their area before they apply. Factors they may consider in choosing a health insurance plan include premiums, deductibles, out-of-pocket costs, provider network, formulary, customer service and more.[3] Consumers may be eligible for financial assistance to help pay for the cost of premiums. In fact, 85 percent of consumers who selected a Marketplace plan in 2014 received financial assistance.[4]

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[1]The Health Insurance Marketplace includes the Marketplaces established in each of the states (and the District of Columbia) and run by the state or the federal government. This report addresses the individual market Marketplaces that use the HealthCare.gov eligibility and enrollment system in both 2014 and 2015.
[2] It is important to note that this brief uses only information on individuals who selected a Marketplace individual market health plan, and the analysis excludes stand-alone dental plans.
[3] This brief does not analyze consumers' final expenses, after considering other health plan features, such as deductibles and copayments. Consumers may examine all elements of health insurance plans in order to estimate expected total out-of-pocket costs. Moreover, while premium tax credits can be applied to a plan in any metal tier with the exception of catastrophic plans, cost-sharing reductions are available only for silver plans.
[4] This represents the percentage of individuals who selected a Marketplace plan and qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction. See: U.S. Department of Health and Human Services, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," *ASPE Issue Brief*, ASPE, May 1, 2014, available at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

This brief presents analysis of Qualified Health Plan (QHP) data in the Marketplace for 35 states, providing a look at the plan choice and premium landscape that new and returning consumers will see for 2015.[5] It also examines plan affordability in 2015 after taking into account premium tax credits. The findings presented here include states for which sufficient plan data were available for both 2014 and 2015.

Key Findings

- The Affordable Care Act is increasing competition and choice among affordable Marketplace health insurance plans in 2015.
- There are over 25 percent more issuers participating in the Marketplace in 2015. About 91 percent of consumers will be able to choose from 3 or more issuers—up from 74 percent in 2014. Consumers can choose from an average of 40 health plans for 2015 coverage—up from 30 in 2014—based on analysis at the county level.
- Premiums for the benchmark (second-lowest cost) silver plan will increase modestly, by 2 percent on average this year before tax credits, while premiums for the lowest-cost silver plan will increase on average by 5 percent. The plans offering the lowest prices have sometimes changed from 2014 to 2015, so consumers should shop around to find the plan that best meets their needs and budget.
- More than 7 in 10 current Marketplace enrollees can find a lower premium plan in the same metal level before tax credits by returning to shop. To illustrate the significance of shopping we consider the following example: if all consumers switched from their current plan to the lowest-cost premium plan in the same metal level, the total savings in premiums would be over $2 billion. These savings represent the sum of savings to consumers and taxpayers.
- For customers returning to the Marketplace, the vast majority of enrollees have low cost plans available to them. If they look across all metal levels, fully 79 percent of current Marketplace enrollees can get coverage for $100 or less, after any applicable tax credits, in 2015.
- Sixty-five percent of current Marketplace enrollees can get coverage for $100 or less for 2015, after tax credits, if they shop for a more affordable plan within their current metal level, compared to 50 percent of current Marketplace enrollees who can get coverage for $100 or less, after any applicable tax credits, if they stay in the same plan in 2015.

[5] The 35 states for which sufficient data in the individual market were available in both 2014 and 2015 for this analysis are listed in the methodology section at the end of this brief. References to the Marketplace in this report refer to the individual market Marketplaces that use the HealthCare.gov eligibility and enrollment system in both 2014 and 2015. The small group Marketplace, also known as SHOP, is not included in this brief.

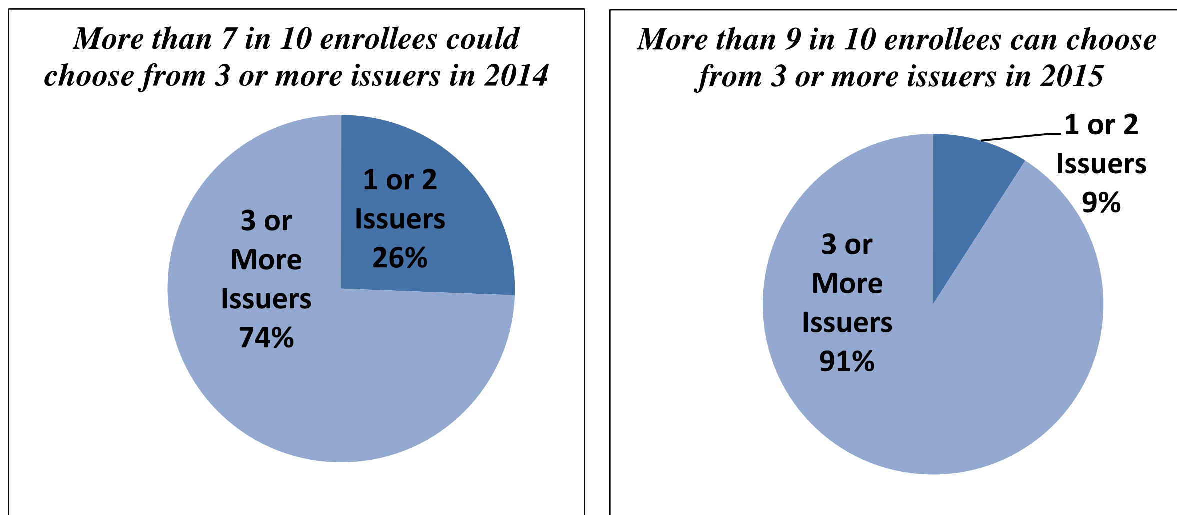
Consumer Choice among Health Insurance Issuers in 2014 and 2015

The Affordable Care Act is working to create a dynamic, competitive Marketplace, with more choice and affordable premiums in 2015. This offers new opportunities for consumers to comparison shop to select the plan that best meets their needs and budget. More choice also means more competition between plans that in turn results in downward pressure on premiums. Consumers who bought a 2014 plan and decide to shop actively for a comparable 2015 plan will often be able to find lower premiums.

There are 25 percent more issuers participating in the Marketplace in 2015, compared with 2014.[6] During the 2014 open enrollment period, 74 percent of the people who enrolled in a qualified health plan lived in counties with three or more issuers offering plans in the Marketplace; for 2015 this percentage has increased to 91 percent.

Figure 1 shows the distribution of the 2014 Marketplace enrollees by the number of issuers in their county.

FIGURE 1
Enrollee Choice of Marketplace Issuers in 35 States in 2014 and 2015



Source: Information on plans and issuers is from the plan landscape files as of November 2014 for 35 states.
Note: See "Methods and Limitations" section for more details regarding data and methods used. "Enrollees" refers to those people who selected a qualified health plan in the Marketplace in 2014 and is based on active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014. The number of issuers available to those who selected a Marketplace plan in 2014 is based on the number of issuers offering qualified health plans in 2015 in the county of residence of those persons.

Consumers can also choose from among more plans for 2015 coverage. On average, there are 40 plans available per county, including catastrophic plans. This is an increase from an average of

[6] The increase in total number of issuers in the 35 states is calculated based on identifying an issuer by its unique five-digit Health Insurance Oversight System (HIOS) ID. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS issuer ID is specific to the state in which it operates, such that a company offering QHPs through the Marketplace in two states would be counted twice—once for each state.

30 total plans per county last year. Note that previous ASPE issue briefs on plan choice and availability presented analyses at the rating area level. Because plans available in some part of a rating area are not always available in all parts of a rating area, conducting the analysis at the county level better captures the set of options consumers will see when they shop and thus more closely matches consumers' shopping experience.

The average number of plans per county in the bronze, silver, gold, and platinum metal tiers—which signify different levels of plan actuarial value or how much of every claim dollar the plan covers—has also increased from 2014 (see Table 1).

TABLE 1
Summary of Marketplace Health Plans and Issuers for 35 States, 2014 and 2015

	2014 Average	2015 Average
Issuers per State	5	7
Issuers per County	3	4
Total Qualified Health Plans *(excluding catastrophic)*	28	37
Total Health Plans	30	40
Catastrophic Plans	3	2
Bronze Plans	9	12
Silver Plans	10	15
Gold Plans	8	9
Platinum Plans	1	2

Source: Information on plans and issuers is from the plan landscape files as of November 2014 for 35 states.
Note: All averages in this table are unweighted. Averages are calculated at the county level for all counties in the 35 states unless otherwise specified. The number of issuers per state is the total number of issuers offering QHPs anywhere in a state. Child-only plans were excluded from these counts. Numbers may not sum due to rounding.

Marketplace Health Plan Premiums in 2014 and 2015

The Marketplace enables consumers to comparison shop for a plan that meets their needs and budget. Many will receive financial assistance to help with the cost of their monthly premiums. In 2014, 64 percent of individuals who selected a plan in the Marketplace selected the lowest cost (43 percent) or second-lowest cost plan (21 percent) in their metal tier—indicating that many Marketplace consumers shop on price.[7]

Consumers who return to the Marketplace will see that premiums for the *benchmark* plan (the second-lowest cost silver plan in each market) increased modestly, by 2 percent on average this year before tax credits. For example, the average premium for the benchmark silver plan for a

[7] Percentages are based on analysis of 2014 Marketplace plan selections in 36 states. See: Amy Burke, Arpit Misra, and Steven Sheingold, "Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014," *ASPE Research Brief,* June 2014, available at: http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf

27-year-old increased from $218 in 2014 to $222 in 2015 before tax credits.[8] The benchmark silver plan premiums are significant because the premium tax credits that are available to help make Marketplace coverage more affordable are calculated based on the premium for those plans.[9] The lowest-cost silver plan in each market saw modest growth of 5 percent on average before tax credits.

The new Marketplace is competitive and dynamic. As described in the last section, the 2015 Marketplace includes many new issuers and plans, and issuers are competing to offer more affordable options to consumers. This means that the plan that was the benchmark or lowest-cost plan in 2014 is often not the benchmark or lowest-cost plan in 2015, so it will be important for returning consumers to shop around in 2015 to ensure that they select the plan that best meets their circumstances.

More than 7 in 10 current Marketplace enrollees can find a lower premium plan in the same metal level by returning to shop. For instance, the average lowest-cost premium for a silver plan available to current silver-level enrollees is $336 for 2015. The average consumer who bought a silver plan last year and decides to shop for a better deal this year can save $41 a month before tax credits—which works out to $492 a year. If all silver plan holders switch to the lowest-cost silver plan for 2015, the total savings for the year would be $1.6 billion. Across all metal levels, the total savings in premiums would be over $2 billion (see Table 2 for all metal levels). These savings represent the sum of savings to consumers and taxpayers.

Eighty-five percent of consumers who selected a plan for 2014 coverage received premium tax credits to help with the cost of monthly premiums. Consumers who receive premium tax credits are protected against excessive rate increases because the Affordable Care Act sets a cap on the amount they pay for the benchmark, second-lowest silver plan. Additionally, during the open enrollment period, all new and returning Marketplace consumers can easily compare plans' pricing and benefits to shop for a plan with a lower premium.

[8] Plan and premium information are from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states. Amounts represent monthly premiums and do not take into account potential premium tax credits. For averages, each county's second-lowest cost silver premium is weighted by the number of Marketplace plan selections in each county. See Table 7 at the end of this brief for average premiums by state.
[9] The Affordable Care Act specifies that an individual or family with a particular household income who is eligible for the premium tax credit will be required to pay no more than a fixed percentage of their income for the second-lowest cost silver plan available in the Marketplace in their local area. See the "Methods and Limitations" section at the end of this brief for more details on benchmark plans and premium tax credits.

TABLE 2
Potential Savings from Shopping Based on Premium if Current Marketplace Enrollees Switch to 2015 Lowest-Cost Premium Plan within Metal Level for 35 States

Premiums Before Tax Credits, Current Marketplace Enrollees	Bronze	Silver	Gold	Platinum
Average Lowest-Cost 2015 Monthly Premium Within Metal Level	$265	$336	$382	$439
Average 2015 Monthly Premium Savings if Consumers Switch to Lowest-Cost Plan within Metal Level	$36	$41	$54	$55
% of Enrollees Who Could Save on Premium Costs by Switching to the Lowest-Cost Plan in Metal Level	78%	78%	77%	71%
ANNUAL Average Potential Savings in Premium Costs per Enrollee	$432	$492	$658	$660
MONTHLY Total Amount of Potential Savings in Premium Costs across All Enrollees	$28 M	$131 M	$23 M	$11 M
ANNUAL Total Amount of Potential Savings in Premiums Costs Across All Enrollees	$336 M	$1.6 B	$271 M	$127 M

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Amounts presented here do not take into account potential tax credits. The lowest-cost premium refers to the plan with the lowest premium within the county within each metal tier and is based on all the plans available in 2015. The lowest cost plan does not take into account other cost-sharing features, but refers only to the cost of the premium charged for that plan. In some cases, plans were tied for lowest premium. This analysis includes only enrollees linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. We assume that *all* enrollee characteristics are unchanged and calculate premiums based on the same age, family composition, and household income as percentage of the FPL as in 2014. See the “Methods and Limitations” section at the end of this brief for more details.

Health Insurance Plan Affordability after Tax Credits in the Marketplace in 2015

With over 25 percent more issuers in the Marketplace this coming year, the increased choice and competition means there are affordable premiums for new consumers and for those who selected a plan last year and are returning to shop.

In order to make health insurance affordable, the Affordable Care Act established premium tax credits to help consumers with the cost of coverage based on their incomes. During the initial open enrollment period, 85 percent of consumers who selected a Marketplace plan received financial assistance.[10] And nearly 7 out of 10 who selected a plan with tax credits found coverage for less than $100 after tax credits.[11]

The tax credits are based on the premium of the so-called benchmark plan in their area (the second-lowest-cost silver plan). The health plan category or "metal level" determines how consumers and plans share the costs of care. For example, with a silver level plan the health plan pays about 70 percent of the total costs of care for essential health benefits, on average, and the consumer pays 30 percent of these costs. This takes into account the plan's deductibles, copayments, coinsurance, and out-of-pocket maximums. The second-lowest cost silver plan premiums are significant because premium tax credits that are available to help make Marketplace coverage more affordable are calculated based on the premium for those plans. The actual payment made by consumers for their insurance depends on the plan they choose and the level of tax credit they qualify for.

Competition and tax credits are related. Increased numbers of plans in a market means more competition. More competition tends to put downward pressure on premiums. As competition intensifies, the benchmark plan (second-lowest cost silver plan) may change. This means that the benchmark premium (and thus the tax credit) may grow more slowly than a consumer's current plan's premium. For this reason, consumers that want to make their tax credit's purchasing power go as far as possible should shop. Another implication is that premium competition serves to benefit taxpayers by holding down tax credit costs.

The percentages in Tables 3, 4, and 5 include current Marketplace enrollees who selected a plan, with or without tax credits. Table 3 shows the percent of current Marketplace enrollees in the 35 states who could get coverage for as little as $100 or less per month, taking into account any applicable tax credits in 2015, *regardless of the metal level they selected in 2014*. For example, 79 percent of all customers returning to the Marketplace can get coverage for $100 or less after tax credits, regardless of their 2014 plan metal level choice. Sixty-six percent can get coverage for $50 or less, and an additional 12 percent could get coverage for as little as $50 to $100. (Percentages of those who could obtain coverage for $100 or less by state are shown in Table 13 in the Appendix at the end of this brief.)

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[10] Represents the percentage of individuals who selected a 2014 Marketplace plan and qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction, from: HHS, ASPE, May 1, 2014, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period."
[11] Amy Burke, Arpit Misra, and Steven Sheingold, "Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014," *ASPE Research Brief,* June 2014.

TABLE 3
It Pays to Shop: Percent of Current Marketplace Enrollees Who Could Obtain Coverage for $100 or Less after Any Applicable Tax Credits in 2015, 35 States
Regardless of Metal Level in 2014

Monthly Premium After Tax Credits	Any Plan Type	Bronze	Silver	Gold	Platinum
$100 or less	79%	79%	64%	36%	9%
$50 or Less	66%	66%	42%	8%	1%
$50 to $100	12%	12%	22%	27%	8%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections by in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees who could be linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

Table 4 shows the percentage of current Marketplace enrollees who could get covered for $100 or less, taking into account any applicable tax credits, *if they keep their current plan* and do not switch to a lower-premium plan for 2015. For example, 58 percent of Marketplace enrollees who selected a silver-level plan in 2014 will have 2015 coverage for $100 or less if they do not change plans.

TABLE 4
It Pays to Shop: Percent of Current Marketplace Enrollees Who Would Be Covered for $100 or Less after Any Applicable Tax Credits in 2015, 35 States
If They Did Not Switch Plans

Monthly Premium After Tax Credits	All Plan Types	Bronze	Silver	Gold	Platinum
$100 or less	50%	47%	58%	8%	4%
$50 or Less	26%	26%	31%	1%	0%
$50 to $100	23%	20%	27%	7%	3%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

However, there may be more affordable plans in 2015 available to current enrollees. Table 5, below, shows the percentage of current Marketplace enrollees in the 35 states that could get coverage for $100 or less, taking into account any applicable tax credits, *while staying in their current metal level*. For example, 65 percent of all people who selected a plan in 2014 could get coverage for $100 or less if they selected a lower-premium plan in their same metal level. Of those who selected a silver plan in 2014, 77 percent could get silver plan coverage for $100 or less in 2015 if they choose a lower-cost plan.

TABLE 5
It Pays to Shop: Percent of Current Marketplace Enrollees Who Could Obtain Coverage for $100 or Less after Tax Credits in 2015, 35 States
within Their Current Metal Level

Monthly Premium After Tax Credits	All Plan Types	Bronze	Silver	Gold	Platinum
$100 or less	65%	58%	77%	14%	7%
$50 or Less	45%	39%	54%	2%	1%
$50 to $100	20%	19%	23%	12%	7%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections by in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

Conclusion

New and returning customers to the Health Insurance Marketplace will see improved choice and affordable premiums in 2015, a clear sign that the Marketplace is succeeding in creating a competitive and dynamic environment. Consumers should take advantage of this by shopping around to find the plan that best meets their needs and their budget. They can do so by going to HealthCare.gov, which provides information for consumers looking to compare plans on premiums and other plan features.

Methodology and Limitations

Data

The plan and premium data reported here are from the Marketplace QHP landscape individual market medical files, which are publicly available at HealthCare.gov.[12] Data were not available for all states. This analysis considers the 35 states which were included in both the 2014 and 2015 Marketplace landscape files: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

For most State-based Marketplaces (SBMs), comprehensive plan and premium data were not available for both 2014 and 2015. The State-based Marketplaces not included in the analysis in this brief are California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Oregon, Nevada, New York, Rhode Island, Vermont, and Washington. Some State-based Marketplaces submit plan data to the Center for Consumer Information and Insurance Oversight (CCIIO) for display using Federal web architecture. New Mexico's SBM utilized the FFM platform to support its eligibility and enrollment functions in 2014, will continue to do so in 2015, and is included in this analysis in this brief. Oregon and Nevada did not rely on the FFM platform in 2014 but will in 2015; Idaho relied on the FFM platform in 2014, but will not in 2015.

The analysis in this brief does not include stand-alone dental plans, child-only plans, or small-group Marketplace plans. In our estimates of Marketplace premiums, we also did not consider catastrophic plans, Virginia morbid obesity plans, and their enrollees. Catastrophic coverage is not available to all consumers.

Most of the increase in number of plans available to consumers for 2015 is due to newly available plans on the Marketplaces. However, a small proportion of the increase in plan offerings is due to returning issuers breaking 2014 plans into two or more plans for 2015 because of changes in the Marketplace rules governing premium rates.

Enrollment information is based on active QHP selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014. In this brief, we use the term "enrollees" to refer to individuals with active Marketplace individual market health plan selections; it does not refer to "effectuated enrollees"—individuals who selected and paid the premium. Additionally, we exclude tobacco users and morbid obesity plan enrollees from our calculations of average premiums because their premium rates may be higher than standard, non-tobacco rates. Our calculations of the savings from switching plans (Table 2) and premium tax credits (Table 3, 4, and 5) are based on only enrollees whom we were able to link to complete premium and plan data for both 2014 and 2015.

[12] The Marketplace plan landscape files can be downloaded at: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Premiums

In this issue brief, we examine the plans and premiums available at the county level. Because some plans may not serve all counties within a rating area, county-level analysis provides a better approximation of plan availability. Note that analysis in previous ASPE briefs on Marketplace premiums was typically at the rating area level; therefore, numbers in this brief should not be compared against those in previous briefs using rating-area analysis.

Our analysis of premiums in Tables 2-5 considers only current enrollees whose 2014 Marketplace plan is available in 2015, based on each plan's unique ID code. Consumers can be auto-enrolled into similar coverage even if their exact plan is not available for the next year.

Premium Tax Credits

The Affordable Care Act specifies that an individual or family who is eligible for premium tax credits will be required to pay no more than a fixed percentage of their income for the second-lowest cost silver plan available in the Marketplace in their local area. This applicable percentage varies only by household income as a percentage of the Federal Poverty Level (FPL) and does not depend on household members' ages, the number of people within the household covered through the Marketplace, or Marketplace premiums. (For examples of 2015 incomes and benchmark premiums for those who are eligible for tax credits, see Table 6.) The applicable percentage is converted into a maximum dollar amount the household is required to pay annually for the benchmark plan, and the tax credit is applied to make up the difference between the maximum dollar amount and the actual premium, if any.[13] The exact dollar amount of the tax credit depends on the premium of the second-lowest cost silver plan available to the household and the cost of covering the family members who are seeking Marketplace coverage.

For example, a 27-year-old woman with an income of $25,000 in 2014 would be at 218 percent of the FPL.[14] For tax credits in coverage year 2014, the amount she pays for the second-lowest cost silver plan is capped at $145 per month. If her premium for the second-lowest cost silver plan available is $336 per month before tax credits, then the amount of the premium tax credit will be $191 per month—the difference between specified contribution to the benchmark plan and the actual cost of the benchmark plan. Her use of the tax credit is not restricted to the second-lowest cost silver plan. She can apply the $191 per month tax credit toward any plan of her choosing in any metal level. By applying her tax credit to the lowest-cost bronze plan, which may be priced at $199 per month, she could obtain Marketplace coverage for just $8 per month after tax credits. If she picks the lowest-cost silver plan, at $226 per month, she pays just $35 per month after tax credits.

[13] If the premium of the second-lowest cost silver plan falls below the maximum amount the household pays for benchmark coverage, then the household does not receive a tax credit and pays the full premium for the benchmark plan.

[14] For coverage in 2014, the 2013 Federal Poverty Guidelines are used to calculate FPL. For coverage in 2015, the 2014 Federal Poverty Guidelines are used to calculate FPL.

Suppose that for 2015, this woman's income is again equivalent to 218 percent of the FPL. The maximum she will pay for the second-lowest cost silver plan in her area in 2015 is capped at $148 for 2015 (see Table 6 for 2015 applicable percentages). She can choose to buy the second-lowest silver plan if she wishes, and it will cost her up to $148 after tax credits—*regardless of how much the second-lowest silver plan's actual premium may have increased*. Her tax credit for 2015 will be the difference between $148 and what the second-lowest cost silver plan premium would be for her in 2015. Again, she can take her tax credit and apply it to whatever plan in any metal tier that best fits her needs.

TABLE 6
Examples of Maximum Monthly Health Insurance Premiums for the Second-Lowest Cost Silver Plan for Marketplace Coverage for a Single Adult in 2015[15]

Single Adult Income[16]	Percent of the Federal Poverty Level	Maximum Percent of Income Paid toward Second-Lowest Cost Silver Plan	Maximum Monthly Premium Payment for Second-Lowest Cost Silver Plan
$11,670	100% [17]	2.01%	$20
$17,505	150%	4.02%	$59
$23,340	200%	6.34%	$123
$29,175	250%	8.10%	$197
$35,010	300%	9.56%	$279
$40,845	350%	9.56%	$325
$46,797	401%	Not Applicable	No Limit

Source: Applicable percentages for 2015 coverage are available at: www.irs.gov/pub/irs-drop/rp-14-37.pdf. The 2014 Federal Poverty Guidelines, used for premium tax credits for 2015 coverage, are at: http://aspe.hhs.gov/poverty/14poverty.cfm.

Many families may also be eligible for premium tax credits. For example, suppose a family with an income of $60,000 was shopping for Marketplace coverage for 2015 for all four family members. The family's income is equivalent to 252 percent of the FPL; therefore, the family's premium is capped at 8.15% of income or no more than $407 per month for the benchmark second-lowest cost silver plan in its local area. If the premium for the second-lowest cost silver plan for the family is $805 per month, the family will receive a tax credit of $398, making the premium after tax credits $407 ($805 – $407 = $398). The family can apply its $398 tax credit toward the purchase of coverage in any metal level. Note that the maximum percent of income paid toward the second-lowest silver plan is adjusted annually by a measure of the difference between premium growth and income growth.

[15] For more information on premium tax credits, see the Internal Revenue Service final rule on "Health Insurance Premium Tax Credit," (*Federal Register*, May 23, 2012, vol., 77, no. 100, p. 30392; available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf).
[16] Income examples are based on the 2014 federal poverty guidelines for the continental United States. Alaska and Hawaii have higher federal poverty guidelines, which are not shown in this table.
[17] In states expanding Medicaid, individuals and families at 100 percent of the FPL who are eligible for Medicaid coverage are not eligible for premium tax credits.

APPENDIX: TABLES BY STATE AND CITY

TABLE 7
Average Monthly Premiums for Second-Lowest Cost Silver Plans for a 27-Year-Old (Before Tax Credits), 2014 and 2015 in Selected States

State	Average Second-Lowest Cost Silver Premium for a 27-Year-Old		
	2014	2015	% Change
AK	$349	$449	28%
AL	$210	$216	3%
AR	$241	$234	-3%
AZ	$164	$158	-4%
DE	$237	$247	4%
FL	$217	$231	6%
GA	$235	$220	-6%
IA	$206	$215	4%
IL	$185	$191	3%
IN	$270	$265	-2%
KS	$196	$187	-5%
LA	$252	$257	2%
ME	$266	$262	-2%
MI	$206	$207	0%
MO	$234	$232	-1%
MS	$311	$249	-20%
MT	$208	$196	-5%
NC	$244	$262	8%
ND	$233	$248	7%
NE	$205	$216	5%
NH	$237	$205	-14%
NJ	$264	$259	-2%
NM	$184	$165	-10%
OH	$216	$220	2%
OK	$175	$184	5%
PA	$200	$196	-2%
SC	$222	$222	0%
SD	$234	$216	-8%
TN	$161	$170	6%
TX	$203	$210	3%
UT	$206	$211	2%
VA	$222	$230	3%
WI	$246	$251	2%
WV	$231	$248	7%
WY	$343	$359	5%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: The numbers in this table represent premiums before the application of tax credits. Premiums are weighted averages across each county in each state, weighted by the number of Marketplace health plan selections in each county, as of May 12, 2014.

TABLE 8
Number of Marketplace Issuers by State, 2014 and 2015 in Selected States

State	Number of Issuers in State		Net Change in Number of Issuers in State	Number of New Issuers to the State	Number of Issuers Exiting the State
	2014	2015			
AK	2	2	0	0	0
AL	2	3	1	1	0
AR	3	4	1	1	0
AZ	10	13	3	3	0
DE	3	3	0	2	2
FL	11	14	3	4	1
GA	5	9	4	4	0
IA	4	4	0	0	0
IL	8	10	2	3	1
IN	4	9	5	6	1
KS	4	5	1	1	0
LA	5	6	1	1	0
ME	2	3	1	1	0
MI	12	16	4	4	0
MO	4	7	3	3	0
MS	2	3	1	1	0
MT	3	4	1	1	0
NC	2	3	1	1	0
ND	3	3	0	0	0
NE	4	4	0	1	1
NH	1	5	4	4	0
NJ	4	6	2	2	0
NM	4	5	1	1	0
OH	12	16	4	5	1
OK	6	4	-2	1	3
PA	14	15	1	4	3
SC	4	5	1	1	0
SD	3	3	0	0	0
TN	4	5	1	1	0
TX	12	15	3	3	0
UT	6	6	0	0	0
VA	8	9	1	1	0
WI	13	15	2	2	0
WV	1	1	0	0	0
WY	2	2	0	0	0

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: An issuer is counted as "new" in 2015 if it did not offer an individual market health plan in a given state's Marketplace in 2014 based on its HIOS ID number, and "exiting" if it was active in a given state in 2014 but not in 2015.

TABLE 9
Average Number of Marketplace Plans per County, 2014 and 2015 in Selected States

State	Average Number of Qualified Health Plans		Net Change in Average Number of Marketplace Plans, 2014-2015
	2014	2015	
AK	34	28	-6
AL	6	17	11
AR	22	34	12
AZ	81	71	-10
DE	19	24	5
FL	66	42	-24
GA	22	41	19
IA	27	23	-4
IL	38	46	8
IN	23	43	20
KS	32	27	-5
LA	33	44	11
ME	17	25	8
MI	29	64	35
MO	17	20	3
MS	13	27	14
MT	26	40	14
NC	18	26	8
ND	23	26	3
NE	23	25	2
NH	10	38	28
NJ	26	45	19
NM	36	43	7
OH	30	54	24
OK	29	29	0
PA	41	50	9
SC	25	59	34
SD	32	38	6
TN	48	71	23
TX	25	31	6
UT	55	69	14
VA	30	23	-7
WI	49	67	18
WV	12	14	2
WY	16	40	24

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: Number of plans in 2014 and 2015 represent the average number of Marketplace QHPs per county within each state. Averages are unweighted and exclude catastrophic plans. Rows may not sum due to rounding.

TABLE 10
Average Monthly Marketplace Premiums, Issuers, and QHPs Available by County, 2014 and 2015 in Selected States

State	2015						2014			
	Total Number of Issuers in State	Average Number of QHPs per County	27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000		27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000	
			Average		Average		Average		Average	
			Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit***	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit
AK*	2	28	$449	$105	$1,624	$319	$349	$107	$1,265	$323
AL	3	17	$216	$143	$783	$407	$210	$145	$761	$410
AR	4	34	$234	$143	$847	$407	$241	$145	$874	$410
AZ***	13	71	$158	$143	$573	$407	$164	$144	$595	$410
DE	3	24	$247	$143	$893	$407	$237	$145	$859	$410
FL	14	42	$231	$143	$835	$407	$217	$145	$787	$410
GA	9	41	$220	$143	$797	$407	$235	$145	$850	$410
IA**	4	23	$215	$143	$777	$407	$206	$145	$747	$410
IL	10	46	$191	$143	$692	$407	$185	$145	$669	$410
IN	9	43	$265	$143	$959	$407	$270	$145	$978	$410
KS	5	27	$187	$143	$677	$407	$196	$145	$710	$410
LA	6	44	$257	$143	$932	$407	$252	$145	$913	$410
ME	3	25	$262	$143	$950	$407	$266	$145	$962	$410
MI	16	64	$207	$143	$751	$407	$206	$145	$745	$410
MO**	7	20	$232	$143	$839	$407	$234	$145	$847	$410
MS	3	27	$249	$143	$901	$407	$311	$145	$1,127	$410
MT**	4	40	$196	$143	$710	$407	$208	$145	$752	$410
NC	3	26	$262	$143	$950	$407	$244	$145	$883	$410
ND	3	26	$248	$143	$898	$407	$233	$145	$842	$410
NE	4	25	$216	$143	$782	$407	$205	$145	$742	$410
NH	5	38	$205	$143	$741	$407	$237	$145	$859	$410
NJ**	6	45	$259	$143	$937	$407	$264	$145	$957	$410

State	2015						2014			
	Total Number of Issuers in State	Average Number of QHPs per County	27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000		27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000	
			Average		Average		Average		Average	
			Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit***	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit
NM	5	43	$165	$143	$597	$407	$184	$145	$665	$410
OH	16	54	$220	$143	$796	$407	$216	$145	$783	$410
OK	4	29	$184	$143	$668	$407	$175	$145	$632	$410
PA***	15	50	$196	$143	$709	$407	$200	$144	$725	$410
SC	5	59	$222	$143	$805	$407	$222	$145	$804	$410
SD	3	38	$216	$143	$783	$407	$234	$145	$848	$410
TN	5	71	$170	$143	$614	$407	$161	$145	$582	$410
TX	15	31	$210	$143	$760	$407	$203	$145	$736	$410
UT	6	69	$211	$143	$681	$407	$206	$145	$619	$410
VA	9	23	$230	$143	$833	$407	$222	$145	$805	$410
WI**	15	67	$251	$143	$909	$407	$246	$145	$891	$410
WV**	1	14	$248	$143	$900	$407	$231	$145	$835	$410
WY	2	40	$359	$143	$1,299	$407	$343	$145	$1,243	$410
35 State Average	7	37	$222	$143	$803	$407	$218	$145	$789	$410

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: The average number of QHPs per county is unweighted across counties within a state and excludes catastrophic plans. Premiums are weighted averages across all counties in each state, weighted by the county's number of Marketplace health plan selections as of May 12, 2014. In this example, the family of four is one 40-year-old adult, one 38-year-old adult, and two children under the age of 21. For households eligible for premium tax credits, after-tax-credit benchmark premiums are capped at a given percentage of household income. As shown in the table, after-tax benchmark premiums will differ slightly between 2014 and 2015 for identical family compositions and income amounts because of changes in the applicable percentages and the Federal Poverty Guidelines. The 2014 guidelines are used to calculate benchmark premiums for coverage in 2015, and 2013 guidelines are used for coverage in 2014. Because poverty guideline thresholds generally increase each year, a given dollar amount of income may equate to a smaller percentage of the Federal Poverty Level (FPL) this year than it did in the year previous. For example, a four-person family with an income of $60,000 is at 252 percent of the FPL by 2014 guidelines and at 255 percent of the FPL by 2013 guidelines. As a result, the percentage of income the family would pay for the benchmark plan is smaller for 2015 than for 2014.
* Alaska's federal poverty guidelines are higher than those for the continental United States; consequently, the after tax credit premium is lower for a given amount of income.
** In all 35 states, our calculations of premiums after tax credits assume that all members of the family of four making $60,000 would be eligible for premium tax credits. However, in states with higher Medicaid/CHIP thresholds the children would be eligible for Medicaid/CHIP and not eligible for premium tax credits.
*** If the benchmark plan premium is below the applicable percentage of income after tax credit, the tax credit-eligible enrollee pays the actual premium. In Pennsylvania and Arizona in 2014, average premiums for second-lowest silver after tax credit for a 27-year-old making $25,000 were below the amount corresponding to the applicable percentage.

TABLE 11
Second-Lowest Cost Silver Plan Monthly Premiums for a 27-Year-Old (Before Tax Credits), 2014 and 2015 in Selected Cities

State	City	County	Second-Lowest Cost Silver Monthly Premium for a 27-year-old		
			2014	2015	% Change
AK	Anchorage	Anchorage	$355	$449	26%
AK	Juneau	Juneau	$334	$449	34%
AL	Birmingham	Jefferson	$211	$217	3%
AR	Little Rock	Pulaski	$251	$245	-2%
AZ	Phoenix	Maricopa	$161	$145	-10%
AZ	Tucson	Pima	$138	$147	7%
DE	Wilmington	New Castle	$237	$247	4%
FL	Ft. Lauderdale	Broward	$199	$198	-1%
FL	Jacksonville	Duval	$210	$223	6%
FL	Miami	Miami-Dade	$221	$225	2%
FL	Orlando	Orange	$225	$244	8%
FL	Tampa	Hillsborough	$199	$240	21%
FL	West Palm Beach	Palm Beach	$220	$236	7%
GA	Atlanta	Fulton	$205	$209	2%
IA	Cedar Rapids	Linn	$209	$202	-3%
IL	Chicago	Cook	$174	$177	2%
IN	Indianapolis	Marion	$290	$270	-7%
KS	Kansas City	Wyandotte	$213	$188	-12%
KS	Wichita	Sedgwick	$184	$179	-3%
LA	New Orleans	Orleans Parish	$255	$243	-5%
ME	Portland	Cumberland	$242	$231	-5%
MI	Detroit	Wayne	$184	$188	2%
MO	St. Louis	Saint Louis	$216	$226	5%
MS	Jackson	Jackson	$332	$253	-24%
MT	Bozeman	Gallatin	$206	$195	-5%
NC	Charlotte	Mecklenburg	$251	$269	7%
NC	Greensboro	Guilford	$228	$259	14%
NC	Raleigh-Durham	Wake	$222	$251	13%
ND	Fargo	Cass	$222	$223	0%
NE	Omaha	Douglas	$222	$216	-3%
NH	Manchester	Hillsborough	$237	$202	-15%
NJ	Newark	Essex	$264	$259	-2%
NM	Albuquerque	Bernalillo	$159	$142	-11%
OH	Cincinnati	Hamilton	$196	$194	-1%
OH	Cleveland	Cuyahoga	$204	$202	-1%
OH	Columbus	Franklin	$207	$219	6%

State	City	County	Second-Lowest Cost Silver Monthly Premium for a 27-year-old		
			2014	2015	% Change
OH	Dayton	Montgomery	$212	$219	3%
OK	Oklahoma City	Oklahoma	$165	$179	8%
OK	Tulsa	Tulsa	$183	$183	0%
PA	Philadelphia	Philadelphia	$246	$219	-11%
PA	Pittsburgh	Allegheny	$139	$141	1%
SC	Columbia	Richland	$220	$226	3%
SD	Sioux Falls	Lincoln	$217	$210	-3%
SD	Sioux Falls	Minnehaha	$217	$210	-3%
TN	Memphis	Shelby	$159	$158	-1%
TN	Nashville	Davidson	$154	$166	8%
TX	Austin	Travis	$205	$197	-4%
TX	Dallas	Dallas	$223	$230	3%
TX	Houston	Harris	$201	$205	2%
TX	McAllen	Hidalgo	$155	$165	6%
TX	San Antonio	Bexar	$196	$191	-3%
TX	San Antonio	Comal	$202	$195	-3%
TX	San Antonio	Medina	$202	$217	7%
UT	Salt Lake	Salt Lake	$197	$202	3%
VA	Richmond	Henrico	$208	$213	2%
WI	Milwaukee	Milwaukee	$258	$273	6%
WV	Huntington	Cabell	$220	$237	8%
WV	Huntington	Wayne	$220	$237	8%
WY	Cheyenne	Laramie	$324	$334	3%

Note: The premiums in this table represent premiums before the application of tax credits. The number of QHPs in the county excludes catastrophic plans. Plan and premium information is from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states.

TABLE 12
Number of Marketplace Plans in County, 2014 and 2015 in Selected Cities

State	City	County	Number of Plans		Net Change in Number of Marketplace Plans 2014-2015
			2014	2015	
AK	Anchorage	Anchorage	34	28	-6
AK	Juneau	Juneau	34	28	-6
AL	Birmingham	Jefferson	10	21	11
AR	Little Rock	Pulaski	38	34	-4
AZ	Phoenix	Maricopa	111	127	16
AZ	Tucson	Pima	110	103	-7
DE	Wilmington	New Castle	19	24	5
FL	Ft. Lauderdale	Broward	132	94	-38
FL	Jacksonville	Duval	86	44	-42
FL	Miami	Miami-Dade	137	90	-47
FL	Orlando	Orange	98	53	-45
FL	Tampa	Hillsborough	102	53	-49
FL	West Palm Beach	Palm Beach	132	94	-38
GA	Atlanta	Fulton	58	89	31
IA	Cedar Rapids	Linn	30	29	-1
IL	Chicago	Cook	65	143	78
IN	Indianapolis	Marion	18	68	50
KS	Kansas City	Wyandotte	16	24	8
KS	Wichita	Sedgwick	36	32	-4
LA	New Orleans	Orleans	44	55	11
ME	Portland	Cumberland	17	25	8
MI	Detroit	Wayne	52	126	74
MO	St. Louis	Saint Louis	22	41	19
MS	Jackson	Jackson	18	24	6
MT	Bozeman	Gallatin	26	40	14
NC	Charlotte	Mecklenburg	28	44	16
NC	Greensboro	Guilford	17	26	9
NC	Raleigh-Durham	Wake	28	39	11
ND	Fargo	Cass	24	30	6
NE	Omaha	Douglas	43	44	1
NH	Manchester	Hillsborough	10	39	29
NJ	Newark	Essex	26	47	21
NM	Albuquerque	Bernalillo	42	51	9
OH	Cincinnati	Hamilton	63	102	39
OH	Cleveland	Cuyahoga	42	102	60
OH	Columbus	Franklin	26	57	31
OH	Dayton	Montgomery	36	92	56
OK	Oklahoma City	Oklahoma	61	50	-11

State	City	County	Number of Plans		Net Change in Number of Marketplace Plans 2014-2015
			2014	2015	
OK	Tulsa	Tulsa	55	50	-5
PA	Philadelphia	Philadelphia	24	40	16
PA	Pittsburgh	Allegheny	35	58	23
SC	Columbia	Richland	28	62	34
SD	Sioux Falls	Lincoln	32	39	7
SD	Sioux Falls	Minnehaha	32	39	7
TN	Memphis	Shelby	72	106	34
TN	Nashville	Davidson	72	106	34
TX	Austin	Travis	76	111	35
TX	Dallas	Dallas	36	64	28
TX	Houston	Harris	39	71	32
TX	McAllen	Hidalgo	24	79	55
TX	San Antonio	Bexar	58	95	37
TX	San Antonio	Comal	53	80	27
TX	San Antonio	Medina	23	33	10
UT	Salt Lake	Salt Lake	85	98	13
VA	Richmond	Henrico	43	23	-20
WI	Milwaukee	Milwaukee	84	109	25
WV	Huntington	Cabell	12	14	2
WV	Huntington	Wayne	12	14	2
WY	Cheyenne	Laramie	16	40	24

Note: The number of QHPs in the county excludes catastrophic plans. Plan information is from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states.

TABLE 13
Number of Marketplace Issuers in County, 2014 and 2015 in Selected Cities

State	City	County	Number of Issuers		Net Change in Number of Marketplace Issuers, 2014-2015
			2014	2015	
AK	Anchorage	Anchorage	2	2	0
AK	Juneau	Juneau	2	2	0
AL	Birmingham	Jefferson	2	3	1
AR	Little Rock	Pulaski	3	4	1
AZ	Phoenix	Maricopa	10	13	3
AZ	Tucson	Pima	10	12	2
DE	Wilmington	New Castle	3	3	0
FL	Ft. Lauderdale	Broward	8	9	1
FL	Jacksonville	Duval	4	5	1
FL	Miami	Miami-Dade	9	9	0
FL	Orlando	Orange	5	6	1
FL	Tampa	Hillsborough	6	6	0
FL	West Palm Beach	Palm Beach	8	9	1
GA	Atlanta	Fulton	4	8	4
IA	Cedar Rapids	Linn	2	2	0
IL	Chicago	Cook	6	8	2
IN	Indianapolis	Marion	2	6	4
KS	Kansas City	Wyandotte	2	2	0
KS	Wichita	Sedgwick	3	4	1
LA	New Orleans	Orleans	4	5	1
ME	Portland	Cumberland	2	3	1
MI	Detroit	Wayne	11	14	3
MO	St. Louis	Saint Louis	2	4	2
MS	Jackson	Jackson	1	1	0
MT	Bozeman	Gallatin	3	4	1
NC	Charlotte	Mecklenburg	2	3	1
NC	Greensboro	Guilford	2	3	1
NC	Raleigh-Durham	Wake	2	3	1
ND	Fargo	Cass	3	3	0
NE	Omaha	Douglas	4	4	0
NH	Manchester	Hillsborough	1	5	4
NJ	Newark	Essex	4	6	2
NM	Albuquerque	Bernalillo	4	5	1
OH	Cincinnati	Hamilton	7	11	4
OH	Cleveland	Cuyahoga	7	11	4
OH	Columbus	Franklin	4	8	4
OH	Dayton	Montgomery	6	10	4
OK	Oklahoma City	Oklahoma	5	4	-1

State	City	County	Number of Issuers		Net Change in Number of Marketplace Issuers, 2014-2015
			2014	2015	
OK	Tulsa	Tulsa	5	4	-1
PA	Philadelphia	Philadelphia	4	6	2
PA	Pittsburgh	Allegheny	5	6	1
SC	Columbia	Richland	4	5	1
SD	Sioux Falls	Lincoln	3	3	0
SD	Sioux Falls	Minnehaha	3	3	0
TN	Memphis	Shelby	4	5	1
TN	Nashville	Davidson	4	5	1
TX	Austin	Travis	7	9	2
TX	Dallas	Dallas	4	7	3
TX	Houston	Harris	6	8	2
TX	McAllen	Hidalgo	3	7	4
TX	San Antonio	Bexar	5	9	4
TX	San Antonio	Comal	4	6	2
TX	San Antonio	Medina	2	3	1
UT	Salt Lake	Salt Lake	6	6	0
VA	Richmond	Henrico	4	3	-1
WI	Milwaukee	Milwaukee	4	6	2
WV	Huntington	Cabell	1	1	0
WV	Huntington	Wayne	1	1	0
WY	Cheyenne	Laramie	2	2	0

Note: Plan information is from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states. Qualified health plan issuers are counted based on unique HIOS issuer ID number.

TABLE 14
It Pays to Shop: Percent of Current Marketplace Enrollees Who Could Obtain Coverage for $100 or Less after Any Applicable Tax Credits in 2015, Regardless of Metal Level Chosen in 2014

State	Monthly Premium After Tax Credits		
	$100 or less	$50 or less	$50 to $100
35 State Total	79%	66%	12%
AK	82%	75%	7%
AL	78%	68%	11%
AR	77%	62%	16%
AZ	72%	49%	22%
DE	69%	52%	16%
FL	85%	76%	9%
GA	81%	71%	10%
IA	74%	57%	17%
IL	67%	49%	18%
IN	78%	67%	12%
KS	73%	56%	17%
LA	84%	76%	8%
ME	77%	63%	14%
MI	81%	67%	14%
MO	80%	69%	11%
MS	89%	82%	8%
MT	65%	48%	17%
NC	85%	76%	9%
ND	70%	51%	19%
NE	78%	61%	17%
NH	67%	51%	16%
NJ	61%	43%	18%
NM	70%	49%	20%
OH	75%	58%	17%
OK	78%	67%	12%
PA	69%	56%	13%
SC	83%	74%	10%
SD	74%	56%	18%
TN	76%	64%	13%
TX	80%	68%	12%
UT	82%	60%	22%
VA	80%	69%	11%
WI	78%	65%	13%
WV	69%	54%	15%
WY	76%	59%	17%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections by in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds all enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees who could be linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the “Methods and Limitations” section for more details.

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WEB FIRST

By Fredric Blavin, Adele Shartzer, Sharon K. Long, and John Holahan

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An Early Look At Changes In Employer-Sponsored Insurance Under The Affordable Care Act

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ABSTRACT Critics frequently characterize the Affordable Care Act (ACA) as a threat to the survival of employer-sponsored insurance. The Medicaid expansion and Marketplace subsidies could adversely affect employers' incentives to offer health insurance and workers' incentives to take up such offers. This article takes advantage of timely data from the Health Reform Monitoring Survey for June 2013 through September 2014 to examine, from the perspective of workers, early changes in offer, take-up, and coverage rates for employer-sponsored insurance under the ACA. We found no evidence that any of these rates have declined under the ACA. They have, in fact, remained constant: around 82 percent, 86 percent, and 71 percent, respectively, for all workers and around 63 percent, 71 percent, and 45 percent, respectively, for low-income workers. To date, the ACA has had no effect on employer coverage. Economic incentives for workers to obtain coverage from employers remain strong.

There have been strong assertions by some that the subsidies provided to adults to purchase coverage in the individual Marketplaces under the Affordable Care Act (ACA) will lead to widespread dropping of employer-sponsored insurance, particularly among firms with many low-wage workers.[1] Under such a scenario, employers would drop coverage if the total value of subsidies available to their workers in the Marketplaces exceeded the value of the tax subsidy for providing employer-sponsored insurance and the penalty they would pay for not offering coverage under the ACA. The consequences of such dropping, if it were to occur widely, would be quite serious. Along with the loss of employer-sponsored insurance benefits to workers, government subsidy costs could skyrocket, potentially making the law financially unsustainable.

There has been little information about changes in employer-sponsored insurance under the ACA. This article takes advantage of timely data from the Health Reform Monitoring Survey (HRMS) for June 2013 through September 2014 to examine early changes in offer, take-up, and coverage rates of employer-sponsored insurance under the ACA.

We begin by summarizing the provisions of the ACA that can potentially affect employer-sponsored insurance. We then review a number of studies that have addressed the potential for changes in this type of insurance under the ACA, including both studies that project widespread dropping of employer coverage and those that expect little change.

Next, we describe the data and methods used in our study to estimate the size of the early employer and employee responses under the ACA, followed by our findings and conclusions. The key result from this analysis is that there were no significant changes in offer, take-up, and coverage rates of employer-sponsored insurance between mid-2013 and late 2014, which captures the first nine months under the new health insurance Marketplaces.

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ACA Provisions That Affect Employers

Before the ACA, the preferential tax treatment of employer-sponsored insurance provided a strong economic incentive for employers to offer coverage, particularly for those with workers who had higher incomes. Employers' contributions to employer-sponsored insurance are not taxed as income for workers. As a result, one dollar in these benefits is more valuable than a dollar of wages for workers with a tax liability. In addition, the value of the benefit increases with the taxpayer's marginal tax rate and the premium paid for the coverage.

The ACA has the potential to affect employers' economic incentives to offer health insurance to their workers. All else being equal, easier availability of coverage outside of employment relationships, particularly when subsidized, would reduce firms' incentives to offer health insurance to their employees. Thus, the establishment of individual insurance Marketplaces under the ACA and the availability of federal subsidies on a sliding scale for people with family incomes of 100–400 percent of the federal poverty level could reduce the incentive for firms to offer coverage—particularly for firms with a large share of low-wage workers who are eligible for more generous subsidies.

Similarly, the Medicaid expansion could reduce workers' take-up of employer-sponsored insurance. It could also reduce the total health care costs of firms that offered affordable coverage because workers could enroll in Medicaid without a penalty to their employers.

To counteract the incentives created by these new coverage options for workers, there are several factors that encourage employers to continue (or begin) to offer health insurance. First, the preferential tax treatment of employer-sponsored insurance remains intact under the ACA and will continue to provide a strong economic incentive for employers to offer coverage.

Second, the ACA establishes new requirements for some employers to contribute to the cost of their employees' health insurance. Employers with more than fifty full-time-equivalent employees (FTEs) will face penalties if they do not offer adequate and affordable coverage to their workers and at least one of their full-time employees receives a subsidy for the purchase of coverage in a Marketplace.

These penalties were originally slated to begin in 2014, but their implementation has been delayed. Collectively they are often referred to as the employer mandate or the employer responsibility requirement. They are intended to encourage employers to provide affordable coverage, thereby limiting the cost of federal subsidies to assist people in purchasing insurance coverage independently.

Third, other elements of the ACA are specifically designed to encourage small firms to offer coverage. In 2010 employers with twenty-five or fewer FTEs with an average pay of $50,000 became eligible for tax credits to assist them in purchasing health insurance. Additionally, firms with fifty or fewer FTEs benefit from the introduction of the Small Business Health Options Program (SHOP) Marketplaces. Starting in October 2013, all firms with fifty or fewer employees (and, beginning in 2016, those with a hundred or fewer) have been able to purchase coverage in the SHOP Marketplaces via a paper application.[2] As of November 2014, small firms could begin to purchase SHOP coverage online.[3]

Finally, the individual mandate will tend to boost workers' demand for employer-sponsored insurance. This is particularly likely in the case of higher-wage workers, whose preferences for the employer-sponsored insurance tax exclusion and whose ability to avoid penalties may carry more weight compared to lower-wage workers in an employer's decision to offer insurance.

In summary, the potential impact of the ACA on employers' offers of coverage and on workers' take-up of those offers is difficult to predict a priori, given the competing incentives under the many components of the legislation. As illustrated by mathematical examples of how different types of firms will fare in offering employer-sponsored insurance under the ACA's provisions,[4] the decision to offer coverage or not will depend on complicated assessments of the benefit to and costs for the firm, and the decision to accept that offer will depend on complicated assessments of benefits and costs by workers.

Expectations Based On Early Research

Leading up to the ACA, national rates of coverage through employer-sponsored insurance had decreased nearly every year since 2000, with the largest declines seen during the 2001 and 2007–09 recessions. This was evident among various subpopulations, including parents, childless adults, and children; income groups; regions; and firm sizes.[5,6] The decline in employer-sponsored insurance was even more pronounced among small-firm and low-income workers, relative to large-firm and high-income workers.

For example, the share of full-time workers and their dependents with employer-based coverage in firms with fewer than ten workers fell from 43 percent in 2000 to 33 percent in 2010. Coverage for their counterparts working in firms with 1,000 or more employees fell from 87 per-

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cent to 82 percent over the same period. Additionally, higher-income people in small firms and lower-income people in large firms experienced relatively large declines in employer-sponsored insurance, while higher-income people in larger firms experienced relatively small declines.[7]

As discussed above, critics frequently characterize the ACA as threatening the survival of employer-sponsored insurance by altering the choices and responsibilities of employers and their workers. For instance, the availability of subsidies to lower-income workers in the Marketplaces could adversely affect employers' incentives to offer health insurance, thereby reducing rates of employer-sponsored insurance.

Focusing more specifically on the changes likely to occur under the ACA, a study by the American Action Forum predicted that workers with incomes of up to 200 percent of poverty might be better off with subsidized individual coverage in the Marketplaces than with employer-sponsored insurance.[1] It assumed that a worker with this income worked at a firm consisting only of workers with the same income—all of whom would benefit equally if the employer dropped coverage, paid the penalty, and shared the savings with employees. Based on these assumptions, the study predicted that thirty-five million workers would lose or drop employer coverage and shift to the Marketplaces, increasing premium subsidy costs by $1.4 trillion over ten years.[1,8–10]

In other work, a 2011 McKinsey survey of 1,300 employers found that 30 percent of respondents said that their company would definitely (9 percent) or very likely (21 percent) drop coverage after 2014, with little variability in responses by firm size.[11,12] However, a recent survey of about 2,500 employers by Mercer found that only 4 percent of large employers and 16 percent of small employers planned to drop coverage in the next five years—lower than estimates from previous years.[13] Similarly, a survey of 3,330 plan sponsors by the Employee Benefit Research Institute and the Society for Human Resource Management reported that just 1 percent of employers planned to eliminate coverage in 2015.[14]

A study by Jean Abraham, Roger Feldman, and Peter Graven that builds on their 2012 work[4] finds that most employers will still have a strong economic incentive to offer coverage to their workers under the ACA.[15] The authors focus on three major policies that drive whether or not firms realize a net financial benefit from offering employer-sponsored insurance. These policies are the tax exemptions for premiums for this insurance, which remain in place under the ACA; the penalties on larger employers that do not offer affordable coverage; and the premium tax credits for individual coverage in the Marketplaces for people with lower incomes.

Abraham and coauthors estimate that employers of the vast majority of workers now offered employer-sponsored insurance will continue to have an economic incentive to offer coverage under the ACA. The largest firms will continue to have a strong incentive to do so because the large benefit of the employer coverage tax exclusion and penalties avoided by offering coverage greatly outweigh the value of the premium subsidies that workers would receive if their employers did not offer coverage. Firms with fewer than fifty workers will face significantly lower economic incentives to offer coverage because they employ a larger share of low-income workers and are not subject to the employer mandate. However, Abraham and coauthors estimate that most small firms that already offer coverage are likely to continue to do so.[15]

Results from microsimulation models also suggest that the overall effects of the ACA on employer-sponsored insurance will be modest. In its most recent estimates, the Congressional Budget Office (CBO) predicts a decline in overall employer-sponsored insurance of six million people by 2016.[16] This represents a modest reduction of 3.7 percent, relative to the CBO's forecast that 161 million people would have employer-sponsored insurance in 2016 without the law.

At the other extreme, RAND estimates that the ACA would lead to a net increase of 8.0 million people with employer-sponsored insurance, relative to a no-reform scenario.[17] Other models—for example, that of the Lewin Group[18] and the Urban Institute's Health Insurance Policy Simulation model[19,20]—predict changes in overall employer-sponsored insurance within the range of the CBO and RAND estimates.

Finally, the Massachusetts experience also suggests that the combination of individual and employer mandates can increase the rate of employer-sponsored insurance, even when subsidized alternatives to the insurance are introduced. From fall 2006 to fall 2009—a period covering both the implementation of the state's health reforms and a rise in the state's unemployment rate—the rate of employer-sponsored insurance in Massachusetts increased about 3 percentage points.[21] A spring 2008 survey of 1,003 randomly selected Massachusetts firms found that the percentage of firms offering health benefits had increased from 73 percent in 2007 to 79 percent in 2008.[22]

We used data from the HRMS to provide real-time insights into the ACA's early effects on employer-sponsored insurance from the perspective of workers. We examined whether the likelihood of workers receiving an offer of

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employer-sponsored insurance and that of workers taking up such offers changed between 2013 and 2014. We explored these outcomes among key subpopulations of workers, including by firm size (fewer than fifty workers versus fifty workers or more) and by family income (below 250 percent of poverty versus 250 percent or more of poverty).

Study Data And Methods

We used the HRMS data to examine changes in offer, take-up, and coverage rates of employer-sponsored insurance in early September 2014 relative to June 2013, which was before the implementation of the ACA's major coverage expansions. The HRMS, a quarterly survey of the nonelderly population, provides real-time estimates on ACA implementation and outcomes to complement the more robust assessments that will be possible when federal household surveys (such as the American Community Survey, Current Population Survey, and National Health Interview Survey) release their estimates of changes in health insurance coverage through 2014.[23–25] The HRMS is based on cross-sectional samples of a nationally representative Internet panel of US households—GfK's KnowledgePanel[26]—and began in January 2013 to provide a basis of comparison for the postimplementation period.

Studies assessing KnowledgePanel for its reliability as a survey have found little evidence of nonresponse bias in the panel on core demographic and socioeconomic variables.[27] Similarly, studies comparing KnowledgePanel and traditional random-digit-dialing telephone surveys have yielded comparable estimates for a range of measures related to demographic and socioeconomic characteristics, health status and behaviors, and other characteristics.[28,29]

Of particular relevance to this analysis, findings from the HRMS from early 2014[30] are consistent with the recent early-release data from the National Health Interview Survey[31] as well as ongoing Gallup survey data. The overall sample size for the HRMS is roughly 7,500 nonelderly adults per quarter. The HRMS is described in more detail in the online Appendix.[25]

DEFINITIONS In this analysis we defined *workers* as nonelderly adults (ages 18–64) who reported working for pay or who were self-employed. The HRMS asks adults who report working for pay whether their employer has fewer than fifty workers or fifty or more workers, counting employees at all locations where the employer operates. We excluded from the analysis workers who did not report work status or firm size ($n = 204$).

Following the phrasing in the HRMS, we defined workers as having employer-sponsored insurance if they reported coverage through their own or a family member's current or former employer, including coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. It also includes TRICARE, military, or Veterans Affairs coverage, as well as write-in responses that listed a valid private group plan. The HRMS asks adults who do not report having employer-sponsored insurance whether their employer or a family member's employer offers health insurance that could cover them. Adults who report having employer-sponsored insurance are presumed to have an offer through their own or a family member's employer.

The employer-sponsored insurance take-up rate was defined as the share of workers who reported such insurance among all workers who had an offer of coverage. For both coverage with and offers of employer-sponsored insurance, the source within the family—self or another worker—is unobservable in the HRMS.

LIMITATIONS This study had several limitations. Each round of the HRMS is weighted to be nationally representative. However, it is important in examining changes over time that we based our estimates on comparable samples. For example, if the share of people with employer-sponsored insurance grew simply because more respondents were older or from higher-income groups in one round of the survey, it would be incorrect to associate such a change with the ACA coverage provisions.

This is a particular challenge in comparing estimates from survey samples over time because the composition of the sample that is surveyed can change from one round to another in ways that are not fully captured in the weights and that may distort the estimates of change. Therefore, we report regression-adjusted trends that correct for the effects of observed shifts in the characteristics of the survey respondents across quarters.[32,33] More details on the regression adjustment methods are available in the Appendix.[25]

Study Results

Exhibits 1–3 present our results for offer, take-up, and coverage rates of employer-sponsored insurance, respectively. As mentioned above, offer rates have been declining for several years, particularly for small firms. Absent the ACA, we might expect the decline to continue. However, the improving economy and tightening labor markets could result in some increase in offer rates. With the ACA, some employers have incentives to continue offering coverage (for example,

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EXHIBIT 1

Nonelderly Workers With An Offer Of Employer-Sponsored Insurance (ESI), By Firm Size And Family Income, June 2013 And September 2014

				Workers with family income of:					
	All workers			<250% of poverty			≥250% of poverty		
Workers	June 2013	Sept. 2014	*p* value[a]	June 2013	Sept. 2014	*p* value[a]	June 2013	Sept. 2014	*p* value[a]
ALL									
With offer of ESI	82.7%	82.2%	0.643	63.3%	62.7%	0.794	93.7%	93.0%	0.439
Sample size	5,025	5,137	—[b]	1,622	1,657	—[b]	3,403	3,480	—[b]
AT SMALL FIRMS OR SELF-EMPLOYED									
With offer of ESI	61.5%	61.4%	0.968	43.7%	43.9%	0.932	80.1%	79.0%	0.593
Sample size	1,730	1,738	—[b]	792	802	—[b]	938	936	—[b]
AT LARGE FIRMS									
With offer of ESI	94.2%	93.4%	0.241	83.1%	81.4%	0.431	98.6%	98.2%	0.382
Sample size	3,275	3,399	—[b]	819	855	—[b]	2,456	2,544	—[b]

SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. "Workers" are nonelderly adults working for pay and self-employed adults. Adults who refused to report work status and those who reported working for pay but refused to report firm size were excluded. Respondents were coded as having an ESI offer if their own or a family member's employer offered health insurance or if they reported having ESI. Small firms are those with fewer than fifty workers; large firms are those with fifty workers or more. [a]*p* values refer to significance tests between June 2013 and September 2014 estimates. [b]Not applicable.

many workers are newly required to have coverage or pay a tax penalty because of the individual mandate, and tax benefits are unchanged), whereas others (such as employers with a large share of low-income workers eligible for subsidies in the Marketplaces) might have an incentive to stop offering coverage.

We found essentially no change in offer rates throughout the study period (Exhibit 1). Overall, the rates stayed steady, at around 82 percent.[34] Offer rates in small firms also held steady, at around 61 percent, and rates in large firms remained in the 93–94 percent range. For workers with incomes below 250 percent of poverty, about 63 percent were offered coverage; the figure was about 93 percent for those with higher incomes. These percentages were statistically unchanged between the two periods. Even for low-income individuals working in small firms—people for whom their employers' incentives to offer insurance are most likely to decline—offer rates remained relatively constant, at close to 44 percent. Thus, there has not been the decline in offers of employer-sponsored insurance that many have feared.

The individual mandate should encourage more workers, assuming they have an offer of affordable insurance, to take up their employer's offer of coverage, whereas the Medicaid expansion could have the opposite effect for low-

EXHIBIT 2

Nonelderly Workers Who Accepted An Offer Of Employer-Sponsored Insurance (ESI), By Firm Size And Family Income, June 2013 And September 2014

				Workers with family income of:					
	All workers			<250% of poverty			≥250% of poverty		
Workers	June 2013	Sept. 2014	*p* value[a]	June 2013	Sept. 2014	*p* value[a]	June 2013	Sept. 2014	*p* value[a]
ALL									
Accepted ESI	86.1%	86.9%	0.35	70.5%	72.8%	0.25	92.0%	92.3%	0.73
Sample size	4,219	4,281	—[b]	1,042	1,047	—[b]	3,177	3,234	—[b]
AT SMALL FIRMS OR SELF-EMPLOYED									
Accepted ESI	80.7%	83.0%	0.27	70.0%	73.6%	0.12	86.9%	88.0%	0.71
Sample size	1,096	1,082	—[b]	349	348	—[b]	747	734	—[b]
AT LARGE FIRMS									
Accepted ESI	88.0%	88.3%	0.71	71.2%	72.2%	0.70	93.6%	93.6%	0.99
Sample size	3,108	3,199	—[b]	687	699	—[b]	2,421	2,500	—[b]

SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. "Workers" are nonelderly adults working for pay and self-employed adults. Adults who refused to report work status and those who reported working for pay but refused to report firm size were excluded. Respondents were coded as having an ESI offer if their own or a family member's employer offered health insurance or if they reported having ESI. Small firms are those with fewer than fifty workers; large firms are those with fifty workers or more. [a]*p* values refer to significance tests between June 2013 and September 2014 estimates. [b]Not applicable.

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EXHIBIT 3

Nonelderly Workers With Employer-Sponsored Insurance (ESI), By Firm Size And Family Income, June 2013 And September 2014

				Workers with family income of:					
	All workers			<250% of poverty			≥250% of poverty		
Workers	June 2013	Sept. 2014	*p* value[a]	June 2013	Sept. 2014	*p* value[a]	June 2013	Sept. 2014	*p* value[a]
ALL									
With ESI	71.2%	71.4%	0.82	44.6%	45.7%	0.60	86.3%	85.8%	0.64
Sample size	5,025	5,137	—[b]	1,622	1,657	—[b]	3,403	3,480	—[b]
AT SMALL FIRMS OR SELF-EMPLOYED									
With ESI	49.7%	51.0%	0.49	30.8%	32.6%	0.42	69.6%	69.5%	0.97
Sample size	1,730	1,738	—[b]	792	802	—[b]	938	936	—[b]
AT LARGE FIRMS									
With ESI	82.9%	82.4%	0.59	59.2%	58.6%	0.82	92.3%	91.9%	0.63
Sample size	3,275	3,399	—[b]	819	855	—[b]	2,456	2,544	—[b]

SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. "Workers" are nonelderly adults working for pay and self-employed adults. Adults who refused to report work status and those who reported working for pay but refused to report firm size were excluded. Respondents were coded as having ESI if they reported having coverage through their own or a family member's current or former employer or union; had Veterans Affairs, military, or TRICARE coverage; or reported having ESI or a private group plan. Small firms are those with fewer than fifty workers; large firms are those with fifty workers or more. [a]*p* values refer to significance tests between June 2013 and September 2014 estimates. [b]Not applicable.

income workers. We found no change in take-up rates overall, or by income or firm size, between June 2013 and September 2014 (Exhibit 2). Although not significant at conventional levels, the one change that approached significance was an increase in the take-up rate from 70.0 percent to 73.6 percent ($p = 0.12$) among workers in small firms with family incomes below 250 percent of poverty. Low-income people working in large firms had no significant change in take-up rates.

As with offer and take-up rates of employer-sponsored insurance, there were no significant differences in coverage rates for the insurance overall or for any subgroup (Exhibit 3). The rates stayed roughly constant at about 71 percent across all workers, about 50 percent among workers in small firms, and about 82 percent among workers in large firms. The rates also remained constant among low- and high-income workers in either small or large firms.

Conclusion

This is the first peer-reviewed study to analyze changes in employer-sponsored insurance after the ACA was implemented and coverage could be obtained through the new health insurance Marketplaces.[35] We found no evidence that offer, take-up, or coverage rates of employer-sponsored insurance declined from June 2013 to September 2014, either overall or for workers with lower incomes in small firms. These results fill the information gap before additional 2014 estimates are available from employer surveys (for example, the Employer Health Benefits Survey of the Henry J. Kaiser Family Foundation and Health Research and Educational Trust, and the Medical Expenditure Panel Survey Insurance Component) and larger federal household surveys in mid-to-late 2015.

Thus, the incentives in current law, including the strong tax incentives to obtain coverage from employers because of the tax exemption of employer contributions to insurance and the individual mandate, remain a strong force. The tax incentives mean that most workers are financially better off if they obtain coverage via employment. Since many people are newly required by the ACA to obtain coverage or pay a penalty, the law has increased incentives for employers to maintain their offers of coverage and for people to take up coverage when it is offered.

The combined effects of these incentives are borne out in the data. However, it is arguably still too early to see the full effects of the ACA on employer-sponsored insurance. Employers may have been slow to understand and react to the new incentives in the first year of implementation of the ACA's major coverage expansions because of uncertainty over the health insurance Marketplaces (which discourages firms from offering coverage) and the employer mandate (which encourages large firms to offer coverage). Nonetheless, results from this study, microsimulation predictions,[16–20] and findings from employer responses under reform in Massachusetts[21,22] suggest that workers will continue to obtain health insurance through employers. ■

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NOTES

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3 Some state-based Marketplaces allowed employers to purchase coverage online in 2014. However, for all states with federally facilitated Marketplaces and most state-based Marketplaces, online enrollment in the SHOP Marketplaces was delayed one year from the planned launch date. The online SHOP enrollment website, https://www.healthcare.gov/small-businesses/employers/, is now available for employers to enroll online.

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January 2015 | Issue Brief

Adults who Remained Uninsured at the End of 2014

Rachel Garfield and Katherine Young

Executive Summary

In January 2014, the major coverage provisions of the Affordable Care Act (ACA)—including the expansion of Medicaid eligibility and the availability of subsidized coverage through Health Insurance Marketplaces— went into effect. As the first year of new coverage under the ACA comes to a close and the end of the second open enrollment period nears, there is great interest in understanding why some people continue to lack coverage and in reaching out to the eligible uninsured. This report, based on the 2014 Kaiser Survey of Low-Income Americans and the ACA, profiles the nonelderly adult population that remained uninsured as of Fall 2014. The survey of 10,502 non-elderly adults was fielded between September 2 and December 15, 2014, with the majority of interviews (70%) conducted prior to November 15, 2014 (the start of open enrollment for 2015 Marketplace coverage; Medicaid enrollment is open throughout the year). Additional detail on the survey methods is available in the methods appendix available on line.

While millions have enrolled in coverage under the ACA, many remain uninsured. Though much attention was paid to difficulties with the application and enrollment process during the 2014 open enrollment period, logistical issues in applying for coverage do not appear to be a leading reason why people went without insurance in 2014. Rather, lack of awareness of new coverage options and financial assistance appear to be a major barrier. When asked in their own words, uninsured adults were most likely to name cost as the main reason they don't have coverage, and this pattern held even among those who appear to be currently eligible for low-cost or free coverage under the ACA. In addition, most uninsured adults (63%) say that they did not try to get health insurance from either their state Marketplace, healthcare.gov, or their state Medicaid agency in 2014. Some who did not seek coverage were ineligible for assistance, but the pattern of the majority not seeking coverage holds even among those who are now likely eligible for help. Thus, despite the availability of subsidies for Marketplace coverage and comprehensive Medicaid coverage, misperceptions about cost or lack of awareness are barriers to reaching some eligible uninsured.

Further, gaps in eligibility or confusion about eligibility are evident among uninsured adults. Among those who did try to get ACA coverage, the most common reason people gave for not obtaining that coverage was that they were told they were ineligible (41%). Notably, many people who appear to be eligible for some type of assistance say someone told them they were ineligible. While it is possible that they were ineligible at the time they applied, it is likely that these people received incorrect information or misinterpreted information they were given. For people who may be eligible but were told they were not, more accurate or easily understood information about the availability of coverage is particularly important. In addition, some who were told they were ineligible encountered difficulty with the application process or paperwork.

Lastly, costs—or perceptions of costs— continue to pose a barrier to coverage according to the survey. Nearly three in ten (29%) uninsured adults who applied for ACA coverage said they did not obtain that coverage because they believed it was too expensive. Many who cited cost barriers were ineligible for financial assistance under the ACA and would have faced the full cost of Marketplace coverage. However, more than four in ten who cited cost as a reason for not enrolling in coverage were eligible for financial assistance. Many appear to be eligible for tax subsidies, but they may have still found Marketplace coverage to be unaffordable even with subsidies.

Those who remained uninsured in Fall 2014 still have substantial health needs, as they were more likely than those who took up coverage to rate their health as fair or poor but less likely to have a diagnosed condition or take a prescription on a regular basis. Still, few uninsured indicated plans to seek ACA coverage in 2015. Even among those likely eligible, only about half of uninsured adults indicate that they plan to get health insurance from any source in 2015, and few who do plan to get coverage identified Medicaid or Marketplace coverage as their goal.

The survey results underscore the importance of reaching the eligible uninsured with information about their eligibility for coverage and the availability of affordable coverage, both comprehensive Medicaid coverage and subsidized marketplace coverage. While Marketplace enrollment closes on February 15, 2015 for most people, Medicaid coverage is available throughout the year. Thus, ongoing efforts to let the eligible uninsured know about the availability of Medicaid coverage will remain important.

Introduction

In January 2014, the major coverage provisions of the Affordable Care Act (ACA) went into effect. These provisions include the expansion of Medicaid in states that opted to expand their programs and the creation of Health Insurance Marketplaces where people can purchase coverage on their own. Medicaid coverage is available to most adults in expansion states with incomes at or below 138% of poverty (about $33,000 for a family of four in 2014), and premium tax credits for coverage purchased in the Marketplace are available for most people with incomes up to 400% of poverty (between $23,850 and $95,400 for a family of four in 2014). Together, these provisions have the promise of substantially improving the availability and affordability of insurance coverage in the United States. While many have already enrolled in coverage and renewed their coverage for 2015, open enrollment for 2015 Marketplace coverage continues until February 15, 2015, and Medicaid coverage is available to eligible individuals throughout the year.

To help understand the early impact of the ACA, the Kaiser Family Foundation is conducting a series of comprehensive surveys of the low and moderate income population. The 2013 Kaiser Survey of Low-Income Americans and the ACA, fielded prior to the start of open enrollment for 2014 ACA coverage, provided a baseline snapshot of health insurance coverage, health care use and barriers to care, and financial security among insured and uninsured adults at the starting line of ACA implementation.[1] In Fall 2014, we conducted a second wave of the Kaiser Survey of Low-Income Americans and the ACA to understand how these factors have changed under the first year of the law's main coverage provisions. The survey of 10,502 nonelderly adults was fielded between September 2 and December 15, 2014, with the majority of interviews (70%) conducted prior to November 15, 2014 (the start of open enrollment for 2015 Marketplace coverage; Medicaid enrollment is open throughout the year). Additional detail on the survey methods is available in the methods appendix available on line.

While millions have enrolled in coverage under the ACA, many remain uninsured. Based on the survey findings, approximately 11 million nonelderly adults were newly insured, meaning they reported that they obtained health coverage in 2014 and were uninsured before that coverage started. However, a large share, equaling about 30 million people, reported that they were uninsured as of the date of the interview. Some of these people are ineligible for ACA coverage, either because of their immigration status or because their state did not expand Medicaid. Others may be eligible but either do not know of the new coverage options or have had difficulty navigating the enrollment process. Still others may have opted not to take up coverage for a variety of reasons, such as affordability or personal preferences.

This report, based on the 2014 Kaiser Survey of Low-Income Americans and the ACA, profiles the adult population that remained uninsured as of Fall 2014. It describes the characteristics of this population, examines why they lack insurance coverage and reasons for not enrolling in ACA coverage, and provides information on the coverage options available to the remaining uninsured and their plans for obtaining coverage in 2015. Future reports will provide information about those who gained coverage in 2014 and their experience with the health care system as well as highlight the experiences of the low-income population in California and Missouri.

Understanding Who Remains Uninsured

In many ways, the population that lacked insurance coverage in Fall 2014 resembled the population that has historically lacked coverage as well as the population that gained coverage in 2014. For example, they are similar with respect to age, work status, and income. As in the past, most uninsured adults work but lack access to coverage through a job. While most uninsured adults have lacked coverage for a long time, some have lost coverage since January 2014, an indication that coverage transitions still pose a challenge. Notably, the remaining uninsured population reports poorer health status than the group that gained coverage.

The remaining uninsured are no more likely to be "young invincibles" than those who gained coverage in 2014. Adults who were uninsured late in 2014 were of similar age distribution as adults who gained coverage in 2014. However, both the uninsured and the newly insured populations were younger than the group of adults who were continuously insured. About a fifth of the uninsured (22%) and newly insured (18%) population were young adults, ages 19 through 25, compared to just 12 percent of the continuously insured (Figure 1). Half of the uninsured and about half of the newly insured were under age 35, compared to just 30 percent of the continuously insured. This pattern reflects the fact that those who lacked coverage prior to 2014 were more likely to be young, since younger adults have looser ties to employment and lower incomes.

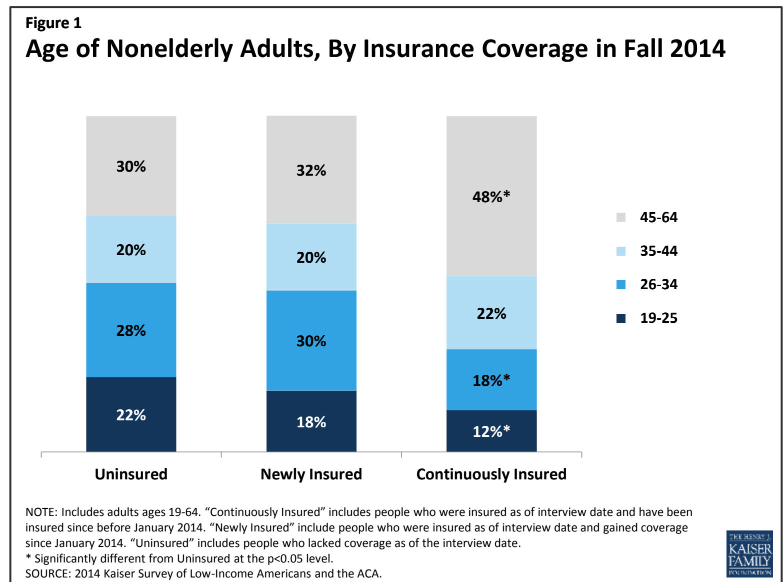


Figure 1
Age of Nonelderly Adults, By Insurance Coverage in Fall 2014

NOTE: Includes adults ages 19-64. "Continuously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date.
* Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

More than half of the remaining uninsured population has family income at or below 138% of poverty, the income range for the Medicaid expansion. More than half of uninsured adults (54%) have family incomes at or below 138% of poverty, or $32,913 for a family of four (Figure 2). Nearly one in four (38%) has family incomes in the range for tax credits (139 to 400% of poverty). This distribution is similar to the newly-insured population. In contrast, the continuously insured population is significantly less likely than either the uninsured or newly insured to be low-income and significantly more likely to be higher income (greater than 400% of poverty). This pattern reflects the longstanding association between having low income and lacking health coverage. Provisions in the ACA aim to make coverage more affordable for low and middle income families.

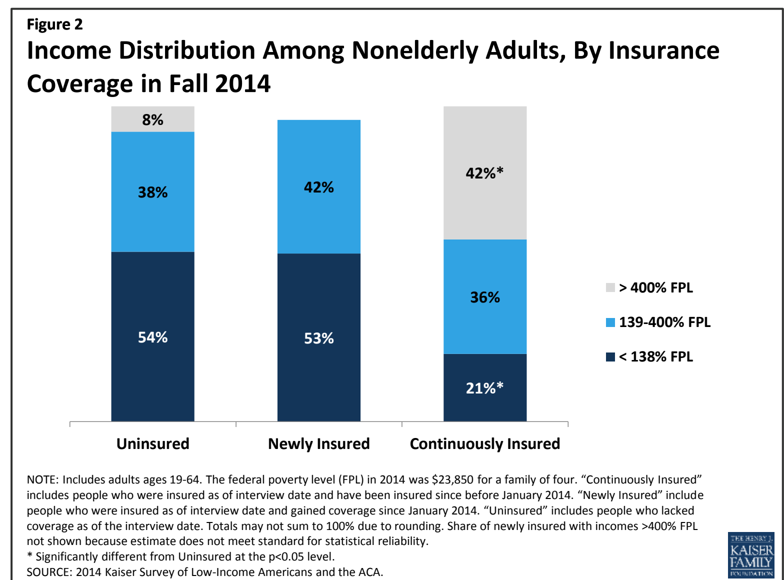
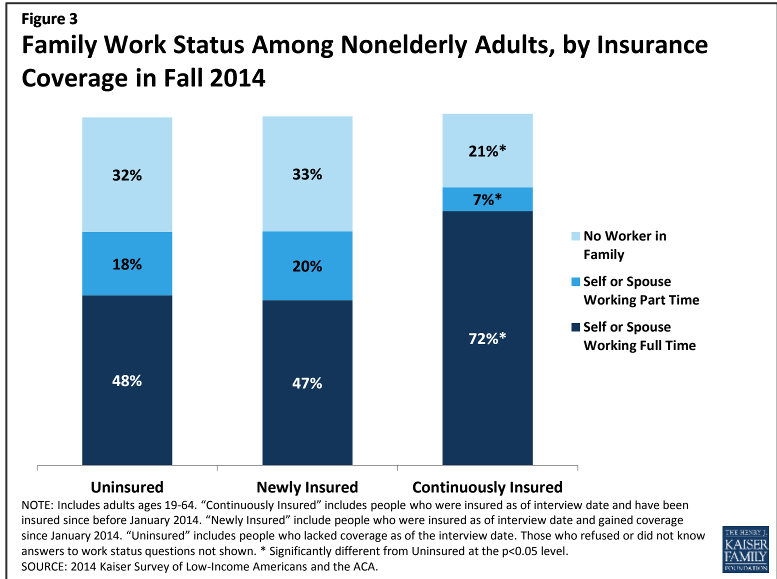


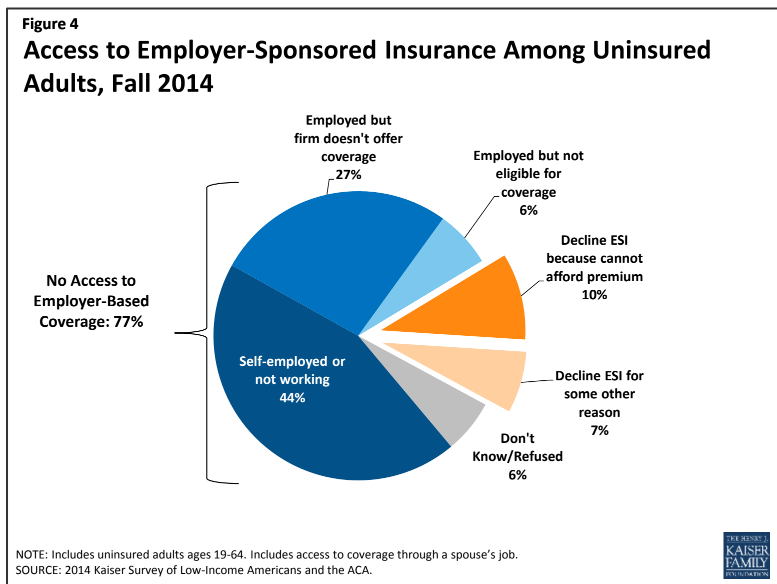
Figure 2
Income Distribution Among Nonelderly Adults, By Insurance Coverage in Fall 2014

NOTE: Includes adults ages 19-64. The federal poverty level (FPL) in 2014 was $23,850 for a family of four. "Continuously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. Totals may not sum to 100% due to rounding. Share of newly insured with incomes >400% FPL not shown because estimate does not meet standard for statistical reliability.
* Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

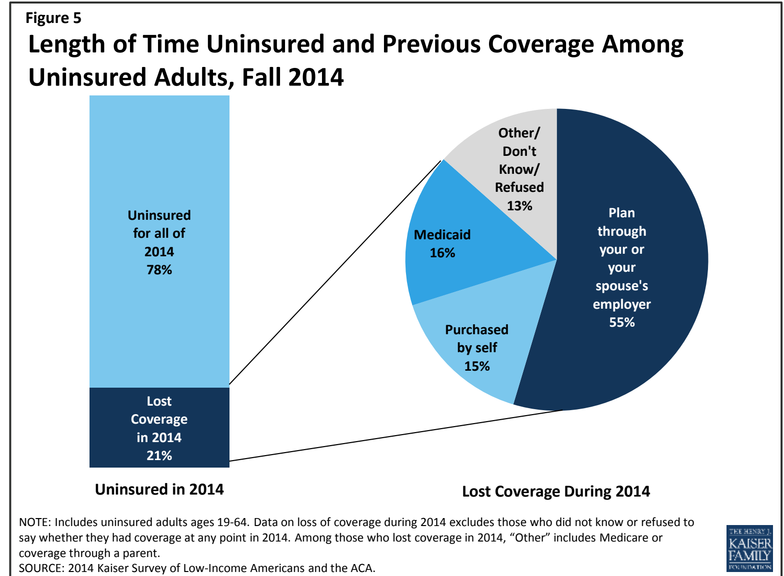
A majority of the remaining uninsured are in a family with at least one worker. Two-thirds of uninsured adults are in a family in which either they or their spouse is working (Figure 3). Nearly half (48%) are in a family with a full-time worker. This distribution is similar to that among the newly-insured population; however, those who have been continuously insured since before 2014 are significantly more likely to be in a family with a full-time or part-time worker. This pattern reflects the historical ties between work and health insurance, since most people who had coverage before the ACA obtained that coverage through a job.



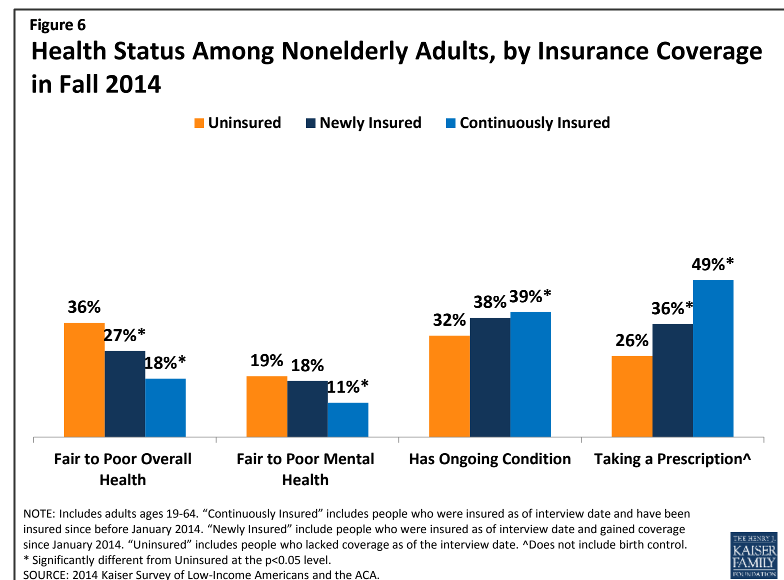
Access to employer-based coverage is limited among uninsured adults. Very few uninsured adults have access to coverage through their or a spouse's job, either because they are self-employed or not in a working family (44%), or because their employer does not offer coverage (27%) or coverage for which they are eligible (6%) (Figure 4). Some uninsured adults do have access to coverage through their or a spouse's job, but most who do report that this coverage in unaffordable to them. Many uninsured adults work for an employer who will not be required to offer coverage under the ACA because they have fewer than 50 workers. With new coverage provisions in place as of 2014, there were more options for health insurance outside employment, particularly for people in states that expanded Medicaid.



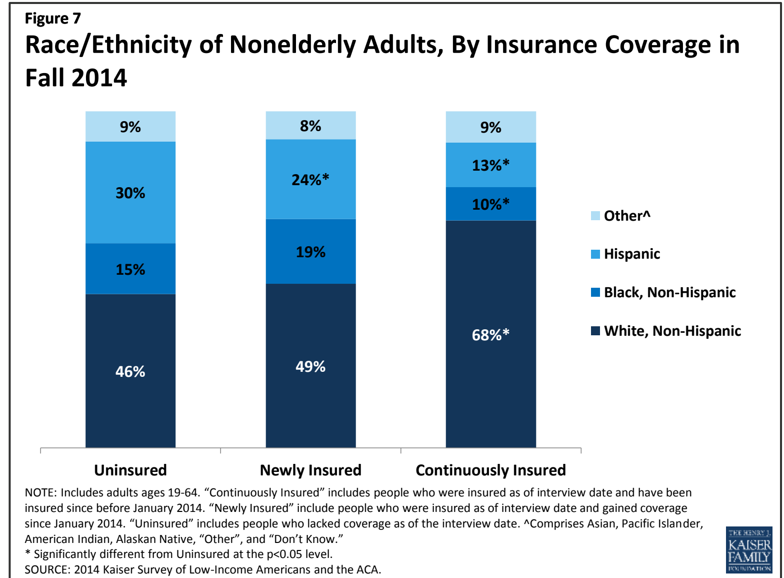
Coverage transitions remain a challenge to continuous coverage. As in the past, lack of coverage remains a long-term issue for most: nearly eight in ten uninsured adults report that they had lacked coverage for all of 2014. However, about one in five actually had coverage at some point in 2014 but lost that coverage (Figure 5). This pattern is similar to that seen in the past: millions of people gain, lose, or change their health coverage throughout the year, and for some, these transitions lead to spells of uninsurance. As in the past, most who lost coverage in 2014 indicated that they lost employer-based coverage. One in six who lost coverage in 2014 reported that they lost Medicaid, and about the same share reported that they lost non-group coverage. As adopted, the ACA envisioned a continuum of coverage with various coverage options available as people's circumstances changed (such as job loss or income change). However, coverage transitions remain a challenge for some.



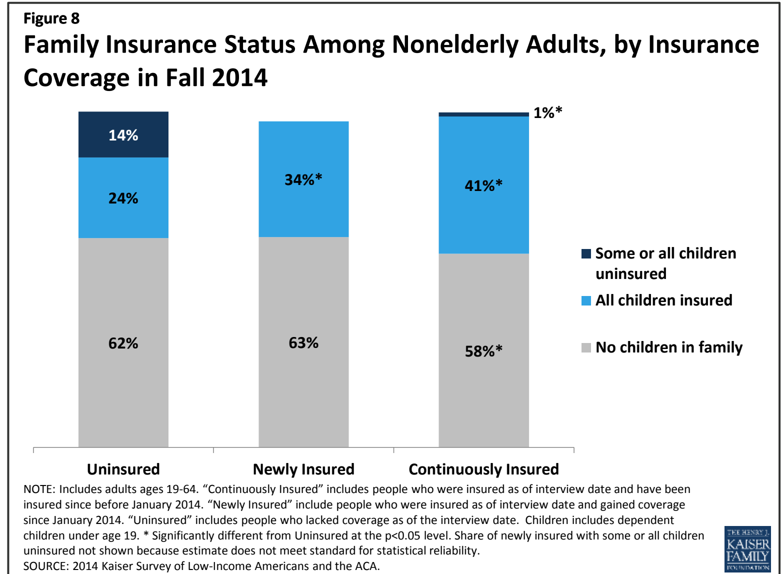
Uninsured adults are more likely than those with coverage to say their health is fair or poor but are less likely to have a diagnosed medical condition. More than a third of uninsured adults (36%) rate their overall health as fair or poor, a higher share than the newly-insured or continuously insured (Figure 6). Nearly a fifth (19%) report their mental health is fair or poor, a share about equal to the newly insured but higher than the continuously insured. These findings refute the idea that those who have coverage are more likely to be in poor health or feel they need medical services. However, those who have coverage *are* more likely than the remaining uninsured to report being under care for a chronic condition. Adults who are continuously insured are more likely than the uninsured to say that they have an ongoing medical condition that requires regular care. Similarly, both the newly insured and continuously insured are more likely than the uninsured to say they take a prescription on a regular basis. These patterns may reflect the fact that uninsured individuals are more likely than insured to have undiagnosed illnesses,[2] and people with insurance coverage are more likely to receive regular and specialty care.[3]



Hispanics are disproportionately represented among the remaining uninsured population. Reflecting historical patterns of the uninsured being more likely to be people of color than the insured, the remaining uninsured and the newly insured are both less likely than the continuously insured to be White, Non-Hispanic (Figure 7). However, the remaining uninsured population is more likely to be Hispanic than either the newly insured or continuously insured population: 30% of the remaining uninsured population is Hispanic, a share significantly higher than among the newly insured or continuously insured. This pattern likely reflects a combination of factors, including language barriers, immigration barriers, and work status.



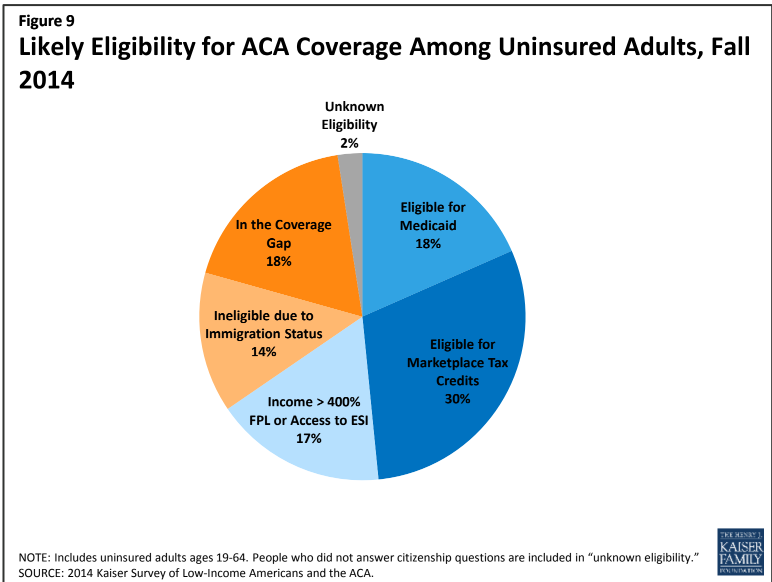
Adults who remain uninsured are more likely than those with coverage to have uninsured children. The majority of uninsured children are eligible for coverage under the ACA: Medicaid and the Children's Health Insurance Program (CHIP) are available to most children in low-income families, and children may be covered along with their parents in Marketplace coverage. Research has found that parent coverage in public programs is associated with higher enrollment of eligible children.[4] Coverage patterns in 2014 support this finding: While uninsured adults are as likely as the newly insured to be parents, they are much more likely to have a child who lacks insurance coverage than the newly insured (Figure 8). Among continuously insured adults, a smaller share are parents, but among those who do have children nearly all have children with insurance coverage.



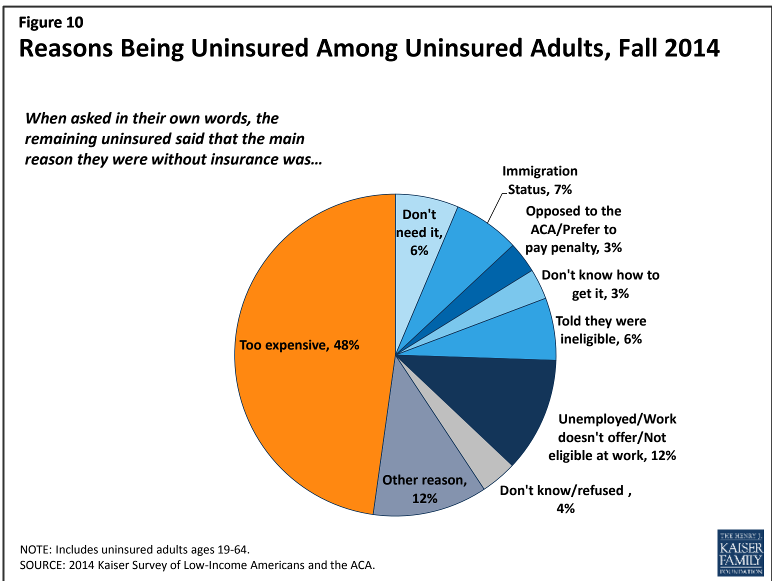
Connecting the Eligible Uninsured to Coverage

Though much attention was paid to the difficulties with the application and enrollment process during the 2014 open enrollment period, logistical issues in applying for coverage do not appear to be a leading reason why people went without insurance in 2014. Rather, lack of awareness of new coverage options and financial assistance appear to be a major barrier. In addition, gaps in eligibility or confusion about eligibility are evident among the remaining uninsured. As of Fall 2014, uninsured adults were largely uncertain about whether they will seek coverage in 2015 or where they will get it, and only a small share of those eligible say they plan to seek ACA coverage.

About half of adults who remained uninsured at the end of 2014 are likely eligible for assistance under the ACA. Based on family income, state of residence, citizenship status, parent status, and access to employer coverage, analysis indicates that 48% of uninsured adults may be eligible for Medicaid coverage (18%) or premium tax credits to purchase Marketplace coverage (30%) (Figure 9). Still, many adults are likely ineligible based on their immigration status (14%) or because they live in a state that has not expanded Medicaid and fall into the "coverage gap" (18%). The remainder either has incomes above the range for premium tax credits (but could still purchase unsubsidized coverage through the Marketplace) or has access to employer-based coverage.



Cost remains a major barrier to coverage. While the ACA aimed to make coverage for affordable, for many—particularly those in non-expansion states—the cost of coverage still poses a problem. The main reason that adults say they lack coverage is cost, with nearly half (48%) of the uninsured saying that they are uninsured because coverage is too expensive (Figure 10). Many also cite limitations on eligibility for coverage, such as immigration status (7%) or being told they are ineligible (6%). A very small share (3%) says they are uninsured because they are either opposed to the ACA or prefer to pay the penalty. Notably, compared to the uninsured before the ACA, uninsured adults in Fall 2014 were less likely to name job-related barriers as a reason for lacking coverage: 12% of uninsured adults named a job-related reason for lacking coverage in 2014, compared to 32% in 2013 (data not shown).



Despite the availability of low-cost or zero premium coverage, a majority of eligible adults still perceive insurance to be too expensive.

When asked why they lacked insurance coverage, more than half of adults who appear to be eligible for assistance volunteered that coverage was too expensive (Figure 11). Under the ACA, most of these individuals are eligible for either free or subsidized (through Medicaid or Marketplace subsidies) coverage. Most who cited cost as a reason for not having coverage did not seek ACA coverage (discussed in more detail below), indicating that the availability of financial assistance to offset the cost of coverage is not getting through to them. A smaller share of people who are not eligible for help under the ACA cited cost as a reason for being uninsured; people in this group were more likely to cite other reasons as the main reason for being uninsured, such as ineligibility due to immigration status.

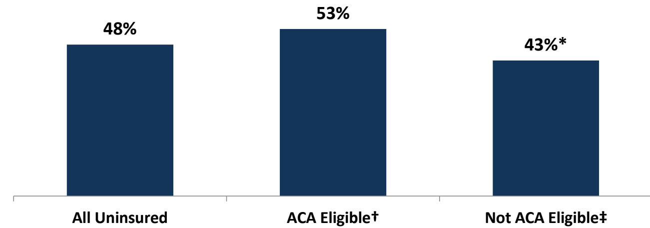
Most adults who were uninsured in Fall 2014 had not tried to get ACA coverage. Nearly two-thirds (63%) of uninsured adults did not try to get coverage from either their state Medicaid program, their state's health care Marketplace or Healthcare.gov (Figure 12). This share does not vary significantly by whether the adult appears to be eligible for financial help through Medicaid or the Marketplace.

Gaps in eligibility or confusion about eligibility are evident among the uninsured who sought ACA coverage. Among those who did try to get ACA coverage, the most common reason people gave for not having ACA coverage was that they were told they were ineligible (41%) (Figure 13). This pattern holds among those who appear eligible for financial help under the ACA and those who do not. Of particular note is that many (37%) people who say they sought ACA coverage in 2014 and appear to be eligible for some type of assistance

Figure 11

Share of Uninsured Adults Citing Cost as the Main Reason for Being Uninsured in Fall 2014, by ACA Eligibility

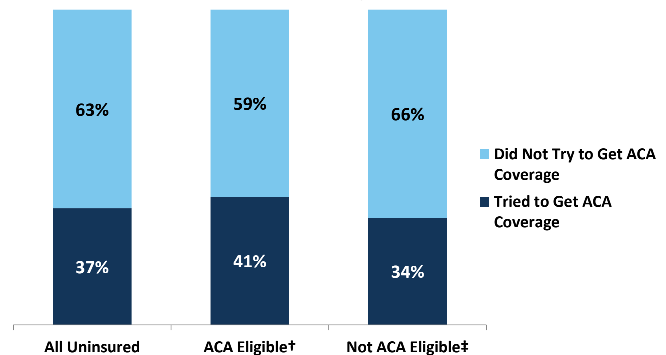
When asked in their own words, share of remaining uninsured who said cost was the main reason they were without insurance:



NOTE: Includes uninsured adults ages 19-64. †Includes those eligible for Medicaid and those eligible for subsidies in the Marketplace. ‡Includes undocumented immigrants, people in the coverage gap, and those with either an offer of ESI or incomes above the level for Marketplace subsidies.
* Significantly different from ACA Eligible at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 12

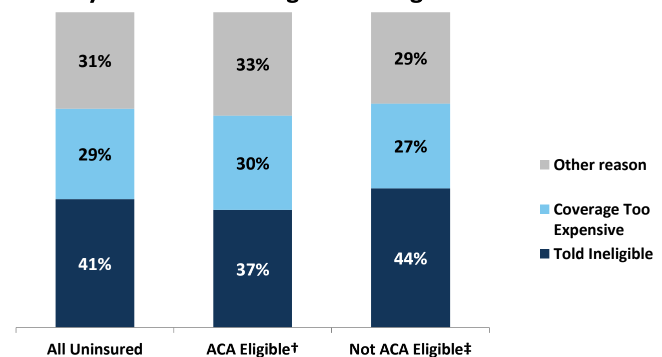
Attempts to Obtain ACA Coverage in 2014 Among Adults Uninsured in Fall 2014, by ACA Eligibility



NOTE: Includes uninsured adults ages 19-64. †Includes those eligible for Medicaid and those eligible for subsidies in the Marketplace. ‡Includes undocumented immigrants, people in the coverage gap, and those with either an offer of ESI or incomes above the level for Marketplace subsidies.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 13

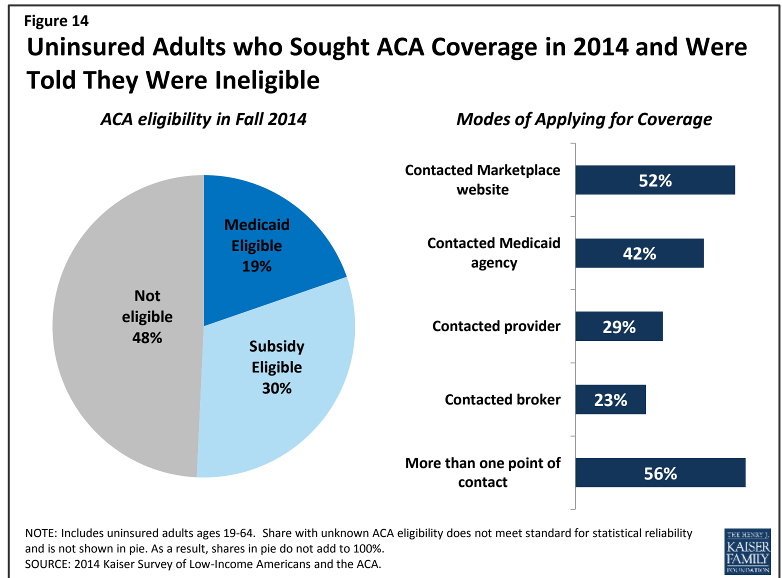
Reason for Not Getting ACA Coverage Among Uninsured Nonelderly Adults who Sought Coverage in 2014



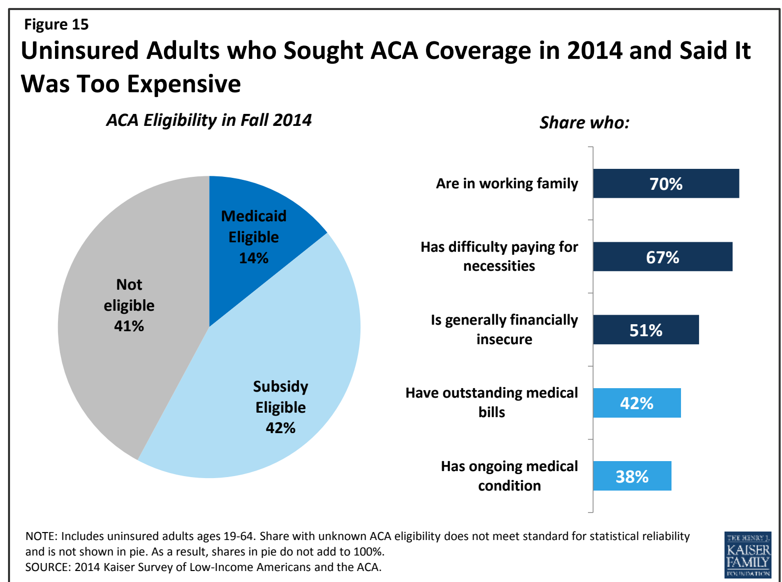
NOTE: Includes uninsured adults ages 19-64. "Other reason" includes those who report they did not finish the application process, their application is still pending, obtained coverage elsewhere, or some other reason. †Includes those eligible for Medicaid and those eligible for subsidies in the Marketplace. ‡Includes undocumented immigrants, people in the coverage gap, and those with either an offer of ESI or incomes above the level for Marketplace subsidies.
* Significantly different from ACA Eligible at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

as of the time of the survey say they were told they were ineligible when they applied for ACA coverage. It is possible that these people were ineligible at the time they applied and have subsequently become eligible. However, this situation is unlikely in expansion states, which provide ACA options across the income spectrum. These individuals may have been told they were ineligible for a certain type of ACA coverage and not another, or they may have received misinformation or misinterpreted information. It is not surprising that many (44%) who sought coverage but appear to be *ineligible* for Marketplace or Medicaid coverage as of the time of the survey also say they were told they were ineligible when they applied. People who appear ineligible also cited other reasons for not having coverage, including cost (since they would have faced the full cost of coverage), having a pending application (and thus not yet being told they are ineligible), finding other coverage (that they subsequently lost), or never completing the application process.

Looking at just the group of uninsured adults that sought ACA coverage and were told they were ineligible, about half appear to be eligible for Medicaid or Marketplace subsidies as of the time of the survey (Figure 14). As discussed above, there are several possible reasons why they may say they were told they are ineligible. Notably, many report that they had direct contact with either their state Marketplace/ healthcare.gov or their state Medicaid agency, and more than half say they tried more than one mode of applying.

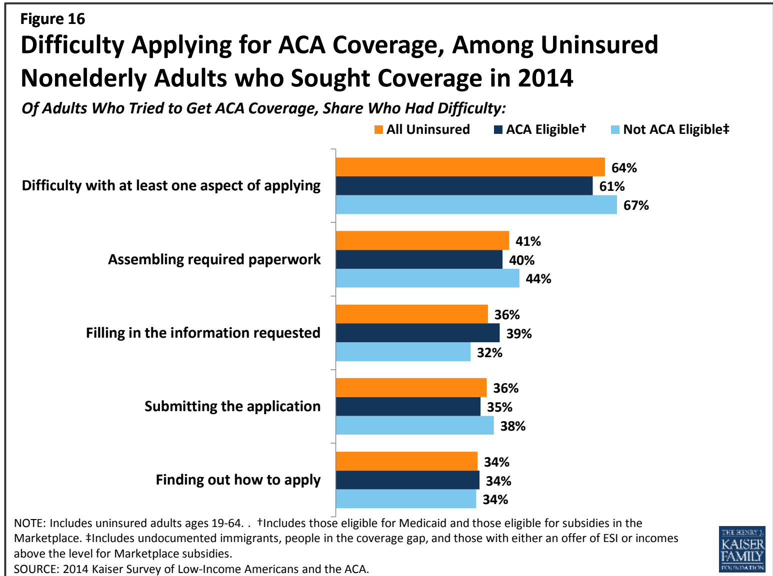


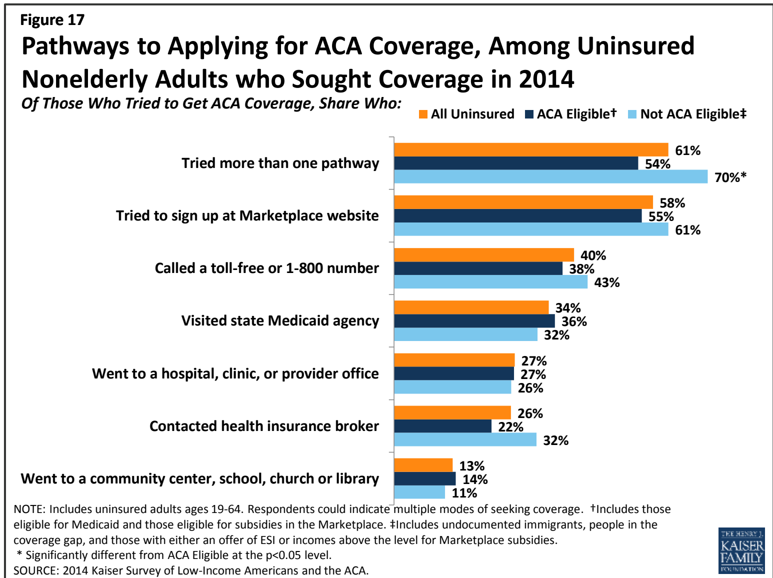
Many uninsured adults who applied for ACA coverage say the coverage offered was unaffordable. Nearly three in ten (29%) uninsured adults who sought ACA coverage said they did not enroll because the coverage was too expensive (Figure 13, previous page). Among those who cited cost as a reason for not having ACA coverage, four in ten were ineligible (41%) for financial assistance under the law. These individuals would face the full cost of coverage in the Marketplace and likely found unsubsidized coverage unaffordable. However, 42% of those who said they did not obtain ACA coverage due to cost appear to be eligible for Marketplace subsidies (Figure 15). Marketplace subsidies are based on income, with those at the lower end of the income spectrum receiving larger subsidies. Still, some people may find the share they were asked to pay too costly to take up the coverage. A small share of those who said the coverage was too costly appear to be eligible for Medicaid, even though only a handful of states charge premiums to adults in Medicaid.[5] These people may have shopped for Marketplace coverage and perceive it to be too costly, they may have received incorrect



or misinterpreted information on Medicaid coverage, or their eligibility may have changed between the time they sought coverage and completed the survey. When looking at the characteristics of people who cited cost, it is clear that many have precarious financial situations and many face medical expenses (Figure 15). Thus, efforts to provide accurate information to these individuals about the availability of low-cost coverage to help with medical expenses may lead them to enroll.

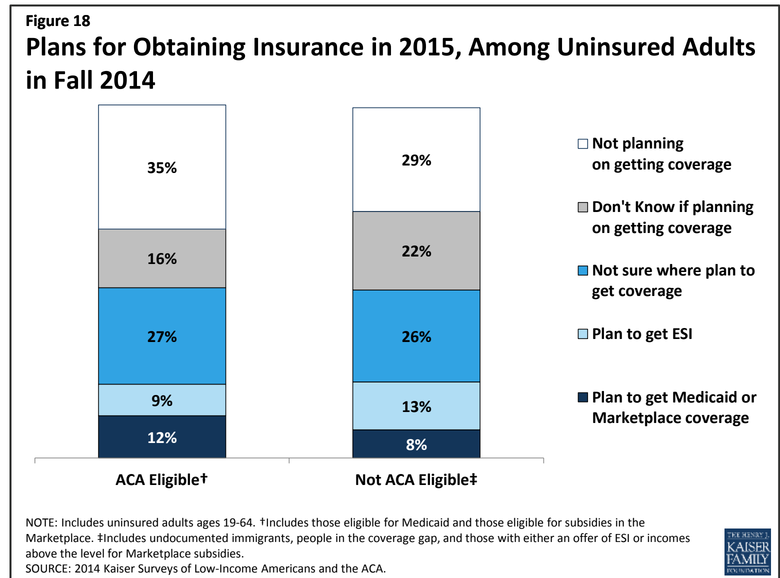
While most uninsured adults did not cite application problems as the main reason for not enrolling in ACA coverage, many did encounter difficulties with the application process. Compared to reasons of ineligibility or cost, smaller shares said that they didn't get coverage due to problems with the application process, such as still having a pending application (12%) or not completing the application process (8%) (data not shown). Still, when asked directly about their experience applying, most (64%) did say they found at least one aspect of the application process difficult (Figure 16). No single aspect stands out as the most difficult: more than one in four (41%) reported difficulty assembling the required paperwork, and more than a third reported difficulty filling in the information requested (36%), submitting the application (36%), or finding out how to apply (34%). There were no statistically significant differences in rates of difficulty between those who appear to be eligible or ineligible for assistance under the ACA.





Among those who tried to get ACA coverage, most reported trying multiple avenues, and most tried to get coverage directly from the state or federal government. While the ACA envisioned a streamlined, "no wrong door" application and enrollment process, most uninsured adults who sought ACA coverage in 2014 said they pursued multiple pathways to coverage. More than six in ten (61%) tried more than one pathway, and those who appear to be ineligible were more likely to try multiple pathways (Figure 17). The most common ways that the uninsured who sought ACA coverage did so was by contacting their state marketplace or healthcare.gov (58%). Four in ten reported that they called a toll-free number to get help, more than a third (34%) visited their state Medicaid agency. While many uninsured adults pursued other avenues for getting coverage—such as going to a provider for help (27%) or contacting a health insurance broker (26%)—much smaller shares indicated that they went community agencies, schools, churches, or libraries (13%).

Even among those likely eligible, few uninsured adults have plans to obtain ACA coverage. Only about half of uninsured adults who appear to be eligible for help under the ACA indicate that they plan to get coverage in 2015, and few who do plan to get coverage identified Medicaid or Marketplace coverage as their goal (Figure 18). Rather, higher shares indicate that they will get coverage elsewhere, don't know where they will get coverage, or plan to get coverage through a job. Further, some who do not appear to be eligible for assistance indicate that they plan to get Medicaid or Marketplace coverage.



Policy Implications

As the first year of new coverage under the ACA comes to a close and the end of the second open enrollment period nears, there is great interest in understanding why some people continue to lack coverage and in reaching out to the eligible uninsured. Findings from the 2014 Kaiser Survey of Low-Income Americans and the ACA provide key lessons for ongoing efforts to extend health coverage in the United States.

Despite the availability of low-cost or free coverage, perceptions of cost or lack of awareness of assistance are barriers to reaching some eligible uninsured. When asked in their own words, uninsured adults were most likely to name cost as the main reason they don't have coverage, and this pattern held even among those who appear to be currently eligible for low-cost or free coverage under the ACA. In addition, most eligible uninsured adults say that they did not try to get health insurance from either their state Marketplace, healthcare.gov, or their state Medicaid agency in 2014, and few indicated plans to obtain ACA coverage in 2015. Ongoing efforts to inform the eligible uninsured of new options for low-cost coverage will be essential to continuing the decline in the number of uninsured Americans.

While ACA application problems were not a leading reason why people went without coverage, many uninsured adults reported difficulty applying. Nearly two-thirds of uninsured adults who sought ACA coverage said they had some difficulty with finding out how to apply, filling in the information, assembling the paperwork, or submitting the application. While the ACA envisioned a streamlined, "no wrong door" application and enrollment process, most people who sought ACA coverage in 2014 said they pursued multiple pathways to coverage. There was much attention to application difficulties in 2014, many of which have been addressed for 2015 open enrollment. However, people who had difficulty applying may be less likely to seek coverage again.

Many who applied for ACA assistance still found the coverage unaffordable. While it is not surprising that people ineligible for financial assistance said coverage was too costly, many who do appear eligible still said the coverage was too expensive. While premium subsidies are based on a sliding scale, it appears that many still find the coverage unaffordable. It is unclear whether people felt the premiums were

unaffordable or whether they felt that the coverage as a whole—including premiums, deductibles, and cost sharing—was unaffordable. Additional work is needed to understand whether affordability provisions in the ACA are sufficient to enable lower-income people to take up coverage.

Gaps in eligibility and complex eligibility rules may prevent many uninsured adults from gaining coverage. About half of remaining uninsured adults do not appear to be eligible for financial assistance under the ACA, either because of their immigration status, because their state did not expand Medicaid, or because they have an offer of ESI or incomes above the limit for premium subsidies, and many remaining uninsured are working for firms that will not be required to offer coverage under the ACA because they have fewer than 50 workers. However, even among those who are eligible for ACA coverage, many say they were told they were ineligible. It is unclear whether these individuals were ineligible at the time they applied, received wrong information, misinterpreted information, or only sought one type of ACA coverage. However, it is likely that complex eligibility rules for different types of assistance contributed to confusion over eligibility. In addition, while the ACA envisioned a continuum of coverage with various coverage options available as people's circumstances changed (such as job loss or income change), one in five uninsured adults actually lost coverage in 2014. Some of these people fall into eligibility gaps, and some were eligible but did not obtain ACA coverage. Thus, coverage transitions remain a challenge to keeping coverage.

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[1] Garfield, R. R. Licata, and K. Young. *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA.* February 2014. Available at: http://kff.org/uninsured/report/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca/.

[2] Wilper AP, Woolhandler S, Lasser KE, McComick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*. 2009;28(6):w1151-9.

[3] *Coverage Matters: Insurance and Health* Care, Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine, National Academy Press, 2001.

[4] Sommers BD. "Insuring children or insuring families: do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP?" *J Health Econ*. 2006 Nov;25(6):1154-69. Epub 2006 Jun 5.

[5] Brooks, T., J. Touschner, S. Artiga, J. Stephens, and A. Gates. *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015.* January 2015. Available at: http://kff.org/medicaid/report/modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015/.

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URBAN INSTITUTE

Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in King v. Burwell

Linda J. Blumberg, Matthew Buettgens, John Holahan

Timely Analysis of Immediate Health Policy Issues

JANUARY 2015

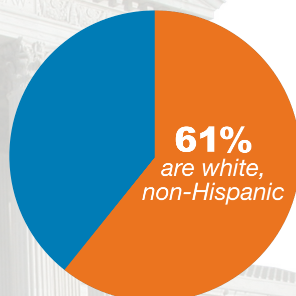
In-Brief

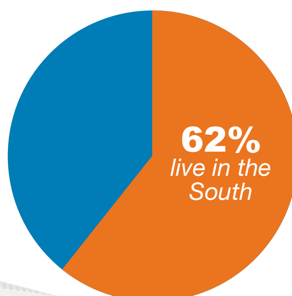
In a recent brief, we examined the broad coverage and premium implications of a ruling that would end federal tax credits for marketplace-based private health insurance coverage in states in which the federal government operates the marketplaces.[1] Here, we provide the characteristics of those affected by such a ruling. Of the 9.3 million people estimated to lose tax credits under a finding for King, two-thirds would become uninsured. Most of these are adults with incomes between 138 and 400 percent of the federal poverty level (FPL). Over 60 percent of those who would become uninsured are white, non-Hispanic and over 60 percent would reside in the South. More than half of adults have a high school education or less, and 80 percent are working.

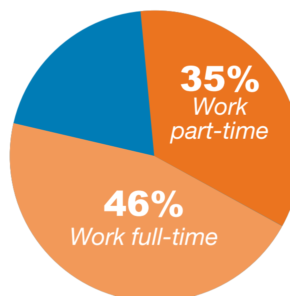
Many others lose nongroup coverage not because of the loss of tax credits but because of the 35 percent premium increase that would occur as healthier people leave the markets. Of the 4.9 million purchasing coverage in the nongroup market without tax credits as the law is currently implemented, about one quarter would become uninsured. Over half of this group who would become uninsured are from the South and over half work full-time. A large share of those who would become uninsured if the Court finds for King have a small-firm worker in their family; almost two million of those who would become uninsured have a self-employed person in the family. A relatively small number of people who would have public insurance or employer-based insurance would also become uninsured as an indirect consequence of eliminating the tax credits.

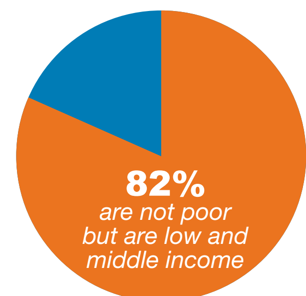
In order to maintain the same insurance coverage as they have under the law's current implementation, individuals and families would have to pay substantially more as a percentage of their incomes; as a result, most would not keep their coverage. The largest changes in financial burdens would be for the lowest income individuals and for those currently receiving tax credits. For those at the lowest income level, the median direct premium payment would increase from 4.1 percent to 29.6 percent of income for single policies and from 3.6 percent to 48.9 percent of income for family policies. Purchasers in all income groups, however, would be significantly affected. In fact, if the Court decides in favor of King, 99 percent of those who would otherwise have purchased nongroup coverage using premium tax credits would face premiums deemed by the ACA to be unaffordable to them, as they would exceed 8.0 percent of family income (data not shown).

If the Supreme Court rules that using federal tax credits to purchase insurance is illegal, here is who becomes uninsured in 2016 because they would not receive tax credits:









Methods

This analysis follows the same methodological approach as the previous brief.[2] We rely upon the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) which simulates full implementation equilibrium of the Affordable Care Act (ACA) in 2016 (i.e., knowledge of the law and its provisions are assumed to have peaked and individual and employer behavior to have fully adjusted to the reforms).

Marketplaces in which the federal government has taken on at least some of the responsibilities of administration are often referred to as federally facilitated marketplaces (FFMs). For purposes of this analysis, we include 34 states, including those where the federal government has taken on complete responsibility (19), those with explicit agreements with the federal government where the state takes on some responsibilities but not others (7), and states without explicit agreements but which have taken responsibility for plan management nonetheless (8). We do not include states that had created the legal framework for a state-based marketplace (SBM) but for which technical problems led to use of the federal IT system (healthcare.gov).

Estimates presented in this analysis reflect effects at a point in time, and therefore understate the number of people who would be affected over the course of a year and over multiple years, as individuals' employment and income fluctuate.

Financial burdens associated with the purchase of nongroup coverage are computed as premiums, net of any premium tax credits, relative to family income. Premium levels for individuals and families for each age and geographic location are determined under full simulations of two scenarios: (A) a simulation of the ACA as currently implemented, including tax credits and (B) a simulation of the ACA without tax credits. Financial burdens for all individuals and families simulated to enroll in nongroup under scenario A are computed, and the median financial burdens for purchasers of single and family policies are provided, separating those purchasing with and without tax credits. Next, for each individual and family simulated to enroll in nongroup under scenario A, we identify the premium that would apply to them under scenario B if they were to enroll (regardless of their actual simulated decision under scenario B), and compute their alternate financial burden.

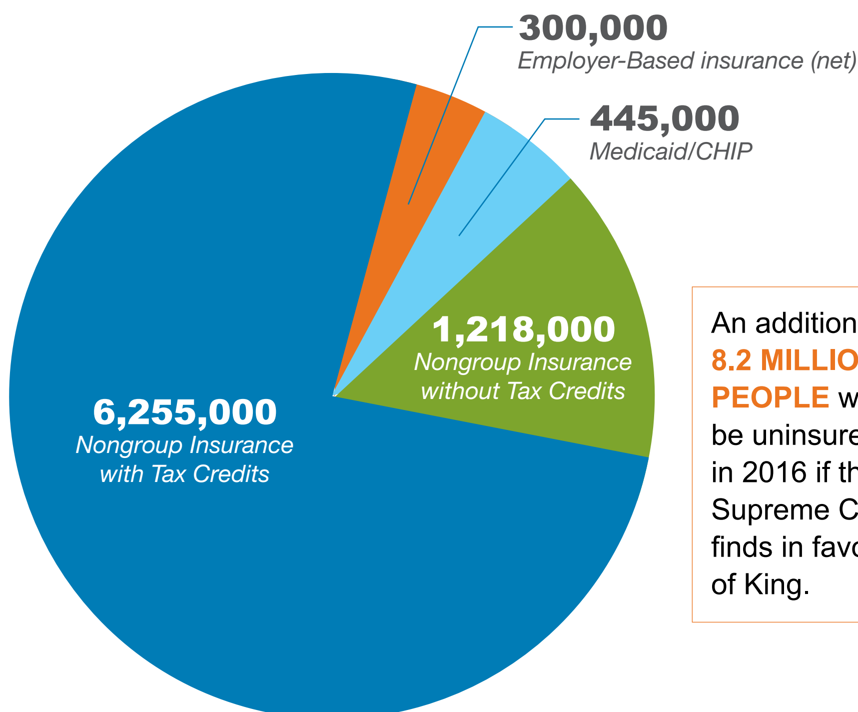
Results

As estimated in our previous analysis of the implications of King v. Burwell, the number of people uninsured would increase, on net, by 8.2 million. As we describe below, approximately 6.3 million of these would have enrolled in nongroup coverage using federal tax credits under current implementation of the law, about 1.2 million would have otherwise enrolled in nongroup coverage fully at their own cost, about 445,000 would otherwise have had Medicaid or CHIP coverage, and about 300,000 would otherwise have had employer-based insurance (Figure 1). The principal emphasis of this analysis is on the two largest portions of this group, those that would otherwise have had nongroup insurance.

Those Losing Tax Credits Under a Finding for King

Table 1 shows the characteristics of the 9.3 million people losing tax credits if the Supreme Court rules in favor of the plaintiff (i.e., King). This entire group would lose the financial assistance that has made coverage affordable for many of them, leading to approximately two-thirds becoming uninsured. Of those obtaining coverage with the tax credits under the current implementation of the law, 885,000 are children, a relatively small share (9.5 percent) as so many children in this income category are eligible for Medicaid or CHIP, making them ineligible for tax credits. Over 35 percent are between the ages of 45 and 64. Of adults losing tax credits, 70 percent (just under 6

Figure 1. Individuals Becoming Uninsured Under King v. Burwell, by Source of Insurance Under ACA as Currently Implemented



An additional **8.2 MILLION PEOPLE** would be uninsured in 2016 if the Supreme Court finds in favor of King.

Source: HIPSM-CPS 2015. ACA modeled in 2016.

million people) would become uninsured as a consequence. The share losing insurance varies between 67.6 percent and 74.8 percent, depending upon the age group. Only 34.0 percent of children losing tax credits become uninsured. The differential rates occur because, on average, the children who lose tax credits are in families with higher incomes compared to adults (lower income children tend to be eligible for Medicaid or CHIP), and most children would have nongroup insurance coverage even if the ACA were not in place. The adults losing tax credits, on the other hand, are much more likely to have lower incomes and thus only 30 percent would have insurance coverage if not for the premium tax credits.

Not surprisingly, most individuals losing tax credits have incomes between 138 percent and 400 percent of the FPL; 35.2 percent have incomes between 138 and 200 percent of the FPL and 48.1 percent have incomes between 200 and 400 percent of the FPL. The lower income individuals (between 100 and 138 percent FPL) losing tax credits are those living in states that elected not to expand Medicaid under the ACA, as well as lower income individuals who are legal immigrants who have not yet been in the country long enough to qualify for Medicaid. Over 70 percent of those with incomes below 200 percent of the FPL who would lose tax credits would become uninsured. Over half (56.1 percent) of those with incomes between 200 and 400 percent of the FPL who would lose tax credits would become uninsured, as well.

A large share of those who would lose tax credits are white, non-Hispanic (65.5 percent), largely consistent with the white share of the population as a whole. About 12.9 percent are black, non-Hispanic, and another 16.3 percent are Hispanic. The remainder are from other racial/ethnic groups. Almost 62 percent of whites who would lose their tax credits under King would become uninsured; over 70 percent of all other racial/ethnic groups would become uninsured.

A very large percentage of people who would lose tax credits live in southern states (58.7 percent), reflecting the large number of states in the South (with the exception of Kentucky) that have FFMs. Another large share of those who would lose tax credits (27.0 percent) live in the Midwest (Wisconsin, Indiana, Ohio, and Illinois have FFMs and relatively large populations). Only a small share of those losing tax credits are in the Northeast or West. Of those losing credits in the South, 70.5 percent would become uninsured, the highest rate among the four regions.

Among adults losing credits, just about 50 percent have a high school education or less; only a small share (15.9 percent) have graduated from college. The share that would become uninsured after losing tax credits increases for those with lower levels of education. Most of those losing tax credits are reasonably healthy, reporting excellent, very good, or good health status (90.3%). Those in fair or poor health are less likely to become uninsured, 58.2 percent, compared to 67.9 percent of those in better health.

Eighty percent of adults who would lose tax credits are working, with 46.5 percent working full time and 33.7 percent working part time. We estimate that 70.1 percent of full-time workers losing tax credits, 73.0 percent of part-time workers and 66.8 percent of those not working would become uninsured.[3] Of those who would lose tax credits, 26.3 percent have a family member who is self-employed and 62.5 percent have a family member employed by a small firm (50 or fewer workers). Among those who would lose tax credits, 65.2 percent of those with a self-employed worker and 70.2 percent of those with a small firm worker in the family would become uninsured.

Those Purchasing Nongroup Coverage Under the Law as Currently Implemented Without Tax Credits

We estimate that in 2016, 4.9 million people will enroll in nongroup coverage that they purchase on their own, without financial assistance, through plans offered inside or outside the marketplaces under the law as currently implemented (Table 2). These people, who tend to have higher incomes than those receiving tax credits, are significantly more likely to remain insured under a ruling in favor of King. Still, about one quarter of this group, or 1.2 million people, would become uninsured. Once 9.3 million marketplace enrollees lose their tax credits and two-thirds of them become uninsured as a consequence, the composition of the nongroup insurance market would change significantly. Many fewer healthy adults would enroll, increasing the average health care cost and risk of those remaining. As a result, as we demonstrated in our earlier analysis, average premiums in the nongroup market would increase by 35 percent.[4] Such a price increase would affect virtually everyone purchasing coverage in the nongroup market, both inside and outside the marketplaces.[5] Therefore, even those never eligible for tax credits would be significantly less likely to enroll in nongroup insurance coverage under a Supreme Court finding for King.

Over 70 percent of those paying full price for nongroup coverage as the law is currently implemented have incomes above 400 percent of the FPL. Of these 3.5 million people, only 15.5 percent would become uninsured under a finding for King. Many of those in this higher income category would continue to be bound by the ACA's individual mandate and would have purchased nongroup coverage in the absence of any reform at all, since their high incomes mean that even the increased premium would be manageable for them.[6] However, there are 1.4 million lower income people who are estimated to buy coverage without assistance in 2016; they do not qualify for tax credits due to having affordable employer-based offers of insurance in their family, or, particularly in the case of young adults, the full premiums for Silver coverage are low enough that they fall below the level covered by the tax credits (i.e., the premium is less than their applicable percent of income cap). The rates at which these lower income purchasers would become uninsured are much higher, ranging from 78.0 percent for individuals below 138 percent of the FPL to 44.6 percent for those between 200 and 400 percent of the FPL.

A very large share of those buying nongroup coverage fully at their own cost under the current implementa-

Table 1. Characteristics of Those Enrolled in Nongroup Marketplace with Tax Credits Under ACA as Currently Implemented & Those Becoming Uninsured Under Supreme Court Finding for King, 2016

	Enrolled in Marketplace Coverage with Tax Credits as ACA is Currently Implemented			
	Total and Composition of Each Subgroup		**Number and Percentage Becoming Uninsured Under Decision for King**	
	Number	*Share of Subgroup*	*Number*	*Percent Becoming Uninsured*
Total	**9,346,000**	**100.0%**	**6,255,000**	**66.9%**
Age				
0 – 18	885,000	9.5%	308,000	34.8%
19 – 24	1,488,000	15.9%	1,005,000	67.6%
25 – 34	1,861,000	19.9%	1,345,000	72.3%
35 – 44	1,715,000	18.3%	1,191,000	69.5%
45 – 54	2,012,000	21.5%	1,371,000	68.1%
55 – 64	1,384,000	14.8%	1,035,000	74.8%
Income				
< 138% FPL	1,558,000	16.7%	1,138,000	73.1%
138 - 200% FPL	3,291,000	35.2%	2,593,000	78.8%
200 - 400% FPL	4,497,000	48.1%	2,524,000	56.1%
400% FPL +	0,000	0.0%	0,000	0.0%
Race/Ethnicity*				
White, non-Hispanic	6,122,000	65.5%	3,786,000	61.8%
Black, non-Hispanic	1,207,000	12.9%	910,000	75.4%
Hispanic	1,522,000	16.3%	1,213,000	79.7%
Other, non-Hispanic	495,000	5.3%	346,000	70.0%
Region				
Northeast	757,000	8.1%	467,000	61.7%
Midwest	2,520,000	27.0%	1,554,000	61.7%
South	5,488,000	58.7%	3,869,000	70.5%
West	580,000	6.2%	365,000	62.8%
Education**				
Less than High School	1,100,000	13.0%	906,000	82.4%
High School Graduate	3,178,000	37.6%	2,361,000	74.3%
Some College	2,829,000	33.5%	1,906,000	67.4%
College Graduate	1,341,000	15.9%	775,000	57.8%
Health Status				
Fair/Poor	906,000	9.7%	527,000	58.2%
Better than Fair/Poor	8,440,000	90.3%	5,728,000	67.9%
Employment Status**				
Full-Time	3,928,000	46.5%	2,753,000	70.1%
Part-Time	2,846,000	33.7%	2,078,000	73.0%
Not Working	1,672,000	19.8%	1,116,000	66.8%
Small-Firm Worker in Family				
No	3,503,000	37.5%	2,151,000	61.4%
Yes	5,843,000	62.5%	4,104,000	70.2%
Self-Employed Work in Family				
No	6,888,000	73.7%	4,654,000	67.6%
Yes	2,457,000	26.3%	1,601,000	65.2%

Source: HIPSM-CPS 2015. ACA modeled in 2016.
** Not available for dependents living alone (NIU).*
*** Analyzed for adults only. This category excludes a small number of dependents age 19-22.*
Analysis assumes the effects of a decision for the plaintiff are limited to the 34 Federally Facilitated Marketplace states.

Table 2. Characteristics of Those Enrolled in Nongroup Insurance Without Tax Credits Under ACA as Currently Implemented & Those Becoming Uninsured Under Supreme Court Finding for King, 2016

	Enrolled in Nongroup Coverage without Tax Credits			
	Total and Composition of Each Subgroup		Number and Percentage Becoming Uninsured Under Decision for King	
	Number	*Share of Subgroup*	*Number*	*Percent Becoming Uninsured*
Total	**4,881,000**	**100.0%**	**1,218,000**	**24.9%**
Age				
0 – 18	783,000	16.1%	54,000	7.0%
19 – 24	569,000	11.7%	252,000	44.2%
25 – 34	838,000	17.2%	239,000	28.5%
35 – 44	849,000	17.4%	197,000	23.2%
45 – 54	1,096,000	22.5%	245,000	22.4%
55 – 64	745,000	15.3%	231,000	31.0%
Income				
< 138% FPL	152,000	3.1%	119,000	78.0%
138 - 200% FPL	101,000	2.1%	59,000	57.9%
200 - 400% FPL	1,109,000	22.7%	494,000	44.6%
400% FPL	3,520,000	72.1%	547,000	15.5%
Race/Ethnicity*				
White, non-Hispanic	3,575,000	73.2%	744,000	20.8%
Black, non-Hispanic	354,000	7.3%	132,000	37.1%
Hispanic	608,000	12.5%	266,000	43.7%
Other, non-Hispanic	336,000	6.9%	76,000	22.7%
Region				
Northeast	670,000	13.7%	137,000	20.5%
Midwest	1,282,000	26.3%	304,000	23.7%
South	2,597,000	53.2%	703,000	27.1%
West	332,000	6.8%	74,000	22.2%
Education**				
Less than High School	284,000	7.0%	151,000	53.1%
High School Graduate	1,064,000	26.1%	357,000	33.6%
Some College	1,282,000	31.4%	392,000	30.6%
College Graduate	1,454,000	35.6%	264,000	18.1%
Health Status				
Fair/Poor	384,000	7.9%	76,000	19.9%
Better than Fair/Poor	4,497,000	92.1%	1,142,000	25.4%
Employment Status**				
Full-Time	2,427,000	59.4%	622,000	25.6%
Part-Time	1,030,000	25.2%	333,000	32.3%
Not Working	627,000	15.3%	209,000	33.3%
Small-Firm Worker in Family				
No	1,461,000	29.9%	381,000	26.1%
Yes	3,420,000	70.1%	837,000	24.5%
Self-Employed Work in Family				
No	2,878,000	59.0%	855,000	29.7%
Yes	2,003,000	41.0%	363,000	18.1%

Source: HIPSM-CPS 2015. ACA modeled in 2016.
** Not available for dependents living alone (NIU).*
*** Analyzed for adults only. This category excludes a small number of dependents age 19-22.*
Analysis assumes the effects of a decision for the plaintiff are limited to the 34 Federally Facilitated Marketplace states.

tion of the law (73.2 percent) are white, non-Hispanic. Only 7.3 percent are black, non-Hispanic and 12.5 percent are Hispanic. Most whites are estimated to remain insured if tax credits are eliminated; only 20.8 percent, or 744,000, are estimated to become uninsured, although they would comprise the largest share of those becoming uninsured. However, a much larger share of individuals from other racial/ethnic groups (37.1 of blacks or 132,000 people, and 43.7 percent of Hispanics or 266,000 people) buying nongroup coverage fully at their own cost would become uninsured.

Over half of those buying nongroup coverage without federal assistance under the current implementation of the law live in the South (53.2 percent). Another 26.3 percent live in the Midwest; the remainder reside in the Northeast or West. As many as 27.1 percent of these people living in the South would become uninsured under a decision in favor of King, the highest of any region.

A much larger proportion of adults buying nongroup coverage at full price as the law is currently implemented have at least some college education (67.0 percent), as compared to those purchasing nongroup with tax credits (49.4 percent). Still, a quarter of these would become uninsured under a finding for King. While only 7.0 percent of adults purchasing nongroup at full cost have less than a high school degree, more than half, 53.1 percent, would become uninsured. As education increases, the share that would become uninsured declines.

As is true in the population at large, the vast majority of those purchasing nongroup coverage at full price under the current implementation of the law are generally healthy, with 92.1 percent reporting being in good, very good, or excellent health. Those reporting being in worse health are somewhat more likely to remain insured under a finding for King (19.9 percent would become uninsured compared to 25.4 percent of their healthier counterparts), likely reflecting a lower responsiveness to premium increases among those expecting to use significant medical services.

A majority of adults buying nongroup coverage at full price under the current implementation of the law work full-time (59.4 percent), another 25.2 percent work part-time, and 15.3 percent do not work, although they are very likely to have a working spouse. Of those who work full-time, 25.6 percent would become uninsured under a victory for King, as would a third of those working part-time or not working.

Seventy percent of those buying nongroup coverage at full cost under the current implementation of the law have at least one family member employed in a small firm. This reflects the significantly lower rate of employer-sponsored insurance offers among small firms compared to large firms.[7] In addition, about 40 percent of individuals buying nongroup coverage at full cost have at least one self-employed family member. Most of these individuals would remain insured under a finding for King.

Summing up, over half of those enrolling in nongroup insurance coverage as the law is currently implemented would become uninsured if the Supreme Court finds in favor of King. Those that are able to retain insurance, either through the nongroup market at significantly higher premiums or through another source, are more likely to be older adults and children, are much more likely to have incomes above 400 percent of the FPL, are more likely to be in fair or poor health, to be white, to be highly educated and to live in regions outside of the South.

Those Losing Other Types of Coverage

Some individuals covered by public insurance (Medicaid or CHIP) or by employer-sponsored insurance as the ACA is currently implemented would also be affected by a Supreme Court ruling in favor of King. Approximately 445,000 individuals otherwise enrolled in Medicaid or CHIP coverage would become uninsured instead. Most of these people are children whose parents would not investigate marketplace coverage due to the lack of financial assistance, thus their children would not be identified as eligible for public insurance and enrolled at the same time. About 72 percent of these individuals have incomes below 138 percent of the FPL, 25.6 percent have incomes between 138 and 200 percent of the FPL, and about 2.6 percent have incomes between 200 and 400 percent of the FPL (data not shown). On net, an additional 300,000 individuals who would be covered by employer-based insurance under the current implementation of the law would also become uninsured, because changes in nongroup insurance premiums and enrollment would lead to changes in some employer decisions whether to offer insurance coverage, as well as some decisions by workers to take up those offers. However, these represent very small changes in an estimated employer market of 104 million people under the ACA in 2016.[8] In total, a finding for King would increase the number uninsured, on net, by approximately 8.2 million people.

Health Care Financial Burdens

Table 3 shows the implications of the loss of tax credits and the consequent increase in nongroup insurance premiums for those who would have enrolled in coverage under the law as currently implemented. In order to maintain the insurance coverage that individuals and families would otherwise have, the share of income devoted to health insurance premiums would increase significantly, with the largest increased financial burdens falling on those otherwise eligible for the credits and those with the lowest incomes.

For those with incomes below 200 percent of the FPL purchasing nongroup insurance with tax credits under the current implementation of the law, the median (50th percentile) individual and family pays approximately four percent of their income for premiums; this takes into account the tax credits that reduce their direct premium costs. Absent the tax credits, if they were to retain the same coverage, the median financial burden for a single adult would be 29.6 percent of income, and the median share of income for a family would be 48.9 percent of income. As a result of the extremely large increase in financial burden, the vast majority of these

Table 3. Potential Changes in Financial Burden for Those Purchasing Nongroup Coverage Under ACA as Currently Implemented
Median Direct Payments by Individuals/Families for Nongroup Market Premiums Under Current Implementation & Under Finding for King, 2016

	Median Premium Payment as ACA is Currently Implemented	Median Premium Payment Under Finding for Plaintiff in King v. Burwell	Difference	Median Premium Payment as % of Income as ACA is Currently Implemented	Median Premium Payment as % of Income Under Finding for Plaintiff in King v. Burwell
Purchasing with Tax Credits Under ACA as Currently Implemented					
< 200% of the Federal Poverty Level					
Single Policies	$763	$5,589	$4,826	4.1%	29.6%
Family Policies	$1,114	$14,318	$13,204	3.6%	48.9%
200-400% of the Federal Poverty Level					
Single Policies	$2,366	$6,427	$4,061	7.8%	19.7%
Family Policies	$4,318	$15,563	$11,245	8.8%	28.9%
Purchasing without Tax Credits Under ACA as Currently Implemented*					
Single Policies	$3,693	$5,693	$2,000	5.8%	9.0%
Family Policies	$9,952	$15,439	$5,487	8.6%	13.5%

Source: HIPSM-CPS 2015. ACA modeled in 2016.

**Note: About 3/4 of those purchasing nongroup insurance without a tax credit have incomes above 400 percent of the FPL. Those with lower incomes purchasing without a credit either have a family member with affordable, adequate insurance coverage available to them or the cost of their premium is sufficiently low that it falls below the percent of income cap for which the individual/family is eligible; the latter occurs most frequently for young adults who face lower premiums due to age-rating.*

individuals and families would drop their coverage. For tax credit recipients with incomes between 200 and 400 percent of the FPL purchasing nongroup insurance, median financial burdens would increase from 7.8 percent for singles and 8.8 percent for families to 19.7 percent and 28.9 percent of income, respectively. Again, many of these people, otherwise enrolled in nongroup coverage, would not be able to maintain health insurance coverage under these circumstances.

In fact, if the Court decides in favor of King, 99 percent of those who would otherwise have purchased nongroup coverage using premium tax credits would face premiums deemed by the ACA to be unaffordable to them, as they would exceed 8.0 percent of family income (data not shown).

Those not receiving tax credits under the current implementation of the law would be affected by a finding for King, as well, as the premiums for everyone would increase due to the worsening health status of those enrolled. Their median financial burden would increase from 5.8 percent to 9.0 percent for singles and from 8.6 percent to 13.5 percent for families. Again, these calculations reflect the difference in financial burdens that would be faced by any particular nongroup purchaser if they choose to purchase coverage in the market that prohibited tax credits, regardless of their actual decision whether or not to enroll. Those that choose to enroll under a ruling for King would have a different age and income distribution compared to those choosing to enroll under the current implementation of the law.[9]

Conclusion

With a ruling in favor of the plaintiff in King v. Burwell, a large number of Americans in the 34 FFM states would be affected by the loss of tax credits and all nongroup purchasers would face large premium increases. Average premiums would increase by an estimated 35 percent and 8.2 million more Americans would become uninsured compared with the law as currently implemented. About two-thirds of those who would lose tax credits would become uninsured as would one-quarter of other purchasers. Not surprisingly, those with incomes below 400 percent of the FPL would be most likely to become uninsured, although over 500,000 individuals with incomes above 400 percent FPL would lose coverage. Those that would become uninsured are more likely to be white, have lower education levels, live in the South, and to have a family member who works for a small firm.

The large increases in financial burdens required to maintain the same coverage would lead to large numbers of people becoming uninsured. These increased burdens are particularly profound for the low-income population (below 200 percent of the FPL), for whom the median cost of premiums relative to income would increase from about 4 percent with tax credits to about 30 percent for singles and 50 percent for families without them. Those between 200 and 400 percent of the FPL would see median financial burdens rise from about 8 to 9 percent of income with tax credits to about 20 percent of income for singles and about 30 percent for families without them.

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

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Linda J. Blumberg is a senior fellow, Matthew Buettgens is a senior research associate, and John Holahan is an Institute Fellow, all in the Urban Institute's Health Policy Center. The authors are grateful for research assistance from Hannah Recht and for comments and suggestions from Genevieve Kenney, Anna Spencer, and Stephen Zuckerman.

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Notes

1. Blumberg LJ, Buettgens M, and Holahan J. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell: 8.2 million More Uninsured and 35% Higher Premiums*. Washington: The Urban Institute, 2014, http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf (accessed January 2015).
2. Blumberg, Buettgens and Holahan. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell.*
3. The vast majority of non-working adults in this income category have a working spouse. Employment status as measured here reflects the status of the individual adult, not their family members.
4. Blumberg, Buettgens and Holahan. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell.*
5. A small share of those purchasing nongroup insurance are expected to remain in grandfathered (non-ACA compliant) policies in 2016. This small share would not be affected by the increased premiums in the ACA compliant market until they ultimately left their grandfathered plans.
6. If these higher income individuals are more likely to drop their coverage in these circumstances, even in the presence of the individual mandate, then the number uninsured as a consequence of King would be considerably higher, likely more consistent with the results in our prior analysis for the alternative scenario without an individual mandate.
7. According to the 2013 Medical Expenditure Panel Survey Insurance Component, 34.8 percent of establishments in firms of fewer than 50 employees offers health insurance coverage to their workers, compared to 95.7 percent of establishments in firms of 50 or more workers. See Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Table I.A.2 (2013), available at: http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/tia2.pdf (accessed January 2015).
8. Blumberg, Buettgens and Holahan. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell.*
9. The relative differences in median premiums shown in table 3 between the current implementation of the ACA and under a finding for King are about 55 percent, higher than the 35 percent of premium increase that we estimated in the nongroup market as a consequence of a finding for the plaintiff. It is important to note that these two measures are calculated in very different ways. The 35 percent estimate from our previous analysis compares the average premium per covered life for a person simulated to enroll under the law with tax credits to the average premium per covered life for a person simulated to enroll in the absence of credits. The people who would remain enrolled in coverage absent the tax credits are a somewhat younger population (since older adults are more likely to become exempt from the individual mandate), although in less good health, on average. Hence, the sicker population increases average premiums, but the shift to a somewhat younger enrollee population also means the average premium does not go up by as much as it might have if the age distribution had not changed. In addition, the 35 percent difference reflects the fact that as premiums increase, some individuals who continue to purchase nongroup coverage would shift to purchase lower actuarial value options (e.g., move from a Silver or Gold plan to a Bronze plan). The estimates presented in table 3 compare median premiums for those simulated to enroll under the law with tax credits, and then we use the premiums computed in the no tax credit scenario to compute what the premiums would be for each of these individuals and families if they remained enrolled. This approach implicitly recognizes that one individual or family making a decision to remain in the nongroup market would act as a premium "taker" – their presence would not affect average premiums. The median difference is even larger than 35 percent because those choosing not to enroll absent the credits are disproportionately older than those that choose to remain, and we are holding the type of coverage they are purchasing constant.

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URBAN INSTITUTE

The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums

Linda J. Blumberg, Matthew Buettgens, John Holahan

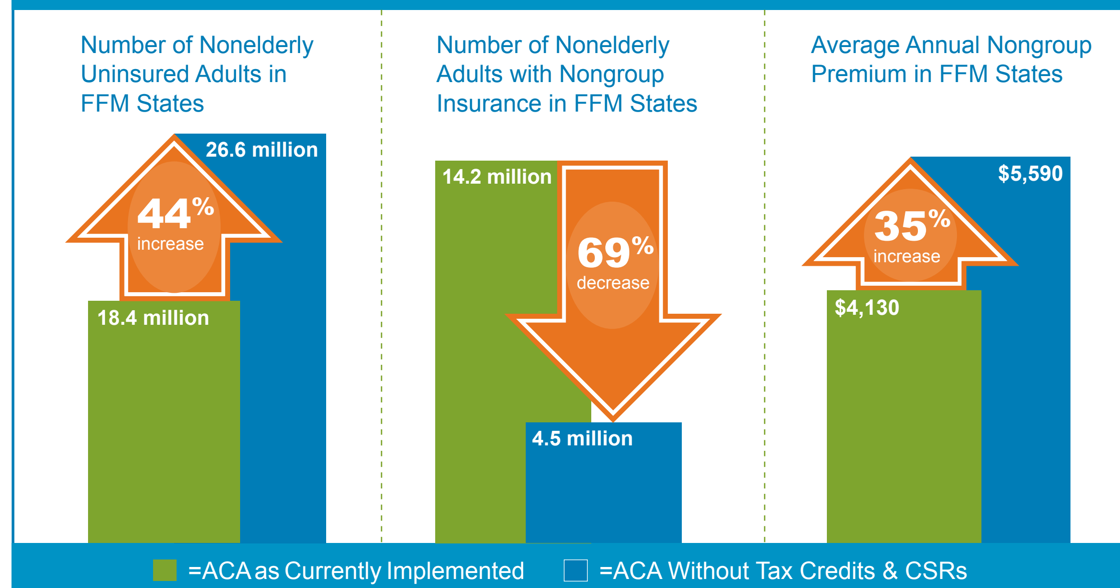
Timely Analysis of Immediate Health Policy Issues

JANUARY 2015

In-Brief

The Supreme Court will hear the King v. Burwell case in early 2015, in which the plaintiff argues that the Affordable Care Act (ACA) prohibits the payment of premium tax credits and cost-sharing reductions to people in states that have not set up state-managed marketplaces. We estimate that a victory for the plaintiff would increase the number of uninsured in 34 states by 8.2 million people (a 44 percent increase in the uninsured relative to the number uninsured under the law as currently implemented) and eliminate $28.8 billion in tax credits and cost-sharing reductions in 2016 ($340 billion over 10 years) for 9.3 million people. In addition, the number of people obtaining insurance through the private nongroup markets in these states would fall by 69 percent, from 14.2 million to 4.5 million, with only 3.4 million of these remaining in the ACA's marketplaces.[1]

If tax credits and cost-sharing reductions are eliminated, there will also be indirect effects. The mix of individuals enrolling in nongroup insurance would be older and less healthy, on average. The lack of tax credits would make coverage unaffordable for many. As a result, fewer people would be required to obtain coverage or pay a penalty because the cost of insurance would exceed 8 percent of income, the affordability threshold set under the law. With lower cost individuals and families leaving the market, average premiums in the nongroup insurance market would increase by an estimated 35 percent, affecting not just marketplace enrollees but those purchasing outside the marketplaces as well. For example, virtually all of the 4.9 million people (mostly with incomes over 400 percent of the FPL) who are estimated to buy nongroup insurance without financial assistance in 2016—under the law as currently implemented—would also face these large premium increases.[2]



Source: HIPSM 2014. ACA simulated in 2016

Note: CSR stands for cost-sharing reduction. FFM stands for Federally Facilitated Marketplace and refers to the 34 states included in this analysis.

Introduction

The Supreme Court will hear oral arguments in the King v. Burwell case in the spring of 2015. The case challenges the Obama Administration's interpretation of the Affordable Care Act (ACA) as it relates to the legality of payments of tax credits and cost-sharing reductions for nongroup insurance coverage[3] through the new health insurance marketplaces (a.k.a., exchanges). The plaintiff argues that wording in the text of the law prohibits the federal government from providing this financial assistance to moderate income individuals if their state does not run its own marketplace but has instead left the responsibility of its administration to the federal government. Elimination of tax credits and cost sharing reductions has direct implications for affordability of coverage and household financial burdens and has indirect yet substantial implications for premiums in the nongroup insurance market.

The direct implications are straightforward: if tax credits and cost-sharing reductions are eliminated, the cost of purchasing coverage will increase for those with incomes up to four times the federal poverty level (FPL), which is $46,680 for a single adult and $95,400 for a family of four in 2015. Fewer people will therefore choose to enroll, and the number of insured individuals will decrease. Those who continue to purchase coverage will only be able to do so by incurring the full cost of the premium themselves, thereby increasing their health care financing burdens.

The premium increases, which will exacerbate the decline in insurance coverage beyond the direct effects, result from the interconnected nature of the ACA's tax credits and cost-sharing reductions with the nongroup market consumer protections and the individual responsibility requirement (a.k.a. the individual mandate). Eliminating insurance discrimination in pricing and coverage for those with health problems (e.g., through guaranteed issue, modified community rating, provision of essential health benefits) requires a mechanism to ensure that the pool of insured individuals includes the healthy as well as those with health problems. Without such a mix, a pool providing comprehensive insurance to all individuals at an average price would be more attractive to the sick than to the healthy. As a result, the average cost of coverage would be very high with many healthy individuals choosing to stay out of the market. Thus, the law includes an individual mandate (i.e., most individuals must obtain minimum essential coverage or pay a penalty) in order to induce the healthy to obtain and maintain coverage, thereby bringing down the average health care costs in the insurance pool. Fairness, however, dictates that individuals cannot be required to purchase coverage that they cannot afford, so tax credits are provided to make coverage affordable to most individuals. Cost-sharing reductions are also provided to tax credit recipients with incomes at or below 250 of the FPL in order to lower their deductibles, co-payments, and other out-of-pocket costs relative to what would otherwise be required in a silver (70 percent actuarial value) plan.

Because the insurance market reforms are interwoven with the measures to expand coverage, removing the tax credits would make coverage unaffordable for more individuals and exempt them from the individual mandate and reduce the number insured. Those most likely to drop coverage would be disproportionately young and healthy. Such a change in the mix of enrollees would increase the average cost of individuals remaining in the nongroup insurance market, increasing nongroup insurance premiums as a consequence. Since the ACA treats the nongroup market inside and outside the marketplace as a single insurance pool,[4] elimination of tax credits affects not just marketplace enrollees but all those covered by private nongroup insurance in the same geographic area.

Our analysis uses The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the changes in insurance coverage and premiums that would result from eliminating the premium tax credits and cost-sharing reductions for otherwise eligible individuals residing in Federally Facilitated Marketplace (FFM) states. In addition, we provide state-by-state estimates of tax credits and cost-sharing reductions that would be foregone, the number of people that would lose the financial assistance, and the increase in the number of people uninsured. This analysis updates our previous work on this topic using the most recent marketplace premium data and expands upon it with a complete assessment of the likely coverage and premium implications.[5]

Methods

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, tax credits for the purchase of health insurance, and insurance market reforms.[6] The model estimates changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA for 2016. The model simulates full implementation equilibrium of the ACA in 2016 (i.e., knowledge of the law and its provisions are assumed to have peaked and individual and employer behavior to have fully adjusted to the reforms). Individuals age 65 and over eligible for Medicare are excluded from the analysis.

Marketplaces for which the federal government has taken on at least some of the responsibilities of administration are often referred to as FFMs. The delineation of FFMs from their State Based Marketplace (SBM) counterparts is challenging, since different states have taken on different degrees of marketplace administration and neither the text of the ACA nor the associated federal regulations provide a definition of the minimum responsibilities a state must take on to be considered to have a marketplace established by the state. For purposes of this analysis, we include 34 states, including those where the federal government has taken on complete responsibility (19), those with explicit agreements with the federal government where the state takes on some responsibilities but not others (7), and states without explicit agreements but have taken responsibility for plan management nonetheless (8). We do not include states

that had created the legal framework for an SBM but for which technical problems led to use of the federal IT system. While some of these 34 states may decide to take the necessary steps to establish a state marketplace once the required steps are delineated, doing so would undoubtedly require the investment of significant state resources and the presence of sufficient political will. Given the high degree of uncertainty around state marketplace establishment, our analysis assumes no change in status of the 34 states.

The version of the model used for this brief incorporates a number of model enhancements from the results previously reported in a brief on tax credits in FFM states.[7] Most importantly, premium tax credits are based on final 2015 reference premiums for each state adjusted for inflation to 2016. Earlier estimates were based on national premiums computed before 2014 premiums were finalized. Premiums for 2014 were lower than many anticipated due to factors such as narrow networks and increased competition in many areas. Reference premiums for 2015 in most states generally saw increases lower than the long-term growth trend.[8]

There is, of course, some uncertainty surrounding the time path along which individuals, families, and employers will respond to policy changes brought about by the ACA. Consistent with the convention followed by the Congressional Budget Office (CBO) and others,[9] we assume that behavioral changes in response to reform will be fully realized by the third year of implementation in 2016. That process, however, could take longer. The Children's Health Insurance Program (CHIP) did not reach a steady state until five years after enactment. If full implementation of the ACA with tax credits and cost sharing reductions is slower than anticipated here, then the foregone credits and the increase in the number uninsured we estimate for 2016 would occur somewhat later. Alternatively, if marketplace enrollment is faster than we assume, the estimated loss of coverage and credits would occur sooner.[10] Marketplace enrollment at the end of the 2015 open enrollment period (February 15) will be informative in these regards. Our estimate of marketplace enrollment nation-wide in 2016 is somewhat lower than the CBO estimate—we estimate 20.6 million will be enrolled nation-wide in 2016 compared to CBO's 24 million.

Results

The findings presented below focus exclusively on the 34 FFM states defined above. Elimination of the premium tax credits and cost-sharing reductions in these states would have the direct effect of decreasing affordability and thus insurance coverage and would indirectly increase nongroup health insurance premiums via the change in the average health status of nongroup insurance enrollees.

Health Care Coverage in FFM States

In 2016, the ACA as currently implemented is estimated to reduce the number of uninsured people in FFM states by 14.4 million (Table 1)—18.4 million people remain uninsured compared to 32.8 million had the ACA not been implemented. We estimate the number of people with nongroup coverage will be 14.2 million compared to 7.3 million without the ACA. The large majority of nongroup enrollment will be in the health insurance marketplaces (13.6 million), the only place where refundable tax credits and cost-sharing reductions for the purchase of health insurance coverage are available.

Table 1. Health Insurance Coverage of the Nonelderly in FFM States

	Without Reform		ACA as Currently Implemented			ACA without Tax Credits & Cost-Sharing Reductions		
	Number	*Rate*	*Number*	*Rate*	*Change*	*Number*	*Rate*	*Change*
Insured	**143,122,000**	**81.3%**	**157,556,000**	**89.5%**	**14,434,000**	**149,405,000**	**84.9%**	**6,284,000**
Employer	102,470,000	58.2%	104,014,000	59.1%	1,544,000	106,142,000	60.3%	3,672,000
Nongroup *(Non-Marketplace)*	7,324,000	4.2%	642,000	0.4%	-6,682,000	1,066,000	0.6%	-6,258,000
Nongroup *(Marketplace)*	0	0.0%	13,584,000	7.7%	13,584,000	3,407,000	1.9%	3,407,000
Medicaid/ CHIP	27,733,000	15.8%	33,721,000	19.2%	5,988,000	33,195,000	18.9%	5,462,000
Other *(including Medicare)*	5,594,000	3.2%	5,594,000	3.2%	0	5,594,000	3.2%	0
Uninsured	**32,835,000**	**18.7%**	**18,401,000**	**10.5%**	**-14,434,000**	**26,552,000**	**15.1%**	**-6,284,000**
Total:	**175,957,000**	**100.0%**	**175,957,000**	**100.0%**	0	**175,957,000**	**100.0%**	0

Source: HIPSM 2014. ACA Simulated in 2016

Medicaid enrollment will be nearly 6 million higher due to the ACA. Some FFM states have expanded Medicaid eligibility, while others have not, and these estimates reflect their current decisions. The number of people with employer coverage will be slightly higher (1.5 million, or 1 percentage point) due to the ACA.

However, if the Supreme Court rules in favor of King and federal tax credits and cost-sharing reductions are eliminated in these states, health coverage would be dramatically different. About 8.2 million more people would be uninsured than would be the case with the financial assistance provided under the ACA as currently implemented. The nongroup market would only cover about 4.5 million people, far less than the 14.2 million enrollees with the tax credits and even less than the 7.3 million absent the ACA at all.

Medicaid and CHIP enrollment would be about 500,000 lower without tax credits and cost-sharing reductions. Many children eligible for Medicaid or CHIP have parents eligible for marketplace tax credits under the current implementation. Without tax credits, fewer parents would seek marketplace coverage and, as a result, fewer children would be screened for and enrolled in public insurance.

Table 2. Marketplace Coverage in FFM States, by Income

	ACA as Currently Implemented	ACA without Tax Credits and Cost-Sharing Reductions	Percentage Difference in Persons Covered
	Persons Covered	*Persons Covered*	
Income Relative to FPL			
<200% FPL	4,861,000	442,000	-91%
200-300% FPL	3,460,000	577,000	-83%
300-400% FPL	1,910,000	457,000	-76%
400%+ FPL	3,354,000	1,932,000	-42%
Total:	**13,584,000**	**3,407,000**	**-75%**

Source: HIPSM 2014. ACA Simulated in 2016

Note: A small percentage of individuals enrolling in marketplace coverage with incomes below 400 percent of the FPL purchase coverage without tax credits under the current implementation of the ACA. Many of these individuals have offers of affordable employer-based coverage in their families and some others, particularly single young adults in the 300-400 percent of the FPL range, face full premiums for silver coverage that are low enough that they fall below the level covered by the tax credits (i.e., the premium is less than their applicable percent of income cap).

FFM Enrollment by Income

Under a finding for King, enrollment in these 34 nongroup marketplaces would fall by 75 percent, with the most dramatic enrollment declines among the lowest income people otherwise insured there (Table 2). The number of FFM enrollees with incomes below 200 percent of the FPL would fall by over 90 percent, the number of enrollees between 200 and 300 percent of the FPL would fall by 83 percent, and the number of enrollees between 300 and 400 percent of the FPL would fall by 76 percent. Enrollment by higher income individuals (over 400 percent of the FPL) is estimated to fall by 42 percent. As a consequence,

Table 3. Premium Tax Credits and Cost-Sharing Reductions Lost in FFM States if the Supreme Court Finds for King

	Persons Losing Tax Credits	% of Total	Lost Premium Tax Credits (millions $)	% of Total	Lost Cost-Sharing Reductions (millions $)	% of Total	Total Lost Tax Credits & CSRs (millions $)	% of Total
Income Relative to FPL								
<200% FPL	4,848,000	51.9%	16,438.9	65.3%	3,232.6	87.9%	19,671.5	68.2%
200-300% FPL	3,127,000	33.5%	6,810.5	27.1%	445.7	12.1%	7,256.1	25.2%
300-400% FPL	1,370,000	14.7%	1,910.1	7.6%	0.0	0.0%	1,910.1	6.6%
Total:	**9,346,000**	**100.0%**	**25,159.4**	**100.0%**	**3,678.3**	**100.0%**	**28,837.7**	**100.0%**

Source: HIPSM 2014. ACA Simulated in 2016

Note: Those with incomes below 250 percent of the FPL who are eligible for premium tax credits are also eligible for cost-sharing reductions (CSRs) when enrolling in silver marketplace coverage.

Table 4. Lost Tax Credits and Cost-Sharing Reductions and Increased Numbers of Uninsured Under a Decision in Favor of King, by State, 2016

	Number of People Losing Tax Credits	Total Value of Tax Credits & CSRs Lost (Millions $)	Average Value of Lost Tax Credits & CSRs Per Person ($)	Increase in the Number of People Uninsured
All FFM States	**9,346,000**	**28,837.7**	**3,090**	**8,151,000**
Alabama	165,000	547.1	3,310	124,000
Alaska	42,000	232.8	5,570	34,000
Arizona	266,000	456.1	1,720	237,000
Arkansas	128,000	418.8	3,280	95,000
Delaware	28,000	92.4	3,320	24,000
Florida	1,184,000	3,891.4	3,290	1,073,000
Georgia	461,000	1,524.9	3,310	435,000
Illinois	438,000	1,089.0	2,490	408,000
Indiana	225,000	924.5	4,110	195,000
Iowa	98,000	289.2	2,940	90,000
Kansas	166,000	419.0	2,520	135,000
Louisiana	214,000	857.4	4,010	199,000
Maine	62,000	257.0	4,150	50,000
Michigan	321,000	905.8	2,820	277,000
Mississippi	147,000	568.0	3,860	137,000
Missouri	299,000	1,006.8	3,370	228,000
Montana	70,000	192.3	2,760	61,000
Nebraska	97,000	282.3	2,900	83,000
New Hampshire	44,000	116.0	2,620	37,000
New Jersey	237,000	727.6	3,070	239,000
North Carolina	465,000	1,830.1	3,940	407,000
North Dakota	39,000	122.6	3,160	29,000
Ohio	497,000	1,510.1	3,040	459,000
Oklahoma	208,000	516.0	2,480	153,000
Pennsylvania	414,000	1,082.8	2,610	329,000
South Carolina	241,000	766.3	3,180	192,000
South Dakota	51,000	147.1	2,910	42,000
Tennessee	320,000	782.7	2,450	230,000
Texas	1,566,000	4,358.1	2,780	1,441,000
Utah	162,000	361.6	2,230	97,000
Virginia	321,000	1,071.4	3,340	280,000
West Virginia	41,000	146.3	3,550	49,000
Wisconsin	289,000	1,127.9	3,900	247,000
Wyoming	40,000	216.3	5,350	37,000

Source: HIPSM 2014. ACA simulated in 2016

Note: Those with incomes below 250 percent of the federal poverty level who are eligible for premium tax credits are also eligible for cost-sharing reductions (CSRs) when enrolling in silver marketplace coverage.

the composition of these much smaller marketplaces would shift from predominantly lower income (61 percent below 300 percent of the FPL) to majority higher income (57 percent above 400 percent of the FPL). Nearly all of those with incomes below 400 percent of the FPL who would still enroll in the marketplaces absent tax credits are those who purchased nongroup coverage before the ACA was implemented.

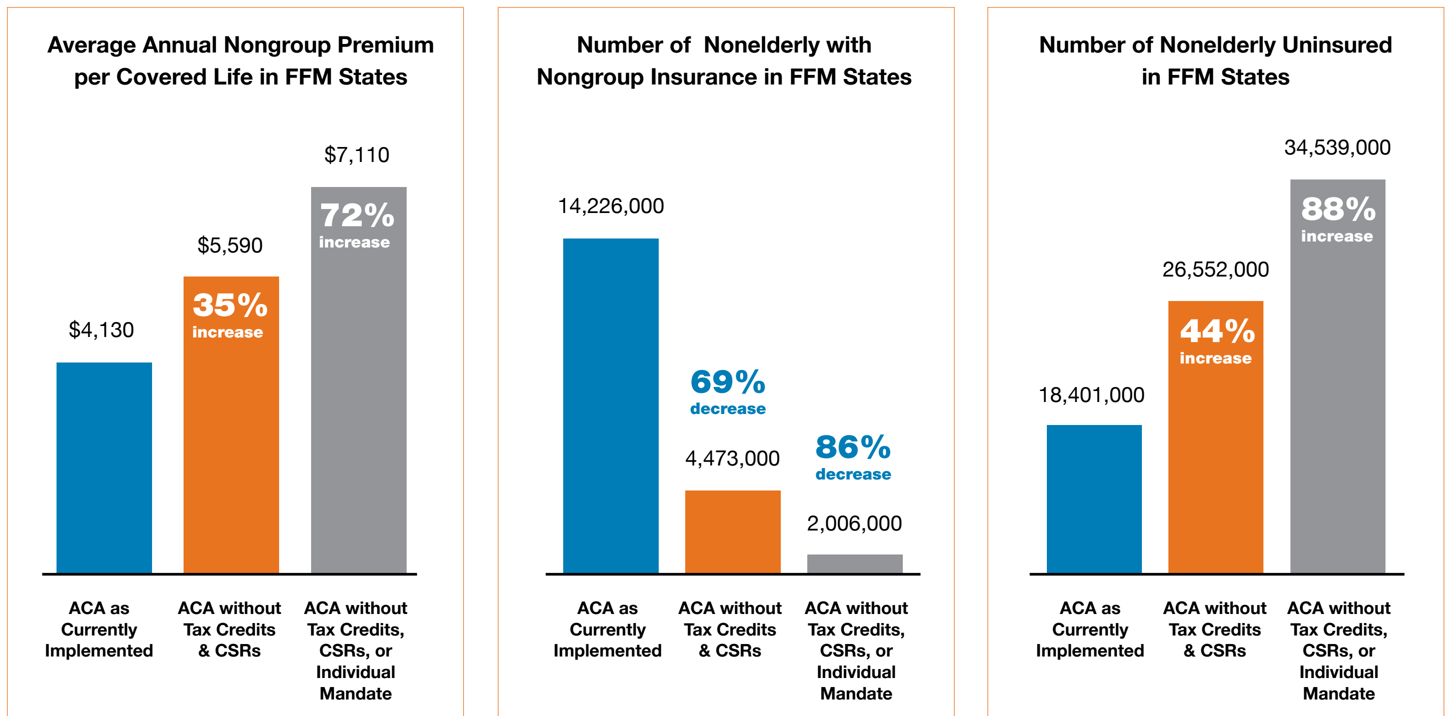
Lost Premium Tax Credits and Cost-Sharing Reductions Under a Supreme Court Finding for King

About 9.3 million people in FFM states would lose marketplace premium tax credits in 2016 if the Supreme Court finds for King (Table 3). Nearly 5 million of these people have incomes below 200 percent of the FPL, 3.1 million individuals have incomes between 200 and 300 percent of the FPL, and the remaining 1.4 million individuals have incomes between 300 and 400 percent of the FPL.

The value of the lost tax credits and cost-sharing reductions is about $28.8 billion in 2016. Foregone premium tax credits amount to $25.2 billion, while foregone cost sharing reductions amount to $3.7 billion. We estimate that, over a 10 year window, the loss of federal financial assistance would be about $340 billion.

In Table 4, for each FFM state, we show the total value of federal tax credits and cost-sharing reductions lost, the number of people who would lose them, the average loss per person who would otherwise receive them, and the number of people who would become uninsured should financial assistance be discontinued. The largest amount of aggregate foregone tax credits and cost-sharing reductions are, not surprisingly, in Texas ($4.4 billion) and Florida ($3.9 billion) because of the size of their populations. The average loss per person varies across states for two reasons. First, there are geographic differences in premiums—individuals of the same income facing higher premiums receive larger tax credits. Second, there are geographic differences in the distribution of income among those eligible

Figure 1. Nongroup Insurance Premiums, Coverage, and the Uninsured in FFM States, 2016



Source: HIPSM 2014. ACA simulated in 2016

Note: CSR stands for cost-sharing reductions

for the credits—areas where higher percentages of those eligible are lower income will have larger average credits since the credits are larger for those in most financial need. The states with the highest average value of lost tax credits and cost-sharing reductions per person are Wyoming ($5,350 per year, about $446 per month) and Alaska ($5,570 per year, about $464 per month), both states with high average premiums. Average nongroup premiums in Arizona are well below average, and thus the average financial assistance lost per person in that state would be considerably lower ($1,720 per year, about $143 per month).

Nongroup Premiums in FFM States

Without federal tax credits, the population purchasing nongroup coverage would be in worse health, on average. As a result, premiums for nongroup coverage would be notably higher in FFM states than they would be with the credits in place. In 2016, the average premium per covered life would increase by 35 percent, from about $4,100 to roughly $5,600 absent marketplace tax credits and cost-sharing reductions (Figure 1). The ACA treats the nongroup market inside and outside the marketplaces as a single risk pool; thus, any policy change that affects premiums in the marketplaces also affects premiums outside them in the same way. The 4.9 million individuals estimated to purchase nongroup coverage fully at their own cost under the ACA as currently implemented would face this 35 percent premium increase. The 9.4 million individuals who would lose federal tax credits would see the out-of-pocket price of their insurance coverage increase by even larger relative amounts, taking both the changing average premiums and lost credits into account.

The Importance of the Individual Mandate

A decision disallowing premium tax credits and cost-sharing assistance would not rescind the ACA's individual mandate, which was upheld by the Supreme Court in July 2010. But millions more would be exempt from the individual mandate because their net cost of insurance would be more than 8 percent of family income. However, the affordability exemption from the requirement is tied to the cost of the lowest cost bronze level coverage available, coverage that is less comprehensive and significantly less costly than the silver level plans most individuals are purchasing thus far through marketplaces. As a consequence, many people would still be subject to the requirement to obtain insurance or pay a penalty.

Older adults with moderate incomes are more likely to be exempt from the individual mandate than younger adults since premiums vary by age, with older adults charged up to 3 times more than younger adults. Thus, the individual mandate plays a larger part in enrolling younger adults than older adults, even absent tax credits. The more young adults enrolled, the lower the average premium in the insurance market. As a result, the 35

percent premium increase would be even higher if not for the individual mandate. Eliminating the mandate would mean an even larger share of young people would leave the nongroup insurance market, further increasing the average health care costs of those remaining.

The Department of Health and Human Services has the authority to define hardship exemptions to the individual mandate requirement and could exempt some or all of those losing tax credit eligibility under a decision in favor of King, just as they have exempted otherwise eligible individuals who live in states not opting for the Medicaid expansion.[11] There is a clear rationale why such a choice would likely be seriously considered. In the absence of tax credits and the subsequent large increases in premiums across all plans, bronze level (60 percent actuarial value) coverage is the tier of plans most likely to still be deemed affordable for those required to obtain coverage or pay a penalty. These plans are generally characterized by large deductibles (e.g., $4000 to $5000 deductibles are not uncommon in this tier) and significant co-payments or co-insurance. Maintaining the individual mandate would require a segment of individuals in the FFM states to purchase coverage with much higher premiums without financial assistance, coverage that has out-of-pocket requirements sufficiently high that many of those with modest incomes would not envision being able to pay the deductibles should the need arise, rendering the policies of little value. Consequently, eliminating the requirement to have coverage or pay a penalty for those affected by a court decision in favor of King would undoubtedly have political and policy appeal.

If the individual mandate is eliminated in the FFM states, premiums per covered life would be 72 percent higher than under the ACA as currently implemented (Figure 1). Nongroup enrollment in those states would fall even more dramatically, to 2.0 million, 86 percent lower than under the ACA as currently implemented. This represents only about 1 percent of the nonelderly population in FFM states. Thus, elimination of both tax credits, cost-sharing reductions and the individual mandate would result in a textbook case of an adverse selection death spiral. Without either credits or the individual mandate, the number of uninsured people in FFM states would rise to 34.5 million, an 88 percent increase relative to the ACA as currently implemented.

Discussion

Elimination of federal premium tax credits and cost-sharing reductions in FFM states would increase the number uninsured by 44 percent and would shrink nongroup insurance markets to levels well below what would have been absent any implementation of reform. As the result of fewer individuals purchasing coverage and the consequent changes in the mix of health status among those remaining, average premiums in those much diminished markets would increase by 35 percent.[12] While HIPSM does not explicitly model the timing of market dynamics, we anticipate the estimated changes to occur quickly. Unlike regulatory changes alone that could take up to a few years to work through a market, eliminating financial assistance will make coverage unaffordable to many enrollees immediately, causing them to drop coverage upon receiving their much higher bills. Insurers can be expected to revise their premiums accordingly at the next opportunity. A forthcoming brief will analyze the characteristics of individuals likely to be affected. Not taken into account here is that such declines in enrollment and the resulting adverse selection is likely to discourage insurers from participating in the marketplaces as well as the larger nongroup markets outside the marketplaces. Areas experiencing increased insurer competition under the ACA's initial years are likely to revert to smaller numbers of insurers, potentially increasing premium costs even further. If the individual mandate is also eliminated in these states, their nongroup markets are unlikely to survive.

FFM states could preserve their tax credits and cost-sharing reductions by assuming responsibility for their marketplaces. As a practical matter, however, doing so would be extremely challenging for most of them. The deadline for states to apply for federal grants to assist the development of SBMs expired in November 2014, leaving the financing of such a change squarely on the states' shoulders. In addition, at least in the near term, the political environments in most of these states are not conducive to participating, and a number of states would be hard pressed to devote the human and financial resources necessary to establish and operate an SBM.

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

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Notes

1 Estimates presented in this analysis of the number of people of different types that would be affected by a finding for the plaintiff reflect effects at a point in time. Some individuals uninsured or enrolled in nongroup insurance during one part of the year are replaced by other similar individuals during other parts of the year, increasing the number of individuals affected if counting over the course of a year rather at a particular moment. In addition, these estimates also understate the number of people who would be affected over time by this change in implementation of the law. Individuals uninsured or enrolled in nongroup insurance in one year are not necessarily the same people uninsured or covered by nongroup in the following year (since some gain coverage while others lose coverage over time).

2 A small share of these individuals purchasing non-group insurance without a tax credit are expected to remain in grandfathered (non-ACA compliant) policies in 2016. This small share would not be affected by the increased premiums in the ACA compliant market until they ultimately left their grandfathered plans.

3 Nongroup, or individually purchased, insurance is private coverage bought independently as opposed to as part of an employer group.

4 The marketplace and non-marketplace insurance markets are treated as a single risk pool to prevent one market from experiencing adverse selection, a phenomenon where high cost individuals are disproportionately covered in certain plans or markets, greatly increasing the premiums for those selected against and risking their destabilization. Within the single risk pool, increases in the average health care costs of enrollees overall, even if the higher cost enrollees are disproportionately enrolled in some plans relative to others, will lead to increases in premiums charged by all nongroup plans, both inside and outside the marketplace.

5 Our current estimates of aggregate tax credits and cost-sharing reductions are lower than in our previous analysis due to the marketplace premiums being lower than originally anticipated. For the same reason, marketplace enrollment is higher in the current analysis. The earlier analysis is available at: Linda J. Blumberg, John Holahan, and Matthew Buettgens. July 2014. "Potential Implications for ACA Coverage and Subsidies." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/413183-Halbig-v-Burwell-Potential-Implications-for-ACA-Coverage-and-Subsidies.pdf

6 For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities." http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

7 Linda J. Blumberg, John Holahan, and Matthew Buettgens. July 2014. "Halbig v. Burwell: Potential Implications for ACA Coverage and Subsidies." op cit.

8 John Holahan, Linda J. Blumberg, Erik Wengle, Megan McGrath, and Emily Hayes. December 2014. "Marketplace Insurance Premiums in Early Approval States: Most Markets Will Have Reductions or Small Increases in 2015." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/413287-Marketplace-Insurance-Premiums-in-Early-Approval-States.pdf

9 Congressional Budget Office (CBO). April 2014. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act." Washington, DC: CBO. http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

10 Total marketplace enrollment may ultimately be lower than we estimated here if purchasers not eligible for tax credits continue to obtain nongroup coverage outside the marketplaces at higher rates than originally anticipated; however, that choice would not affect our estimates of the impact of the King decision on the uninsured, the number purchasing nongroup coverage in total, or nongroup premiums.

11 See point 12, in Healthcare.gov. "Hardship Exemptions from the Fee for Not Having Health Coverage." https://www.healthcare.gov/fees-exemptions/hardship-exemptions/

12 Our findings are roughly consistent in relative terms with those from a study by researchers at the Rand Corporation which simulated the effects of eliminating the ACA's tax credits nation-wide. They estimated a 43 percent increase in nongroup premiums, compared to the 35 percent estimated here, and a 68 percent decrease in ACA compliant nongroup insurance coverage, compared to the 69 percent reduction estimated here. See Christine Eibner and Evan Saltzman. 2014. "The Individual Health Insurance Market – The Effects of Young Adult Enrollment and Subsidies," RAND Corporation Research Highlight. Santa Monica, CA: RAND Corporation. http://www.rand.org/pubs/research_briefs/RB9798.html

HEALTH POLICY ISSUE BRIEF

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Medicare Physician Payment Reform: Securing the Connection Between Value and Payment

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Executive Summary

Last year, Congress reached agreement in principle on legislation that would move Medicare's payment of physicians and other clinicians away from fee-for-service (FFS), which pays based on the volume and intensity of services they provide. Instead, Medicare would begin paying clinicians for providing better care, keeping patients healthy, and lowering overall costs – a "pay for value" approach. The bill also would end the sustainable growth rate (SGR) formula that has been ineffective in limiting physician spending growth or supporting better care. The proposed legislation represents a once-in-a-generation opportunity for Medicare to move away from volume-based payment to value-based payment and better support clinician-led efforts to improve care. At the same, we believe that some specific modifications to the legislation would enable it to do more to support better care and more value in Medicare. Our recommended modifications are in three major categories:

1. **Encourage the movement to effective alternative payment models (APMs)** by providing bigger rewards for APMs that are strongly related to value.
    - APMs that qualify for the bonus should require providers to make a meaningful shift from FFS payment, either by accepting "downside risk" or reduced FFS rates.
    - APMs should cover multiple services, ideally spanning sites of care and providers.
    - Qualifying APMs should be supported by evidence that they can reduce overall spending, including pilots.
    - Organizations that use APMs with more advanced measures of performance should receive additional bonus incentives.

2. **Improve Medicare's physician FFS payment system** by instituting policies that will achieve a higher-value set of services for Medicare beneficiaries, reducing costs without harming the quality of care.
    - Medicare's bonuses for care improvements and lower costs should not be multipliers on FFS payments.
    - Physicians who report on more meaningful, outcome-oriented performance measures in the new Merit-based Incentive Payment System (MIPS) should receive larger bonuses.
    - The payment differences for physician services provided in hospitals v. an office setting should be removed.
    - A test of utilization review tools for selected high-cost, discretionary procedures/ services should be implemented.
    - Revised documentation guidelines should be evaluated and considered as a replacement for the current rules governing billing for office visits.

3. **Improve and simplify the quality measures used in MIPS and APMs,** by implementing more meaningful performance measures and better support systems for clinicians to improve performance.
    - Initially, reporting and payment adjustments for physicians should be based on patient experience and engagement, as well as a limited number of core measures reflecting the patient conditions they treat. The measures should progress over time toward measures of appropriateness, clinical outcomes, patient-reported outcomes, and total patient cost/resource use.
    - In both MIPS and APM programs, physicians should be eligible for a higher bonus payment if they report on more meaningful measures.
    - Centers for Medicare & Medicaid Services (CMS) should provide additional support for developing and implementing better performance measures in APMs, including improved Medicare data sharing with physicians to enable them to take action to improve care.
    - The selection of core measures for use in payment and public reporting should be based on input from an independent, multi-stakeholder process.

These steps would not require major revisions in the bipartisan legislation, and in some cases could potentially be addressed through comments in the legislative history or CMS implementation. They would also help offset the costs of the legislation. Addressing these modifications now will enable Congress to achieves the goals of providing necessary support for clinicians to improve care, while avoiding excess Medicare costs and ineffective reforms.

Part 1

INTRODUCTION AND OVERVIEW

The U.S. health care system is on the verge of historic change. Since Medicare was passed in 1965, physicians have been paid on a FFS basis, building on the way they had been paid through commercial insurance for many decades. Last year, however, Congress reached agreement in principle on legislation that would move Medicare's payment of physicians away from FFS, which pays doctors based on the volume and intensity of services they provide. Instead, Medicare would begin paying physicians for providing better care, keeping patients healthy, and lowering overall costs – a "pay for value" approach.[1] The bill also would have ended the "sustainable growth rate" (SGR) formula that ineffectively attempted to cap physician payment rates. Although the legislation stalled due to disagreements about how it would be paid for, it will be considered again within the next year; one-year "patch" to avoid SGR cuts expires in March 2015.[2]

Key elements of the proposed legislation include:

- Termination of the SGR formula and provision of a 0.5% increase in payment rates over the next 5 years.
- Combination of three current physician payment programs into a new "Merit-based Incentive Payment System" (MIPS). Under MIPS, physicians in the traditional FFS program would receive a multiplier on their FFS payments based on a combined measure of performance on quality, "meaningful use" of electronic health records (EHRs), clinical practice improvement activities, and resource use (cost).
- Encouragement of physicians to participate in "alternative payment models" (APMs) via a 5% bonus for physicians who receive a significant portion of their revenue from an APM. Key elements of APMs include risk of financial loss if financial performance targets are not met, as well as quality measurement and improvement.
- Provision of funding for the development of quality measures. The measures would be developed and selected for use by CMS with input from multiple stakeholders, with heavy reliance on physician specialty societies. Certain types of measures, including resource use measures and those extracted from clinical registries, are exempt from the multi-stakeholder process.

Altogether, the reforms include not only the development of a new set of payment alternatives to FFS built into the traditional Medicare program. They also include some improvements in the FFS payment system that could also support higher-value care. And they include both positive incentives (e.g., payment bonuses) and negative incentives (e.g., relatively low updates to physicians staying in FFS payment) to encourage the shift to APMs.

The stakes are high. This is a once-in-a-generation opportunity to move away from volume-based payment to value-based payment in Medicare – a step for which policy experts, patients and many providers have been advocating for many years. If we get it right, Medicare physician payment reform can have a significant positive impact on: quality of care for patients; affordability for beneficiaries and taxpayers; and physician payment arrangements in commercial insurance, including the new health insurance exchanges.

Although the proposed legislation is an important step in the right direction, we believe it could be strengthened. The purpose of this paper is to identify specific improvements in the physician payment segment of the SGR replacement bill. We do not fully address the important issue of how to pay for the legislation here, though some of our proposals could offset part of the costs of the legislation. We recognize the limits on the political feasibility of making changes in the legislation at this stage, but we believe these proposals are key modifications required for the legislation to achieve its intended goals.

In developing our recommendations, we were guided by **four primary objectives**:

1. Make improvements in Medicare's FFS payment system that reinforces the goals of physician payment reform.
2. Accelerate movement to alternative payment models that represent feasible and substantial enhancements in care delivery and that cannot be achieved through current CMMI pilot authority.

3. Encourage meaningful measurement and transparency regarding quality and cost.
4. Reinforce other needed reforms in Medicare and the US health care system -- in particular, reforms to achieve sustainable spending trends and improved health outcomes.

Our recommendations fall into **three major categories**:

1. **Encouraging the movement to effective APMs** by assuring that bonuses for APM adoption are: 1) based on clear measures of shifting from FFS to episode- and person-level payment with financial risk; and 2) likely to produce higher quality care with better health outcomes.
2. **Improving Medicare's physician FFS payment system** by correcting payment differences for physician services provided in hospitals vs. an office setting; by testing utilization review tools for selected high-cost, discretionary procedures and services; and by changing the MIPS formula so that it does not reward and encourage higher volume.
3. **Improving and simplifying the quality measures used in MIPS and APMs**, with better outcome measures and stronger incentives and support for using them.

Each of these reforms includes elements that promote system-wide improvement; in addition, as Congress identifies ways to pay for physician payment reform, we encourage other reforms that reinforce the same goal.

Part 2

ALTERNATIVE PAYMENT MODELS THAT SUPPORT BETTER, LESS COSTLY CARE

The SGR replacement bill has clinicians who adopt an APM can qualifying for a payment bonus equal to 5% for a qualifying plan, if a minimum share of their payments are not traditional, unconstrained FFS. While the bonus is an important incentive for shifting from FFS payments, it will not have the intended effects on driving substantial changes in payment to enable higher quality and lower costs. The bonus is a fixed percentage of total payments if a payment system qualifies, which means that APMs with very different implications for reforming care may potentially qualify for the same bonus payments. For example, a physician group receiving shared savings on its overall costs for all of its payers could claim that this is 100% of payments in an APM, even though the group is at no financial risk and the vast majority of its payments remain FFS-based. In contrast, a physician group that has 25% of its patients paid on a capitation basis could be scored at 25% and not qualify, even though this payment reform represents a significantly larger share of revenue that could enable much more substantial changes in care. It is imperative to define an APM bonus system that moves away from unconstrained FFS, and that provide larger rewards for larger shifts, as opposed to offering new revenue opportunities without encouraging a meaningful transformation of the business model. Finally, having a bonus that is proportional to the change from unconstrained FFS also addresses how to determine a bonus for organizations participating in multiple APMs.

Legislation should modify the criteria for APM bonus determination to include some specific criteria. Our legislative recommendations involve six key points to support effective APMs:

1. **The bonus should be a fixed payment, not a multiplier on fees.** This is important because a fee multiplier would increase FFS incentives and thus offset the intended effect of the reform.

2. **In determining whether an APM qualifies for a bonus, what matters is how Medicare pays the provider organization**. The organization may allocate the payments and any bonus as they see fit; those decisions do not affect our definition of the APM.

3. **APMs that qualify for the bonus should require providers to make some meaningful shift from unconstrained FFS payment, either by accepting "downside risk" or reduced FFS rates with bundled or per-member per-month payments**. This criterion is important to prevent providers from getting bonuses in models that still

remain essentially status quo FFS-based payment. For example, a supplemental payment for participation in a PCMH would not qualify as an APM by itself. Nor would a shared savings model without a transition to downside risk. However, qualifying APMs that include downside risk could still rely on FFS payment, to manage day to day operations and allocate funds across different providers in the organization. The point is that the FFS payments would be constrained by the shared accountability. The shift from unconstrained FFS should be large enough so that if physicians do not improve the care that they deliver, their total payments (excluding the bonus) should be lower under the APM.

4. **APMs should cover multiple services, ideally spanning sites of care and providers.** For example, a global budget model, episode payment, or partial capitation payment would meet this criterion.

5. **To be implemented nationally, qualifying APMs should be supported by evidence that they can reduce overall spending.** For example, while episode based bundled payments may meet other criteria, they may encourage an increase in the number of episodes, offsetting cost savings within the episode. In the absence of evidence that the bundled payment would not increase spending, it should qualify for the bonus only as a pilot APM not a national APM.

6. **Organizations that use APMs with more advanced measures of performance should receive additional bonus payments,** such as those reflecting the outcome and patient experience priorities outlined in the National Quality Strategy or the NQF Measure Application Partnership.

The legislation or legislative history could include a specific illustrative formula to accomplish these principles. The formula would link the size of the payment bonus to the magnitude of the payment reform's movement toward greater accountability for patient costs and quality of care. The Appendix describes a general formula for determining the APM bonus payment amount (not a multiplier of fees) for a provider or group.

Part 3

IMPROVEMENT IN MEDICARE'S FEE-FOR-SERVICE PHYSICIAN PAYMENT SYSTEM

Medicare's FFS payment system, as modified in the legislation to include payment adjustments based through MIPS, will likely remain a major part of Medicare physician payment for a long time. For this reason, Congress and CMS should continue to focus on ways to improve the accuracy and the function of Medicare FFS. The MIPS payments related to quality and efficiency should also align with Medicare's broader payment reform goals. A well-designed FFS payment system can help physicians move toward alternative, more effective payment and delivery models when they are available.

Avoid providing MIPS payment adjustments in proportion to FFS rates where possible

If MIPS is a multiplier on FFS rates, then physicians will receive more payment when their volume and intensity increases, undermining the goal of providing more support for physicians providing better, more efficient care. One approach is to provide a per-practice or per-beneficiary adjustment. This could be based on Medicare payments to the physician or practice in a base period (e.g., one to three years preceding the measurement period for calculating MIPS). Another approach is to provide the MIPS payment as a per-beneficiary or per-episode payment in the specialty, for example as an expanded version of the chronic care management fee for primary care physicians, or in conjunction with (but not as a multiplier of) the procedure fee for surgeons and other specialists. Beneficiaries should not be responsible for copays on these payments. While a volume-related MIPS payment may be unavoidable in some cases, CMS should be encouraged to use other approaches that are more aligned with the goal of moving payments away from volume and with the episode- and beneficiary-based payments that will be used in the APMs.

Reward use of more meaningful performance measures in MIPS

We previously described how physicians who participate in APMs that use more meaningful performance measures

should be eligible for a higher bonus payment. Physicians who use patient-reported outcomes in MIPS should receive higher potential payment for reporting these measures, transitioning to higher payment for superior results. An initial bonus of around 2% would support significant progress toward meaningful performance measurement. CMS should aim to align both MIPS and APMs around meaningful outcome measures, as we describe in more detail below.

Address site of service differentials for services not uniquely provided in hospital outpatient settings[3]

One problem with the current system of relative prices is that differences in prices across care settings are causing distortions in provider incentives. In particular, hospital outpatient department rates are not aligned with rates paid for the identical services in physicians' offices; for common services including physician office visits and cardiac imaging, Medicare pays as much as twice as much to the hospital because it pays both a hospital facility fee and a physician service fee, whereas it pays just a physician service fee for the service when billed by a physician's office. The payment for the service provided in the physician's office does include an amount for the office's incurred practice expense but that amount is far less than the facility fee, which is based on hospital cost reporting.

The result of this "provider-based payment" policy is that hospitals have an incentive to acquire physician practices to receive the higher payment, while physicians who order and perform affected services can demand a commensurately high compensation package from the hospital in exchange for a flow of relatively higher paid outpatient services. The provider-based policy applies whether or not the employed physician practice is located physically in close proximity to the hospital, serving an extension of the hospital and thereby to some extent assuming some of the unique hospital obligations independent physicians don't have, or, alternatively practice some distance away and functioning equivalent to an independent practice. In short, the physician employee of a hospital often continues to practice in the very same location with the same cost structure as when they were independent practice, but the employment arrangement permits the hospital to bill the physician's service as a Hospital Outpatient Department (HOPD) service.

The Medicare Payment Advisory Commission (MedPAC) has recommended that higher rates for HOPD services should be limited to select services for which the hospital does bear unique costs, such as for standby emergency and operating room services and for certain other services provided to HOPD patients who are systematically more medically complex than patients receiving the services in a freestanding physician office. In MedPAC's analysis, 66 of 450 conditions in the Ambulatory Payment Classification coding system for HOPD services did not require standby capacity, have extra costs associated with clinical complexity, and otherwise did not require additional overhead associated with their provision. MedPAC divided the identified services into those for which HOPD services could equal physician office payment rates and those for which a higher rate can be supported but at a substantially reduced amount compared to current levels. [4]

MedPAC estimates that changing payment rates for ambulatory payment classifications (APCs) for the designated conditions would, on net, reduce program spending and beneficiary cost sharing by a total of $1.1 billion in one year – about $0.9 billion in program spending and $0.2 billion in cost-sharing.

Implement a Prior Authorization Pilot Program

Prior authorization is widely used by private payers for advanced imaging services, including CT, MRI, and PET scanning and nuclear imaging, but has not been adopted by Medicare. Indeed, Medicare's legislative authority to engage in prior authorization programs is unclear. Many policy experts have recommended that Congress provide CMS with clear authority to administer prior authorization programs not only for advanced imaging services but also perhaps for other rapidly growing, elective services, like physical and radiation therapy and for particular high cost, non-urgent services for which there is evidence of or likelihood for inappropriate provision. [5]Inappropriate provision of services raises program and Medicare beneficiary costs and, sometimes, compromises the quality of care.

Medicare would face some distinct administrative and policy challenges in applying even the most successful private insurance prior authorization approaches. A pilot program testing prior authorization for advanced imaging services, which has been a mostly successful application in recent years by private insurers, could be a model for expansion

nationally for imaging but also as a model for other clinical areas to reduce inappropriate care and improve quality, especially for rapidly growing elective services that exhibit significant practice variation.

In 2008, the Government Accountability Office recommended that CMS examine the feasibility of imaging prior authorization, based on success of the approach by private plans contracting with Radiation Benefit Managers. In 2011, MedPAC suggested a modified approach that would require only well-documented, high-use practitioners to participate in a prior authorization program for advanced imaging. [6] Medicare would pilot in a region of the country an approach that would require physician outliers – those who order a significantly greater number of advanced imaging services than other physicians who treat clinically similar patients – to participate in a prior authorization process. The approach to targeting only outlier physicians for prior authorization is referred to as "gold-card" recognition, because the majority of physicians who have patterns of high approval rates would receive automatic approval when they order studies. This gold card approach permits targeting of scarce administrative resources, while avoiding any new burdens on most physicians, a very important attribute for use in Medicare. The targeting approach would also encourage all physicians to be more prudent in their use of imaging to avoid being subject to the new oversight.

To further promote cost-effectiveness, the pilot program would attempt to apply the prior authorization only to imaging services that account for a significant share of spending and service volume, have evidence-based guidelines for appropriate use, and exhibit substantial variations in use among ordering physicians and across geographic areas. The pilot could include both high and low use areas to learn whether physician receptivity to prior authorization and operational issues vary across high and low use areas. Further, the pilot could explore the approach if delegation of determining appropriateness to hospitals and other organizations using decision support systems (DSS), which has undergone preliminary testing by CMS. DSS are decision aids that provide real-time feedback to ordering physicians on the appropriateness of ordered imaging studies based on clinical guidelines and administered by the organizations themselves.

The pilot test would be conducted under the authority of the Centers for Medicare and Medicaid Innovation. Using rapid cycle evaluation, CMS would determine whether the approach shows savings and stable or improved quality, in which case it promptly would be expanded broadly. Also, based on findings from the demonstration, CMS might be in a position to recommend statutory provisions for expansion of prior authorization to other services while preserving the commitment to the targeting the approach to outlier clinicians based on valid analysis of their ordering practices, consistent with recommendations made by MedPAC.

Further, as with other provisions in the SGR Repeal legislation, if the pilot testing is found successful and the concept expanded more broadly in Medicare, physicians who participate in a meaningful alternative payment model, such as those described above that involve assuming financial risk for attributed patient populations, would be excluded from the prior authorization program.

As a pilot program, we do not assume programmatic savings from this initiative. In 2008, CBO estimated that a prior authorization program applied to all Medicare physicians for advanced imaging services would reduce spending by $220 million over 5 years and about $1 billion over 10 years. [7]

Review Documentation Guidelines for Office Visits

We propose that the physician payment legislation include a provision to reexamine the "documentation guidelines" that physicians must follow for coding office visits. For nearly 20 years, CMS has relied on these guidelines to assist physicians and auditors in coding properly for office visits under the Medicare Physician Fee Schedule, payment for which constitute almost half of spending under the Fee Schedule. The guidelines were developed because of concerns that the ambiguity in the five levels of Current Procedural Terminology (CPT) code descriptors for office visits was permitting substantial up-coding of services being performed and billed for.[8] They require health professionals to document in the medical record specific elements of patient histories, physical examinations, and clinical decision-making to justify the specific code level for which payment is being claimed.

Unfortunately, the application of the documentation guidelines likely has not reduced up-coding. In fact, they may facilitate up-coding because the widespread adoption of EHRs encourages "cut-and-paste," permitting practices to document clinical activities that may not accurately reflect the content of the office visit for which payment is being sought. In addition, the documentation requirements may cause clinicians actually to over-document, making the medical record an ineffective source of communication among clinicians. To address the elements of care associated with different code levels that are specified in the guidelines, some clinicians may engage in extraneous clinical activity that does not benefit patients but supports the higher than necessary code for payment purposes. Other clinicians, fearing sanctions for misrepresenting the contents of a medical visit, may down-code their services. Finally, concerns have risen in recent years that the transformative potential of EHRs has been seriously hindered because software developers have been oriented toward providing documentation needed to support coding rather than developing important functions, especially clinical decision support that would improve the quality, safety and efficiency of patient care. [9]

While there is widespread agreement among physicians and other health professionals that the documentation guidelines are misguided, they remain in place, unchanged for more than 15 years, largely because there has been no consensus about how to fix the underlying CPT office visit code descriptors. Yet, for at least the last decade, there have been no attempts to consider developing alternative office visit code descriptors or systematically assess whether the current application of the documentation guidelines are counterproductive, with negative impacts on the integrity of the clinical record, the potential of EHRs, while increasing costs.

To address this problem, Congress should ask the Medicare Payment Advisory Commission (MedPAC) to conduct a study of documentation guidelines and the underlying CPT codes to which they apply to be completed within 12 months. The study should include an assessment of the impact of the guidelines on:

- The accuracy of codes being submitted for payment;
- The accuracy of information and usefulness of clinical records, both paper and electronically-based;
- The potential of EHRs to improve clinical care and efficiency rather than facilitate coding for payment.

The study also would provide an assessment of the feasibility of adopting other coding structures and descriptors would obviate the need for documentation guidelines and what additional work would be needed to accomplish such alternative coding structures. Finally, the MedPAC study would consider whether the current application of documentation guidelines might be waived for clinicians qualifying for participation in Alternative Payment Models.

Part 4

BETTER AND SIMPLER PERFORMANCE MEASURES FOR PHYSICIANS

The proposed legislation addresses many of the problems with the current measures used in Medicare's public reporting and physician payment programs, including:

- Complexity due to the use of multiple reporting and payment incentive programs: Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM);
- Over-reliance on process measures that are often unrelated to outcomes;
- A dearth of standardized outcomes measures;
- A lack of comparative data on physician performance;
- Providers' lack of access to timely, actionable that can help them improve their performance.

In particular, in 2018, the MIPS program would replace the current programs for quality measurement (PQRS, Meaningful Use, and the Value-based Modifier). Performance reporting and payment incentives under the MIPS would be based upon four categories: quality, resource use, meaningful use of EHR, and clinical practice improvement activities. Providers would select which quality measures (from an annual list published by CMS) on which to report and be assessed.

The bill would provide $15 million/year from 2014-2018 for the development of better performance measures. The Secretary would be required to develop a measure development plan, using the following criteria to set priorities:

- Outcome measures
- Patient experience measures
- Care coordination measures
- Measures of appropriate use of services
- Consider gaps
- Consider applicability of measures across health care settings

The proposed legislation also references the use of a multi-stakeholder consensus-based entity, such as the National Quality Forum (NQF), to endorse measures and make recommendations for their use in public reporting and Medicare payment programs. Under the proposed bill, however, measures might be selected for MIPS regardless of whether they were endorsed or recommended by a consensus-based entity. Furthermore, certain types of measures, including resource use measures and those extracted from clinical registries, would be exempt from the multi-stakeholder process.

Simplifying the measure reporting process in MIPS and accelerating the movement to population-based and condition-specific outcomes measures that are most meaningful to patients and physicians are a key part of the proposed legislation. We believe they should be more prominent parts with more substantial financial support. Success will mean physicians will have measures that they believe should be the object of efforts to improve practice (and data showing them how to improve on the measures), the measures can be consistently applied to a variety of alternative payment models and Medicare's other payment systems, and consumers and others will be able to compare providers, all with less administrative burden. These are all very important steps for the success and sustainability of payment reform, but we believe that achieving success will require additional implementation steps and more financial support.

Our proposed approach is based on the following principles:

- Physicians with core activities amenable to accurate measurement without undue administrative burden should be recognized and rewarded or penalized for better performance mostly on measures of outcomes and patient experience.
- Measures and complementary payment rewards and penalties should be strategically applied to focus on priority quality and safety problems amenable to accurate assessment by measurement of outcomes. Other important quality problems not currently amenable to accurate outcome measurement should also receive attention and should be addressed through quality improvement approaches that do not rely primarily on measurement.
- Measure development and endorsement should be focused on a limited set of key, outcome-oriented measures, reflecting a set of principles for meaningful progress on measurement such as those used by the NQF Measure Application Partnership.
- The measures should be standardized to ensure fair comparisons among providers
- Measures should be designed to facilitate the transition from FFS to APMs.
- Measures used in public reporting and payment should be based on input from an independent multi-stakeholder consensus group that uses objective criteria for endorsement and recommendations.
- Providers should receive timely data related to their performance on the measures, so that they have a meaningful opportunity to improve care or address measurement problems, before the measures are publicly reported or used for payment.
- Providers should be rewarded for shifting to the use of meaningful, outcomes-based, comprehensive measures.

SPECIFIC RECOMMENDATIONS

Meaningful and Simplified Measures

Strengthen and streamline measures used in MIPS. We recommend reducing the scope of reporting requirements for physicians under MIPS, which are built on existing requirements under PQRS, Meaningful Use, and the Value-based Modifier. Instead, physicians in the MIPS program should be required to use patient experience and engagement measures at the individual physician level, as well as a **limited number of core measures reflecting the patient conditions they treat**.

At present, physicians can generally use individual-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures; suitable outcome measures are not available for most specialties, but progress is occurring and should be accelerated. The measures should progress over time from appropriateness measures toward use of clinical outcome measures, patient-reported outcomes measures and total patient cost/resource use measures. Individual outcome measures should be used only for certain specialties and procedures/services in which it is feasible and appropriate to attribute the outcomes to a specific physician.

Strengthen and streamline measures used in APMs. We recommend that physicians in APMs be expected to measure a **similar concise set of meaningful performance measures** reflecting these same priorities: clinical outcomes, patient-reported outcomes, patient experience, and appropriateness. These key quality measures should be accompanied by total cost/resource use and efficiency measures. By 2018, such measures should reflect most of the patient care that they provide, as well as for care of their total patient population.

Accelerated Measure Development

CMS should prioritize the development of measures in MIPS and APMs for the top 20 conditions/clinical areas based on high cost, high volume, variation, and opportunities for care improvement. These should include crosscutting measures for situations in which condition-specific measures may not be appropriate, e.g., for patients with multiple chronic conditions. For each of these, high priority should be placed on measures of clinical outcomes, patient-reported outcomes (e.g., Patient Reported Outcomes Measurement Information System), patient experience, appropriateness and total cost of care. CMS should aim for these measures to be available for use in the top 20 clinical areas by 2018.

Measure selection process

The selection of core measures for use in payment and public reporting should be based on input from consumers, purchaser, payers and other stakeholders. The best way to assure this is through an **independent, multi-stakeholder process**. The proposed bill language would weaken the multi-stakeholder process and does not assure stakeholder input. To assure that measures are comparable and meaningful, there should be **no exceptions for certain data sources** (e.g., clinical registries) **or types of data** (e.g., cost/resource use or appropriateness). If there are important issues or problems with the multi-stakeholder process that need to be addressed, Congress should direct CMS to do so through its process of contracting with the responsible organization.

Specialty societies should be encouraged to nominate measures to be considered, and should receive support for developing and piloting measures that can be produced interoperably by different providers and electronic record systems. There should be no requirement for review of proposed measures in peer-reviewed specialty journals. An effective multi-stakeholder review process would assure that the measures are carefully considered.

Health Information Technology

Office of the National Coordinator (ONC)/CMS should facilitate mapping of recommended measures among registries, EHR systems, and CMS reporting requirements, to encourage both reporting and improvement feedback.

ONC/CMS should assure that mechanisms are widely available to physicians who use electronic records and/or participate in electronic registries to permit widespread capture of relevant data for key performance measures. The highest priority should be capture of patient experience data and of patient-reported outcomes (PROs) for high-burden conditions by eligible providers.

Access to Data for Quality Improvement

Medicare should build on its current mechanisms for sharing claims data with physicians to give them better and timelier data to support care improvement activities. This includes providing regular, timely updates on data relevant to key performance measures (e.g., quarterly updates on, with access to underlying data to enable physicians to determine how they could improve performance), and "baseline" measures of how physicians or physician groups would fare in performance measurement and reimbursement if they chose to adopt an available APM. Such data should be available ahead of public reporting and payment, and ideally in time for physicians to make any needed practice adjustments. The highest priorities for such actionable data access are the priority measures described in this section and any measures related to resource use in MIPS.

Higher Payment for Use of More Meaningful Performance Measures.

In both MIPS and APMs, we have proposed physicians should be eligible for a higher bonus payment if they report on more meaningful measures. In particular, physicians who use outcome-oriented measures in MIPS should receive higher potential payment for reporting these measures (i.e., a 2 percent bonus), transitioning to higher payment for superior results. APMs that initially rely on meaningful outcome measures should receive a higher payment bonus (at least 2 percent) than APMs that rely mainly on process measures, and APMS should be required to transition to priority, outcome-oriented measures within five years, along the lines we have described above.

APPENDIX

Illustrative APM Bonus Formula That Provides More Support for More Meaningful Physician Payment Reforms

Below, we describe a general formula determine an APM bonus in a manner that reflects our principles for providing more support for more meaningful physician payment reforms. This APM flat amount per provider/group (not a multiplier to fees) based on our principles:

Bonus = (Adjustment Factor) x (Benchmark Spending) x (Payment Shift) x (Outcome Measure Adjustment)

Adjustment Factor would be set by CMS based on overall budget target or other high-level policy guidance. This is a scaling factor.

Benchmark Spending is the (risk-adjusted) spending benchmark for the provider/group. For episode payment models, it could be the episode rate, multiplied by the expected number of episodes for the physicians involved. For primary care per member per month (PMPM) models, it could be the benchmark used to determine shared savings or losses for the primary care group. For global payment models and other payment reforms that combine physician payment with payment to other providers, it is the component of the overall spending benchmark derived from physician payments (i.e., other provider payments are not counted in the physician incentive benchmark). It could also be "baseline" Medicare spending for the physician group trended forward. Essentially, this is the expected total spending for the physicians involved in the payment reform – actual spending is not appropriate for determining the bonus, since that would reward groups that increase spending.

Payment Shift is a measure of the magnitude of the APM. It reflects two factors: "Share" and "Strength".

"Share" represents the share of payments shifting from FFS to risk-based payment under the APM. It is the ratio of payments involved in the APM (e.g. subject to risk such as episode payment or PMPM) to total baseline payments, net of any new payments in the APM. For example, if 20% of a physician's payments in a bundled payment initiative involve partial or full bundles that replace FFS payments, the share would be 0.2. If fees for office visits are replaced by a PMPM, the share equals the ratio of the eliminated FFS payments to baseline payments. For example, if the APM reduced all of the provider's FFS rates by 20%, and set up a PMPM payment equal to those expected FFS payments, the share would be 100%.

"Strength" of the APM measures the risk Medicare transfers to the provider organization. It should be computed as the 1 minus the ratio of Medicare spending change that would occurs under the APM *if* volume increases or decreases relative to the Medicare spending change that would have occurred under the previous FFS system. For example, in an APM that shifted to a fixed payment for the services involved*, if* volume of those services increases 10%, or *if* volume fell 10%, Medicare spending would not change at all, so the ratio of the Medicare spending increase under the APM to that under FFS is 0 and thus the strength of the APM is 1. In an APM with 60% loss sharing above the benchmark, the strength would be 0.6, because *if* volume of the services involved in the APM were to rise 10%, Medicare spending would increase only 4% (that is, 1-4%/10%=.6).

The same principles apply to models that combine PMPM payments with reductions in FFS payment rates. For example, consider the previous APM example that includes a PMPM along with a 20% reduction in FFS rates. If under that model volume were to increase 10% (maybe because utilization was still profitable and thus there was induced demand), the increase in volume would result in only an 8% increase in spending. Since Medicare would only pay 80% of the traditional FFS amount, the strength would be 0.2.

Payment Shift = Share * Strength

Note that this approach would apply to both episode and capitated APMs. In contrast to a partial- or fully-capitated APM, in which the share is 100%, the share in an episode APM is the proportion of physician payments covered by the episode payment. The strength measures the degree of loss sharing if the benchmark is exceeded. However, in episode models, even if the strength is 1, Medicare spending could increase if the volume of episodes increases. For this reason, we recommend not piloting episode payment models until there is supporting evidence that the volume of episodes does not increase, or including other adjustments in the APM to offset the effects of a higher volume of episodes.

Outcome Measure Adjustment is a further bonus for physicians using APMs that involve endorsed and/or validated patient outcome and experience measures as the basis for their reimbursement. The intent is to encourage continuing progress toward more meaningful performance measures in APMs. This could be implemented as a further upward adjustment in the payment bonus. For example:

- Minimum value=1 if no endorsed patient outcome and experience measures
- Maximum value=1.10 (i.e. an additional 10% increment to the bonus) if all measures are endorsed outcome and experience measures.

For systems with mixed structure/ process/ outcome/ experience measures, the value could be in proportion to the share of endorsed outcome/experience measures (or if possible, the share of APM payments tied to outcome/experience measures).

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ISSUE BRIEF
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The Commonwealth Fund

The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014

Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel

Abstract New results from the Commonwealth Fund Biennial Health Insurance Survey, 2014, indicate that the Affordable Care Act's subsidized insurance options and consumer protections reduced the number of uninsured working-age adults from an estimated 37 million people, or 20 percent of the population, in 2010 to 29 million, or 16 percent, by the second half of 2014. Conducted from July to December 2014, for the first time since it began in 2001, the survey finds declines in the number of people who report cost-related access problems and medical-related financial difficulties. The number of adults who did not get needed health care because of cost declined from 80 million people, or 43 percent, in 2012 to 66 million, or 36 percent, in 2014. The number of adults who reported problems paying their medical bills declined from an estimated 75 million people in 2012 to 64 million people in 2014.

OVERVIEW

In 2014, 6.7 million people enrolled in health plans sold through the Affordable Care Act's marketplaces, with most signing up through the federal marketplace website, HealthCare.gov. For the 2015 open enrollment period—which began on November 15, 2014, and ends on February 15, 2015—the pace has been brisk, with 6.8 million people in 37 states reenrolled or newly enrolled through the federal website by the beginning of the year.[1] In addition, at least 600,000 people have signed up through the 14 state-operated marketplaces.[2] Nearly 10 million people have newly enrolled in Medicaid since October 2013.[3]

These new subsidized options for people who lack insurance from employers are helping to reverse national trends in health care coverage and affordability. The latest Commonwealth Fund Biennial Health Insurance Survey of 2014, the longest running nonfederal survey of U.S. health insurance coverage, shows that uninsured rates have declined to their lowest levels in more than a decade. Rates among young adults and low-income adults are at their lowest levels in 14 years. For the first time since we began asking the question in 2003, there was a decline in the number of adults who reported not getting needed care because of cost. And for the first time, there was a decline in the number of people who had problems paying their medical bills or who are paying off medical debt over time. The survey was conducted from July 22, 2014 to December 14, 2014 by Princeton Survey Research Associates International, with 4,251 adults ages 19 to 64.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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SURVEY FINDINGS IN DETAIL

Number of Uninsured Adults Began to Decline in 2012

The number of uninsured adults ages 19 to 64 declined to 29 million in 2014, or 16 percent of the population, from a high of 37 million, or 20 percent, in 2010 (Exhibit 1, Table 1).[4,5] The decline from 2012 to 2014—after the first year of full implementation of the health reform law's insurance options for people without employer-sponsored health insurance—is the first statistically significant decline measured by the survey since it began in 2001. The uninsured rate is now at its lowest level since 2003.

Exhibit 1. The Number of Uninsured Adults Dropped to 29 Million in 2014, Down from 37 Million in 2010

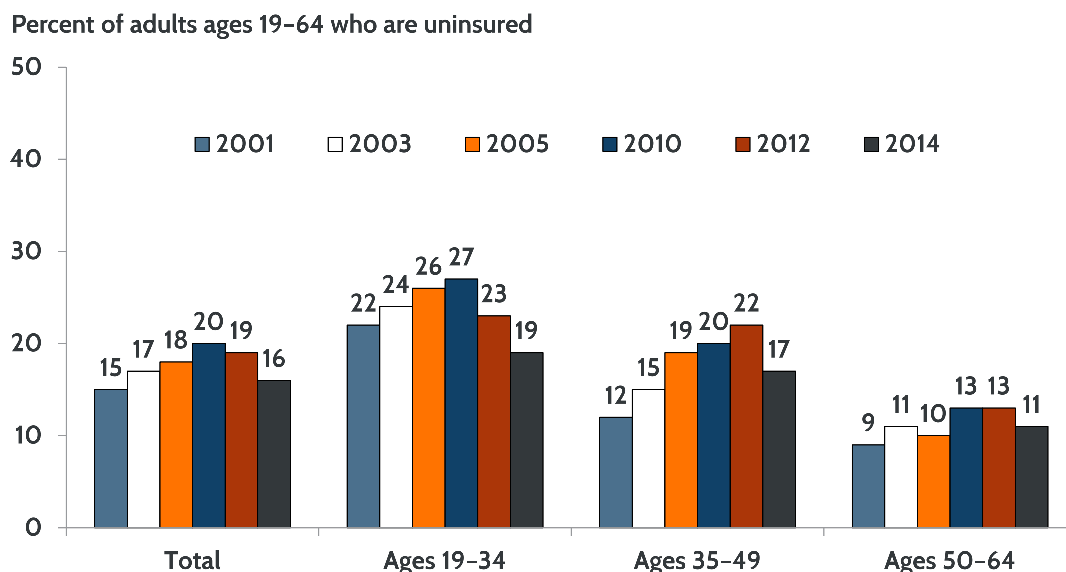
Adults ages 19–64

	2001	2003	2005	2010	2012	2014
Uninsured now	15% 24 million	17% 30 million	18% 32 million	20% 37 million	19% 36 million	16% 29 million
Insured now	85% 138 million	83% 142 million	82% 141 million	80% 147 million	81% 148 million	84% 154 million

Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, and 2014).

Among young adults ages 19 to 34, the uninsured rate has fallen sharply, from 27 percent in 2010 to 23 percent in 2012 and down to 19 percent in 2014 (Exhibit 2). This decline reflects an array of new coverage options for this group, some of which began in 2010: the ability to join a parent's policy, protections for enrollees in college health plans, and subsidized marketplace plans and expanded eligibility for Medicaid. This is the lowest uninsured rate among young adults since the survey was first fielded in 2001.

Exhibit 2. Young Adults Have Made the Greatest Gains in Coverage of Any Age Group

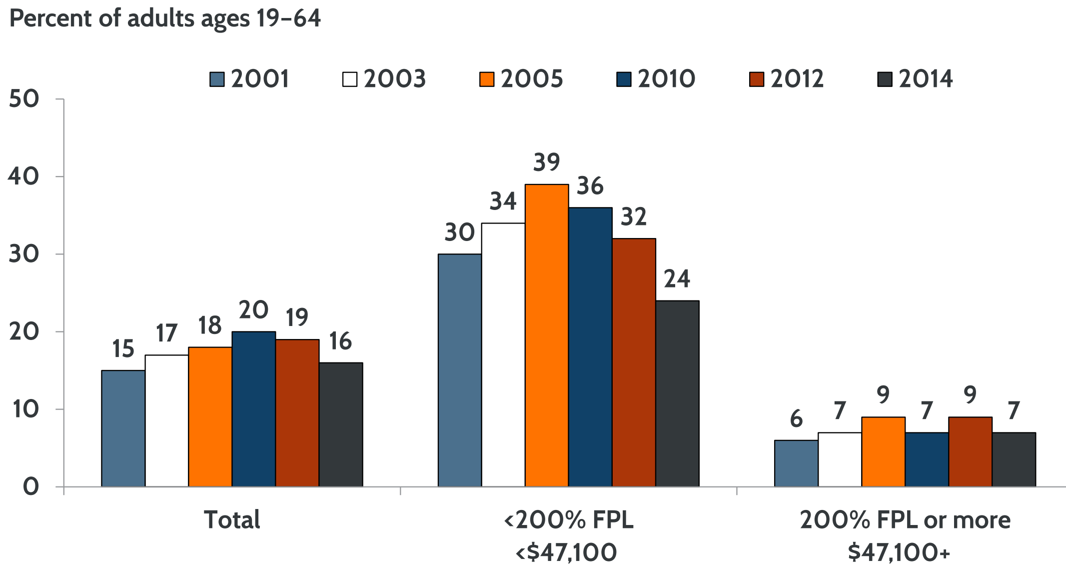


Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, and 2014).

Low-income adults also saw striking improvements in their insurance status. The rate of uninsurance among people with incomes under 200 percent of the federal poverty level, or $47,100 for a family of four, declined from 36 percent in 2010 to 24 percent in 2014. This uninsured rate is not only the lowest among adults at this income level since the survey was first fielded in 2001 but is significantly below the 2001 rate (Exhibit 3).

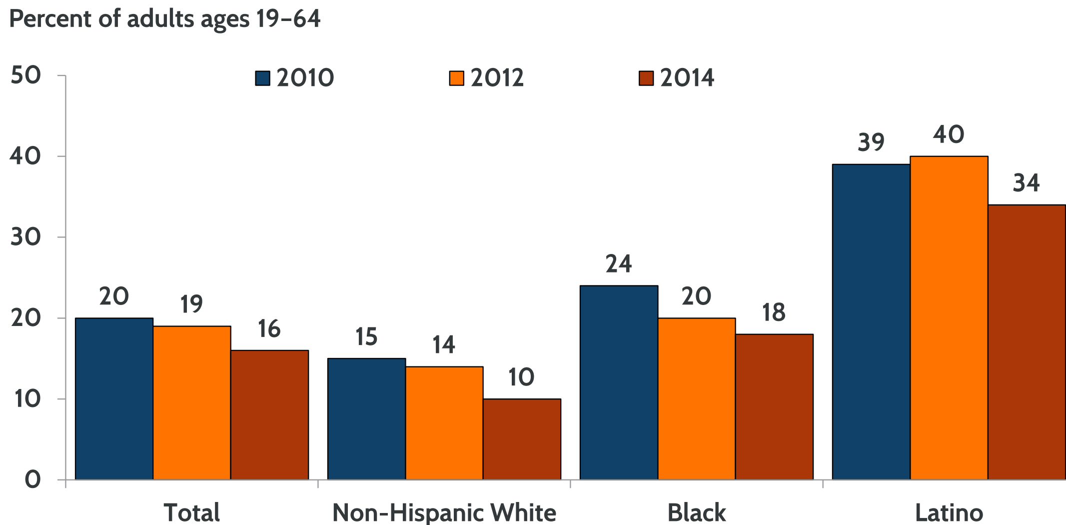
There were gains across racial and ethnic groups. Among non-Hispanic whites, the percentage of uninsured fell from 15 percent in 2010 to 10 percent in 2014; among African Americans, the percentage fell from 24 percent to 18 percent; and among Latinos, it fell from 39 percent to 34 percent (Exhibit 4). Despite these declines, African Americans and Latinos continue to be much more likely than whites to be uninsured.[6]

Exhibit 3. People with Incomes Under $48,000 for a Family of Four Experienced the Largest Declines in Uninsured Rates



Note: FPL refers to federal poverty level. Income levels are for a family of four in 2013.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, and 2014).

Exhibit 4. Uninsured Rates Declined Among Whites, Blacks, and Latinos in 2014



Source: The Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, and 2014).

Decline in Number of Adults Who Reported Cost-Related Problems Getting Needed Care

Expanded insurance coverage is helping people get the care they need by reducing financial barriers to care. The number of adults who did not get needed care in the past 12 months because of cost declined from 80 million in 2012, or 43 percent, to 66 million, or 36 percent, in 2014 (Exhibit 5, Table 2). This marks the first year the survey has found a decline in this measure since the question was added in 2003. Rates fell to levels reported by adults a decade ago.

Exhibit 5. The Number of Adults Reporting Not Getting Needed Care Because of Cost Declined in 2014 for the First Time Since 2003

Percent of adults ages 19–64

	2003	2005	2010	2012	2014
In the past 12 months:					
Had a medical problem, did not visit doctor or clinic	22% 38 million	24% 41 million	26% 49 million	29% 53 million	23% 42 million
Did not fill a prescription	23% 39 million	25% 43 million	26% 48 million	27% 50 million	19% 35 million
Skipped recommended test, treatment, or follow-up	19% 32 million	20% 34 million	25% 47 million	27% 49 million	19% 35 million
Did not get needed specialist care	13% 22 million	17% 30 million	18% 34 million	20% 37 million	13% 23 million
Any of the above access problems	37% 63 million	37% 64 million	41% 75 million	43% 80 million	36% 66 million

Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, and 2014).

There were declines in all four cost-related areas asked about in the survey. The percentage of adults who said that, because of cost, they had not gone to the doctor when they were sick fell from 29 percent to 23 percent. Nineteen percent of adults said they had not filled a prescription because of cost in 2014, down from 27 percent in 2012. The share of adults reporting that they had skipped a recommended test, treatment, or follow-up visit because of cost fell from 27 percent to 19 percent, and 13 percent said they had not gotten needed care from a specialist because of cost, down from 20 percent in 2012.

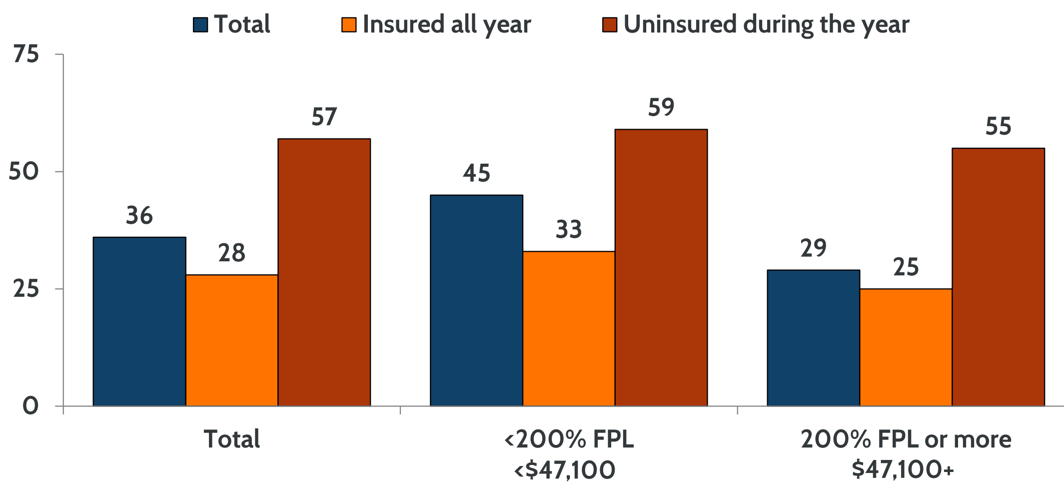
Overall, these declines are most likely driven by the increased number of Americans with health insurance. As in past surveys, adults who had spent any time uninsured in 2014 reported cost-related problems getting care at about two times the rate of adults who were insured all year (Exhibit 6). About three of five (55%–59%) uninsured adults across the income spectrum said they had not received needed care because of cost in the past 12 months.

In 2014, insured adults also reported fewer problems getting care because of concerns about costs for the first time since 2005. In 2012, 34 percent of adults who had been insured all year reported they had not gotten needed care because of cost. This declined to 28 percent in 2014 (data not shown). The drop may reflect the law's new consumer protections in the individual market, which include banning preexisting condition exclusions and guaranteeing an essential health benefit package. It also may reflect an improving economy over the last two years.

Nevertheless, despite these improvements, the rates of cost-related access problems among insured adults remain high, particularly among people with lower incomes. In the survey, 33 percent of adults who had been insured all year with incomes under 200 percent of poverty ($47,100 for a family of four) and 25 percent with incomes above that level said they did not get needed care because of costs in the past 12 months. A recent Commonwealth Fund survey found that high deductibles and cost-sharing in both employer and individually purchased private plans lead many adults to delay or avoid needed care.[7]

Exhibit 6. Uninsured Adults Report Cost-Related Problems Getting Needed Care at Twice the Rate of Insured Adults

Percent of adults ages 19–64 who had any of four access problems* in past year because of cost



Notes: FPL refers to federal poverty level. Income levels are for a family of four in 2013.
* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

Number of Adults with Medical Bill Problems or Medical Debt Declined

Fewer Americans reported medically related financial difficulties in 2014. The number of adults who said they had problems paying their medical bills in the past 12 months or were paying off medical debt declined from 75 million people in 2012, or 41 percent, to 64 million, or 35 percent, in 2014 (Exhibit 7, Table 3). This is the first time since The Commonwealth Fund began asking these questions in 2005 that these numbers have dropped. The 2014 rates were similar to those reported by adults in 2005.

Exhibit 7. The Number of Adults Reporting Medical Bill Problems Declined in 2014 for the First Time Since 2005

Percent of adults ages 19–64

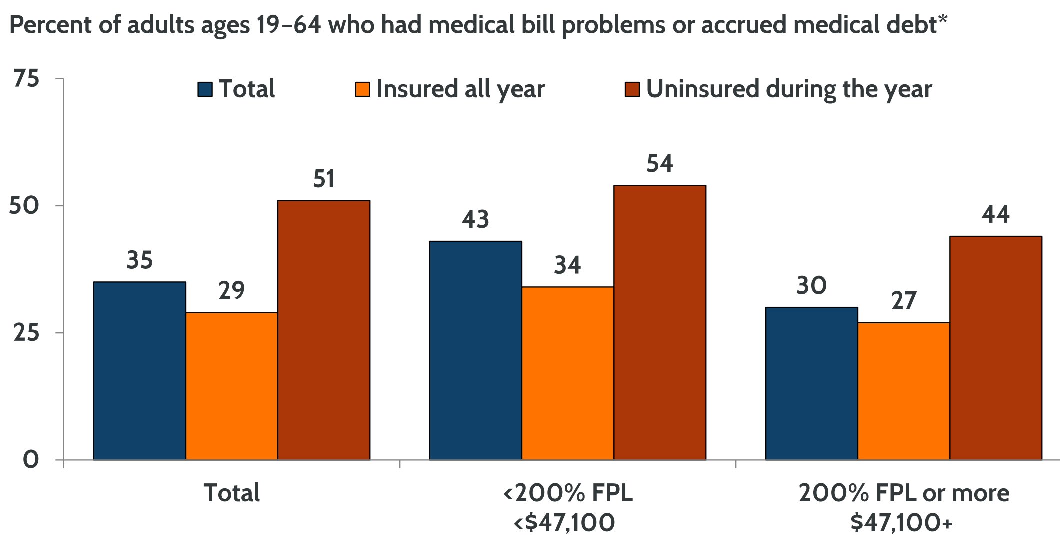
	2005	2010	2012	2014
In the past 12 months:				
Had problems paying or unable to pay medical bills	23% 39 million	29% 53 million	30% 55 million	23% 43 million
Contacted by a collection agency about medical bills*	21% 36 million	23% 42 million	22% 41 million	20% 37 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 30 million	18% 32 million	15% 27 million
Contacted by a collection agency because of billing mistake	7% 11 million	5% 9 million	4% 7 million	4% 8 million
Had to change way of life to pay bills	14% 24 million	17% 31 million	16% 29 million	14% 26 million
Any of three bill problems (does not include billing mistake)	28% 48 million	34% 62 million	34% 63 million	29% 53 million
Medical bills being paid off over time	21% 37 million	24% 44 million	26% 48 million	22% 40 million
Any of three bill problems or medical debt	34 % 58 million	40% 73 million	41% 75 million	35% 64 million

* Subtotals may not sum to total: respondents who answered "don't know" or refused are included in the distribution but not reported.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, and 2014).

From 2012 to 2014 there were statistically significant declines in three of the four aspects of medical bill problems asked about in the survey. The percentage of adults who said they had problems paying or were unable able to pay their bills fell from 30 percent to 23 percent. The percentage reporting they had been contacted by a collection agency about unpaid medical bills fell from 18 percent to 15 percent, and the percentage saying they were paying off accrued medical debt over time dropped from 26 percent to 22 percent.

Declines in medical bill problems nationwide are likely driven by expanded access to health insurance. As seen in prior years of the survey, uninsured adults are more likely to say they had difficulties paying medical bills or were paying off medical debt than adults with health insurance. In 2014, half (51%) of adults who spent any time uninsured during the year reported medical bill problems or debt compared with about one-third (29%) of adults who had health insurance all year (Exhibit 8).

Exhibit 8. Uninsured Adults Reported Having Medical Bill Problems at Higher Rates Than Did Insured Adults



Notes: FPL refers to federal poverty level. Income levels are for a family of four in 2013.
* Had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

There has been some minor improvement in the share of insured adults who reported medical bill problems. In 2012, 33 percent of adults who had been insured all year reported problems paying their medical bills or were paying off medical debt; this rate declined for the first time in 2014 to 29 percent (data not shown). Improved insurance coverage under health reform and a recovering economy may be contributing factors.

Still, there remain large shares of adults who were insured all year but still struggle to pay their medical bills. People with lower incomes reported these problems at the highest rates. One-third (34%) of adults with incomes under 200 percent of poverty who were insured all year reported problems paying their medical bills or were paying off debt last year.

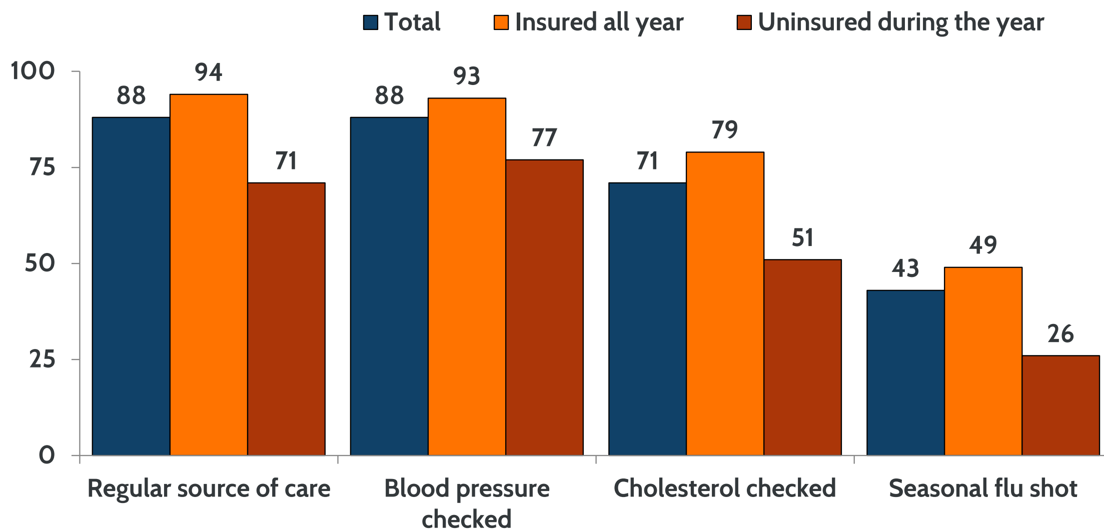
Stark Differences Remain Between Uninsured and Insured Adults in Having a Regular Doctor, Preventive Care

Having health insurance coverage paves the way for people to have a regular doctor and get timely medical care. In the survey, insured adults are far more likely than uninsured adults to have a regular source of care and to report receiving preventive care tests in recommended time frames. Nearly all (94%) adults who were insured all year reported having a regular doctor or source of care compared with 71 percent of adults who spent some time uninsured during the year (Exhibit

9). Nearly eight of 10 (79%) insured adults had their cholesterol checked in the past five years compared with about half (51%) of uninsured adults. Uninsured adults reported receiving flu shots at about half the rate as insured adults.

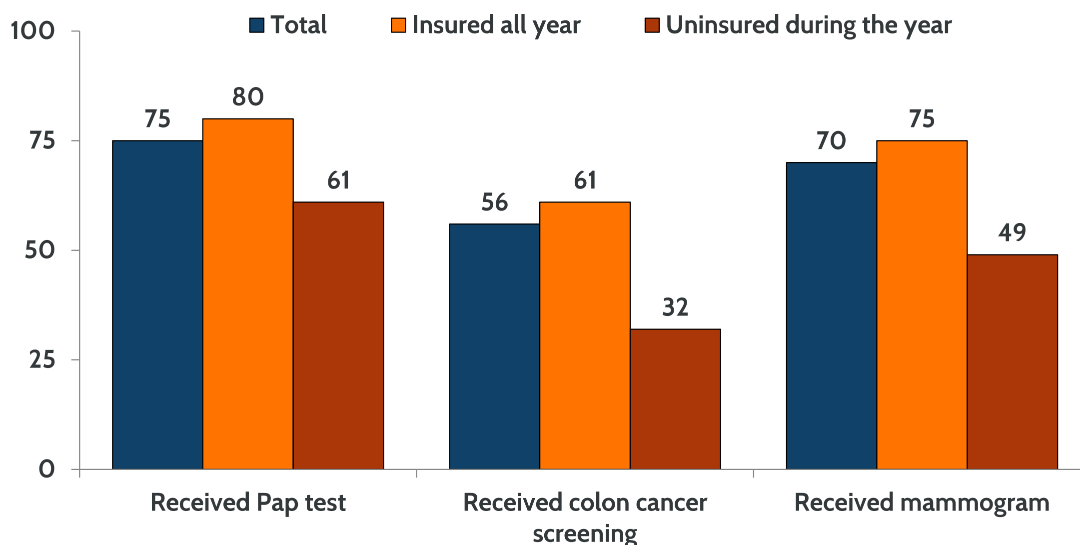
Insured adults in 2014 were also substantially more likely than uninsured adults to say they had received timely cancer screenings. Among adults who were ages 50 to 64, only 32 percent who had spent some time uninsured during the year had received a colon cancer screen in the past five years compared with 61 percent who were insured all year (Exhibit 10). Among women ages 40 to 64, only 49 percent of those who had spent some time uninsured had a mammogram in the past two years, compared with three-quarters of insured women.

Exhibit 9. Uninsured Adults Are Less Likely to Have a Regular Source of Care, 2014



Notes: Blood pressure checked in past two years (in past year if has hypertension or high blood pressure); cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); seasonal flu shot in past 12 months.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

Exhibit 10. Uninsured Adults Have Lower Rates of Cancer Screening Tests, 2014



Notes: Pap test in past three years for females ages 21–64; colon cancer screening in past five years for adults ages 50–64; and mammogram in past two years for females ages 40–64.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

While Uninsured Rates Drop, Low-Income Adults Lag in States Not Expanding Medicaid

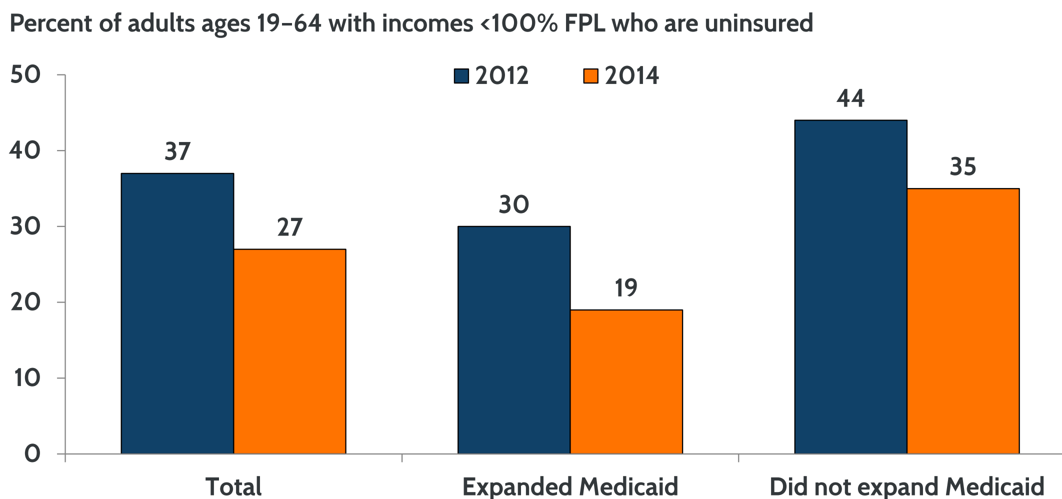
The Affordable Care Act allows states to decide whether to run their own marketplaces or to leave it to the federal government. In 2012, the Supreme Court made it optional for states to expand eligibility for Medicaid to people with incomes up to 133 percent of the federal poverty level. States' decisions not to expand their Medicaid programs had a larger effect on coverage than choosing not to run their own marketplaces, this survey finds.

Since Congress could not have anticipated the Supreme Court decision, people with incomes below the poverty level ($23,550 for a family of four) who would be eligible for Medicaid have no new affordable coverage options if they live in a state that did not expand eligibility. Adults with incomes under 100 percent of poverty in the 24 states that as of July 2014 were not enrolling people in an expanded Medicaid program had much higher uninsured rates in 2012 than did adults in states that expanded their programs (44% vs. 30%). In 2014, uninsured rates fell in both groups of states as people likely enrolled in existing Medicaid programs in states that did not expand. But the disparity between the two groups of states remained: more than one-third (35%) of adults with incomes under the poverty level in states that had not expanded Medicaid remained uninsured in 2014 compared with one-fifth (19%) in states that did expand eligibility (Exhibit 11).

Among all adults, uninsured rates in 2014 declined both in the 34 states that had federally operated marketplaces and in the 16 states and the District of Columbia with state-run marketplaces (Exhibit 12).[8] But, uninsured rates fell the most in states that expanded their Medicaid programs, this includes states that run their own marketplaces and those with federally operated marketplaces.[9] People with incomes between 100 percent and 400 percent of poverty are eligible for tax credits to offset the cost of their premiums, regardless of whether they enroll through the federal website or through a marketplace operated by their state. But people with incomes under 100 percent of poverty who live in a state that did not expand Medicaid are shut out of all the law's subsidized coverage options.

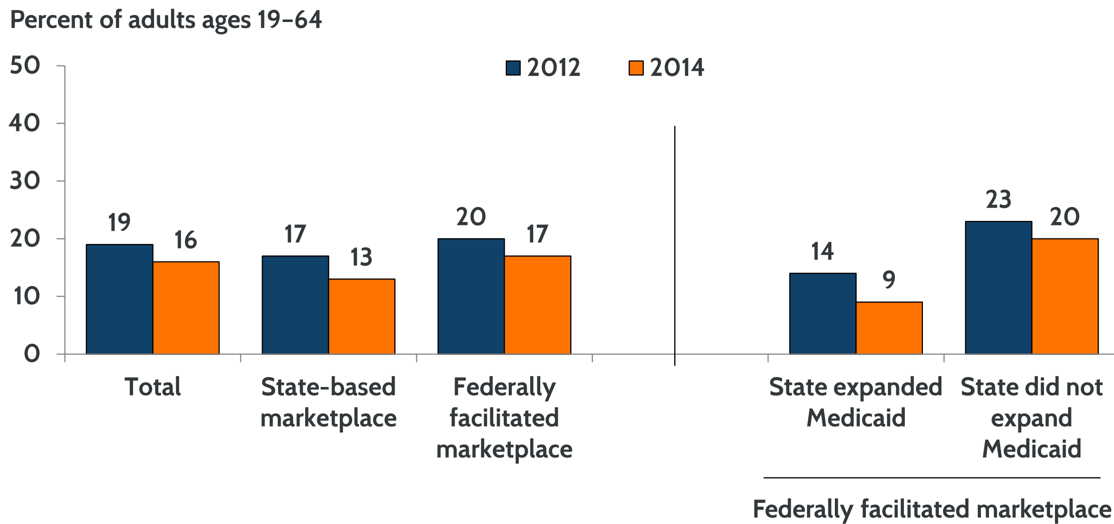
The ability of the nation to insure most of its residents will be hindered by states that do not expand their Medicaid programs. Of the remaining 29 million adults estimated to be uninsured at the end of 2014, 61 percent were living in states that had not yet expanded their Medicaid programs (Exhibit 13).

Exhibit 11. Among Adults with Incomes Below $24,000 for a Family of Four, the Uninsured Rate Is Lowest in States That Expanded Medicaid



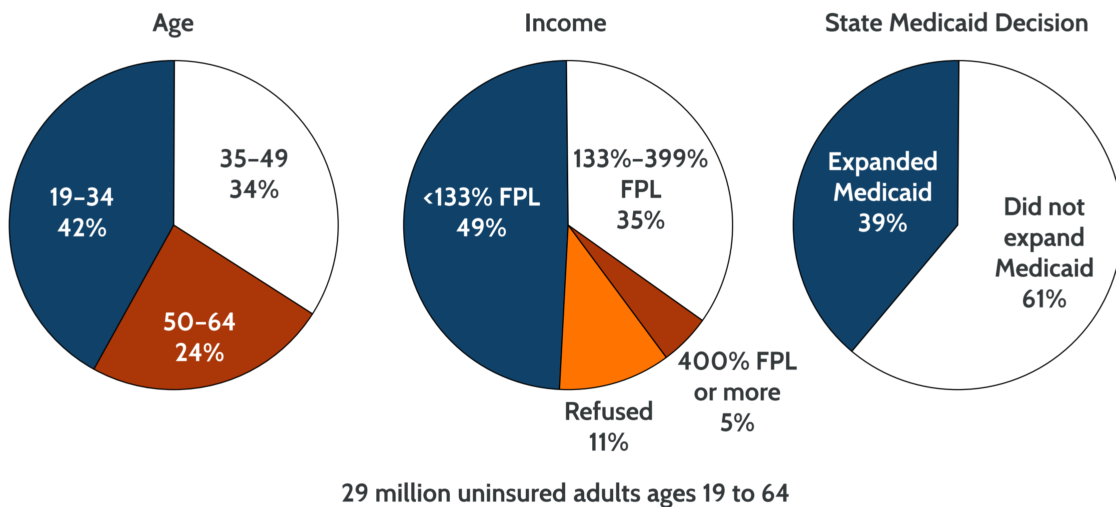
Note: FPL refers to federal poverty level. 26 states and DC had expanded eligibility for their state Medicaid program and begun enrolling individuals by July 2014: AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV.
All other states were counted as not expanding Medicaid. AK and HI were not included in the survey sample.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2012 and 2014).

Exhibit 12. Uninsured Rates Have Dropped in Both States with State-Based Marketplaces and Those with Federally Facilitated Marketplaces



Note: The following 16 states and DC have state-based marketplaces: CA, CO, CT, DC, HI, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, VT, WA. All other states have federally facilitated marketplaces. 26 states and DC had expanded eligibility for their state Medicaid program and begun enrolling individuals by July 2014: AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV. All other states were counted as not expanding Medicaid. AK and HI were not included in the survey sample.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2012 and 2014).

Exhibit 13. Nearly Half of the Remaining Uninsured Have Incomes That Would Make Them Eligible for Expanded Medicaid



Notes: FPL refers to federal poverty level. Segments may not sum to 100 percent because of rounding. 26 states and DC had expanded eligibility for their state Medicaid program and begun enrolling individuals by July 2014: AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV. All other states were counted as not expanding Medicaid. AK and HI were not included in the survey sample.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

CONCLUSION

For the first time since it was launched in 2001, the Commonwealth Fund Biennial Health Insurance Survey has found significant declines in the number and share of U.S. adults who lack health insurance. The survey also finds evidence to suggest that the coverage gains are allowing working-age adults to get the health care they need while reducing their level of financial burden because of medical bills and debt.

But, while there were minor improvements reported by insured adults in cost-related access and medical bill problems, rates of these problems remain high, especially among adults with low incomes. Prior Commonwealth Fund survey results have found that the increasing size and prevalence of high deductibles and copayments in private health plans, including employer-based plans, is leading many people with low and moderate incomes to avoid or delay needed health care.[10] Excessive cost-sharing for Americans across all insurance types could jeopardize improvements in access to care and medical bill burdens documented in the survey.

States' decisions to reject the Medicaid expansion have left large numbers of the poorest Americans in the country without health insurance. Since the survey was fielded in July, one additional state has expanded its program, seven others are in discussions to move to forward, and still others may follow their lead this year.

METHODOLOGY

The Commonwealth Fund Biennial Health Insurance Survey, 2014, was conducted by Princeton Survey Research Associates International from July 22 to December 14, 2014. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 6,027 adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial (RDD) samples was used to reach people. In all, 3,002 interviews were conducted with respondents on landline telephones and 3,025 interviews were conducted on cellular phones, including 1,799 with respondents who live in households with no landline telephone access.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,251). Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2013 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 182.8 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 15.8 percent response rate and the cellular phone component achieved a 13.6 percent response rate.

We also report estimates from the 2001, 2003, 2005, 2010, and 2012 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2014, except the 2001, 2003, and 2005 surveys did not include a cellular phone random-digit dial sample. In 2001, the survey was conducted from April 27 through July 29, 2001, and included 2,829 adults ages 19 to 64; in 2003, the survey was conducted from September 3, 2003, through January 4, 2004, and included 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; and in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64.

Notes

[1] Three state-based marketplaces are using the federal website in 2015. *Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report, For the Period: November 15, 2014–December 15, 2014, ASPE Issue Brief (Washington, D.C.: U.S. Department of Health and Human Services, Dec. 30, 2014),* http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Dec2014/ib_2014Dec_enrollment.pdf; and "Open Enrollment Week 8: January 3, 2015–January 9, 2015," HHS.gov/HealthCare blog (Washington, D.C.: U.S. Department of Health and Human Services, Jan. 14, 2015), http://www.hhs.gov/healthcare/facts/blog/2015/01/open-enrollment-week-eight.html.

[2] *Health Insurance Marketplace 2015 Open Enrollment Period,* 2014. Data on enrollment are not complete for all 14 state-based marketplaces.

[3] *Medicaid and CHIP: October 2014 Monthly Applications, Eligibility Determinations and Enrollment Report, CMS Report (Washington, D.C.: U.S. Department of Health and Human Services, Dec. 18, 2014),* http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/october-2014-enrollment-report.pdf.

[4] All reported differences are statistically significant at the $p \leq 0.05$ level or better unless otherwise noted.

[5] These estimates are in the range of those found in other recent surveys. The federal government and a number of private organizations including The Commonwealth Fund have used different surveys and methodologies aimed at measuring the change in insurance coverage as a result of the coverage expansions under the Affordable Care Act. Most recently, the Center for Disease Control's National Health Interview Survey found that in the first six months of 2014, 17 percent of adults ages 18 to 64, or 33.1 million people, were uninsured (http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201412.pdf). Gallup reported in its most recent poll in the fourth quarter of 2014 that the uninsured rate had dropped to 15.5% for U.S. adults ages 18 to 64 (http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx). The Commonwealth Fund reported in July using its ACA Tracking Survey that the uninsured rate had declined from 20 percent in July–September 2013 to 15 percent in April–June 2014, or an estimated decline of 9.5 million (http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/health-coverage-access-aca). RAND, The Urban Institute, and Sommers et al., using Gallup survey data have estimated uninsured declines in the range of 8.0 million to 10.6 million people. RAND, http://www.rand.org/pubs/research_reports/RR656.html; Urban Institute, http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.html; Sommers et al., http://www.nejm.org/doi/full/10.1056/NEJMsr1406753.

[6] These 2014 uninsured rates among Latinos are similar to those reported by the Center for Disease Control's National Health Interview Survey for the first half of 2014 and the Gallup poll conducted Oct. 1 to Dec. 30, 2014. The National Health Interview Survey's uninsured estimate for Latinos ages 18 to 64 was 34.5 percent for the January–June 2014 period. Gallup's most recent poll from the fourth quarter of 2014 estimates the uninsured rate for Latinos ages 18 and older to be 32.4 percent. M. E. Martinez and R. A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2014 (Washington, D.C.: National Center for Health Statistics, Dec. 2014),* http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201412.pdf; Levy, *In U.S., Uninsured Rate Sinks, 2015.* The uninsured rate reported by this biennial survey for Latinos is higher than that reported in The Commonwealth Fund's ACA Tracking Survey in July 2014. The Latino uninsured estimate reported in The Commonwealth Fund's ACA Tracking Survey in July 2014 was lower (23%) and had a 95% confidence interval of [19.5%–27.5%]; the 2014 biennial survey Latino uninsured estimate of 34 percent has a 95% confidence interval of [29.4%–37.8%]. The confidence intervals in these surveys are wider than NHIS or Gallup which have larger sample sizes. However, the upper bounds of the ACA Tracking Survey estimate come close in range to the lower bounds of the biennial survey. In sum, across these four national surveys that reported uninsured rates among Latinos over 2012 to 2014, the trends are in the same direction but vary in the magnitude of the decline.

[7] S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Too High a Price: Out-of-Pocket Health Care Costs in the United States* (New York: The Commonwealth Fund, Nov. 2014). See also: C. Schoen, D. C. Radley, and S. R. Collins, *State Trends in the Cost of Employer Health Insurance Coverage, 2003–2013* (New York: The Commonwealth Fund, Jan. 2015); and S. R. Collins, D. C. Radley, C. Schoen, and S. Beutel, *National Trends in the Cost of Employer Health Insurance Coverage, 2003–2013* (New York: The Commonwealth Fund, Dec. 2014).

[8] In 2014, Idaho and New Mexico used the federal website HealthCare.gov to enroll their residents. But they are considered state-based marketplaces in this analysis.

[9] All states with state-based marketplaces, except Idaho, expanded eligibility for their Medicaid programs. Only 11 of the 34 states with federal marketplaces expanded eligibility for their Medicaid programs and had begun enrolling individuals by July 2014.

[10] Collins, Rasmussen, Doty et al., *Too High a Price*, 2014.

Table 1. Insurance Status by Demographics, 2014 (base: adults ages 19–64)

	Total (ages 19–64)	Insured now	Uninsured now
Total (millions)	182.8	154.2	28.7
Percent distribution	100%	84%	16%
Unweighted n	4,251	3,566	685
Age			
19–34	34	81	19
35–49	31	83	17
50–64	35	89	11
Race/Ethnicity			
White	61	90	10
Black	13	82	18
Hispanic	17	66	34
Asian/Pacific Islander	4	93	7
Other/Mixed	4	78	22
Poverty status			
Below 133% poverty	30	74	26
133%–249% poverty	18	81	19
250%–399% poverty	19	89	11
400% poverty or more	25	97	3
Below 200% poverty	44	76	24
200% poverty or more	48	93	7
Fair/poor health status, or any chronic condition or disability*	51	85	15
Adult work status			
Full-time	52	89	11
Part-time	13	77	23
Not currently employed	35	81	19
Employer size**			
1–19 employees	26	72	28
20–49 employees	8	78	22
50–99 employees	9	85	15
100 or more employees	54	95	5

* At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.
** Base: Adults ages 19–64 employed full and part time.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

Table 2. Cost-Related Access Problems, by Insurance Status, State Reform Decisions, and Poverty, 2014 (base: adults ages 19–64)

	Total (ages 19–64)	Insurance status		State decision on Medicaid expansion		State marketplace type		Federal poverty level			
		Insured all year	Uninsured during the year	Expanded Medicaid	Did not expand Medicaid	State-based marketplace	Federally facilitated marketplace	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	182.8	131.1	51.8	95.4	87.4	62.9	119.9	54.6	32.8	35.3	45.4
Percent distribution	100%	72%	28%	52%	48%	34%	66%	30%	18%	19%	25%
Unweighted n	4,251	3,032	1,219	2,223	2,028	1,611	2,640	1,286	788	798	1,035
Access problems in past year											
Went without needed care in past year because of cost:											
Did not fill prescription	19	14	32	18	21	17	21	26	23	19	12
Skipped recommended test, treatment, or follow-up	19	15	31	18	20	17	20	23	24	21	11
Had a medical problem, did not visit doctor or clinic	23	15	44	21	25	20	24	31	29	23	11
Did not get needed specialist care	13	9	23	12	13	11	14	16	19	13	6
At least one of four access problems because of cost	36	28	57	33	39	32	38	45	43	36	22
Delayed or did not get preventive care screening	13	7	27	11	14	11	13	18	15	12	6
Delayed or did not get dental care	32	25	50	32	32	33	31	40	39	32	19
Preventive care											
Regular source of care	88	94	71	89	86	88	88	81	86	91	95
Blood pressure checked in past two years¥	88	93	77	88	88	86	89	82	86	90	96
Dental exam in past year	60	68	38	62	57	61	59	42	53	65	79
Received mammogram in past two years (females age 40+)	70	75	49	73	67	71	69	58	58	81	79
Received Pap test in past three years (females ages 21–64)	75	80	61	76	73	74	75	67	74	76	85
Received colon cancer screening in past five years (age 50+)	56	61	32	60	51	59	54	45	52	56	65
Cholesterol checked in past five years¥¥	71	79	51	72	70	72	70	58	66	77	87
Seasonal flu shot in past year	43	49	26	43	43	44	42	36	41	44	51
Access problem for people with health conditions											
Unweighted n	*1,940*	*1,456*	*484*	*967*	*973*	*666*	*1,274*	*620*	*373*	*367*	*439*
Stayed overnight in a hospital or visited the emergency room because of [this/any of these] problem[s]^	12	10	19	12	13	11	13	20	16	8	4
Skipped doses or didn not fill a prescription for medications for [this/any of these] health condition[s]^	18	12	35	15	20	13	20	26	24	15	7

Notes: The following 16 states and DC have state-based marketplaces: CA, CO, CT, DC, HI, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, VT, WA. All other states have federally facilitated marketplaces. 26 states and DC had expanded eligibility for their state Medicaid program and begun enrolling individuals by July 2014: AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV. All other states were counted as not expanding Medicaid. AK and HI were not included in the survey sample.

¥ Checked in past year if respondent has hypertension or high blood pressure.

¥¥ Checked in past year if respondent has hypertension or high blood pressure, heart disease, or high cholesterol.

^ Base: Respondents with at least one of the following health problems: hypertension or high blood pressure, heart disease, diabetes, asthma, emphysema, lung disease, or high cholesterol.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

Table 3. Medical Bill Problems, by Insurance Status, State Reform Decisions, and Poverty, 2014 (base: adults ages 19–64)

		Insurance status		State decision on Medicaid expansion		State marketplace type		Federal poverty level			
	Total (ages 19–64)	Insured all year	Uninsured during the year	Expanded Medicaid	Did not expand Medicaid	State-based marketplace	Federally failitated marketplace	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	182.8	131.1	51.8	95.4	87.4	62.9	119.9	54.6	32.8	35.3	45.4
Percent distribution	100%	72%	28%	52%	48%	34%	66%	30%	18%	19%	25%
Unweighted n	4,251	3,032	1,219	2,223	2,028	1,611	2,640	1,286	788	798	1,035
Medical bill problems in past year											
Had problems paying or unable to pay medical bills	23	17	39	21	26	19	26	32	32	26	9
Contacted by collection agency for unpaid medical bills	15	10	26	13	17	10	17	22	19	16	5
Had to change way of life to pay bills	14	10	25	13	16	12	16	18	21	16	6
Any bill problem	29	22	47	26	32	24	32	40	38	31	12
Medical bills/debt being paid off over time	22	20	28	18	26	16	25	20	30	31	15
Any bill problem or medical debt	35	29	51	31	40	29	38	43	43	40	19
Base: Any medical debt (n=970)											
How much are the medical bills that are being paid off over time?											
Less than $2,000	45	47	42	45	46	46	45	44	41	44	52
$2,000 to less than $4,000	21	19	22	20	21	18	21	16	27	22	17
$4,000 to less than $8,000	16	20	9	18	14	17	16	14	12	21	21
$8,000 to less than $10,000	3	3	3	3	3	3	3	5	3	1	2
$10,000 or more	13	9	21	13	13	14	13	18	16	11	6
Was this for care received in past year or earlier?											
Past year	53	57	46	52	53	51	54	43	52	54	69
Earlier year	41	36	50	38	43	40	41	51	44	40	24
Both	6	6	4	9	3	9	5	6	4	5	7

Notes: The following 16 states and DC have state-based marketplaces: CA, CO, CT, DC, HI, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, VT, WA. All other states have federally facilitated marketplaces. 26 states and DC had expanded eligibility for their state Medicaid program and begun enrolling individuals by July 2014: AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV. All other states were counted as not expanding Medicaid. AK and HI were not included in the survey sample.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2014).

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The Commonwealth Fund

What's Behind Health Insurance Rate Increases? An Examination of What Insurers Reported to the Federal Government in 2013–2014

Michael J. McCue and Mark A. Hall

Abstract The Affordable Care Act requires health insurers to justify rate increases that are 10 percent or more for nongrandfathered plans in the individual and small-group markets. Analyzing these filings for renewals taking effect from mid-2013 through mid-2014, this brief finds that the average rate increase submitted for review was 13 percent. Insurers attributed the great bulk of these larger rate increases to routine factors such as trends in medical costs. Most insurers did not attribute any portion of these medical cost trends to factors related to the Affordable Care Act. The ACA-related factors mentioned most often were nonmedical: the new federal taxes on insurers, and the fee for the transitional reinsurance program. On average, insurers that quantified any ACA impact attributed about a third to these new ACA assessments.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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OVERVIEW

The Affordable Care Act requires health insurers in the individual and small-group markets to explain their rationale for premium rate increases of 10 percent or more for nongrandfathered products. (A nongrandfathered health plan is one that was introduced or that changed substantially after the Affordable Care Act was signed on March 23, 2010.) The federal government does not have authority to refuse insurers' rate increases, but it issues a determination of whether it considers requested increases to be justified in the minority of states that lack the authority or decline to make this determination themselves.[1]

These explanations provide a valuable resource for understanding the factors that drive large increases in health insurers' rates. In this issue brief, we analyze filings for rate increases of 10 percent or more that took effect from July 2013 to June 2014 and were for products covering at least 150 people. Medical costs were the main drivers of these increases, including both increased use of medical services and higher unit prices. Rising administrative overhead and profits were a smaller factor. In most of these rate filings, which were submitted just before the major provisions of the Affordable Care Act took effect, insurers attributed a portion of the increase to new taxes and fees under the law. However, among the insurers that quantified this impact, less than 5 percentage points of their increases were because of these ACA-related factors.

ABOUT THIS STUDY

The researchers collected insurer data from the U.S. Department of Health and Human Services that explain:

- why insurers seek rate increases greater than 10 percent;
- how the increase is allocated across medical services, administrative services, and underwriting gains and losses;
- whether rate increases are being driven by regulatory factors, such as new mandated benefits or governmental taxes and fees.

An insurer must submit a separate rate filing for each nongrandfathered individual or small-group policy that requests an increase of 10 percent or more. Insurers may pool several similar products into a single rate filing if they differ only by branding or by cost-sharing features, for instance.

We limited the study sample to rate filings with effective dates from July 2013 to June 2014 and enrollment of more than 150 members. This resulted in a final dataset of 47 unique rate filings in the individual market and 66 in the small-group market.[2] It is important to note that these filings do not cover the new "ACA-compliant" policies that insurers began to sell in 2014. Because those are new policies, they were not subject to the requirement to justify rate increases.

SIZE OF AND REASONS FOR RATE INCREASES

For the year beginning July 2013, the average annual increase submitted for review by individual-market insurers was $395, and the average for small-group insurers was $616 (Exhibit 1). (These averages reflect only rate increases of more than 10 percent.) In each market, this represented an average overall rate increase of 13 percent over these insurers' prior-year premiums.

Exhibit 1. Components of Requested Rate Increases Greater Than 10 Percent, July 2013–June 2014

	Individual market (n=47)		Small-group market (n=66)	
Component of increase	Average annual $	% of increase	Average annual $	% of increase
Requested premium increase:	$395		$616	
Administrative expense	$76	19%	$153	25%
Profit	($11)	-3%	($18)	-3%
Medical expense:	$330	83%	$482	78%
Utilization	$108	27%	$190	31%
Unit costs	$132	33%	$248	40%
Other trend factors	$89	23%	$43	7%

Source: Authors' analysis of U.S. Department of Health and Human Services data, for plans covering at least 150 people.

Medical and Administrative Costs

Exhibit 1 shows the medical and overhead cost components of these rate increases. Overall, increased medical expenses accounted for more than three-quarters of these requested rate increases. The remainder was attributed to increased administrative expense. In each market segment, insurers with larger rate increases reduced their operating profits slightly.

These insurers reported that the projected increase in medical expenses was attributed to a variety of factors, including greater utilization of services, higher unit costs for these services, and adjusting for underpredicting medical costs in the previous year. Although medical factors differed between the two market segments, in general, medical prices were reported as a stronger driver of medical costs than utilization.

Costs Related to the Affordable Care Act

In addition to this quantitative information, the filings include detailed narrative explanations by insurers about the factors driving the rate increases. In this section, we focus on insurers' narrative explanations that relate to the Affordable Care Act. Of the 113 filings in the study sample, 69 percent attributed some portion of their rate increase to taxes or fees that the federal government began to assess in 2014.[3] These include an insurance premium tax totaling $8 billion and a transitional reinsurance assessment of $12 billion, both of which were allocated among insurers according to market share. These fees apply to policies in effect any time in 2014, even if the rate increase took effect in 2013. Rates that take effect before 2014 are proportionately less affected by these fees than those that take effect in 2014.

Sixty-three insurance filings quantified the impact of these ACA taxes and fees. Of these, the average full-year rate impact was 4.5 percent—about a third of their overall rate increase on average.[4] Insurers were fairly consistent in the way they calculated the rate impact of these new assessments.[5] They attributed about half of the impact to the ACA's new insurance tax and about half to the transitional reinsurance fee, which declines in the subsequent two years and sunsets after three years. Thus, the initial impact of the ACA's permanent insurance tax is less than 2.5 percent.[6] Insurers are also eligible to receive reinsurance payments for their high-cost claims during 2014, but none of these insurers projected any reduction in claims costs or premium rates based on reinsurance. Overall, the Affordable Care Act's requirements had only a moderate impact on insurers' larger rate increases in 2013 and 2014 for existing coverage.

About half of these filings also mentioned the ACA's regulation of medical loss ratios (MLRs). The ACA requires individual and small-group insurers to spend at least 80 percent of their premiums on medical claims or quality improvement, limiting administrative overhead and profits to no more than 20 percent. Of the 58 filings that mention this aspect of rate setting, about a third were ambiguous regarding the impact of the MLR rule, stating only that they expected to comply with the rule. Thirty-six filings indicated a specific expected medical loss ratio. Of these, about a third—13 filings—targeted the 80 percent limit.[7] The remaining 23 filings expected to report MLRs of 82 percent or more.

This suggests that the MLR rule is having some restraining effect on larger rate increases. Some insurers appear to be setting their rates as high as they can within the limits of the rule, suggesting that without it they might seek even higher increases. However, only a minority of insurers seeking higher rate increases are doing this.

SUMMARY AND IMPLICATIONS

This study finds that rate increases of 10 percent or more (by insurers with more than 150 members) averaged 13 percent in the individual and small-group markets, for renewals taking effect from mid-2013 through mid-2014. Insurers attributed the great bulk of these larger rate increases to routine factors like trends in medical costs, driven by increased utilization of medical services and rising medical costs. Insurers did not attribute any substantial portion of these medical cost trends to factors related to the Affordable Care Act. The only ACA-related factor that insurers mentioned frequently was new taxes and fees that started in 2014. Insurers that quantified any ACA impact attributed an average of 4.5 percent of their renewal rates—about a third of their overall rate increases—to these new assessments, but about half of that amount is based on the transitional reinsurance program that sunsets after another two years. Prior to that, insurers may receive some significant reinsurance payments that will help to lower next year's increases or produce consumer rebates in the current year.

Insurance policies in the individual and small-group markets that are not renewals of existing policies became subject to several major regulatory provisions on January 1, 2014, including guaranteed issue, community rating, and essential health benefits. When these new ACA-compliant policies are renewed for 2015, these rate filings also will be a valuable source of information about how these new market rules affect insurance rates.

Notes

1. Kaiser Family Foundation, *Quantifying the Effects of Health Insurance Rate Review* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 2012); U.S. Center for Consumer Information & Insurance Oversight, *2012 Annual Rate Review Report: Rate Review Saves Estimated $1 Billion for Consumers* (Baltimore, Md.: CCIIO).

2. We combined rate filings by each insurer within a state when the filings had identical rate increases and medical costs, since this indicates the filings probably cover products in the same rating pool that are being sold under different names or product types (e.g., PPO vs. HMO or HSA vs. non-HSA). We also treated Time Insurance and John Alden Insurance as the same company within the same state, since they are both owned by Assurant Health and their filings were identical to each other in each of 14 states.

3. In addition to these two, the ACA also imposes a fee of $2 per person to fund comparative effectiveness research.

4. For the 39 filings that were in effect for only part of 2014, we annualized to reflect the rate effect assuming a full year's impact. This is a somewhat imprecise estimation because it assumes that subscribers renew at consistent intervals throughout the year, which often is not the case.

5. There was some variation, however, because of two factors: 1) insurers are allowed to "gross up" these fees to reflect the fact that states typically collect an additional premium tax, which varies among states and among different types of insurers; and 2) some fees are calculated based on members rather than premiums, and so their impact on premiums will vary according to the size of the base premium.

6. However, this tax is scheduled to increase over the next four years, to reach between 2.8% and 3.7% of premium, depending on assumptions about base premium increases and other factors. C. Carlson, *Estimated Premium Impacts of Annual Fees Assessed on Health insurance Plans* (Milwaukee: Oliver Wyman, 2011).

7. This includes all insurers that projected an MLR up to 81 percent.

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ASPE RESEARCH BRIEF

HEALTH INSURANCE MARKETPLACE 2015: AVERAGE PREMIUMS AFTER ADVANCE PREMIUM TAX CREDITS THROUGH JANUARY 30 IN 37 STATES USING THE HEALTHCARE.GOV PLATFORM

February 9, 2015

Arpit Misra and Thomas Tsai

The Affordable Care Act helps families afford health insurance coverage by providing financial assistance in the form of advanced premium tax credits and cost-sharing reductions in the Health Insurance Marketplaces (the "Marketplaces"). From November 15, 2014 through January 30, 2015, almost 7.5 million individuals had selected or been automatically re-enrolled into 2015 Marketplace plans in the 37 states that use the HealthCare.gov platform.[1] The vast majority of these individuals are receiving financial assistance. Data in this report are preliminary, and data in this report will be updated after the close of the 2015 Open Enrollment Period.

Premium tax credits are available to reduce premium costs for qualified individuals.[2] As an initial step to assess the affordability of coverage for individuals selecting or being automatically reenrolled into Marketplace plans during the 2015 Open Enrollment Period, this report measures 1) the proportion of individuals with plan selections paying a reduced monthly premium as a result of the advance premium tax credit; 2) the effect of advance premium tax credits on net premium costs; and 3) the proportion of individuals who could receive a plan with a net premium cost of less than $100.

[1] All premium estimates in this report are based on plan selections during the 11-15-14 to 1-30-15 reporting period.
[2] The premium tax credit ("PTC") is calculated as the difference between the cost of the adjusted monthly premium of the second-lowest cost silver plan with respect to the applicable taxpayer and the applicable contribution percentage that a person is statutorily required to pay deter-mined by household income. An individual may choose to have all or a portion of the PTC paid in advance (advance premium tax credit or "APTC") to an issuer of a qualified health plan in order to reduce the cost of monthly insurance premiums. APTCs are generally available for individuals with a projected household income between 100 percent (133 percent in states that have chosen to expand their Medicaid programs) and 400 percent of the Federal Poverty Level (FPL). For 2015, the percentage of household income that a qualified individual or family will pay toward a health insurance premium ranges from 2.01 percent of household income at 100 percent of the FPL to 9.56 percent of income at 400 percent of FPL. For more information on the required contribution percentage, see http://www.irs.gov/pub/irs-drop/rp-14-37.pdf

Key Highlights

In the 37 States using the HealthCare.gov platform from November 15, 2014 through January 30, 2015, among consumers who selected or were re-enrolled in a plan for 2015 coverage:

- More than 8 in 10 individuals with a plan selection for 2015 Marketplace plans qualify for an advance premium tax credit.
- Advance premium tax credits will reduce premium costs by over $1 billion a month.
- Almost 6.5 million individuals qualify for an average advance premium tax credit of $268 per month.
- The average advance premium tax credit covers about 72 percent of the gross premium.
- The average net premium is $105 per month among individuals with plan selections qualifying for an advance premium tax credit.
- Nearly 8 in 10 individuals had the option of selecting a plan with a premium of $100 or less after applying the advance premium tax credit.

More than 8 in 10 Individuals in the Marketplace Receive an Advance Premium Tax Credit in the 37 States Using the HealthCare.gov Platform

In all 37 states using the HealthCare.gov platform, the large majority of individuals selecting or being automatically reenrolled into a Marketplace plan qualify for an advance premium tax credit, with almost 6.5 million individuals qualifying for an advance premium tax credit. Across all 37 states using the HealthCare.gov platform, 87 percent of individuals with a plan selection qualify for an advance premium tax credit.[3,4] Based on plan selections and re-enrollments as of January 30, 2015 for the current open enrollment period, advance premium tax credits are estimated to reduce premiums by over $1 billion a month for individuals selecting health insurance coverage through the Marketplaces in the 37 states using the HealthCare.gov platform.[5]

[3] An individual qualifying for an advance premium tax credit was defined as any individual with an APTC amount >$0.

[4] Averages in this brief refer to plan-selection-weighted averages across individuals with plan selections with advance premium tax credits in the 37 HeatlhCare.gov states.

[5] Data included in this report are based on plan selections as of January 30, 2015. APTC payments are made on effectuated policies (rather than plan selections), and as such actual APTC payment amounts paid may differ. Information regarding effectuated enrollment and payment from the financial system will be available at a later date.

Advance Premium Tax Credits Significantly Reduce Monthly Consumer Premiums in the States Using the HealthCare.gov Platform

Substantial financial relief from monthly premium costs is available for individuals qualifying for advance premium tax credits. On average, advance premium tax credits reduced monthly premiums for individuals by 72 percent. Among individuals qualifying for an advance premium tax credit, average gross monthly premiums before advance premium tax credits for 2015 coverage would have been $374. The average advance premium tax credit amount for qualifying individuals was $268, resulting in a net premium after advance premium tax credit of $105.

Nearly 8 in 10 Individuals Could Select a Plan with a Premium of $100 or Less after Applying the Advance Premium Tax Credit in the HealthCare.gov States

Across all consumers plan selections with or without advance premium tax credits,79 percent have available an option with a net premium of less than $100 after the advance premium tax credit given the available plans in their rating areas.[6] Based on *actual* plan choices and re-enrollments to date, 53 percent of individuals have selected or re-enrolled in a plan with a net premium of $100 or less after advance premium tax credit.

Similarly, 66 percent of individuals could select a plan with a premium of $50 or less after the advance premium tax credit, but based on plan selections and re-enrollment to date, only 31 percent of individuals have selected or re-enrolled in plans with a net premium of $50 or less after the advance premium tax credit.[7]

[6]For more information see the ASPE Issue Brief "Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace" (December 2014), available at: http://aspe.hhs.gov/health/reports/2015/premiumReport/healthPremium2015.pdf.

[7] Among new plan selections and re-enrollments qualifying for an APTC, 89 percent of individuals could have selected a plan with a premium after tax credit of $100 or less, but among actual plan selections or re-enrollments, 61 percent of individuals have selected a plan with premium after tax credit of $100 or less. Similarly 76 percent of individuals qualifying for an APTC could have selected a premium after credit of $50 or less, but among actual plan selections or re-enrollments, 35 percent of individuals qualifying for an APTC have selected a plan with a premium after advance premium tax credit of $50 or less.

TABLE 1: Reduction in Average Monthly Premiums from Advance Premium Tax Credits from November 15, 2014 through January 30, 2015, 37 HealthCare.gov States[8]

State	Total Number of Individuals with a Plan Selection (as of 1-30-15)	Percent of Plan Selections with APTC	Average Monthly Premium before APTC	Average Monthly APTC	Average Monthly Premium After APTC	Average Percent Reduction in Premium after APTC
Alaska	17,466	88%	$652	$534	$119	82%
Alabama	142,525	89%	$360	$268	$92	75%
Arkansas	56,970	88%	$397	$287	$110	72%
Arizona	174,440	75%	$288	$158	$130	55%
Delaware	21,276	83%	$411	$265	$146	64%
Florida	1,339,791	93%	$384	$297	$88	77%
Georgia	448,512	90%	$353	$277	$76	79%
Iowa	38,243	85%	$380	$263	$117	69%
Illinois	296,293	78%	$343	$210	$133	61%
Indiana	193,567	88%	$446	$325	$120	73%
Kansas	82,960	80%	$307	$214	$94	70%
Louisiana	148,552	89%	$430	$322	$108	75%
Maine	64,069	89%	$434	$337	$97	78%
Michigan	304,679	88%	$373	$240	$133	64%
Missouri	219,065	88%	$370	$284	$86	77%
Mississippi	87,356	94%	$411	$364	$47	89%
Montana	48,356	84%	$351	$232	$119	66%
North Carolina	479,748	92%	$418	$317	$100	76%
North Dakota	15,997	86%	$375	$230	$145	61%
Nebraska	64,008	88%	$355	$245	$110	69%
New Hampshire	47,434	70%	$392	$251	$141	64%
New Jersey	216,425	83%	$481	$309	$172	64%

[8] Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 1-30-15.

State	Total Number of Individuals with a Plan Selection (as of 1-30-15)	Percent of Plan Selections with APTC	Average Monthly Premium before APTC	Average Monthly APTC	Average Monthly Premium After APTC	Average Percent Reduction in Premium after APTC
New Mexico	44,431	75%	$332	$202	$130	61%
Nevada	56,421	90%	$373	$248	$125	67%
Ohio	202,379	84%	$397	$247	$150	62%
Oklahoma	105,668	79%	$302	$208	$95	69%
Oregon	94,126	78%	$343	$203	$141	59%
Pennsylvania	429,996	81%	$361	$230	$132	64%
South Carolina	172,360	88%	$373	$283	$90	76%
South Dakota	18,554	88%	$364	$234	$130	64%
Tennessee	193,207	82%	$321	$211	$110	66%
Texas	969,461	86%	$337	$242	$95	72%
Utah	120,391	88%	$250	$159	$92	63%
Virginia	329,447	83%	$353	$260	$93	74%
Wisconsin	182,581	89%	$450	$319	$130	71%
West Virginia	28,482	85%	$457	$314	$143	69%
Wyoming	18,463	91%	$558	$423	$135	76%
Total for 37 States Using HealthCare.gov Platform	***7,473,699***	87%	***$374***	***$268***	***$105***	***72%***

Methodology and Limitations

Enrollment information is based on active qualified health plan (QHP) selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) from November 15, 2014 to January 30, 2015. We use the term “enrollees” to refer to individuals with active Marketplace individual market health plan selections; it does not refer to “effectuated enrollees”—individuals who selected a health plan and paid the premium.[9] Data in this report are based on plan selections and auto-reenrollment: as such, they do not reflect (a) any updated information for re-enrollees that could change the premium or value of the advance premium tax credits that may have occurred after January 30, 2015; and (b) effectuated enrollees for whom coverage takes effect after payment of monthly premiums.

Average Premiums

For the purposes of this analysis, an individual qualifying for an advance premium tax credit is defined as any individual with an advance premium tax credit greater than $0. Averages for gross premiums, advance premium tax credits, and net premiums after applicable advance premium tax credits are taken over all individual enrollees qualifying for an advance premium tax credit with non-zero advance premium tax credit amounts in the MIDAS database.

The advance premium tax credit amounts used in this report reflect the amounts active in MIDAS when the data were analyzed. Some individuals have elected to take a smaller advance premium tax credit than they were eligible for and instead will receive the remaining amount when they file their taxes in 2016. In addition, for individuals automatically re-enrolled in 2015 coverage, the APTC was held constant at the amount the individual was eligible for in 2014 unless individuals actively updated household income. Thus, data on advance premium tax credits for auto-enrolled individuals may not reflect any changes in household income or in the benchmark premium for the second-lowest cost silver health plan in 2015. Due to these factors, the estimates in this report may vary from the actual after-tax-credit premiums individuals will pay for 2015 coverage.

Premium Tax Credits

The Affordable Care Act specifies that an individual or family who is eligible for premium tax credits will be required to pay no more than a fixed percentage of their income based on the second-lowest cost silver plan available in the Marketplace in their coverage area. This applicable percentage varies only by household income as a percentage of the Federal Poverty Level (FPL) and does not depend on household members’ ages, the number of people within the household covered through the Marketplace, or Marketplace premiums. (For examples of 2015 incomes and benchmark premiums for those who are eligible for premium tax credits, see Table 2.) The applicable percentage is converted into a maximum dollar amount the household is required to pay annually for the benchmark plan, and the premium tax credit is applied to make up the difference between the maximum dollar amount and the actual premium, if any. The exact dollar amount of the premium tax credit depends on the premium of the second-lowest cost silver

[9] APTC payments are made on effectuated policies (rather than plan selection) and as such actual APTC payment amounts paid will differ.

plan available to the household and the cost of covering the family members who are seeking Marketplace coverage.

For example, a woman with an income in 2015 equivalent to 218 percent of FPL will pay a maximum amount of $148 (see Table 2 for 2015 applicable percentages) for the second-lowest cost silver plan in her area. She can choose to buy the second-lowest silver plan if she wishes, and it will cost her up to $148 after premium tax credits. Her premium tax credit for 2015 will be the difference between $148 and what the second-lowest cost silver plan premium would be for her in 2015. She can take her premium tax credit and apply it to whatever plan in any metal tier that best fits her needs.

TABLE 2: Examples of Maximum Monthly Health Insurance Premiums for the Second-Lowest Cost Silver Plan for Marketplace Coverage for a Single Adult in 2015[10]

Single Adult Income[11]	Percent of the Federal Poverty Level	Maximum Percent of Income Paid toward Second-Lowest Cost Silver Plan	Maximum Monthly Premium Payment for Second-Lowest Cost Silver Plan
$11,670	100% [12]	2.01%	$20
$17,505	150%	4.02%	$59
$23,340	200%	6.34%	$123
$29,175	250%	8.10%	$197
$35,010	300%	9.56%	$279
$40,845	350%	9.56%	$325
$46,797	401%	Not Applicable	No Limit

Source: Applicable percentages for 2015 coverage are available at: www.irs.gov/pub/irs-drop/rp-14-37.pdf. The 2014 Federal Poverty Guidelines, used for premium tax credits for 2015 coverage, are at: http://aspe.hhs.gov/poverty/14poverty.cfm.

Many families may also be eligible for premium tax credits. For example, suppose a family with an income of $60,000 was shopping for Marketplace coverage for 2015 for all four family members. The family's household income is equivalent to 252 percent of the FPL; therefore, the family's premium is capped at 8.15 percent of income or no more than $407 per month for the benchmark second-lowest cost silver plan in its local area. If the premium for the second-lowest cost silver plan for the family is $805 per month, the family will receive a tax credit of $398, based on a premium after advance premium tax credits of $407 ($805 – $407 = $398). The family can apply its $398 premium tax credit toward the purchase of coverage in any metal level. Note that the maximum percent of household income paid toward the second-lowest silver plan is adjusted annually by a measure of the difference between premium growth and income growth.

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[10] For more information on premium tax credits, see the Internal Revenue Service final rule on "Health Insurance Premium Tax Credit," (*Federal Register*, May 23, 2012, vol., 77, no. 100, p. 30392; available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf).
[11] Income examples are based on the 2014 federal poverty guidelines for the continental United States. Alaska and Hawaii have higher federal poverty guidelines, which are not shown in this table.
[12] In states expanding Medicaid, individuals and families at 100 percent of the FPL who are eligible for Medicaid coverage are not eligible for premium tax credits.

California HealthCare Foundation

Disease Matters:
Comparing Prescription Drug Benefits in Covered California Plans

FEBRUARY 2015

About the Author

Avalere Health is a strategic advisory company that creates innovative solutions to complex health care problems. Based in Washington, D.C., the firm provides business intelligence tools and custom analytics for leaders in health care business and policy.

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The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

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Introduction

The Affordable Care Act of 2010 (ACA) transformed the individual health insurance market. Among myriad reforms, health insurance companies can no longer deny coverage to consumers with pre-existing conditions, they must cover prescription drugs and other "essential health benefits" (EHBs), and limits are placed on consumers' out-of-pocket costs. Millions of Californians without access to job-based coverage can now purchase individual insurance through Covered California, the state's health insurance marketplace set up under the ACA. Those who qualify can receive subsidies to make Covered California's insurance plans more affordable. Taken together, these changes have greatly reduced barriers to coverage, including coverage for prescription medications, for large numbers of consumers.

Even with these changes, however, there appears to have been considerable variation in coverage for prescription drugs among health plans offered through Covered California in 2014, as well as differences in coverage between these plans and California's most common employer-sponsored health plans. Researchers compared these new individual market plans to employer-sponsored insurance in this study because most Californians get their insurance through their jobs. Although coverage in the individual market is typically less generous than employer-sponsored insurance, comparing individual and employer-sponsored products on formulary placement and utilization management requirements for specific drug classes provides insight into which consumers are most affected by the differences between the benefits offered in the two markets.

This report examines these differences and considers how easy it is for consumers to compare their options. The report also offers insights on how barriers to necessary prescription drugs might further be reduced and how consumer access to drug cost and coverage information could be improved across the individual market.

While this report focuses on 2014 Covered California plans, many of the characteristics and issues identified here are reflective of the broader individual market as well as larger trends in formulary design. Issuers that offer plans on and off California's health insurance exchange report that they use the same formulary for all segments of the individual market. And while broader market dynamics and state and federal regulatory requirements shape drug coverage in California's individual market as a whole, Covered California has a unique opportunity to influence coverage in this larger market through standardized benefit design decisions.

Background

Prior to implementation of the ACA, consumer participation in California's individual market for health coverage was fairly low compared to employer-based group coverage. The market also experienced substantial turnover as nationally, fewer than half of people with nongroup policies retained their coverage for more than 12 months.[1] In 2013, about 1.5 million in California purchased individual coverage compared to 12.4 million in the group market.[2] Wide variation in plan design and benefits made comparison shopping in the individual market difficult. Consumers with pre-existing conditions could be denied coverage or face much higher premiums based on their health status. Insurers and health plans were not required to provide coverage for prescription drugs or could offer a severely limited formulary that consisted of a small number of generic drugs. Nationally, nearly one out of five health insurance plans in the individual market lacked prescription drug coverage.[3]

The ACA insurance reforms and coverage mandates and associated California laws seek to make the individual market more stable and more affordable, establishing it as a viable option for the uninsured. Created in compliance with the ACA, state health insurance exchanges, including California's, serve as a portal where individuals can access information about available health plans, compare coverage options, and enroll in the plan that best matches their needs.[4] To make insurance more affordable, premium tax credits and cost-sharing subsidies are available to enrollees who qualify based on income and immigration status. The exchanges have transformed the individual market for health insurance and have expanded access to coverage to many consumers who were previously uninsured due to cost or their health status.

By the end of 2014 open enrollment, nearly 1.4 million California residents selected a plan through the exchange. As of April 2014, about 88% of Covered California enrollees were receiving subsidies to help reduce overall costs.[5]

Prescription Drug Coverage Requirements

The ACA requires that all health plans offered in the individual market, including those in Covered California, cover a standard set of EHBs, which include hospitalizations, doctor visits, emergency services, and prescription drugs, among other benefits.[6] This sets a minimum standard for coverage. The Affordable Care Act also requires EHBs to be equal in scope to benefits offered by a "typical employer plan" as defined by a state-selected EHB benchmark plan. For prescription drugs, health plans subject to the EHB requirement must cover the greater of one drug in every category and class, or the same number of drugs in each category and class,[7] as the state-selected EHB benchmark plan.[8,9]

ACA regulations require that health plans providing EHBs have procedures in place to allow enrollees to request and gain access to clinically appropriate drugs not listed on the plan's formulary.[10] In cases where an enrollee's life, health, or ability to regain maximum function may be seriously jeopardized, or where the enrollee is undergoing a current course of treatment using a nonformulary drug, the health plan must expedite the process and notify the enrollee of its coverage determination no later than 24 hours after it receives the request.[11]

Federal rules also limit the amount of annual out-of-pocket costs patients pay for care. Prescription drug costs for on-formulary medications are counted toward the out-of-pocket cap. Federal law does not require that costs for medications not listed on plan formularies be counted toward the cap; however, California state regulations require consumer costs to be "reasonable so as to allow access to medically necessary outpatient prescription drugs."[12,13]

California applies additional requirements to health plans with the aim of ensuring consumer access to necessary medications. All health plans and insurance offered in individual and small group markets, including those in Covered California, must provide coverage for any medically necessary prescription drugs.[14] If a plan has denied the claim for a particular drug, the route to coverage is a formal process of requesting an exception to the denial. Similarly, California plans must offer an expeditious process to authorize exceptions to step therapy requirements.[15] Step therapy, sometimes called "fail first," refers to the requirement that before accessing a prescribed drug, patients must "fail" first on at least one alternative drug. It is usually applied to more expensive drugs to ensure less expensive alternatives are first tried.

To ensure drug continuity when appropriate, plans are prohibited from limiting coverage for a drug previously prescribed and approved by the plan — provided that the physician continues to prescribe the drug, the drugs is prescribed for an approved US Food and Drug Administration (FDA) use, and it is considered safe and effective for treating the enrollee's medical condition.[16] By contract, Covered California requires health plans to give enrollees advance notice prior to removing a drug from their formularies.

The California law that created Covered California also imposed specific requirements on both exchange and nonexchange plans related to the products they must offer.[17] To make comparison shopping easier, the ACA groups plans into four "metal levels" — platinum, gold, silver, and bronze and a catastrophic plan — based on how much of the costs, on average, the plan covers. California law requires all issuers participating in Covered California to offer at least one product at each of the five levels. In addition, for all its offerings, Covered California developed standardized benefit designs, which established fixed deductibles and cost-sharing amounts for each type of service, including prescription drugs.

California law also requires issuers to offer the standardized benefit designs for products outside Covered California. Issuers not participating in the exchange must offer at least one of the standard benefit design products in each of the four metal tiers.[18] (They may also offer nonstandardized benefit products.) The vast majority of individuals in plans regulated by the Department of Managed Health Care (DMHC) are in plans with standardized benefits. In the first quarter of 2014, 1.4 million of the 1.9 million lives in the segment of the individual market regulated by DMHC were in standardized benefit designs, including 1 million enrolled in Covered California as of March 31, 2014, and 400,000 in the outside market.[19,20]

All of these requirements mean that prescription drug coverage in California's post-ACA individual market is more comprehensive overall than it was prior to implementation of health reform. The standardization of benefits on and off Covered California, the participation of the state's

largest commercial insurers in the exchange, and the fact that the exchange comprises a large and growing portion of the individual market all make the examination of Covered California plans an important exercise in understanding the larger individual market.

Methodology

The researchers examined formularies from the 11 carriers participating in Covered California in 2014 and assessed variations in coverage, tier placement, and utilization management.[21] All but one carrier in Covered California maintained the same formulary for all their plan offerings in the exchange.[22] The report presents the findings based on combinations of formulary and benefit design; it does not provide enrollment-weighted averages.

To approximate the prescription drug needs for exchange enrollees, researchers analyzed coverage for the 100 most commonly prescribed drugs in the US commercial market based on 2014 data from Symphony Health Solutions, a health care data analytics company that focuses on physician prescribing and pharmacy fulfillment, among other issues.

Researchers also focused on 11 drug classes used to treat five common chronic conditions that rely heavily on medication management: HIV/AIDS, mental health, diabetes, autoimmune disorders, and asthma/chronic obstructive pulmonary disease (COPD).[23] (See Figure 1.) The selected drug classes represent therapies for a mix of primary care conditions and more specialized disorders commonly treated with long-term medications. Medications analyzed represent those on the market as of mid-2014; new products have launched in these areas since the time of analysis.

Researchers reviewed formulary inclusion, tiering, and utilization management for each product in the class, combining brands and their generic equivalents when available.[24] Combination drugs and distinct formulations like extended-release and intramuscular (IM) formulations were counted separately. Drugs administered by a physician are typically covered under plans' medical benefits and not usually included in formularies. As such, these products were excluded from the analysis.

Comparing Individual Market and Employer-Sponsored Plans

Researchers also compared exchange formularies to those of selected employer-sponsored health insurance plans.[25] The comparator group includes the formularies for fully insured plans from the top four fully insured carriers in the California group market. Each of these insurers reported using a single formulary for both large and small

Figure 1. Categories and Classes of Drugs Analyzed, 2014

	USP CATEGORY	USP CLASS
HIV/AIDS	Antivirals	Anti-HIV agents: ▸ Non-nucleoside reverse transcriptase inhibitors (NNRTIs) ▸ Nucleoside and nucleotide reverse transcriptase inhibitors (NRTIs) ▸ Protease inhibitors (PIs) ▸ Other (HIV-other)
Mental Health	Antidepressants	Serotonin/norepinephrine reuptake inhibitors (SNRIs)
	Antipsychotics	Second generation/atypicals (atypicals)
Diabetes	Blood glucose regulators	▸ Antidiabetic agents (antidiabetics) ▸ Insulins
Immunology	Immunological agents	Immune suppressants
COPD/Asthma	Respiratory tract agents	▸ Bronchodilators, sympathomimetic (B_2 agonists) ▸ Anti-inflammatories, inhaled corticosteroids (ICS)

group products. In addition, researchers examined the formulary used by CalPERS, the health and retirement benefits administrator for state employees.

The purpose of this comparison is to offer a common point of reference from an established market. Employer-based insurance, which covers 53% of nonelderly California residents, is used as this point of comparison for examining benefits because it is the single largest source of insurance for Californians,[26] and because it is frequently considered to be the standard when stakeholders assess the merits and limitations of other types of coverage.

There are, however, important differences between the individual and employer-sponsored insurance markets. Employer-sponsored coverage has historically included richer benefits packages than insurance offered in the individual market, including more generous prescription drug benefits. Employer plan formularies are less likely to use four tiers than individual market plans. In 2014, on average, 91% of exchange formularies nationwide had four or more tiers, compared to 20% in the employer market.[27] Further, benefits at large firms tend to be, on average, more generous than those offered by smaller firms.[28]

Therefore, it is not surprising that formularies in the individual market, whether on or off the exchange, might generally be more restrictive than employer-sponsored plans. Comparing individual and employer-sponsored products on formulary placement and utilization management requirements for specific drug classes allows more insight into these differences and which consumers are most affected.

Limitations of the Data

Researchers relied on publicly available formulary documents, which vary in format, comprehensiveness, and accuracy across carriers. Due to the ever-evolving nature of coverage policies and the lag time in updating public documents, the formularies reviewed in this study may not reflect the most up-to-date prescription drug benefits for the plans analyzed.

Many formularies include language that specifically stresses that the document is not a comprehensive list of medications available and that it is possible that additional products may be covered without requiring a patient to navigate an appeals and exceptions process. For example, some plans might choose to include the most commonly used medications and then only add additional drugs as they are requested by enrollees and as claims are processed.

In addition, some carriers may routinely cover nonlisted drugs without a prior authorization and subject these medications to the nonpreferred branded drug cost-sharing amount. Moreover, it is also possible that some plans cover over-the-counter medications, which may not typically appear on formularies, under the pharmacy benefit. In such cases, due to the limitations of publicly available information, these products would be classified as "not listed" for the purposes of this report. The limitations and challenges in using publicly available formularies apply to all segments of the health insurance market and are not a product of or specific to Covered California.

The analysis focused on pharmacy-benefit drugs and excluded over-the-counter medications. The researchers used the most updated formularies and summaries of benefits and coverage information as of May 2014, but plans can change formulary documents at any time and may not include all covered medications in formulary lists.

Findings

Commonly Used Medications

For consumers with relatively limited drug needs, Covered California plans provided comprehensive, affordable access to the most commonly used medications, which were predominantly generic drugs. Ninety of the top 100 most commonly prescribed drugs in 2014 were generics, which were widely included on Covered California formularies and almost always placed on a generic tier with low cost sharing.

For instance, the top 100 list included generic medications used to treat high blood pressure, high cholesterol, and acid reflux, as well as prescription painkillers. Copayments for generic drugs ranged from $5 to $19 and were as low as $3 for the lowest-income enrollees receiving cost-sharing reductions in enhanced silver plans.[29] On average, 94% of the generics most commonly used and 82% of the top brand medications reviewed were included in Covered California formularies.

Chronic Disease Drug Access

While commonly used medications were broadly included on plan formularies with low cost sharing, some consumers with chronic diseases or those who rely on specialty drugs may have faced access and affordability challenges in 2014.

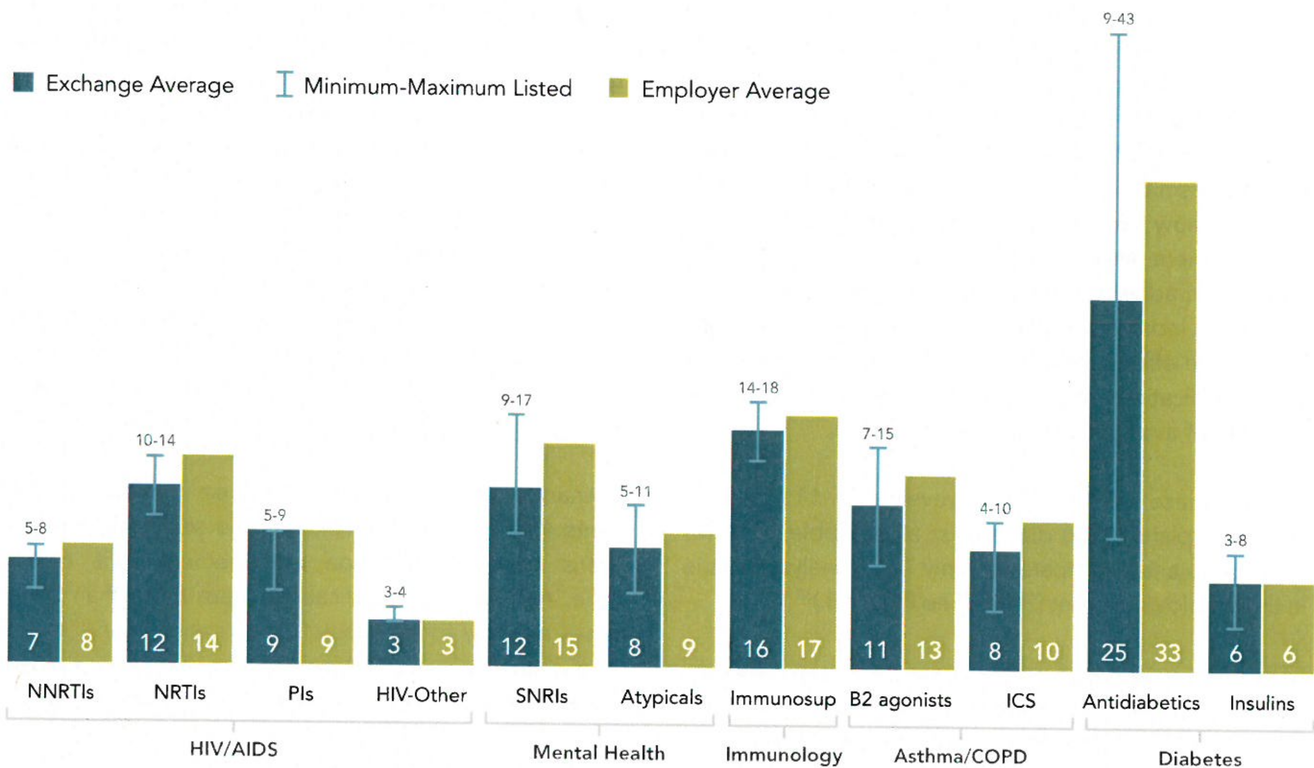
Formulary Breadth

Compared to typical products in the employer market, Covered California plans, on average, included slightly fewer listed drugs for the chronic diseases studied. In an analysis of 11 classes of drugs for medication-dependent chronic diseases, exchange plans listed an average of 80% of analyzed drugs in their formularies, while selected employer plans listed an average of 88%. Exchange formulary breadth varied substantially by class from a low of 58% for antidiabetic agents to a high of 97% of protease inhibitors, a class of antiviral drugs that can be used in a drug regimen for patients with HIV/AIDS.

The analysis uncovered wide variation in breadth of formularies among different plans offered on Covered California. For example, the number of listed atypical antipsychotics used to treat severe mental illness ranged from a low of 5 listed drugs to a high of 11 products. Variation was even more pronounced for antidiabetics, where out of the 44 unique drugs in the class, plans ranged from listing a low of 9 products to a high of 44 products. On average, exchange plan formularies included 58% of antidiabetic agents, which was significantly less than the 75% of products listed in employer plans. (See Figure 2.)

On average, Covered California formulary inclusion for HIV/AIDS drugs was broad, but formulary breadth varied across plans: On average, Covered California plans listed 88% of HIV/AIDS drugs; formularies ranged from listing 75% to 100% of HIV/AIDS products across plans. However, combination therapies used to treat HIV/AIDS

Figure 2. Number of Chemical Entities Listed in Exchange Plan Formularies, 2014



Notes: Anti-HIV agents: **NNRTIs** – nonnucleoside reverse transcriptase inhibitors; **NRTIs** – nucleoside and nucleotide reverse transcriptase inhibitors; **PIs** – protease inhibitors. **SNRIs** – serotonin/norepinephrine reuptake inhibitors; **Atypicals** - second generation/atypical. **B_2 Agonists** – bronchodilators, sympathomimetic; **ICS** – anti-inflammatories, inhaled corticosteroids. **Antidiabetics** – antidiabetic agents.

Source: Author analysis of Covered California exchange plan formularies using Avalere's PlanScape, a proprietary tool to analyze exchange plan features.

Is a Broader Formulary Better?

A broader formulary is not necessarily a better formulary. For example, in the case of antidiabetics, the more limited qualified health plan (QHP) formulary breadth means that consumers who have successfully controlled their diabetes symptoms with a particular medication under nonexchange coverage may want to verify whether their drug is included on an exchange plan's formulary before they enroll in a new plan. But because antidiabetics are a particularly large class with many therapeutic alternatives, patients may be able to work with their physicians to switch to another listed drug that is equally or more effective and perhaps less costly.[30]

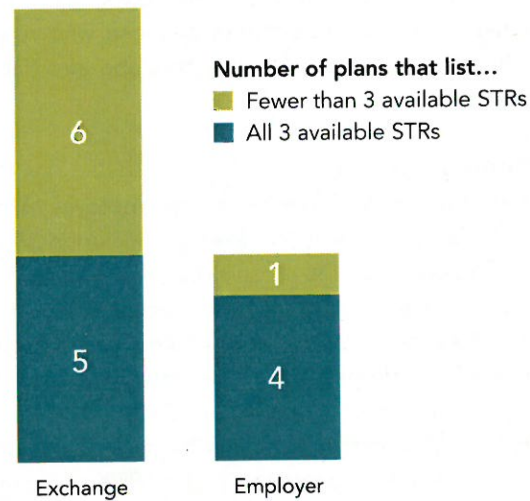
were less likely to be listed on Covered California formularies relative to employer plans.

HIV/AIDS treatment is complicated and usually requires a combination of antiretroviral therapies from at least two different classes to keep the virus from developing. A single-tablet regimen (STR) contains several different drugs in one tablet, which reduces pill burden for patients and has been shown to improve drug adherence. Appropriate adherence slows disease progression, improves individual health outcomes, and can dramatically reduce the risk of transmitting HIV disease to partners. As a result, STRs are now widely recommended and used as first-line treatment since they have been found to improve medication adherence and result in improved viral suppression.[31] Individual differences in tolerance, blood HIV levels, side-effects, and interactions with diet and with other medications make it important for plans to cover the suite of available single-tablet regimens.

Despite these advantages, however, 6 of 11 Covered California plans (55%) did not list all available STRs on their formularies, compared to only 1 of 5 analyzed plans in the employer market (20%). (See Figure 3.)[32]

STRs are a newer and more expensive therapy, and do not have generic equivalents at this time. As a result, patients may not be able to readily access other equivalent therapies on plan formularies.

Figure 3. Formulary Inclusion of Single-Tablet Regimens, Exchange and Employer Plans, 2014



Source: Author analysis of Covered California exchange plan formularies using Avalere's PlanScape, a proprietary tool to analyze plan features.

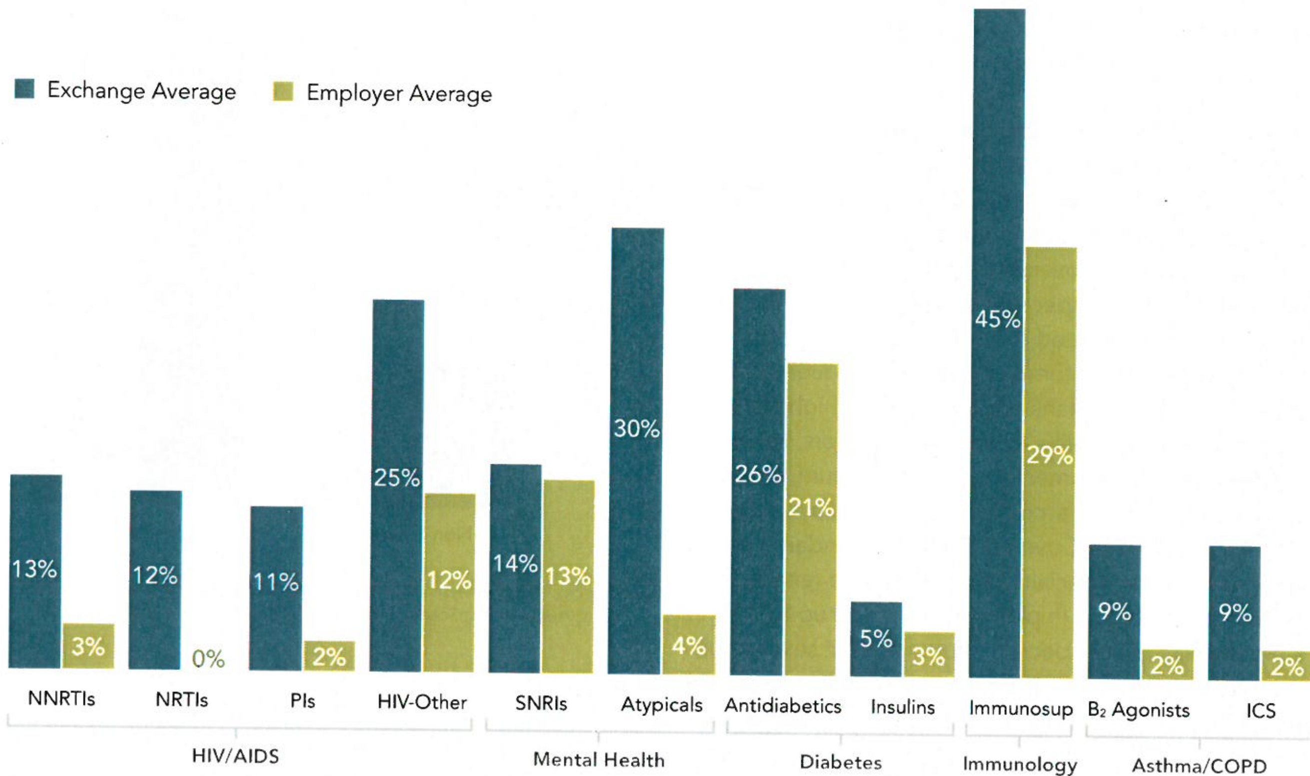
Utilization Controls

Covered California plans were more aggressive than selected employer plans in managing drug use through administrative controls, such as prior authorization and step therapy. Although the average formulary breadth of exchange plans was only slightly less than employer coverage, Covered California plans imposed utilization management much more frequently than employer-based plans. On average among classes reviewed, the percentage of listed medicines subject to utilization management was twice as high in the exchange plans compared to employer plans. The difference was particularly pronounced for immune suppressants, HIV/AIDS drugs, and antipsychotics. (See Figure 4 on page 9.)

Exchange plans placed restrictions on immune suppressants 45% of the time, whereas the selected employer plans imposed utilization management 29% of the time. Antipsychotic medications were more than seven times as likely to be subject to utilization management in exchange plans compared to the selected employer plans (30% in exchanges versus 4% in employer plans).

Finally, across the four HIV classes examined, exchange plans exercised much stricter control, while the selected employer plans generally provided open access to these drugs. On average, Covered California QHPs required

Figure 4. Listed Medicines Subject to Utilization Management, Exchange and Selected Employer Plans, 2014



Notes: Anti-HIV agents: **NNRTIs** – nonnucleoside reverse transcriptase inhibitors; **NRTIs** – nucleoside and nucleotide reverse transcriptase inhibitors; **PIs** – protease inhibitors. **SNRIs** – serotonin/norepinephrine reuptake inhibitors; **Atypicals** - second generation/atypical. **Antidiabetics** – antidiabetic agents. **B_2 Agonists** – bronchodilators, sympathomimetic; **ICS** – anti-inflammatories, inhaled corticosteroids.

Source: Author analysis of Covered California exchange plan formularies using Avalere's PlanScape, a proprietary tool to analyze exchange plan features.

utilization management for HIV/AIDS drugs 15% of the time compared to only 4% in select employer plans.

Medicare prohibits utilization management for HIV/AIDS drugs, citing that prior authorization and step therapy controls are not considered best practice in formulary design.[33] Similarly, low-income individuals in California who are enrolled in Medi-Cal do not face utilization controls for HIV/AIDS medications. Under Medi-Cal, all FDA-approved drugs for treating AIDS and AIDS-related conditions are included on the drug list and carved out of managed care,[34] thus offering Medicaid beneficiaries more unrestricted access to their therapies than exchange enrollees.[35]

Because the purpose of utilization management is to help ensure that drugs are being used appropriately (e.g., targeting indicated patients and ensuring no contraindications), high rates of utilization management for certain medications that have contraindications are not necessarily inappropriate. However, the disparity in utilization management among plans both in and outside Covered California could be cause for concern, because for some prescribers, strict administrative controls can be a barrier that translates to restricted access for consumers. In particular, providers who work in small office practices with limited administrative staff support, or specialists who have not previously had to process frequent utilization management controls (e.g., infectious disease doctors specializing in HIV/AIDS), may find these procedures burdensome. For consumers, this could ultimately lead to rejected claims or administrative delays.

Tier Placement

Products used to treat complex chronic conditions, especially those for autoimmune conditions like rheumatoid arthritis, were disproportionately placed on the specialty tier in Covered California plans compared to the selected employer plans. Specialty tiers are typically reserved for high-cost medications and

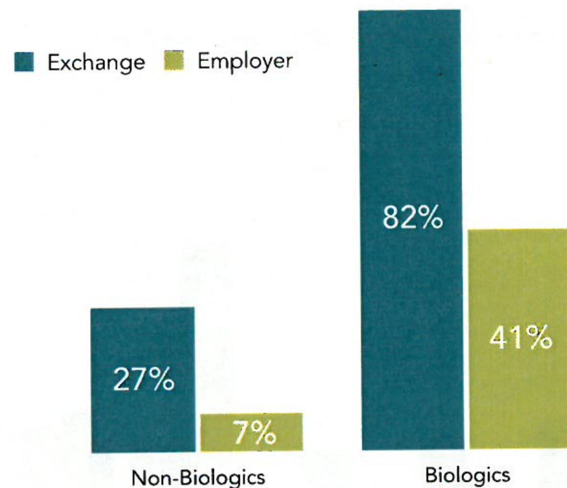
require higher copayments or coinsurance for enrollees. By putting particular drugs on higher tiers, plans are discouraging consumers from using these drugs because of their high out-of-pocket cost.

California law does not provide a uniform definition of a specialty product. Covered California standardized benefit designs allow participating plans to establish specialty tiers and to define the drugs to be included in the tiers.[36] Among Covered California plans, 82% of formularies included a specialty tier, while only 40% of the employer plans selected for this analysis had a structure with more than three formulary tiers; consequently, more drugs in exchange plans are placed on a high tier with high cost sharing. Unlike lower formulary tiers, for which insurers charge consumers a set copay amount, specialty tiers usually impose a coinsurance as a percentage of the drugs' cost. The Covered California standard benefit designs allow for specialty tier coinsurance ranges from 10% of the drug cost in platinum plans and up to 40% in a bronze plan. Since specialty drugs can cost several hundred to several thousand dollars per month, consumers who take these medications may experience high out-of-pocket costs until they reach the annual out-of-pocket cap, which was $6,350 in 2014.[37]

Products in the immune suppressant class, which treat rheumatoid arthritis (RA), Crohn's disease, psoriasis, and organ transplant patients, were placed on a specialty tier 42% of the time in Covered California plans compared to 15% of the time in the selected employer plans. The disparity was particularly pronounced for biologic medications, which were three times as likely to appear on the specialty tier compared to oral pills among Covered California plans.

While most RA patients begin therapy on a traditional oral pill medication, those with severe conditions may progress to biologic medications, which are more effective at slowing disease progression. At the extreme, Covered California plans placed as many as 82% of listed biologic immune suppressants on specialty tiers. Which tier a plan chooses for these drugs has a big impact on consumer out-of-pocket costs. (See Figure 5.) For example, for the 2014 and 2015 plan years, someone taking a biologic RA drug on the specialty tier of a silver plan can expect to pay approximately $550 each time they fill their medication after the deductible.[38] By comparison, if a plan places the same drug on a nonpreferred brand tier, the cost per fill would be $70.

Figure 5. Listed Medicines on Specialty Tier (Tier 4), Biologic and Non-biologic Immune Suppressants, Exchange and Employer Plans, 2014



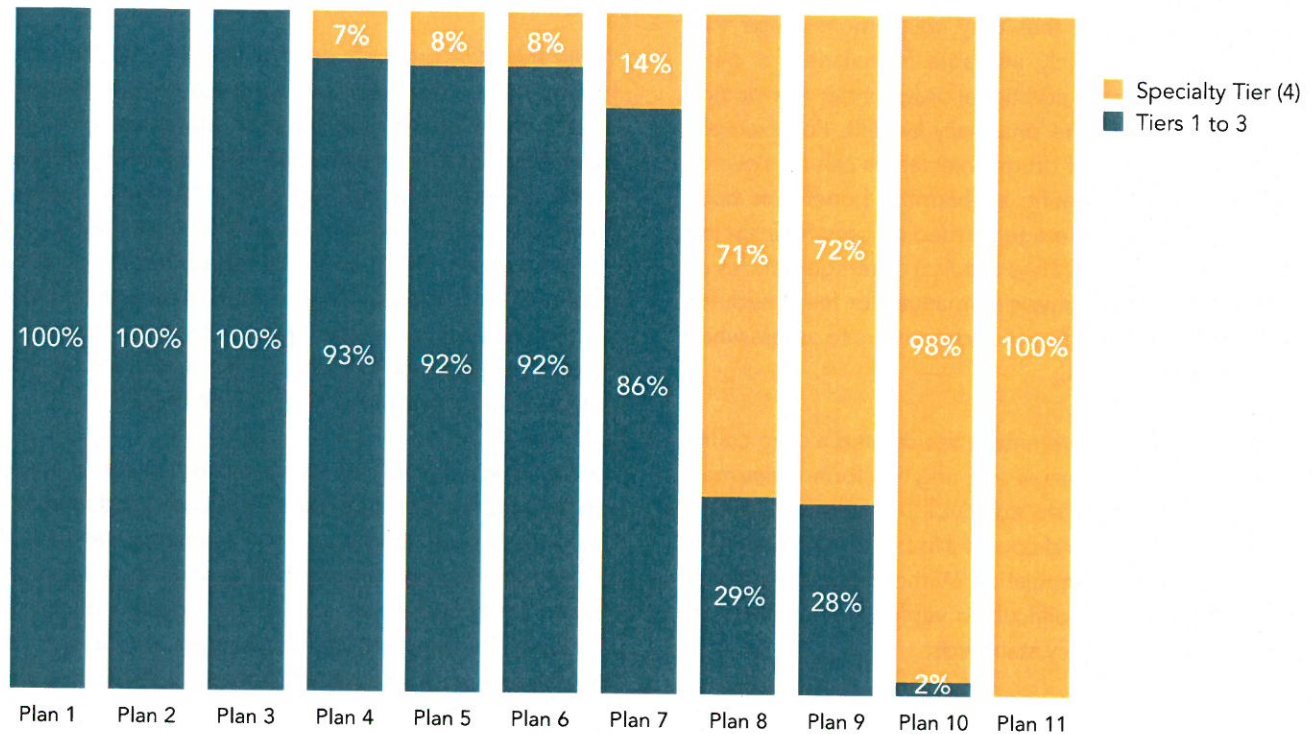
Source: Author analysis of Covered California exchange plan formularies using Avalere's PlanScape, a proprietary tool to analyze plan features.

Tier placement for HIV/AIDS drugs varied dramatically across Covered California plans, with a few plans placing most or all of the listed drugs on the specialty tier. When combination therapies were listed, they were more likely to be placed on high tiers in Covered California plans than in selected employer plans.

Some Covered California insurers placed HIV/AIDS drugs, which are typically oral medications, on the specialty tier. On average, Covered California plans used specialty tiers for listed HIV medicines 27% of the time compared to only 1% in the selected employer plans, but there was wide variation among exchange plans. (See Figure 6 on page 11.)

One plan placed all listed HIV/AIDS drugs on the specialty tier for its Covered California products, including brands and generics. Another plan placed 98% of listed drugs in the HIV/AIDS class on the specialty tier. Two other carriers placed more than 70% of listed HIV/AIDS drugs on the specialty tier for Covered California products. Among the other seven plans in the market, three did not use specialty tiers and an additional four placed more than two-thirds of HIV/AIDS drugs on non-specialty tiers. Notably, some of the plans that placed many HIV/AIDS drugs on specialty tier are small carriers. The four plans that placed more than 70% of listed HIV/

Figure 6. Frequency of Placement of HIV/AIDS Medicines on Specialty Tier Among Listed Products, 2014



Source: Author analysis of Covered California exchange plan formularies using Avalere's PlanScape, a proprietary tool to analyze exchange plan features.

AIDS drugs on the specialty tier represented 5% of 2014 Covered California enrollment.[39]

Availability of Information

Comprehensive information on drug coverage and out-of-pocket costs was difficult to find. This lack of access could be a barrier to consumers who wish to make informed purchasing decisions. Across all segments of California's health care market, it was difficult for researchers to find comprehensive, easily understandable information on drug cost and coverage information by health plan. In addition, during the 2014 enrollment period, formularies for Covered California plans were not available on the exchange website, and instead needed to be retrieved from individual carriers' web pages, where ease of navigation varied widely. While Covered California launched a web page with carrier formulary information after this study's data analyses were completed, formulary links were not readily available on the same web page where consumers shop for and compare plans at the time of the writing of this report.

This lack of consolidated information makes it difficult for consumers in California to consider drug coverage and tier placement when selecting a plan. Researchers found inconsistent formulary formats and structures, which may make it hard for individuals to understand whether their products are listed and whether utilization management controls apply. Furthermore, public formulary information was often found to be incomplete, and it was unclear whether the public documents represented 100% of covered pharmacy-benefit drugs. Cost information was not always easily identifiable or understandable. Researchers experienced these challenges firsthand as they gathered and interpreted data for this report.

Incomplete and nonstandardized public formulary information also makes comparison of plan coverage to the state-selected EHB benchmark difficult, creating challenges for enforcement. For example, in rare instances, based on publicly posted data, plans appeared to cover fewer drugs per class than the number required by the state-selected EHB benchmark. While these differences were small in some cases, in others, plans listed only half of the required number of drugs per class.

Generally, plans reported that these discrepancies reflected incomplete public formulary lists, rather than noncompliance, and that they cover more drugs than were listed on publicly available formularies. In other cases, plans covered additional drugs under the medical benefit, instead of the pharmacy benefit. For example, unlike traditional oral drugs, injectables can be covered under a medical benefit, a pharmacy benefit, or both. Plans typically list coverage for medical benefit drugs in a series of documents called medical coverage policies on their websites or in physician manuals or fee schedules, which can make it difficult for consumers to assess which products are covered.

While the federal government has created a drug counting tool for the purpose of ensuring that formularies meet EHB standards, they do not publish a crosswalk of how drugs are mapped and counted in the tool compared to publicly available formularies. Without public lists of all covered drugs, it is difficult to verify whether plans are meeting the regulatory standards.

Policy Considerations

Relative to the pre-ACA individual market, California's implementation of the ACA and creation of Covered California has greatly improved access to medicines, especially for many previously uninsured individuals. However, some chronically ill patients are likely to face access and affordability challenges in the individual market. Policymakers, regulators, and Covered California staff might consider the following policy changes that would improve transparency and enhance access to prescription drugs for Californians purchasing coverage in the individual market.

Monitor Health Plans for Discrimination

Based on the publicly available formularies, the research found that one Covered California plan placed all HIV/AIDS drugs on the highest-cost specialty tier; another placed 98% of these medications on the specialty tier. Also, Covered California plans excluded STR from formularies at a higher rate than selected employer-sponsored plans. These benefit design choices could amount to a form of discrimination against patients with HIV/AIDS. High rates of specialty tier placement for medicines used to treat other complex chronic conditions are also cause for concern.

While the ACA prohibits discrimination by health plans, federal rules provide limited guidance on the definition of discrimination for drug benefits. States are given primary responsibility for enforcing nondiscrimination rules. In the preamble to proposed federal guidance released November 2014, the US Department of Health and Human Services (HHS) explicitly stated that they believe plan designs that place all or most of the drugs that treat a specific condition on the highest-cost tiers "effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions."[40]

HHS also noted that "if an issuer refuses to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, we believe that, absent an appropriate reason for such refusal, such a plan design effectively discriminates against, or discourages enrollment by, individuals who would benefit from such innovative therapeutic options."[41]

California regulators should actively monitor all health plans to ensure that formulary exclusions and tier placement of particular classes of drugs do not constitute discrimination.

Strengthen Oversight and Rules for Formulary Coverage

Covered California's standard benefit design allows issuers to develop formularies that include a fourth tier — the specialty tier — primarily used for expensive specialized drugs, but state law does not impose a definition of specialty drugs, nor specify what drugs are appropriate to include on that tier. Researchers found significant variation in formulary tier placement for certain classes of drugs. Products used to treat complex chronic conditions, such as autoimmune conditions like rheumatoid arthritis, were more likely to be placed on the specialty tier in Covered California plans than the employer-sponsored plans that were examined.

California law does not impose a definition of specialty drugs for any market segment. In comparison, in the Medicare Part D market, CMS allows plans to place drugs on specialty tiers only if their negotiated prices exceed the dollar-per-month threshold established annually.[42]

Proposed federal guidance released in the November 2014 design points to clinical guidelines and reasonable medical management, rather than cost thresholds, as critical for formularies regulated under the Affordable Care Act. If California implemented a standardized definition of specialty medications, depending on this definition, plans might be precluded from placing all drugs in a class, including generics, on the highest tier. A definition of specialty drugs should take into account the development of new medications and potential new classes of medication as well as variations in approaches by health plans to managing prescription drug costs.

California could also consider additional regulatory scrutiny of formulary designs to identify outlier plans that, compared to other plans, list on formulary significantly fewer drugs in a class, require more utilization management, or fail to list whole sets of drugs (e.g., combination therapies) that are commonly considered clinical best practice. Alternatively, California could pursue a more extreme approach that would specify a standard drug list that must be used by all Covered California plans. Such an approach has been used by some state Medicaid programs, though it has not been attempted in the exchange market at date of publication.

Increase Transparency of Plans' Prescription Drug Coverage for Consumers[43]

Implement new market-wide reforms. Accessing accurate, comprehensive, and consistent information about which drugs are covered by California health plans and what utilization controls or formulary tiers are applied to those products is difficult. These challenges exist across California's health insurance markets; more restrictive drug coverage in the individual market makes transparency in this setting even more important.

In an effort to improve the transparency of drug coverage policies, in September 2014 California enacted SB 1052.[44] This law requires the Department of Insurance and the Department of Managed Health Care to jointly develop a standard formulary template for reporting and displaying formulary information, including coverage, tiering, and utilization management information, as well as details about the plan's medical benefit drug coverage. All plans offering prescription drug coverage will be required to post searchable formularies following this format on their websites and keep them updated monthly. In addition, the law requires Covered California to create a direct link from its website to each QHP's formulary — a requirement that has been implemented.

This legislation represents an important step toward presenting information to consumers clearly. The law applies to formularies in the group as well as the individual markets and to plans inside and outside of Covered California. This level of comprehensiveness is appropriate, as the challenges exist across market segments. State regulators can enhance the effectiveness of the new law by:

- Working together to swiftly develop the template and put it in place
- Using information on consumer needs and preferences to inform development of the template
- Monitoring health plans' compliance with posting and updating complete and searchable formularies

State policymakers should consider future enhancements to the requirements, such as including standardized, easy-to-understand cost information in the template.[45]

Meanwhile, federal policymakers are also considering sweeping changes to improve transparency with a target implementation date of 2016. Plans would be required to make public an up-to-date, accurate, and complete list of all covered drugs, with all corresponding tiering and utilization management clearly outlined. HHS is also considering nationwide implementation of a standardized formulary display template.

Improve consumers' ability to comparison shop Covered California plans based on medication needs. Covered California staff might consider building an online formulary search tool that allows consumers to compare plans based specifically on drug coverage and restrictions. Medicare Part D uses such a tool, known as the Plan Finder,[46] which enables beneficiaries to search for plans by entering their specific medication list and preferred pharmacy. The tool's results include premiums, out-of-pocket costs for the beneficiary's specific medications, and any related utilization controls. Nevada was the only exchange website in 2014 that offered a drug lookup tool to help consumers chose plans based on coverage of medications, but unlike Medicare's Plan

Finder, it did not provide users with the ability to estimate out-of-pockets costs. Such search tools allow consumers to more easily compare plans side-by-side as opposed to searching individual plan formulary documents.

Strengthen the transparency of the EHB regulatory standards regarding prescription drugs. In 2014, federal EHB regulations set requirements for minimum formulary coverage by class in QHPs. However, public information about how particular drugs map to these classes and how state and federal regulators oversee and enforce these rules is extremely limited, even for participating plans.

In recognition of the shortcomings of the current standards for drug coverage in the exchanges, HHS recently proposed changes to EHB drug coverage requirements and solicited comments from stakeholders on the best model to ensure adequate access for consumers. The agency also reiterated the statutory prohibition on benefit design that discriminates based on a person's age, gender, or health status. In addition to the federal guidance, given that states have the primary responsibility for enforcing EHB requirements, California policymakers should consider more specifically identifying criteria for measuring compliance with the ACA nondiscrimination requirement.

Better inform California consumers about the exceptions process and other relevant consumer protections. The lack of clear information about drug coverage for consumers makes consumer awareness of existing protections and alternative routes to coverage particularly important. Health plans, state regulators, and Covered California should ensure that easy-to-understand information on how to access needed drugs is widely available. As part of its partnership with Health Consumer Alliance (HCA), Covered California may want to consider an aggressive consumer education effort on the topic. Regulators may consider ways to increase awareness across markets.

Specify Utilization Management and Exceptions/Appeals Processes

Until recently, the prior authorization (PA) process could vary significantly among health plans. To ease the burden on patients and providers, the California legislature passed a law in 2011 requiring a uniform PA form for all health plans in the state. The new requirement, fully implemented on October 1, 2014, also reduces turnaround time, giving plans two business days to respond to a PA request. While existing California regulations[47] outline requirements for appeals and utilization management, policymakers could consider additions to such rules. For example, policymakers could consider specifying the level of cost sharing that would apply when an appeal is granted, which would help consumers understand what to expect in out-of-pocket costs.

Glossary

Actuarial Value. The average percentage of total health care costs that a plan will pay for covered benefits based on a standard population. For example, a silver plan in Covered California has an actuarial value of 70%, meaning that on average, the plan covers 70% of enrollees' annual health costs.

Biologic Drugs. Medicines generated by genetically engineering a living system, like plant or animal cells. Many biologics must be stored under refrigeration and administered via injection.

Cost-Sharing Subsidy. Additional financial assistance to reduce out-of-pocket costs in Covered California plans for individuals earning between 100% and 250% of the federal poverty level ($11,670 to $29,175 for an individual and $23,850 to $59,625 for a family of four in 2014). Qualified consumers must purchase specific cost-sharing reduction plans at the silver level to take advantage of this subsidy.

Essential Health Benefits (EHBs). Ten categories of services, including hospitalization and prescription drugs, that must be covered by Covered California plans and plans sold on the individual and small group markets outside of the exchange.

EHB Benchmark Plan. The health plan that sets the minimum standards for coverage of EHBs in Covered California. In 2014 and 2015, California's benchmark plan is the Kaiser Foundation Health Plan Small Group HMO 30 ID 40513CA035. For prescription drugs, Covered California plans must cover, at a minimum, the same number of distinct chemical entities in each category and class of medicines covered by the benchmark plan.

Exceptions and Appeals Process. Procedure for consumers to request coverage of certain medicines and services from their health insurance plan. Through a formulary exception process, patients may work with their prescriber to request access to a drug that is not covered by the patient's plan.

Formulary. A list of pharmacy-benefit drugs that are covered by a given health plan. Formularies typically include information about required utilization management. Most formularies use multiple tiers that tie to increasing patient cost sharing to encourage use of preferred medications.

Maximum Out-of-Pocket. The maximum amount that an individual can pay in deductibles, copayments, and coinsurance toward covered, in-network benefits in a benefit year.

Metal Level. Description of the actuarial value of a health plan. In Covered California, plans are offered at four metal levels: bronze (60% actuarial value), silver (70%), gold (80%), and platinum (90%). Catastrophic coverage with a lower actuarial value is available only to people under age 30 or who obtain a hardship exemption from the exchange.

Out-of-Pocket Costs. Consumer spending on deductibles, copayments, and coinsurance related to the use of health services; does not include premiums.

Pre-Existing Condition. A disease or condition for which an individual had received a diagnosis and/or sought treatment prior to enrolling in a new insurance policy.

Premium Tax Credit. Known officially as an Advanced Premium Tax Credit, financial assistance offered through Covered California that reduces premiums for people earning between 100% and 400% of the federal poverty level ($11,670 to $46,680 for an individual and $23,850 to $95,400 for a family of four in 2014). (Note that those earning up to 138% FPL may qualify for Medi-Cal.)

Qualified Health Plan. Health plan offered through Covered California that meets standards for actuarial value, covers the EHBs, and meets requirements for deductibles and cost-sharing structure.

Single-Tablet Regimens. HIV/AIDS medications that combine several chemical compounds into a single pill.

Standardized Benefit Design. Covered California created standard plan designs, including deductibles, copayment, and coinsurance amounts for services and prescription drugs, and maximums on out-of-pocket spending.

Tier Placement. Covered California plans group covered drugs into four tiers. Typically, drugs placed on higher tiers are subject to higher cost sharing.

- **Generic Tier.** The lowest formulary tier (Tier 1), usually reserved for generic drugs and with the lowest cost sharing and fewest limits on access.
- **Preferred Brand Tier.** The second formulary tier (Tier 2), for a plan's recommended branded drugs. Preferred drugs are selected based on a combination of price and quality.
- **Nonpreferred Brand Tier.** The third formulary tier (Tier 3) for branded drugs whose use is discouraged by the plan due to cost or clinical considerations.
- **Specialty Tier.** The highest formulary tier (4 or higher), on which drugs are subject to the highest cost sharing.

Utilization Management. Procedures required by health plans or pharmacy benefit managers that govern patient access to drugs.

- **Prior Authorization.** Requirement that a health plan reviews requests for certain medicines, on an individual patient basis, before granting coverage.
- **Step Therapy.** Requirement that, before accessing a prescribed drug, patients try and "fail" on at least one alternative drug.

Appendix A: Unique Products Analyzed by Issuer, by Metal Level, 2014

CARRIER	REGIONS	BRONZE	SILVER	GOLD	PLATINUM	TOTAL
Anthem Blue Cross	19	4	3	3	3	**13**
Blue Shield of California	19	4	2	2	2	**10**
Chinese Community Health Plan	2	1	1	1	1	**4**
Contra Costa Health Plan*	1	1	1	1	1	**4**
Health Net	13	1	2	2	2	**7**
Kaiser Permanente	18	2	1	1	1	**5**
L.A. Care	2	1	1	1	1	**4**
Molina Healthcare	4	1	1	1	1	**4**
Sharp Health Plan	1	2	2	2	2	**8**
Valley Health	1	1	1	1	1	**4**
Western Health Advantage	2	2	1	1	1	**5**
Total	—	**20**	**16**	**16**	**16**	**68**

*Not participating in Covered California in 2015.

Appendix B: Employer Formularies Analyzed, by Issuer, 2014

INSURANCE CARRIER	FORMULARY ANALYZED
Anthem*	Group
Blue Shield of California*	Group
CalPERS	Preferred Drug List
Health Net*	Group
Kaiser Permanente*	Group

*Report using the same formulary in the small and large group markets.

Endnotes

1. B. D. Sommers, "Insurance Cancellations in Context: Stability of Coverage in the Nongroup Market Prior to Health Reform," Health Affairs (Millwood) 33, no. 5 (May 2014): 887-94.
2. CHCF-supported independent analysis of Department of Managed Health Care (DMHC), Enrollment Summary Report – 2013, www.dmhc.ca.gov; California Department of Insurance (CDI), Covered Lives Report, www.insurance.ca.gov. Publication forthcoming.
3. Kev Coleman, "Almost No Existing Health Plans Meet New ACA Essential Health Benefit Standards," HealthPocket.com, September 28, 2014, www.healthpocket.com.
4. Although the ACA also creates exchange options for small businesses, this report focuses solely on the individual market.
5. Covered California Enrollment Statistics, April 17, 2014, 3.bp.blogspot.com.
6. The federal EHB requirement applies to all fully insured nongrandfathered health plans in the individual and small group market. It does not apply to self-funded plans, large group plans, or grandfathered plans. The full list of EHBs is as follows: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
7. Drug counts reflect unique chemical entities, meaning that they combine brands and their generic equivalents as well as drugs with multiple formulations.
8. For 2014 and 2015, California's selected benchmark plan is Kaiser Foundation Health Plan Small Group HMO 30 ID 40513CA035, www.cms.gov.
9. The drug classes are defined by the US Pharmacopeial Convention (USP), a scientific nonprofit required by federal law to maintain a classification system whereby drugs are categorized based on their therapeutic uses.
10. 45 CFR 156.122.
11. Ibid.
12. 28 CCR 1300.67.24.
13. Building off the 24-hour exceptions process for exigent circumstances, in the November 2014 proposed 2016 Notice of Benefit and Payment Parameters, HHS proposed to create a standard 72-hour process for nonurgent drug exception requests. Furthermore, the proposed rule stipulates that if the exception is granted, any cost sharing would count toward the consumer's out-of-pocket maximum.
14. 28 CCR 1367.215.
15. 28 CCR 1300.67.24 and CIC §10112.27; see also 10 CCR 2594.4. Requirement applies to all nongrandfathered plans in the individual and small group markets and all managed care plans (regardless of market).
16. HSC §1367.22.
17. AB 1602, Chapter 655, Statutes of 2010.
18. Issuers are prohibited from offering catastrophic plans outside the exchange.
19. The California Department of Managed Health Care (DMHC) regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers, which offer benefit coverage to their enrollees through health insurance policies.
20. Individual Market Enrollment Data, Q1 2014 changes, August 20, 2014 meeting of Financial Solvency Board, Department of Managed Health Care. Market-wide figures for CDI-regulated plans are not available at this time.
21. One carrier is captured in the analysis that is not participating in Covered California in 2015.
22. One carrier uses separate Northern and Southern California formularies; for ease of analysis, the Northern formulary is used in this analysis as this formulary captures a larger share of enrollment. Differences between the Northern and Southern California formularies are nominal and would not materially impact the findings of this analysis.
23. Drug classes are based on the US Pharmacopeia Medicare Model Guidelines 5.0, which are the basis for the EHB drug count requirements.
24. Many Covered California plans operate across multiple regions in the state, including three plans that operate nearly statewide. As a result, researchers found very limited variation in results across regions.
25. Select employer plans include Anthem's large group formulary, Blue Shield of CA's large group formulary, CalPERS's preferred drug list, Health Net's large group formulary, and Kaiser Permanente's large group formulary, which is the same formulary as the small group formulary — the state-selected EHB benchmark.
26. Avalere analysis of Census Bureau Current Population Survey for 2013 Insurance Coverage.
27. Exchange data: Avalere PlanScape plan information from both federally facilitated and state-based exchanges in a sample of over 600 plans, updated November 2013. Employer data: Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2014 Annual Survey.
28. Jon Gabel et al., "Health Insurance Reforms: How Will They Affect Employment-Based Coverage in California?," UC Berkeley Center for Labor and Education, April 2012, laborcenter.berkeley.edu. "Large" is defined as 1,000+ employees; "small" is defined as 3 to 49 employees.

29. This excludes the 40% HDHP bronze standard plan. Cost-sharing subsidies that lower consumers' out-of-pocket costs are also available to individuals with incomes up to 250% of the federal poverty line who purchase a silver plan. This is referred to as the "enhanced silver" plan. See www.coveredca.com.

30. Also, as noted, consumers have access to an exceptions process to seek access to off-formulary medications.

31. P. E. Sax et al., "Adherence to Antiretroviral Treatment and Correlation with Risk of Hospitalization Among Commercially Insured HIV Patients in the United States," PLoS ONE 7 no. 2 (2012): e31591, doi:10.1371/journal.pone.0031591.

32. Note that at the time of analysis only three STRs were available on the market.

33. The Medicare "Guidelines for Reviewing Prescription Drug Plan Formularies and Procedures" notes that CMS's formulary review focuses on best practices in existing drug benefits to ensure appropriate access for Medicare beneficiaries.

34. California Code §14105.43.

35. *Medicare Prescription Drug Benefit Manual,* Chapter 6: 24, www.cms.gov.

36. For Medicare Part D, CMS uses a specialty tier threshold of $600 per month based on the negotiated price; 2015 Call Letter, February 21, 2014, www.cms.gov.

37. The out-of-pocket limit for Covered California plans for the 2015 plan year will be $6,250.

38. Healthcare Blue Book "fair price" for Humira and Enbrel in Los Angeles, assuming 20% coinsurance.

39. This statistic represents individuals who finished their applications and selected plans through April 15, 2014. Covered California blog, April 17, 2014, news.coveredca.com.

40. 45 CFR 144, 146, 147, et seq. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule.

41. Ibid.

42. For 2014, the Medicare Part D specialty threshold is $600 for a 30-day supply of the medication.

43. While not the subject of this report, information about coverage for physician-administered drugs is especially challenging to find. Many plans do not list these drugs on formularies, which are typically limited to pharmacy-benefit products. As a result, consumers must navigate separate medical-benefit coverage policies, for which public availability is variable.

44. Senate Bill 1052 (Torres, 2014) approved by the governor on September 25, 2014.

45. At publication time, CMS has solicited comments on whether to mandate inclusion of cost information in published exchange formularies. CMS does not specify a planned implementation date for such a requirement.

46. Medicare Plan Finder tool: www.medicare.gov.

47. California HSC Code §1367.24.

RESEARCH REPORT

Enrollment Periods in 2015 and Beyond

Potential Effects on Program Participation and Administration

Stan Dorn

February 2015

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Executive Summary

Several leading experts believe that allowing enrollment in qualified health plans (QHPs) early in the calendar year could yield major reduction s in the number of uninsured and an improved risk pool under the Patient Protection and Affordable Care Act (ACA).

The Centers for Medicare and Medicaid Services (CMS) propose scheduling open enrollment periods (OEPs) for 2016 and later years from October 1 through December 15, with coverage starting each January. Under an alternative calendar, the OEP could instead run from January 20 or February 1 through March 31, with plan years beginning in May. During the latter OEP, applicants would project their incomes for the rest of the calendar year. Calendar-year income would remain the basis of subsidy eligibility, as it is today.

Potential advantages of an early calendar-year OEP

More eligible uninsured would probably gain coverage, particularly among the relatively healthy.

- *Penalties for going without coverage would likely prompt more uninsured to enroll when the previous year's penalties are fresh in their minds*—immediately after they have filed tax returns and lost their tax refunds. If the uninsured must instead wait until October to enroll, behavioral economics research suggests that a more distant memory of loss will motivate fewer to act.

- *An October to mid-December OEP overlaps with the holiday season's financial pressures, which are likely to undermine QHP enrollment. February and March, after those pressures are gone, historically see higher sales of products like insurance*. Consumer debt rises in October through December, falls in January, and reaches its lowest levels in February to April. In the $20,000 to $50,000 income range typical of QHP subsidy eligibility, 85 percent of taxpayers receive tax refunds, averaging nearly $2,700; two-thirds of refunds arrive by the end of March. Sales of all kinds of insurance, as shown by broker revenue, are thus lowest in the year's final quarter, when consumer finances are most constrained, and highest in the year's first two quarters, when household balance sheets are more favorable. Sales of autos and new homes, which like insurance require regular monthly payments, similarly peak in March through June, after recovering from annual lows during November through January (figure ES-1).

- *Brokers and tax preparation services could help more consumers sign up for coverage*. Participation grows when assisters relieve consumers of the need to complete paperwork. If QHP enrollment occurred in late winter and early spring, more insurance brokers could help with Insurance Affordability

Program (IAP) applications. In October through December, Medicare Advantage and most employer plans hold open enrollment, which pulls brokers away from QHP sign-ups.

Tax preparers could also help consumers apply for IAPs if QHP enrollment overlapped with tax season. More than 74 percent of the IAP-eligible uninsured, including 88 percent of those who qualify for QHP subsidies, file federal income tax returns, typically using paid tax preparers. Uninsured, subsidy-eligible tax filers are relatively low risk: 43 percent are adults under age 35 and 13 percent are age 55-64, compared to 28 percent and 25 percent, respectively, among QHP enrollees. After clients provide tax information, just five to six minutes of extra questions are needed, on average, to finish an IAP application. More than 700,000 tax preparers are registered with the Internal Revenue Service—nearly 20 times the 38,000 full-time staff who provided application assistance in the 2014 OEP.

There is a reasonable chance (though not a certainty) that tax preparation services could transition into a major new role helping uninsured clients enroll into IAPs, greatly improving overall coverage and risk levels. However, that transition could be prevented unless OEPs overlap with tax season.

- *Fewer consumers would probably be denied subsidies for failing to file timely tax returns*. When people who receive advance payment of tax credits (APTCs) in one year do not file returns by the following April 15, they become ineligible for subsidies. If QHP enrollment overlapped with tax season, Marketplaces and application assisters could focus on the relatively few subsidy applicants who do not file early returns, intervening to ensure that they file by April 15. With an October to December OEP, by contrast, Marketplaces can do little more than include notices about April 15 filing along with other information they send to all beneficiaries; such notices can easily be forgotten or overlooked. And by October it is too late to meet the previous April due date.
- *Consumers could change plans rather than be forced to drop coverage if they learn, during tax filing, that they must lower their APTC amount* to prevent later reconciliation problems. If the OEP overlapped with tax season, they could switch to a cheaper plan. If the OEP is over, however, they cannot typically change plans. Consumers who must cut their APTCs could face increased premium costs they perceive as unaffordable. Some may be forced to drop coverage until the next OEP.
- *More consumers could receive the full subsidies for which they qualify*. For example, tax preparers could inform the self-employed that they can receive additional subsidies by deducting from taxable income QHP premium costs not covered by APTCs.

Subsidies could be determined more accurately and reconciliation problems could decrease.

- *The OEP would take place after the year begins*. Final annual income could thus be predicted more accurately than during October through December the previous year.

- *Last year's tax return could begin the eligibility process*. In October to December, the process starts with a return showing income two years before the subsidy period, which is more likely to be outdated.
- *If more consumers received expert help in applying for subsidies, applications would be more accurate*, based on experience with pre-ACA health programs.
- *Consumers could compensate for APTC errors*, which could easily occur at the end of QHP plan years, long after Marketplaces first determined subsidy eligibility. Inertia often prevents consumers from reporting income changes. If the QHP plan year started in May, APTC errors in the final months of the plan year would occur early in the calendar year. Consumers could prevent reconciliation problems by adjusting their APTC amounts for later in the calendar year. This cannot happen under the current schedule, since the QHP plan year ends with the calendar year's final months.

However, APTCs paid between the start of the calendar year and the OEP would continue at the same level as in the prior year unless beneficiaries report income changes to the Marketplace. To adjust subsidies for the new calendar year, Marketplaces could institute an income updating process in November or December. Decisions about that process involve a trade-off between improving subsidy accuracy and risking adverse selection with SEPs that result from significant changes to subsidy eligibility.

Administrative burdens could lighten for carriers, brokers, and employers. An OEP early in the calendar year would let premium calculations, development of marketing materials, and similar tasks happen for QHPs at different times than for Medicare and most employer-sponsored insurance (ESI), which hold open enrollment late in the year. Carrier enrollment staff and brokers could likewise respond to demands from QHP enrollees at different times than for Medicare beneficiaries and most ESI recipients. Workloads would spread out over the calendar and become more manageable. Employers' administrative costs could also drop if QHP enrollment overlapped with tax filing. Most workers learn about employer identification numbers (EIN) from tax forms. More applicants know their current employers' EINs during tax season, when tax forms show last year's employer, than during October to December, when tax forms show the employer from two years ago. If more applicants provided current EINs, more applicants' ESI information could be verified via electronic data matches, rather than new paperwork from employers.

The calendar would be less politically charged. Annual QHP premiums would be announced around the late January start of open enrollment, rather than, as under the current schedule, near October 1, roughly a month before Election Day in even-numbered years. Also, state and federal officials would no longer be tempted to delay the announcement of important rules until after Election Day; currently, such delays can greatly compress insurance product development and regulatory review, risking the adequacy of coverage.

Potential disadvantages of an early calendar-year OEP

Shifting to QHP plan years that start in May would involve a costly and potentially disruptive transition.

- *An extensive infrastructure has developed around plan years that begin in January* for QHPs and other individual plans. That infrastructure includes carrier rate and form filing, other data provision, review by insurance regulators and Marketplaces, state laws, and federal regulations. Changing this structure to fit a plan year that begins in May would require considerable effort.

- *To fit "bridge coverage" that transitions to a May start day for QHP plan years, federal rules and plan design would need to change, adding further costs*. For example, a four-month bridge-coverage period from January 2017 to April 2017 or a 16-month bridge from January 2017 to April 2018 would require federal agencies to adjust rules that now assume 12-month coverage periods. Risk adjustments, actuarial value calculators, plan payments for cost-sharing reductions, and medical loss ratio rules would all need to change. Carriers would need to develop new plans to fit those adjusted rules.

Consumer confusion would likely increase, according to several leading experts.

- *A QHP plan year that no longer aligns with the calendar year used to determine subsidy eligibility* could make planning more confusing for families who already face complex insurance choices. If the QHP year began in May, each calendar year would contain portions of two QHP plan years. In thinking through health insurance choices, some families would need to analyze multiple time periods, each less than a year in length, each combining a partial QHP plan year and part of a calendar year.

- *Some clarifying simplicity might be lost if QHP schedules differed from those used for most employer plans*. While there is little overlap between consumers who qualify for QHP subsidies and those with ESI, some subsidy-eligible consumers formerly received ESI and could benefit from a familiar schedule. Moreover, a small proportion of subsidy-eligible consumers face a choice between ESI and QHPs. That choice would be easier to make if open enrollment periods for the two coverage systems aligned.

- *Tax reconciliation would become more complex*. That would likely have modest rather than severe effects, despite the start of QHP plan years each May. In January, Marketplaces must send consumers reports about monthly coverage the prior year. The reports should make reconciliation calculations no harder than if a consumer moved to a new county in May where QHPs charged different premiums. However, if Marketplaces send additional reports because of the mid-year change to QHP plan years, administrative errors or snafus could become more common. Tax preparation services will handle reconciliation for most consumers, which could mitigate many problems and complications.

Despite this increased complexity, more people would likely receive guidance from insurance brokers and tax preparation services. That could reduce confusion for some consumers.

Short-term considerations

Changing future OEPs would require significant lead time to minimize costs and lessen disruptions. If federal officials start implementing this change within the next few months in a way that seriously addresses the above transition issues, a new OEP would not take full effect until 2018 or 2019.

In 2015, a federal or state special enrollment period (SEP) could aid uninsured consumers who pay their tax penalty for failing to get coverage in 2014. As proposed by Families USA and Timothy Jost, such an SEP would let them enroll in QHPs from February 16 through April 15, 2015.

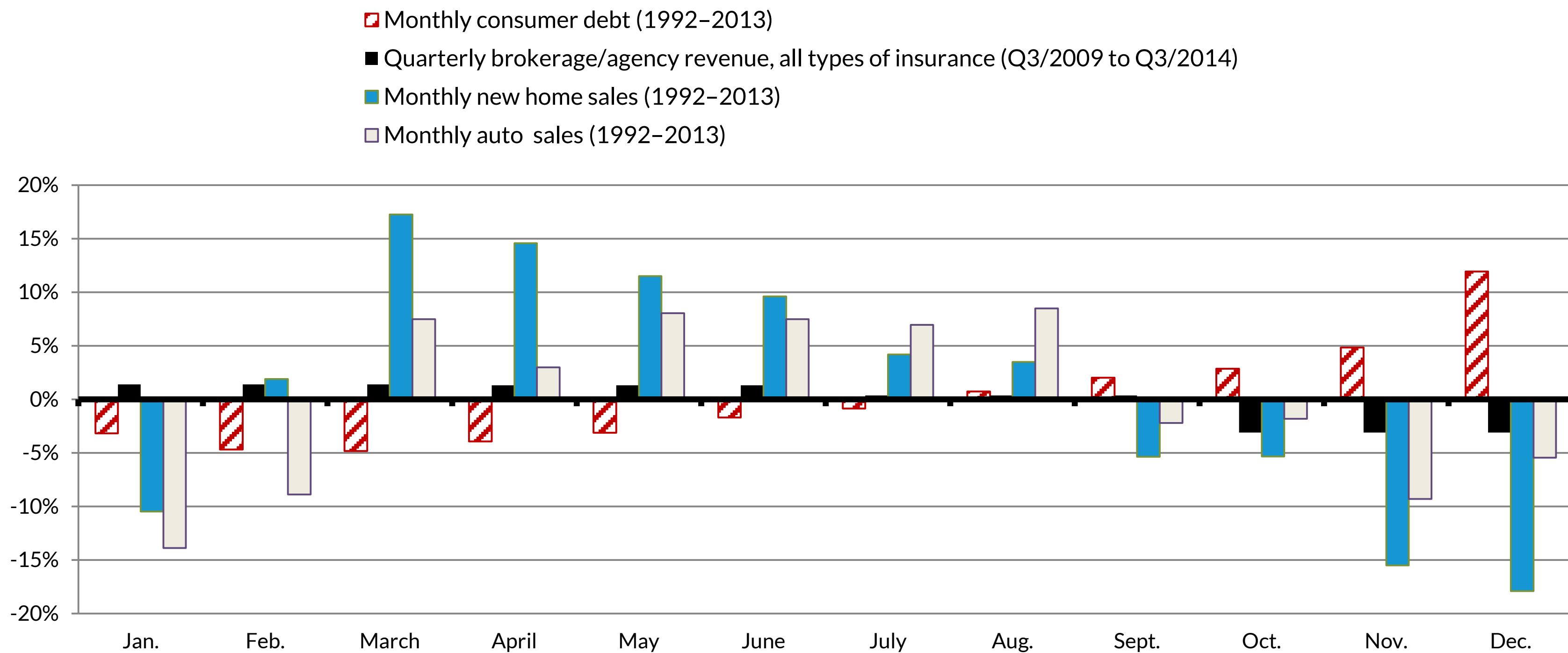
Without the SEP, these consumers will find themselves doubly disadvantaged when they file their tax returns after February 15 and learn, for the first time, how the ACA's penalties affect them. They will: (1) pay a penalty for lacking coverage in 2014; and (2) pay a much larger penalty for lacking coverage in 2015, which they will be powerless to avoid because they filed their returns after February 15. Had they filed earlier, they would have learned about the 2015 penalty in time to avoid it by enrolling in coverage.

Such an SEP would have trade-offs. For example, while it would improve QHP risk pools by letting many healthy consumers enroll, it would also create offsetting adverse selection. Some previously healthy uninsured consumers would sign up for QHPs after getting sick or injured between February 16 and April 15. It would also worsen communications challenges facing Marketplaces that encouraged enrollment by emphasizing the general unavailability of coverage after February 15. It would require verification from SEP applicants, such as by uploading electronic copies of tax forms proving penalty payment. It would unfairly treat some uninsured by denying help to those who were exempt from penalties in 2014 or who lost coverage in 2015. And it would require careful limits to prevent the "SEP exception from swallowing the rule" that most enrollment ends after the OEP.

Put simply, important gains could result from letting consumers enroll into QHPs early rather than late in the calendar year. Several options are available for making this shift, both in 2015 and beyond. On the other hand, each option also has accompanying disadvantages that policymakers must carefully weigh before deciding whether, how, and when to make a change.

FIGURE ES.1.

How Total Consumer Debt, Revenue for Insurance Brokerages and Agencies, and Sales of New Homes and Autos Varies from the Average in Particular Months or Quarters



Source: Board of Governors of the Federal Reserve System 2014; U.S. Census Bureau, Quarterly Services Survey 2014, Monthly Retail Trade Survey 2014, Survey of Construction 2014.
Note: Bars falling below the 0% line indicate months with lower than average values while bars above the line indicate higher than average values. For each year: (1) average amounts per month (or quarter, in the case of brokerage/agency revenue) were calculated, and (2) the difference between that average and the amount for each specific month (quarter, in the case of brokerage/agency revenue) was estimated. The latter estimate, for each specific month (quarter, in the case of brokerage/agency revenue), was averaged for all years covered by the figure. Insurance revenue data are available only by quarter, shown here as identical monthly amounts within each quarter. For more information, see figures 2, 4, and 5, below.

Acronym glossary

ACA	Patient Protection and Affordable Care Act
AGI	Adjusted gross income
APTC	Advance premium tax credit
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CSR	Cost-sharing reduction
CY	Calendar year
EITC	Earned Income Tax Credit
EIN	Employer identification number
ESI	Employer-sponsored insurance
FPL	Federal poverty level
HRMS	Health Reform Monitoring Survey
IAP	Insurance affordability program
IRS	Internal Revenue Service
MAGI	Modified adjusted gross income
OEP	Open enrollment period
PTC	Premium tax credit
QHP	Qualified health plan
SEP	Special enrollment period
SLCSP	Second-lowest cost silver plan

"Right timing is in all things the most important factor."

-Hesiod

"Strategy and timing are the Himalayas of marketing. Everything else is the Catskills."

-Al Ries

Introduction

Despite daunting obstacles, the first open enrollment period under the Patient Protection and Affordable Care Act (ACA) ushered in a substantial reduction in the number of uninsured, with more Americans receiving coverage in health insurance Marketplaces than many observers expected.[1] Replicating that feat could prove difficult. Fewer resources will be available to provide critically important hands-on application assistance;[2] mass media is paying less attention to Marketplaces; many of those easiest to reach have presumably already signed up for coverage; and the second open enrollment period (OEP) lasts just three months—November 15, 2014, through February 15, 2015—half the first period's length. The Centers for Medicare and Medicaid Services (CMS) have proposed 11-week OEPs for 2016 and beyond, from October 1 to December 15 before the start of each year.[3]

Regardless of the duration of open enrollment, several experts believe that changing its timing could greatly increase participation. Katherine Swartz of the Harvard University School of Public Health and Vanderbilt University's John Graves conclude that "holding open enrollment just before or during the holiday season is a mistake;" and that "the ACA's goals of maximizing enrollment … and maintaining a healthy balance of enrollees with low and high risks … are more likely to be achieved" if the annual OEP were shifted to February 15 through April 15.[4] Washington and Lee University's Timothy Jost describes a similar policy of letting the uninsured enroll into qualified health plans (QHPs) during February through April 2015 as a "vitally important step that the administration could take to substantially increase 2015 open enrollment," as it would "extend coverage to many otherwise uninsured individuals and draw into the exchanges a group that is likely to be relatively low risk."[5] Leading behavioral economists suggest that, with benefit programs that have seasonal applications, enrollment gains might result from "synchronizing the timing" of applications "with the tax season," because "much of the information needed for determining eligibility … is already contained on the tax return" and could be used to apply for benefits.[6]

The first part of this paper examines these conclusions by exploring factors that could enhance participation if QHP enrollment took place in late winter and early spring. The paper then explores the feasibility of modifying the 2015 open enrollment period and structuring future OEPs to incorporate such a

schedule. It concludes that gains would likely result; that several approaches are possible to implement such a change; but that each approach has disadvantages as well as advantages that require careful thought.

QHP Enrollment in Late Winter and Early Spring Could Increase Participation and Improve Risk Pools

This analysis assumes that, despite subsidies and the ACA's individual coverage requirement, a key challenge for the foreseeable future will involve persuading relatively healthy uninsured consumers to enroll into subsidized QHPs. Affordability appeared to be the most important factor limiting QHP participation among uninsured consumers who examined Marketplace options in 2014 and chose not to sign up.[7] In lowering enrollment projections for the 2015 OEP, federal officials noted the country's experience with the Children's Health Insurance (CHIP) program and other initiatives, suggesting that a five- or six-year ramp-up may be a realistic trajectory to steady-state enrollment under the ACA.[8] Factoring in the ACA's coverage mandate, independent estimates project that, after the initial transition period, approximately 27.2 million Americans will remain uninsured, of whom 4.1 million will qualify for QHP subsidies but not enroll.[9] For reasons discussed below, QHP sign-ups in late winter and early spring could increase participation among the relatively healthy, eligible uninsured, lowering risk levels and supporting the sustainability of Marketplaces that are funded based on the number of QHP enrollees.

The tax penalty may be more effective in motivating action when it is being applied, not just remembered

Beginning in 2014, the ACA requires most individuals to obtain health insurance coverage or pay a tax penalty, with the size of the penalty phasing up between 2014 and 2016. These penalties are likely to have the largest effects on healthy consumers, who do not have health problems that motivate them to purchase health insurance. However, the Internal Revenue Service (IRS) can collect penalties only by reducing or denying tax refunds. If consumers can enroll immediately after that occurs, a tax preparer could say to an uninsured client, "You just lost $98 in refunds because you were uninsured. Next year, you will lose $325. You can reduce that penalty by enrolling into coverage right now, which I can help with." By contrast, if enrollment is not possible during tax season, the uninsured can only resolve to act during the following open

enrollment period, at least six months in the future. By then, the memory of the previous year's penalty will be less likely to prompt action.

When loss is being experienced, the prospect of a similar future loss seems more vivid, and action is more likely than when losses are merely remembered from the past. Behavioral economics findings about "availability" repeatedly show that the ease with which something comes to mind—because of recent timing, personal experience, or other factors—can make it seem more probable and increase its likelihood of motivating action.[10] Observing that, "'The impact of seeing a house burning … is probably greater than the impact of reading about a fire in the local paper,'" one leader in the field illustrated the role of timing in insurance decisions with several research findings: "If floods have not occurred in the immediate past, people who live on flood plains are far less likely to purchase insurance. In the aftermath of an earthquake, many more people buy insurance for earthquakes, but the number declines steadily from that point, as vivid memories recede."[11]

Another example of this effect involved a randomized, controlled trial with participants who served as jurors on a simulated products liability trial. All participants received the same written set of facts and jury instructions. Two groups were shown a news article about a $14 million award in a similar case. One group saw it three days before the simulated trial, and the other saw the article three weeks in advance. Members of the first group awarded plaintiffs an average of $1.3 million. Those in the second group awarded an average of $226,000—less than one-fifth the first group's award, even though the only difference involved the time since seeing the news article.[12]

None of these studies involved the precise equivalent of QHP enrollment, but each showed that the recent timing of events can be irrationally influential in shaping decisions. This suggests that the ACA's penalty for remaining uninsured could be much more effective in motivating action if enrollment can occur immediately after the penalty is imposed.

Consumers are more likely to buy insurance when their credit balances have recovered from the holidays and they are receiving tax refunds

Swartz and Graves, examining internet search patterns, found that financial anxieties are highest during the November to December holiday period and do not significantly recede until February and March. Citing behavioral economics research showing that such stresses can prevent effective decisionmaking, the authors suggested that more uninsured are likely to buy health insurance during late February and March,

when many receive tax refunds, rather than November through mid-February, which “are particularly financially stressful for many people.”[13]

These research findings and conclusions are consistent with seasonal patterns of consumer purchases and credit balances. Sales of such items as clothing, sporting goods, and electronics, which are often bought as holiday gifts, typically peak during the final quarter of the year then plummet during the year’s initial months. Census Bureau data show that, during the average year from 1992 through 2013 (figure 1):

- Sales at clothing stores, sporting goods/hobby/book/music stores, gift/novelty/souvenir stores, electronic shopping and mail-order houses, and electronics and appliances stores are 9 to 20 percent above average levels in November and 47 to 96 percent above average in December; while
- Sales at such stores are below average monthly levels by 9 to 31 percent in January; 11 to 23 percent in February; and 4 to 19 percent in March.

Federal Reserve data about consumer credit show a corresponding worsening of consumer debt during the year’s last few months, with major improvements after the holidays. During the average year from 1992 through 2013, consumer debt exceeded the year’s average by ever-increasing amounts from August through December, peaking at 2.9 percent, 4.8 percent and 11.9 percent above average levels in October, November, and December, respectively (figure 2).[14] After the holiday season, consumer credit improves, reaching its most favorable levels in February, March, and April. During those months, total consumer debt falls below annual average amounts by 4.7 percent, 4.8 percent, and 3.9 percent, respectively (figure 2).[15]

At the same time that credit balances have recovered from holiday purchases, many consumers claim tax refunds, starting in late January. As figure 3 shows, half of all refunds are in hand after the first week in March, and 66 percent are received by the end of that month. In 2013, 114.8 million out of 144.9 million federal income tax returns (79 percent) involved refunds or overpayments.[16]

Most people who are financially eligible for QHP subsidies receive significant tax refunds. Precise percentage estimates are not easy to provide, however. IRS data show tax filers in terms of adjusted gross income (AGI), and subsidy eligibility is based on income as a percentage of the federal poverty level (FPL), which reflects household size as well as dollar income. The typical eligibility range for subsidies, 138 to 400 percent of FPL,[17] equals $16,105 to $46,680 for a single adult and $32,913 to $95,400 for a family of four. Among all filers with AGI between $20,000 and $50,000, 85 percent received refunds in 2013, averaging $2,690; in the $50,000 to $75,000 range, 76 percent received refunds, averaging $2,852 (table 1).[18]

This analysis suggests that consumers are better positioned to buy insurance in February, March, and April than during October through December. Census data confirm that agencies and brokerages receive their greatest earnings for selling all types of insurance (not just health coverage) during the first half of the

year and their least in the final quarter. During the average year from 2009 through 2014 (the period for which data are available), agency and brokerage income was 3.1 percent below average in the final calendar quarter—the holidays, when consumer credit was most over-extended. It was 1.4 percent and 1.3 percent *above* average levels during the first and second calendar quarters, respectively (figure 4).

While suggestive, this finding does not resolve the timing of insurance sales to consumers, since agent and broker revenue comes from employers as well. Other data, involving auto and new home sales, does focus specifically on consumers. Like buying insurance, purchasing autos and homes typically involves committing to future monthly payments. As with broker revenue, auto and new home sales typically decline in the final calendar quarter and rise in the year's first half. According to Census Bureau data, during the average year from 1992 through 2013 auto sales were at their lowest levels from November through February and their highest levels in March, May, June, and August; and new home sales were similarly at their lowest levels in October through January and their peak during March through May (figure 5).

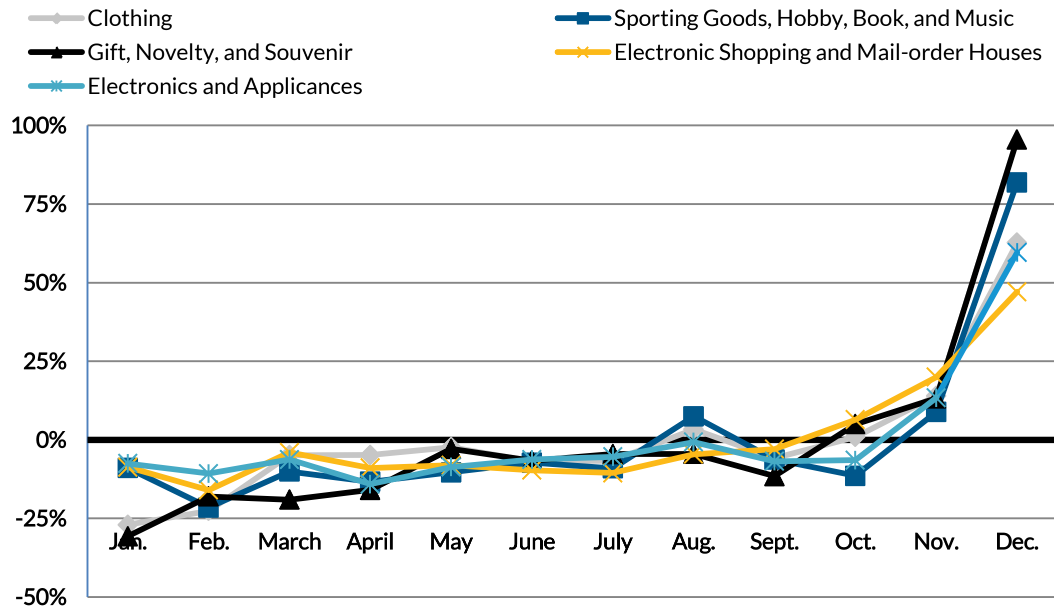
During the year's final months, sales of gift items spike, consumer debt reaches its highest levels, and sales of products that can seem more mundane and that require ongoing financial commitments reach their lowest points of the year. In February and March, by contrast, gift sales have plummeted, consumer debt reaches its lowest point, consumers receive significant tax refunds, and sales of autos, new homes, and insurance sold by brokers and agents are at or near peak levels. This suggests that QHP sales to relatively healthy consumers, which could present a challenge at any point on the calendar, will likely be highest during the same part of the year when similar costly necessities have historically been easiest to sell, for understandable reasons.

With homes, climate also affects sales. Spring weather makes house-hunting more appealing, and winter weather dampens sales. However, the same patterns for new home purchases are present in the Western U.S. (figure 5), where nearly 3 in 5 home sales (59 percent) occur in California, Arizona, and Hawaii,[19] states with seasonal weather patterns that differ greatly from those elsewhere in the country.

Unique dynamics affect seasonality of sales in each market. None of these metrics—earnings by insurance brokerages and agencies, auto sales, or new home sales—is a precise match for QHP purchases. But they form a coherent pattern. During the year's final months, sales of gift items spike, consumer debt reaches its highest levels, and sales of products that can seem more mundane and that require ongoing financial commitments reach their lowest points of the year. In February and March, by contrast, gift sales have plummeted, consumer debt reaches its lowest point, consumers receive significant tax refunds, and sales of autos, new homes, and insurance sold by brokers and agents are at or near peak levels. This suggests that QHP sales to relatively healthy consumers, which could present a challenge at any point on the calendar, will likely be highest during the same part of the year when similar costly necessities have historically been easiest to sell, for understandable reasons.

FIGURE 1

How Sales Amounts in Particular Months Differ from Average Monthly Sales: Consumer Goods Sold by Various Types of Stores, 1992–2013



Source: U.S. Census Bureau, Monthly Retail Trade Survey 2014.[20]
Note: For each calendar year, (1) average sales per month were calculated, and (2) the difference between that average and the sales for each specific calendar month in the year was estimated. The latter estimate, for each specific calendar month, was then averaged for all of the years covered by the figure.

TABLE 1

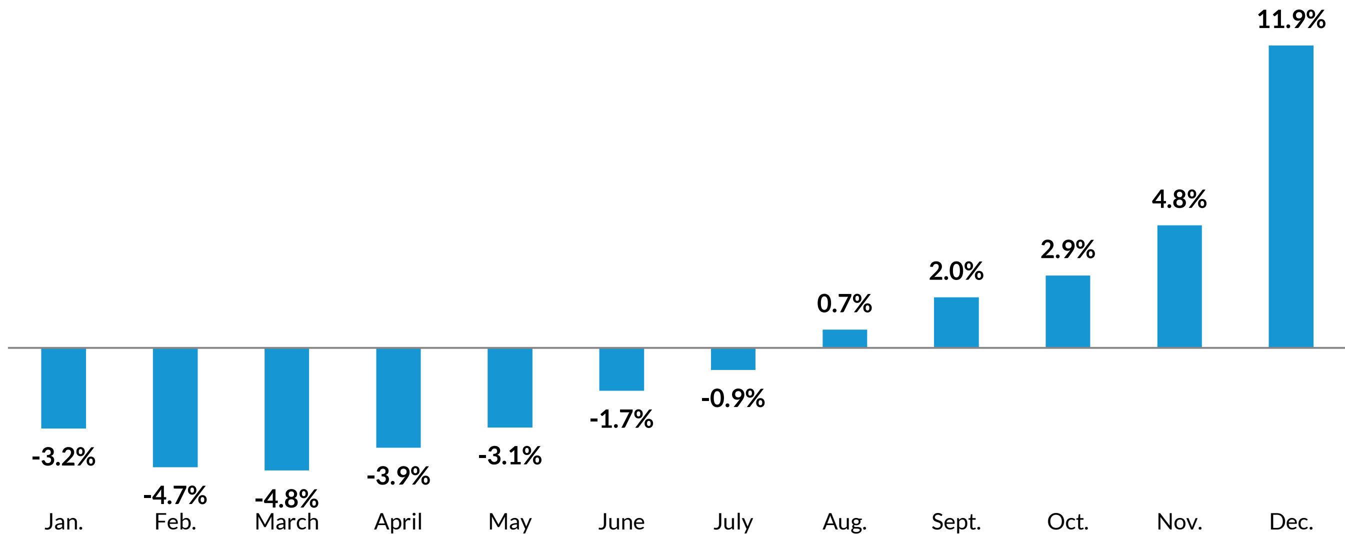
Percentage of Individual Income Tax Returns Filed in 2013 That Received Refunds and Average Refund per Return, by Adjusted Gross Income

Adjusted Gross Income	Percentage of returns with refunds	Average refund per return
<$20,000	81%	$1,918
$20,000 to $49,999	85%	$2,690
$50,000 to $74,999	76%	$2,852
$75,000 to $99,999	73%	$3,354
$100,000+	55%	$5,762

Source: IRS, Statistics of Income Division, Publication 1304, July 2014.[21]
Note: Average refunds are among returns claiming refunds.

FIGURE 2

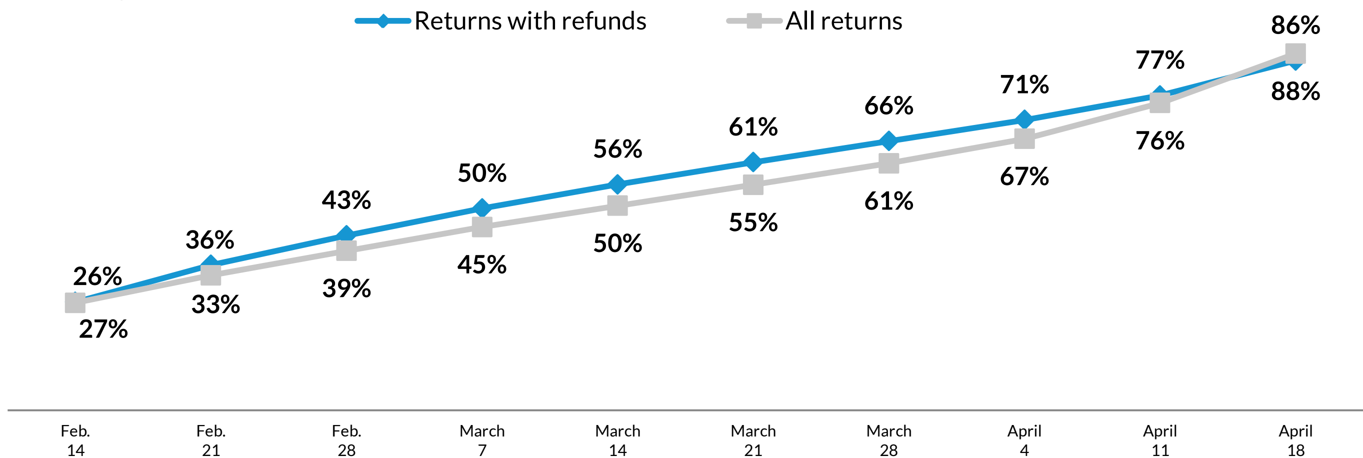
How Total Consumer Debt in Particular Months Differs from Average Monthly Debt: 1992–2013



Source: Board of Governors of the Federal Reserve System, 2014.[22]
Note: For each calendar year, (1) total consumer debt was calculated for the average month, and (2) the difference between that average and total consumer debt for each specific calendar month in the year was estimated. The latter estimate, for each specific calendar month, was then averaged for all of the years covered by the figure.

FIGURE 3

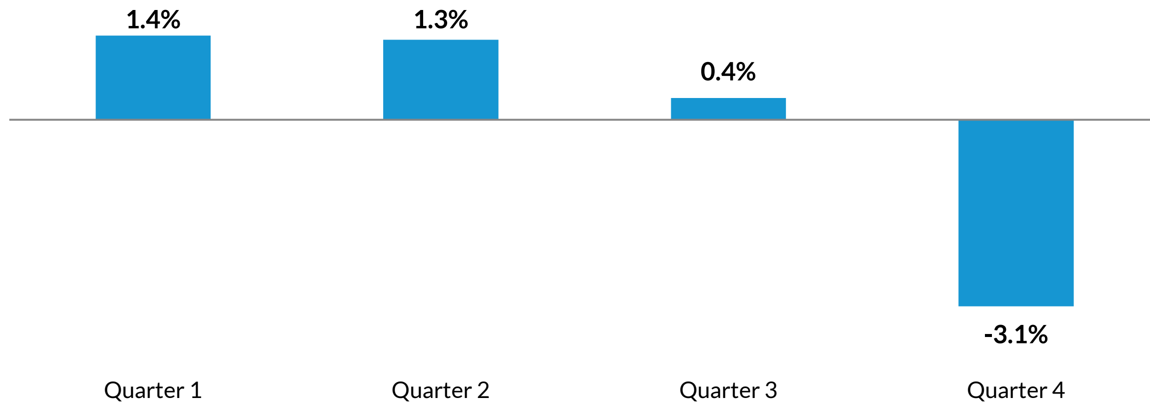
Percentage of Federal Income Tax Returns Filed by Various Dates, 2013–14



Source: Internal Revenue Service, 2013 and 2014 Filing Season Statistics.[23]
Notes: Return filing information is shown only through the date immediately following the April 15 end of non-extended federal income tax filing, by which APTC claimants are required to file federal income tax returns.[24] The displayed percentages represent averages of data from 2013 and 2014. As of this writing, the most recent available 2014 tax filing data ends with May 16 filing. The numbers displayed assume that the same percentage of all returns filed in 2014 will be filed by May 16, 2014, as were filed in 2013 by May 17, 2013.

FIGURE 4

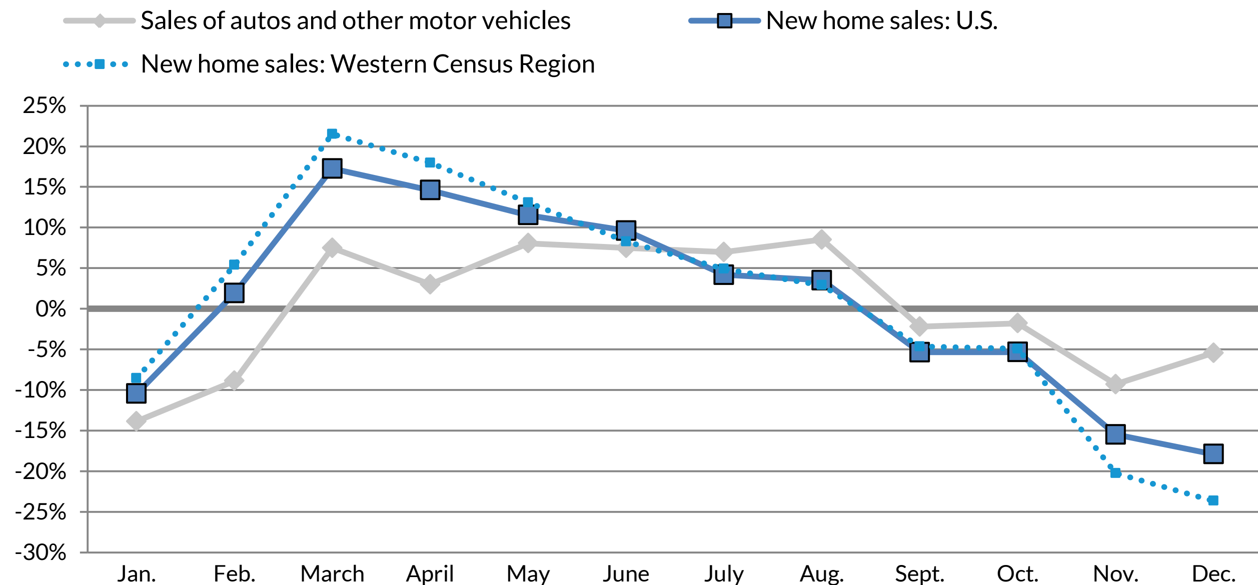
How Insurance Agency and Brokerage Revenue in Particular Calendar Quarters Differs from Average Quarterly Revenues: Quarter 3, 2009 through Quarter 3, 2014



Source: U.S. Census Bureau, Quarterly Services Survey, 2014.[25]
Note: For each four quarter period (1) average revenue per quarter was calculated, and (2) the difference between that average and the revenue for each specific quarter in the year was estimated. The latter estimate was then averaged for all of the four-quarter periods covered by the figure. Because the available data cover five years and one quarter, averages were calculated for Q3 2009 through Q2 2014, with average revenue per quarter calculated over four-quarter periods beginning in the third quarter, and for Q4 2009 through Q3 2014, with such revenue calculated over periods beginning in the fourth quarter. The figure displays the average of the two results.

FIGURE 5

How Sales of Autos and New Homes in Particular Months Differ from Average Monthly Sales: 1992–2013



Source: U.S. Census Bureau, Monthly Retail Trade Survey 2014,[26] Survey of Construction 2014.[27]
Note: For each calendar year, (1) average sales per month were calculated, and (2) the difference between that average and the sales for each specific calendar month in the year was estimated. The latter estimate, for each specific calendar month, was then averaged for all of the years covered by the figure. The Census Bureau's Western region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, New Mexico, Oregon, Utah, Washington, and Wyoming.

More consumers could receive application assistance

Behavioral economists studying application procedures in public and private benefit programs repeatedly find that adding even minor steps can greatly reduce participation levels.[28] Simple "human frailties—procrastinating filing a form, or being put off by the tediousness or hassle of completing it, or failing to understand program rules" can "lead qualifying individuals to forgo benefits."[29] Conversely, participation can greatly rise when people receive assistance that, while providing information and guidance, eliminates the need for consumers themselves to complete paperwork.[30] The 2014 OEP provided additional evidence that consumers are much more likely to enroll if someone else completes the necessary forms:

- A national survey by Enroll America found that, compared to those who received no help, uninsured consumers who received in-person application assistance were approximately twice as likely to receive coverage—31 percent, compared to 16 percent.[31]
- Data from the Urban Institute's Health Reform Monitoring Survey (HRMS), a quarterly national survey tracking the ACA's effects, showed that, among previously uninsured adults who visited Marketplaces, 54 percent of those who enrolled by June 2014 used application assistance, compared with 32 percent of those who did not enroll.[32]

Unfortunately, state-based Marketplaces are likely to provide much less application assistance than in the past, because federal grants are no longer available to pay Marketplace administrative costs, including for application assistance. Marketplaces must now be financially self-sufficient, so application assistance is competing with other functions for the limited administrative dollars that Marketplaces must raise. Each Marketplace is legally obliged to provide Navigators, but the resources devoted to this function could fall short of what is needed to maximize participation by the eligible uninsured.[33] If enrollment into QHPs and other individual plans occurs in late winter and early spring, two sources of application assistance could potentially help fill this gap: insurance brokers and tax preparation services.

More insurance brokers could help consumers with QHPs and other individual plans

In late winter and early spring, brokers and agents will not face conflicting demands from Medicare Advantage, which holds open enrollment during October through December, and the many employer plans that conduct open enrollment late in the year. Brokers often see these alternative sources of business as more profitable than individual coverage. This is particularly true with QHPs, where applications for insurance affordability programs (IAPs) can consume considerable broker time without providing additional compensation. If QHP enrollment takes place when these more remunerative alternatives are unavailable, additional brokers are likely to help consumers enroll into QHPs and other individual plans.

In some states, brokers made important contributions enrolling consumers into coverage during the 2014 OEP, even though completing IAP applications was a new role. For example, they were responsible for more than 40 percent of Marketplace enrollees in Kentucky and more than 46 percent of subsidized Marketplace enrollees in California.[34] Nationally, adults reported that brokers and agents were more useful than any other source in providing information about and help with Marketplace coverage.[35]

Tax preparation services could help with IAP applications

If the OEP overlaps with tax filing season, tax preparation services could more easily transition into a new role of helping their clients qualify for IAPs. If that became a regular part of tax preparers' work, a considerable coverage increase could result. Federal income tax returns are filed by more than 74 percent of IAP-eligible uninsured consumers, including more than 88 percent of those who qualify for QHP subsidies.[36] The "tax filing moment" is almost certainly the single setting with the largest number of IAP-eligible uninsured. By comparison, only 55.8 percent of the uninsured obtained health care in 2012 from any source, many fewer than file federal income tax returns.[37]

Tax preparation services enjoy considerable efficiency advantages in helping the uninsured apply for IAPs. Not only do they have a client service infrastructure in place, they have already gathered, for tax purposes, most of the necessary information. Jackson-Hewitt found that, by asking their tax clients an average of five to six additional minutes of questions,[38] they could gather all the information needed to complete IAP applications.

Most low-income tax filers use in-person tax preparers, the vast majority of whom are paid.[39] Among taxpayers who claimed earned income tax credits (EITC) in 2007–08, 68 percent used paid preparers, and 3 percent used volunteer or free services provided by IRS-sponsored or other programs.[40]

A considerable work force provides these services. Altogether, more than 700,000 tax preparers were registered with the IRS as of December 1, 2014.[41] If only 1 in 10 helped their uninsured clients enroll in IAPs, that would roughly double the approximately 38,000 full-time-equivalent staff who provided application assistance during 2014 OEP as certified Navigators, In-Person Application Assisters, or Certified Application Counsellors.[42]

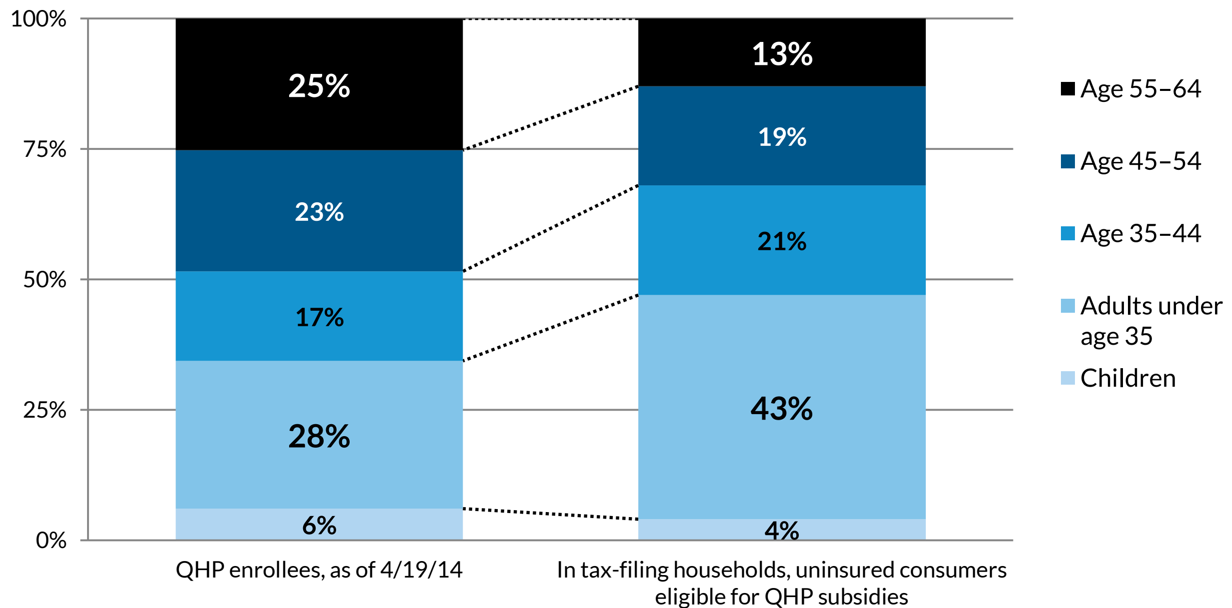
If the tax filing setting can be effectively leveraged for IAP enrollment, the resulting coverage increase would improve the individual market's risk pool. Compared to Marketplace enrollees after the 2014 OEP, uninsured tax filers eligible for QHP subsidies include more young adults and fewer older ones (figure 6):

- Adults under age 35 comprise 43 percent of uninsured tax filers who qualify for QHP subsidies but just 28 percent of all consumers who enrolled in QHPs by mid-April 2014.

- Adults ages 55 through 64 made up a quarter (25 percent) of QHP members after the 2014 OEP, compared to just 13 percent of uninsured, subsidy-eligible tax filers.

FIGURE 6

Age Distribution of QHP Enrollees after 2014 Open Enrollment vs. Uninsured Consumers in Tax-Filing Households Who Qualify for QHP Subsidies



Sources: HHS 2014,[43] Health Insurance Policy Simulation Model 2014.[44]
Notes: The QHP enrollment estimates (left bar) classify as children people under age 18. The tax filing estimates (right bar) count 18-year-olds as children, consistent with the definition used for purposes of Medicaid and CHIP. QHP enrollment counts are as of April 19, 2014, including from both open enrollment and special enrollment periods.

Tax preparation services are thus likely to encounter the bulk of the eligible uninsured—especially among those who are young adults and eligible for QHP subsidies. Tax preparers will also have the capacity to efficiently enroll them into IAPs. That said, it is unknown how much of the industry would likely transition to playing this new role, given the opportunity. During the 2014 open enrollment period, national tax preparation services provided considerable information about the ACA on their websites and in their offices, but most helped only a limited number of uninsured clients qualify for IAPs.[45] On the other hand, California's Marketplace, which provides unusually detailed information about individual application assisters, reports that, among the state's 30 most productive assisters during the 2014 OEP, four were tax preparers—more than 1 in 8.[46] Helping clients apply for IAPs and accurately calculate APTC amounts could present a business opportunity for additional tax preparers, because of several factors:

- *Cost avoidance with repeat clients*. Ensuring that that a tax client receives health coverage and claims an appropriate APTC during one tax season could reduce the need for a tax preparer to spend significant uncompensated time the following tax season addressing that client's non-compliance with the ACA's individual coverage requirements or handling the client's tax reconciliation problems.
- *Revenue*. Tax preparers can receive revenue from fee-splitting arrangements with insurance brokers, through which brokers share the commissions they receive from insurers with the tax preparers who referred clients to the brokers. Also, in states like California, Medicaid agencies pay tax preparers, along with others, for each successful Medicaid application. Some Marketplaces also pays tax preparers as certified Navigators.
- *Customer service and market share*. Helping clients qualify for IAPs, claim appropriate APTCs, and avoid future tax problems could help tax preparation services furnish good service and gain customer loyalty. The resulting market share gains could be particularly important to in-person preparers, since it might help them counter recent years' losses to software vendors. Moreover, avoiding future tax reconciliation problems and uninsurance penalties can preserve market share by preventing repeat clients from going elsewhere out of frustration and anger.

When tax preparers sought to help clients apply for IAPs during the 2014 OEP, unfamiliarity with health issues was not a major barrier. Some preparers became certified assisters or Navigators.[47] Other preparers partnered with health experts:

- For clients who qualified for QHP subsidies, the enrollment process that followed the initial determination of IAP eligibility, including the often arduous step of plan selection,[48] was handled by licensed insurance brokers or certified assisters who partnered with tax preparation services.
- For clients who were eligible for Medicaid or CHIP, one major tax preparer mailed the clients' applications to the relevant state agency, after which the Medicaid/CHIP program completed the clients' enrollment.[49]

We do not yet know what role has been played by tax preparation services during the 2015 OEP. For those services to transition into a major new role of helping millions of uninsured tax clients qualify for IAPs, work would likely be needed to overcome challenges like the following:

- *Taxpayers must consent before their tax information can be used for non-tax purposes*. The IRS has released guidance explaining how preparers can obtain such consent without risking criminal liability.[50] However, some preparers find that significant time is required to obtain consent. It will be important to develop consent procedures that (1) satisfy legal requirements and policy reasons to safeguard

taxpayer privacy while (2) effectively and efficiently educating consumers about the reasons why providing consent may be to their advantage in this context.

- *IAP forms and procedures could be streamlined for tax preparers*. A tax software vendor cannot automatically complete and file an IAP application form unless the vendor knows that a properly completed form will be accepted by the relevant Marketplace. Income tax agencies thus publish final tax forms well in advance of each tax filing season, which lets tax software vendors prepare and file tax returns; something similar would be needed for IAP applications. In addition to making advance copies of final forms available, Marketplaces could operate portals through which approved tax preparation firms, whether software vendors or in-person assisters, submit IAP applications. After using their own procedures to gather client information, firms meeting data security and privacy requirements could send that information through these portals to Marketplaces in electronic form. That would address current inefficiencies that sometimes: (1) require preparers to manually reenter on a Marketplace website client data that the preparers already entered into their systems for tax purposes; or (2) require Marketplace staff to enter or scan information into the Marketplace's eligibility system from a written IAP application the tax preparer printed out and mailed to the Marketplace.

Policymakers incorporating tax preparers into ACA enrollment strategies would also need to face the serious past problems that have been reported with some preparers' competence and ethics. Returns filed by preparers often contain significant errors. [51] Mistakes are least frequent among volunteer tax preparers and most common among paid preparers who are not Certified Public Accountants (CPAs), attorneys, affiliated with national tax preparation companies, or otherwise formally registered with the IRS.[52] Ethical problems reported by the IRS Office of the Taxpayer Advocate include "misconduct cases in which the return preparers have altered return information without their clients' knowledge or consent in an attempt to obtain improperly inflated refunds or divert refunds for [preparers'] personal benefit."[53] To address such problems, agreement to a code of conduct could be a precondition of tax preparation services receiving the kind of favorable treatment, described above, that would facilitate their clients' enrollment into IAPs. A code of conduct might include elements like (1) joining the IRS's voluntary initiative to improve tax preparer competence and enforceable agreement to ethical standards;[54] (2) providing clients with Marketplace-certified application-assistance, either themselves or through a contracting partner (which could include a broker that does not preferentially provide information about plans based on the broker's potential compensation); and (3) helping uninsured clients apply to any IAP for which they appear to qualify.

In sum, there is a reasonable chance (though not a certainty) that tax preparation services could transition into a major new role helping their clients participate in IAPs thereby improving overall coverage and risk levels. According to some knowledgeable observers, perhaps the most important current limitation on the industry's willingness to invest in this transition has been the absence of a future overlap between

OEPs and tax filing season.[55] If there is no such overlap, the opportunity for tax preparation services to develop this new capacity could be substantially constrained.

Fewer consumers would be denied APTCs for failing to file timely tax returns

If a consumer receives any APTCs, even for a month, during one calendar year, the consumer must, by April 15 the following year, file an individual income tax return. Someone who fails or whose spouse fails to file such a timely return and use it to reconcile APTCs with actual income becomes ineligible for later APTCs.[56]

As noted earlier, most subsidy-eligible uninsured already file tax returns, and the majority of returns that claim refunds are filed well before April 15. Most APTC beneficiaries will thus meet this requirement, even though few are probably aware of it.[57] That said, some APTC recipients may not file returns by April 15. Some may face difficult life circumstances that lead them to extend their tax filing until October 15 or to forget tax filing altogether; some may not read the notices they receive from the Marketplace or fail to receive them because of address changes; some may forget APTCs they or their spouse received the prior year, perhaps during a short period of transitioning between non-Marketplace sources of coverage; still others may have incomes below the mandatory threshold for income tax filing and, particularly if they are childless adults, may not qualify for sufficiently large EITCs to warrant the work needed to file a return.[58]

Many fewer consumers would probably lose APTC eligibility for failure to file by April 15 if open enrollment overlapped with tax filing. During tax season, Marketplaces and application assisters could greatly increase the likelihood that IAP applicants who received APTCs the previous year file their returns on time. They could (1) ask applicants and beneficiaries whether they have filed their tax returns; (2) explain to those who not done so that failing to file by April 15 will make them ineligible for subsidies; (3) focus on the minority of late filers by sending them reminders until they file; and (4) even make referrals to approved tax preparers, with discount coupons, as one state-based Marketplace did during the 2014 OEP.[59] By contrast, with enrollment in October to December, Marketplaces and assisters cannot focus their efforts on the small proportion of applicants who do not file early returns. Instead, they can do little more than include notices about the obligation to file by April 15 along with other information they furnish to all APTC beneficiaries. Such notices can easily be forgotten or overlooked; and by October it is too late to meet the requirement to have filed tax returns by the previous April 15.

Consumers could change plans rather than be forced to drop coverage if they learn, during tax filing season, that they enrolled in the wrong QHPs based on mistaken income projections

Tax filing season is when most Americans, after receiving W-2s, 1099 forms, and other tax records, gain the clearest picture of their financial situation. A consumer who has been receiving APTCs may realize, for the first time, that too much is being claimed. If QHP enrollment is open when the consumer learns this, the consumer can change to a plan with lower premiums. But if open enrollment is over, plan changes are not allowed based on a clearer understanding of household circumstances. An APTC reduction could nevertheless be needed to avoid tax reconciliation problems. It may also be required to avoid misleading the Marketplace, as intentionally failing to correct APTCs that the beneficiary knows are excessive can lead to up to $25,000 in civil penalties.[60] If consumers cut their APTCs at tax time but cannot change QHPs, some will feel forced by the resulting increased premium costs to drop coverage entirely until the next OEP.

More consumers could receive the full subsidies for which they qualify

Some consumers would be more likely to enroll because, with tax preparation services' advice, consumers would receive additional financial help for which they qualify. For example, consumers with self-employment income may learn that they can deduct from that income the portion of QHP premiums not covered by tax credits—potentially a significant supplemental subsidy for many such consumers.[61] Conversely, in states that have not expanded Medicaid eligibility, some uninsured IAP applicants could learn about tax planning strategies that project annual income as exceeding rather than falling below 100 percent of FPL, thereby qualifying for subsidies that help pay for coverage.[62] So long as the Marketplace qualifies a consumer for APTCs based on annual income that is reasonably projected between 100 and 400 percent of FPL, no penalty applies at reconciliation if the consumer turns out to earn less than 100 percent of FPL.[63]

A Special Enrollment Period in 2015

Special enrollment periods (SEPs) let consumers who meet specified conditions join QHPs after open enrollment ends. Families USA[64] and Timothy Jost[65] have proposed an SEP that would run from February 15, 2015 (the end of the 2015 OEP), through April 15, 2015 (the end of the standard tax filing period), to let uninsured consumers who pay their tax penalty for lacking coverage in 2014 enroll into QHPs for 2015. Such an SEP could be established nationally[66] or by states. [67] Here, we explore this approach's advantages and disadvantages.

Advantages

In addition to increased enrollment, as described earlier, the proposed SEP would prevent consumers from being surprised by penalties that they have no ability to avoid.

Many uninsured lack basic knowledge about the ACA. A Kaiser Family Foundation poll found that, in early November 2014, just 11 percent of the uninsured knew open enrollment would begin within weeks.[68] In June 2014, shortly after the 2014 OEP ended, uninsured adults surveyed by HRMS reported that[69]

- 40 percent had heard little or nothing about Marketplaces;
- 60 percent had heard little or nothing about subsidies to help pay for Marketplace coverage; and
- 42 percent had heard little or nothing about requirements to purchase coverage or pay a fine.

Penalties for uninsurance have not yet been applied. Many uninsured will thus learn the facts relevant to their situations only when they file 2014 federal income tax returns, in early 2015. Jost explains:

> "Many will become aware at that point for the first time that they will have to pay a penalty for not having had minimum essential coverage for 2014. These penalties are relatively small—for 2014, [the higher of] $95 per adult or 1 percent of income over the filing limit. Penalties for 2015 will be much higher, $325 per adult and 2 percent. *But many will discover that they owe the penalty after February 15 when open enrollment closes and it is no longer possible to enroll for 2015.... [A] special enrollment period lasting through April 15 for anyone who has to pay a shared responsibility penalty for 2014 could diminish hostility to the ACA, which will surely increase if individuals are blind-sided by a penalty they can do nothing to avoid.*"[70] (Emphasis added)

In the future, most Americans will presumably understand the relationship between enrollment periods and the ACA's penalties for lacking coverage. During tax season 2015, however—the first time penalties are applied—many of those affected will lack that understanding. A one-year, transitional SEP that lets the uninsured who pay their penalty for 2014 enroll into QHPs after February 15, thereby reducing their 2015 penalties, would serve the appearance of fairness and, arguably, the reality of it as well.

Disadvantages

The proposed SEP would have several disadvantages. First, some adverse selection would offset the influx of healthy enrollees resulting from February through April enrollment. A number of uninsured consumers who began the open enrollment period in good health, not intending to enroll, will contract an illness or experience an accident between February 16 and April 15 that leads them to sign up. For example, data from the National Center for Health Statistics suggest that, during the average two-month period,

- approximately 0.17 percent of adults ages 18–44 and 0.11 percent of adults age 45–64 experience a non-fatal auto accident;[71] and
- cancer in some form is diagnosed for an estimated 0.07 percent of adults ages 20–49 and 0.27 percent of adults ages 50–65.[72]

It is not clear whether, on balance, bad risks like these would outweigh the good risks joining the individual market's risk pool as a result of the SEP.

Second, an SEP that allows enrollment after February 15 could undermine the credibility of Marketplace messages stressing the need to enroll by February 15. Experience with 2014 open enrollment suggests the potential effectiveness of such messages.[73] Of course, Marketplaces using those messages will face credibility challenges, with or without the suggested SEP. After February 15, eligible consumers can still join Medicaid and CHIP. Also, nationally applicable SEPs let QHPs enroll many who experience events like job loss or divorce. That said, the suggested SEP could further complicate this communications task.

Third, Marketplaces may need to develop SEP verification procedures. For example, applicants could be asked to upload signed and dated copies of their tax returns showing they paid the penalty for lacking coverage in 2014. Marketplaces could not immediately verify with IRS whether those copies were accurate. However, consumers would know that, eventually, Marketplaces would learn from IRS the facts of their tax filing. Much evidence shows that when taxpayers know that reports like W-2s will permit the later detection of falsehoods, returns are nearly always accurate.[74]

Fourth, some uninsured would be treated unfairly. For example, the SEP would not help consumers who were exempt from penalty in 2014 or who did not lose coverage until 2015. Policymakers concerned about those limitations could expand the SEP's scope.[75] However, the above limits would probably not exclude numerous people. Many consumers exempt from penalties in 2014—for example, because their state did not expand Medicaid or they lacked affordable access to coverage—will continue to be exempt in 2015, and most uninsured in early 2015 previously lacked coverage in 2014.

The fifth and final problem is the flip side of the fourth problem. An SEP cannot be defined so broadly that, as a practical matter, open enrollment never ends.[76] The SEP under discussion here thus has limits. It helps only consumers who are uninsured, not those with individual coverage or unaffordable employer-sponsored insurance (ESI). Among the uninsured, it covers only those who were also uninsured in 2014 and who were subject to and paid a penalty. It also ends on April 15. Policymakers could impose additional limits:

- *Enrollment could be required immediately after paying the penalty*—perhaps within days. This restriction would constrain opportunities for adverse selection. It would also fit the SEP's purpose of permitting uninsured consumers, at one stroke, to pay the penalty for being uninsured in 2014 while enrolling into 2015 coverage to limit the application of additional penalties.
- *The SEP could end on March 31 rather than April 15*. That would prevent this SEP from extending beyond the end date for 2014 open enrollment and slightly reduce opportunities for adverse selection. However, it would also limit the number of uninsured who could receive coverage. [77]
- *The SEP could be limited to people with incomes at or below 400 percent of FPL,* the maximum income level for subsidy eligibility. The assumption underlying this limit is that consumers with incomes too high for subsidies, who are in the top 37 percent of the U.S. income distribution for the nonelderly,[78] generally have the financial capacity to purchase coverage. The disadvantage of this limitation is that some older adults with incomes over 400 percent of FPL may have difficulty affording coverage, because individual premiums in most states are higher for older adults. However, this limitation would improve the SEP's risk pool effects. Adults over age 44 are 40 percent of nonelderly people above and just 26 percent of those below 400 percent of FPL.[79]

Adding limits to the SEP could make it more complicated to administer. For a one-year transitional policy, policymakers need to carefully consider whether such complications yield commensurate gains.

Open Enrollment Periods After 2015

As noted earlier, CMS has proposed OEPs for 2016 and beyond that run from October through mid-December before the year begins. Here, the paper explores how an OEP could instead operate early in the calendar year, along with the potential advantages and disadvantages of such a change.

How an OEP could operate early in the calendar year

Certain features of such an OEP schedule seem clear:

- The OEP could start on January 20 or February 1 and end on March 31, and the QHP plan year could begin on May 1.[80] That schedule reflects the following facts: February and March is when most tax refunds are received and consumer credit balances are strongest; longer OEPs increase adverse selection risks, but also opportunities for enrollment; and increasing the gap between the OEP's conclusion and the plan year's start reduces adverse selection dangers, stresses on Marketplaces and plans, and the likelihood of enrollment "snafus" experienced by consumers.[81]

- During the OEP, consumers would project their incomes for the calendar year that had already begun. Such projections would be the basis for their IAP applications and Marketplace determinations of APTC eligibility. Income projections would not reach the next calendar year.

- Tax reconciliation would take place on a calendar year basis, as with the current OEP schedule. However, the 12 months of APTCs that are reconciled would be paid during two QHP plan years: four months during the plan year that ends in April, and eight months of APTCs during the plan year that starts in May. For a beneficiary who stays in the same plan, the following would typically change in May: the QHP premium, the second-lowest-cost silver premium, and the appropriate APTC amount. Reconciliation would be calculated much as if, under the current schedule, a beneficiary moved to a new location in May where QHPs charged different premiums.

- A long transition to the new schedule would be required. Moving the start of the QHP plan year from January to May would require "bridge" coverage that lasts for something other than twelve months. Federal policies currently predicated on 12-month coverage periods—such as those involving risk-adjustment, cost-sharing reductions, medical loss ratios, and the actuarial value calculator— would require modification. After such modifications are proposed and finalized, plans would prepare premium bids for bridge coverage, which regulators and marketplaces would review, and then conduct

negotiations around those bids. Only after those negotiations are complete could QHP consumers be presented with their bridge plan choices. Insufficient time remains for this to take place before January 2016. For the first bridge coverage period to begin in January 2017, a decision to move in this direction probably needs to be made in the next few months.

Other issues about how best to structure an OEP in late winter and early spring are less clear:

- What transition approach, including bridge coverage periods, would be least costly and disruptive?
- Late in the calendar year, should Marketplaces encourage APTC beneficiaries to evaluate their incomes to see if they need to change APTC amounts when the new calendar year begins? If so, what form should that encouragement take?
- Should states be allowed to depart from the national schedule for the OEP and QHP plan year?

These issues are generally addressed later, in the context of analyzing the relevant advantages and disadvantages of shifting to a new schedule for open enrollment.

Figure 7 shows how an OEP ending in March, following by a QHP plan year starting in May, could operate in calendar year (CY) 2019, assuming that this new schedule began in 2018.

FIGURE 7

Operation of an OEP Ending in March, with a QHP Plan Year Starting in May (CY 2019, Assuming Prior Operation in 2018)

Jan 2019	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec 2019
Final four months of plan year 2018–19				Plan year begins 5/1. First eight months of plan year 2019–20; benchmark premiums and APTCs different from January through April.							
Employers and insurers mail forms showing coverage offered and received in CY 2018	Open enrollment; consumer projects total income for CY 2019									[Optional: Marketplace initiates income-updating process for the first months of 2020]	
Marketplace mails 1095-A forms showing APTCs and benchmark premiums in CY 2018	Income tax filing reconciles CY 2018 APTCs with CY 2018 income										

Advantages

An OEP in late winter and early spring could yield several advantages in addition to the enrollment and risk pool gains discussed earlier.

Fewer subsidy errors and tax reconciliation problems for consumers

If QHP enrollment occurs early during the year—such as February and March— subsidy eligibility for the year would be determined more accurately than during the previous October through December, safeguarding program integrity and reducing tax reconciliation risks. Several factors play a role:[82]

- *The year would have started*. In February and March, one or two months of the year's income have already been received, so applicants would need to project income for only ten or 11 months. Also, no uncertainty would be caused by delay between the application and the period covered by the projection. Projections made during October 1 to December 15 are more likely to err, as two weeks to three months must pass before the year starts, and estimates are needed for all 12 months.
- *A more recent tax return may be available*. Financial eligibility determination for QHP subsidies begins with the most recent tax return. [83] If enrollment occurred in tax filing season, IAP applications could be completed simultaneously with or immediately after the filing of tax returns that describe the year ending just before the subsidy period. If enrollment takes place during October through December, the most recent return will describe the year ending 12 months before the subsidy period. Significant income fluctuations affect many subsidy-eligible people,[84] so using a more recent return as the starting point for eligibility determination should improve accuracy.
- *More applicants are likely to get help*. As noted earlier, more brokers would likely help with IAP applications when brokers face fewer competing demands from Medicare Advantage and employer plans. Also, during tax season tax preparers would be more likely to help QHP-enrolled clients estimate APTCs.[85] Experience with Massachusetts' reforms suggests that applications are generally more accurate when consumers receive knowledgeable help than when they apply on their own.[86]
- *APTC errors could be prevented from causing reconciliation problems*. QHP plan years can end as many as 15 months after subsidy applications. Because of fluctuating incomes, the correct APTC amount is could easily vary from the amount determined at application towards the end of the QHP plan year. APTC beneficiaries may not make the adjustments needed to prevent their APTCs from drifting out of touch with changing household circumstances.[87] Any resulting errors at the end of the QHP plan year

will occur at the start of the calendar year if the plan year begins in May. To prevent those mistakes from causing reconciliation problems, consumers could make offsetting adjustments to APTCs for subsequent months in the calendar year. Such adjustments are not possible under the current schedule, since the end of the QHP plan year coincides with the end of the calendar year.[88]

On the other hand, if a February to March OEP is when consumers project their income for the rest of the calendar year, several months of APTCs could remain on "automatic pilot" at the start of the following calendar year, before the next OEP begins. Unreported raises in January could create later reconciliation problems, but that seasonal pattern does not appear to typify the low- and moderate-income workers who are most likely to qualify for QHP subsidies. For production and non-supervisory employees, average employment fell by 3.2 percent and average wages fell by 0.8 percent during January in the average year from 1993 through 2014 (table 2).

TABLE 2

Monthly Changes to Average Weekly Payroll and Average Weekly Earnings of Production and Nonsupervisory Employees (Average for 1993–2014)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Employment	-3.2%	0.7%	0.9%	1.4%	1.1%	1.4%	0.1%	0.7%	0.0%	0.4%	0.2%	0.4%
Earnings	-0.8%	0.4%	0.2%	0.5%	0.3%	0.5%	0.1%	0.6%	0.4%	0.2%	0.0%	0.5%

Source: Bureau of Labor Statistics, Employment, Hours, and Earnings from the Current Employment Statistics survey, Feb. 1993-Nov. 2014 (National, Not Seasonally Adjusted).

Despite the above factors, an OEP that leaves the initial months of the calendar year without an income projection may trouble some policymakers. To address that concern, an income updating process in November or December could provide such a projection. Marketplaces would either:

- Remind consumers of the obligation to report changes in income or other household circumstances that could affect APTC eligibility, including during the first months of the next calendar year;
- Couple such a reminder with a statement of household income as previously estimated by the Marketplace; or
- Couple such a reminder with an updated income estimate based on matches with available data, such as state workforce agency quarterly wage records, while asking beneficiaries to confirm or correct those estimates. Such updated estimates would not take effect until they the beneficiary confirms them.[89]

In deciding whether and how to implement such a process, policymakers face a trade-off. Notices that effectively encourage consumers to reexamine their financial circumstances at the start of the calendar year could lead to more accurate APTCs. However, changes to subsidy eligibility that move household income

above or below 150, 200, or 250 percent of FPL, thereby changing eligibility for cost-sharing reductions, trigger SEPs,[90] which risk adverse selection. In practice, it is unclear how many consumers would be affected by these trade-offs. Marketplaces send enrollees numerous notices, and inertia or inattention could prevent many beneficiaries from reporting even income changes that increase subsidies.[91]

Reduced administrative burdens for carriers and brokers

The 2014 OEP, which began in October 2013, overlapped with the October-December OEP for Medicare and the late-year OEP used by much ESI. Some carriers and brokers were overwhelmed by the resulting combined requests for help with enrollment assistance, problem-solving, and answers to questions. Some bottlenecks resulted that affected customer service. Because Marketplace OEPs apply to individual insurance sold outside the Marketplace, these issues involved both QHPs and other individual plans.[92]

To prevent a recurrence, some insurers hired additional staff for the 2015 OEP.[93] If the future OEPs continues to be scheduled for October through December, carriers could need annual December employment spikes. Some brokerages may have less ability to make rapid staffing changes. By contrast, an OEP in late winter and early spring would spread the demand for help over a longer period, reducing burdens for insurers and brokers while potentially improving consumer service.

If QHPs and other individual plans could operate on a different calendar than most ESI, Medicare Advantage, and Medigap, carriers could also realize other administrative gains. Premium estimation, bid preparation, payor negotiations, and development of marketing plans and materials could be spread across the calendar for multiple markets, rather than conducted simultaneously. This could provide a more manageable workload for insurers' staff responsible for these functions.

Reduced administrative burdens for employers

Scheduling open enrollment to overlap with tax filing could reduce the amount of manual verification employers must provide about the health coverage they do or do not offer. Compared to October through December of the previous year, tax season will provide more subsidy applicants with tax documents that contain up-to-date information about their companies' employer identification numbers (EINs). ESI information could then be verified through data-matching rather than firms' completion of questionnaires or manual provision of documents or answers to Marketplace queries.

To qualify for QHP subsidies, one must be without an offer of ESI that the ACA classifies as affordable and offering minimum value (that is, having an actuarial value of at least 60 percent). The ACA creates

systems through which, starting in 2015, larger employers (i.e., those with 50 or more full-time-equivalent employees) will provide the federal government with data about the health coverage they do or do not offer; information about the health coverage provided by firms with fewer than 50 workers will be reported either by the employer or the firm's health insurer.[94] In the meantime, subsidy applicants who are offered ESI give their employers a document to complete—"Appendix A" to the family application, which requests:[95] employer name, EIN, address, and phone number; contact person for ESI information, including phone number and email address; whether the employee is currently eligible for ESI or is in a waiting or probationary period and, if the latter, the date on which such period ends; all family members who are eligible for ESI; whether the employer offers a plan that meets the ACA's minimum value standard; the premium cost to the employee of the lowest-cost plan that meets the minimum value standard, assuming that the employee receives the maximum tobacco-related discount and no other wellness discounts; the frequency with which the employee would make premium payments for such a plan; changes the employer will make for the new plan year, including whether the employer will begin or stop offering coverage, or whether the employer will change the premium for the lowest-cost plan that meets the minimum value requirement; if the employer will make changes for the new plan year, the date the change becomes effective, the amount the employee would then have to pay in premiums for the lowest-cost plan that meets the ACA's minimum value requirement, and the frequency of such payments.

Even after employers and their plans provide the federal government with data about ESI, the information will not always be sufficient to verify eligibility. Presumably, applicants will be asked to use burdensome forms like Appendix A in seeking documentation from employers when electronic data-matching proves insufficient. If no verification is available from any source, Marketplaces will determine access to ESI based on applicant attestations, according to CMS regulations. Among applications granted based on these attestations, the Marketplace will seek verification from a sample of employers.[96]

The ground rules for employers' future documentation of ESI are not entirely clear. But it seems likely that if Marketplaces are limited in their ability to verify applicants' eligibility by matching with sources of electronic data provided by firms or their insurers, employers will need to shoulder additional burdens, by completing forms for employees, by responding to government queries, or both.

For a Marketplace to verify an applicant's eligibility based on data employers or their insurers have already provided, the Marketplace must match the employer's EIN with an EIN listed on the subsidy application. As a practical matter, most people know their employers' EINs only through the forms they receive for tax purposes. If open enrollment takes place in October to December, tax returns from two years in the past will provide the EIN. Such EINs will not fit current employers for applicants who changed jobs during the past two years. If the OEP overlaps with during tax filing season, only one year's job changes will have occurred since the period covered by the return.[97] An OEP early during the year should thus increase

the number of applications with up-to-date EINs. As a result, more ESI-related eligibility should be verified through data matches, reducing employers' verification burdens.

A less politically charged calendar

Changing the schedule for open enrollment and QHP plan years could mitigate some potentially harmful political pressures that now focus on ACA implementation.

Under the current schedule, premiums for QHPs and other individual plans are announced around the October 1 start of open enrollment—approximately one month before Election Day in every even-numbered year. Such announcements could have unpredictable political effects out of proportion to their policy relevance. By analogy, imagine the political impact if gas prices changed once a year, and the change was announced every October.

Another implication of the current calendar is that officials can be tempted to delay the release of "potentially costly or otherwise controversial rules during an election year."[98] Some observers suggest that, to avoid political risks, HHS delayed issuance of key ACA rules in 2012 from September until after the Presidential election, creating a "time crunch" that contributed to later problems with Marketplace roll-outs.[99] Whether or not that observation was accurate, an October OEP start date in future years risks delays to annual Notices of Benefit and Payment Parameters. These notices can govern key elements of Marketplace operations. The notice for 2016, for example, addresses risk adjustment, reinsurance, and risk corridors programs; cost sharing rules for QHPs by metal tier; cost-sharing reductions for low-income consumers; user fees for federally-facilitated Marketplaces (FFMs); OEP timing; standards for Essential Health Benefits; network adequacy standards; etc.[100] These notices are supposed to be published as proposed rules by mid-October, two calendar years before the applicable benefit year, with comments due two months later, and final rules published by mid-January.[101] This should leave two to three months for plans to develop products in time for submission to FFMs by the proposed mid-April due date. Marketplaces and regulators can then complete the lengthy review and negotiation required for plan submissions to be approved and QHPs offered by the October 1 start of open enrollment.[102] If the Notice of Benefit and Payment Parameters is delayed—for example, the proposed rule for 2016 was not published until November 26, 2014, and the final rule had not been published at this writing in early February 2015—the time for product development and review is shortened. This could create serious problems in the coverage offered to consumers.

Suppose the OEP was instead scheduled for late January through March and the QHP plan year started in May. In December 2018, for example, CMS could announce proposed rules for the QHP plan year that would begin in May 2020. Electoral considerations would not interfere with the timing of this

announcement. CMS could finalize those rules by mid-March 2019, leaving ample time for plans, regulators, and Marketplaces to develop and approve coverage before open enrollment began in late January 2020.

Under such an alternative calendar, new QHP premiums would be announced every year in late January, around the time the CMS Office of the Actuary releases its annual analysis of overall health care spending.[103] This timing might enrich the public conversation about health care costs. Most important, annual changes to QHP premiums would no longer be announced during the heat of political campaigns.

Disadvantages

Transition costs for carriers, regulators, and Marketplaces

Since CMS's July 2011 announcement of Marketplace OEP and plan year schedules,[104] a considerable private and public infrastructure has developed around a plan year that starts in January for QHPs and other individual plans. This infrastructure involves carrier rate and form filing, review by insurance regulators, data provision to FFMs, state statutes governing the individual market, and federal regulations.[105] Changing this infrastructure could require significant work.

Moreover, a period of bridge coverage would be needed to transition from a plan year that starts in January to one that begins in May. To illustrate, Massachusetts' 2006 reforms used a plan year that started in July, when the state's fiscal year begins. In moving to the ACA's QHP plan year that started in January 2014, the state provided six months of bridge coverage from July 2013 through December 2013. Deductibles were reduced on a pro-rata basis, reflecting six- rather than 12-month coverage periods. No serious disruptions were reported.[106]

An analogous approach, in this context, would involve four months of bridge coverage from January through April 2017. However, such a short transition would likely prove more costly and disruptive than Massachusetts's six-month bridge. Plan design is much more diverse nationally than was the case in Massachusetts. QHP deductibles and limits on consumer costs can be prorated from annual to part-year coverage, but copayments and coinsurance would presumably be unchanged, whether coverage lasts for four or 12 months. Technical revisions to the CMS actuarial value calculator would thus be needed to square the resulting hybrid cost-sharing structures with the actuarial value standards that, under the ACA, define both the metal tiers into which all QHP consumers enroll and cost-sharing reductions (CSRs) for low-income enrollees. Examples of other necessary changes required by shifting from 12 months to four months of coverage include medical loss ratio rules, risk-adjustments, and CSR payment procedures.[107]

Carriers would likely need to undertake considerable work developing products that conform to revised federal specifications. The reward for offering those new products would be limited, consisting of four months of premiums. Moreover, the risks of offering such products could be significant; plans have no prior experience with insurance that operates in this way, and the combination of a new OEP early during bridge coverage and the ACA's rules for three-month grace periods following non-payment of premiums could present troubling opportunities for "gaming" and adverse selection.[108]

Any bridge coverage would last for something other than 12 months and so require a recalibration of federal rules. However, a transition that lasts longer than four months could reduce adverse selection risks and increase plans' ability to recoup the investments required to respond to changed federal standards. To lower the amount of overall disruption, policymakers could use either:

- A single, 16-month period of bridge coverage (January 2017 through April 2018);
- Two eight-month bridge periods (January 2017 through August 2017 and September 2017 through April 2018); or
- Two 14-month periods (January 2017 through February 2018 and March 2018 through April 2019).

Each of these options has trade-offs. The third would entail a longer delay before realizing the enrollment and risk pool gains of an OEP scheduled for late winter and early spring. The new OEP would not begin until 2019, unlike the first two approaches, which would start the new OEP in 2018. On the other hand, the third approach would provide coverage periods almost 12 months in length, which could simplify the necessary federal modifications and make claims easier to predict, based on carriers' prior experience with 12-month coverage periods. Generally speaking, shorter bridge periods would reduce carriers' risks of mispriced products and give uninsured consumers more chances to enroll; while longer duration of a single type of bridge coverage would help plans recoup product development costs.

Increased confusion for consumers

A number of leading experts have concluded that consumer confusion could significantly increase if the QHP plan year was changed so that it no longer coincided with the calendar year.[109] Several factors could contribute to such confusion.

First, the QHP plan year would no longer coincide with the calendar-year accounting period used for tax credit eligibility. This change would further complicate already difficult decisions that currently face some families. For example, an APTC-beneficiary family may have an 18-year-old child who is considering leaving home mid-year, which would reduce household size. That would increase the FPL that determines the

family's year-end tax credit, since such FPL is generally[110] based on household size as of December 31.[111] If this occurs, APTCs claimed appropriately based on circumstances before the child left home could create income tax liabilities at reconciliation.

Choices like these would become harder if QHP plan years began in May. Families would need to think about each option's effects through multiple time periods, each less than a year in length, each involving various combinations of partial QHP plan years and partial calendar years. By contrast, if the QHP plan year stays aligned with the calendar year, the analysis would be simpler, proceeding one calendar year at a time.

Second, some increase in consumer confusion would result if QHPs no longer used OEPs and plan years like those employed by Medicare and most ESI.[112] It is true that there is little current overlap between QHP subsidies, on the one hand, and Medicare or ESI, on the other. Medicare-eligible consumers cannot receive QHP subsidies. And only 22 percent of QHP-eligible uninsured adults work or have spouses who work for firms that offer ESI.[113] Even among adults (1) who work or whose spouses work at firms offering ESI and (2) whose income is in the range that qualifies for subsidies (138 to 400 percent of FPL), access to ESI and eligibility for QHP subsidies rarely coincide:

- Between 97.8 and 99.8 percent of ESI recipients in this group are ineligible for QHP subsidies because the ACA classifies their ESI as affordable.
- Between 96.5 and 99.6 percent of those who do *not* receive ESI within this group are either (1) not offered ESI because of part-time employment or other reasons; or (2) offered ESI that makes them ineligible because it is deemed affordable.[114] The latter have rejected these disqualifying ESI offers.

It is also true that little consumer confusion about plan years was evident under Massachusetts's 2006 reforms, which used a plan year that began in July, and reduced the percentage of uninsured residents below 3 percent—the lowest level of any state.[115] While that state's experience does not shed light on the impact of departing from the calendar-year period used for tax credits under the ACA, Massachusetts's track record suggests that uninsured consumers can easily comprehend the difference between a subsidy system's enrollment schedule and the schedule used by Medicare and most ESI.

On the other hand, while subsidy-eligible consumers rarely have *current* access to ESI, many are *former* ESI recipients. Given the confusion numerous consumers experience with the ACA, many would likely benefit from familiarity with a QHP schedule that resembles the schedule used by former employers. Moreover, a small proportion of subsidy-eligible consumers face a choice between ESI and QHPs. That choice would be easier to make if open enrollment periods for the two coverage systems aligned.

Third, tax reconciliation would become more complex if it encompassed two different QHP plan years. Carefully analyzed, a mid-year change in QHP plan years should be viewed as likely to result in modest

rather than severe effects. If the QHP plan year began in May, reconciliation would not straddle two calendar years or become a two-year process. Consumers would still claim APTCs during a single calendar year based on income projections for that year. Taxpayers would still reconcile APTCs received during a calendar year with final annual income shown on their tax return for that year.

When a new QHP plan year began in May, monthly benchmark premiums and APTCs would change, just as if an APTC beneficiary had moved to a new county. The benchmark premium—that is, the premium charged by the second-lowest-cost silver plan (SLCSP) available to QHP enrollees—affects the taxpayer's tax credit amount. That amount equals the difference between (1) the SLCSP and (2) the taxpayer's income-based payment. Today, when a QHP beneficiary moves mid-year to a place where the SLCSP charges a different amount, the benchmark premium and APTC amount change. The same thing would happen if the start of a new QHP plan year in May changed the SLCSP because of adjustments to local QHP offerings combined with the beneficiary being one year older than at the start of the previous QHP plan year.

Depending on how Marketplaces respond, mid-year changes to SLCSPs and APTCs could modestly worsen reconciliation's complexities by introducing new possibilities of administrative error and snafus. Reconciliation requires adding up all of a taxpayer's monthly APTCs. When SLCSPs change mid-year, one likewise adds all 12 months' SLCSPs to calculate the annual tax credit amount.[116] Marketplaces must send APTC recipients "1095-A forms" in late January that provide all the information needed to do the arithmetic of reconciliation. These forms list, from the prior year, each month's APTC and SLCSP (figure 8). If there is a problem with those forms, beneficiaries or their authorized representatives can look up the relevant information on line.

Mid-year changes to QHP plan years should present few problems with the arithmetic of reconciliation. However, such changes might lead Marketplaces to send beneficiaries two rather than a single 1095-A form for each year, as happens currently when consumers change plans mid-year.[117] If so, opportunities for administrative error and misplaced paperwork could increase. Rather than do the reconciliation themselves, however, most APTC beneficiaries are likely to use tax preparation services, which could help address these and other complications or problems. Overall, beneficiaries could be affected in minor ways by changes to reconciliation if, because the QHP plan year started in May, mid-year changes to APTCs and SLCSPs became universal rather than occasional.

FIGURE 8

Excerpts from the 1095-A Marketplace Reporting Form

Part III **Household Information**

Month	A. Monthly Premium Amount	B. Monthly Premium Amount of Second Lowest Cost Silver Plan (SLCSP)	C. Monthly Advance Payment of Premium Tax Credit
21 January			
22 February			
32 December			
33 Annual Totals			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60703Q Form **1095-A** (2014)

Source: IRS 2014.

One final mitigating factor is important to note. Many QHP enrollees are likely to perceive the ACA as complicated, no matter what happens to the enrollment schedule. As explained earlier, an OEP early during the calendar year would let more consumers get help from brokers and tax preparers. Those who receive assistance in navigating the ACA's complications will probably experience less overall confusion. [118]

Conclusion

For Medicare, federal employees, and most ESI, the same basic schedule applies: open enrollment takes place near the end of the year, and coverage begins the following January.

In some observers' view, common sense calls for comparable treatment of Marketplace plans. QHPs are health insurance, like employer plans and Medicare Advantage—why time QHP enrollment any differently? Aligning the plan year with the calendar year seems, on its face, particularly logical with QHPs, since the premium tax credits that help fund most QHP coverage are based on the income that taxpayers earn during the calendar year. Furthermore, many consumers are already confused about the ACA; why compound the confusion by arranging a plan year that differs from the calendar year used for tax credit accounting and an enrollment schedule that differs from Medicare and most employer coverage?

More than common sense is needed, however, to resolve this issue thoughtfully. Even with the ACA's subsidies, QHP costs can be much higher, relative to income, than those imposed on Medicare beneficiaries and most ESI enrollees. Affordability has already emerged as perhaps the most important factor deterring QHP enrollment among uninsured consumers who examined their Marketplace options in 2014 and chose not to sign up. Unless they suffer from health problems that motivate participation, consumers eligible for Marketplace coverage must be persuaded to enroll. Compared to October through December, February and March are likely to be more successful months for such persuasion. Scheduling enrollment for late

winter and early spring could also improve subsidies' accuracy, lower reconciliation risks, lighten administrative burdens for some stakeholders, and limit political pressures on parts of the insurance cycle.

From February 16 through April 15, 2015, an SEP could let uninsured consumers who pay their penalty for lacking coverage in 2014 quickly enroll into QHPs for the remainder of 2015. Not only would participation by young and healthy consumers increase (albeit with offsetting enrollment of consumers who experience an injury or are diagnosed with an illness during the SEP), uninsured consumers would not be surprised by the application of unexpectedly large penalties for uninsurance in 2015 that they cannot avoid if they first learn about those penalties while filing their tax returns after February 15.

For future years, policymakers seeking the benefits of an OEP in late winter and early spring would need to analyze the cost of moving to a QHP plan year that starts in May. Policymakers would also need to weigh the gains of such an OEP against the confusion that some consumers would experience from a QHP plan year that no longer aligns with the calendar year that determines subsidy eligibility. If officials decide to make this change, it would be important to select a schedule and approach that limits overall transition costs as much as possible.

In his novel, *The Alloy of Law,* Brendan Sanderson stressed the importance of knowing "when to set aside the important things in order to accomplish the vital ones." In that spirit, those who believe the ACA's vital goals involve enrolling the eligible uninsured into coverage could consider three questions:

1. If the OEP is scheduled for early in the calendar year, rather than October through December, is there a good chance that significantly more eligible uninsured would enroll? If so:

2. What combination of transition schedules and other policies, along with an OEP early in the calendar year, would produce the most favorable total results, considering both advantages and disadvantages?

3. How does that policy combination's likely gains compare to its expected losses? Which of those anticipated results are vital and which are merely important?

Notes

[1] Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. Measuring Marketplace Enrollment Relative to Enrollment Projections: Update. Washington, DC: Urban Institute, 2014, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf. Several months ago, federal officials announced that their early estimates of enrollment were too high because they included recipients of dental-only coverage. Nevertheless, survey data, independent of HHS administrative reports, show considerable reductions in uninsurance since the start of the 2014 open enrollment period. Long SK, Kenney GM, Zuckerman S, Wissoker D, Shartzer A, Karpman M, Anderson N and Hempstead K. Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014. Washington, DC: Urban Institute, July 29, 2014, http://hrms.urban.org/briefs/taking-stock-at-mid-year.pdf. Long SK, Karpman M, Shartzer A, Wissoker D, Kenney GM, Zuckerman S, Anderson N and Hempstead K. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. Washington, DC: Urban Institute, December 2014, http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.pdf.

[2] Jost T. "Implementing Health Reform: Medicaid Eligibility, 2015 Navigator Grants, And FAQs (Updated)." *Health Affairs Blog,* Sept. 8, 2014, http://healthaffairs.org/blog/2014/09/08/implementing-health-reform-medicaid-eligibility-2015-open-enrollment-and-faqs/.

[3] CMS. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016." *Federal Register*, Feb. 26, 2014, http://s3.amazonaws.com/public-inspection.federalregister.gov/2014-27858.pdf. This followed CMS's earlier statement, "we intend to propose open enrollment dates for the 2016 plan year in the 2016 draft Payment Notice. Finalizing open enrollment dates for the 2016 plan year in the 2016 Payment Notice will allow an additional year's experiences to inform the finalization of realistic enrollment dates." CMS. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule. 79 Fed. Register 13744, 13797 (March 11, 2014).

[4] Swartz K and Graves JA. "Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices." *Health Affairs,* July 2014, 33 (7):1–8.

[5] Jost, T, "Implementing Health Reform: New HHS 2015 Marketplace Enrollment Estimates," *Health Affairs Blog*, November 11, 2014, http://healthaffairs.org/blog/2014/11/11/implementing-health-reform-new-hhs-2015-marketplace-enrollment-estimates/.

[6] Congdon W, Kling JR, and Mullainathan S. "Behavioral Economics and Tax Policy." *National Bureau of Economic Research Working Paper 15328.* September 2009.

[7] Dorn, S. *Affordability of Marketplace Coverage: Challenges to Enrollment and State Options to Lower Consumer Costs,* December 2014, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/2000039-Affordability-of-Marketplace-Coverage.pdf.

[8] ASPE/HHS. How Many Individuals Might Have Marketplace Coverage after the 2015 Open Enrollment Period? November 10, 2014, http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf, citing U.S. Department of Health and Human Services, Health Insurance Marketplace: November Enrollment Report, Nov. 13, 2013, p. 20-25. http://aspe.hhs.gov/health/reports/2013/marketplaceenrollment/rpt_enrollment.pdf.

[9] Buettgens M, Kenney GM, and Recht H*. Eligibility for Assistance and Projected Changes in Coverage under the ACA: Variation across States,* May 2014 Update. Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/413129-Eligibility-for-Assistance-and-Projected-Changes-in-Coverage-Under-the-ACA-Variation-Across-States.pdf.

[10] See studies described in Kahneman K. " Maps of Bounded Rationality: Psychology for Behavioral Economics." *The American Economic Review*, Dec. 2003, 93 (5)1449–75; Sunstein CR. "What's Available? Social influences and behavioral economics." *Northwestern University Law Review.* Spring 2003. 97(3): 1295–1314; Shams, Michele A., "The Availability Heuristic in Judgments of Research Findings: Manipulations of Subjective Experience" (2002). All Volumes (2001–08). Paper 112, http://digitalcommons.unf.edu/ojii_volumes/112.

[11] Sunstein, What's Available? Social influences and Behavioral Economics. Another study involved a randomized, controlled trial that tested the impact of timing by creating a computer-operated video game that, during each round, let participants observe the game and then "bet" on what would happen next. Participants were informed that, throughout

each round, fixed rules determined what would occur. Although participants knew all observations were equally relevant, 59 percent of their bets reflected observations in the first half of each round, while 75 percent reflected the second, more recent half. Hertwig R, Barron G, Elke U. Weber, Erev I. "Decisions from Experience and the Effect of Rare Events in Risky Choice." *Psychological Science*, Vol. 15, No. 8 (Aug., 2004), pp. 534–9.

[12] Platania J and Crawford J. "Media Exposure, Juror Decision-Making, and the Availability Heuristic." *The Jury Expert,* November/December 2012, Volume 24, Issue 5, 1–6.

[13] Swartz K and Graves JA. "Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices." *Health Affairs,* July 2014, 33 (7):1–8.

[14] For the sake of consistency, we analyze data for consumer credit and new home sales from 1992 to 2013, even though data in these two categories are readily available for earlier periods. Data regarding sales in other categories shown here, including new cars, are readily available from the Census Bureau's Retail Trade Survey in comparable fashion, over time, starting in 1992.

[15] Along similar lines, the Harris poll found that, in November 2014, households earning between $50,000 and $75,000 a year expected to take an average of 2.6 months to pay off their holiday debts, and those earning less than $50,000 expected to require an average of two months. Glazer J, "Middle Class Families Will Have the Hardest Time Paying Off Holiday Debt," *Five Thirty Eight,* Dec. 1, 2014, http://fivethirtyeight.com/datalab/middle-class-families-paying-off-holiday-debt/.

[16] Refunds are likely to be received even earlier during 2015, as the tax filing season began on January 20. During the two previous years, data from which was the basis for figure 3, that season began at the very end of January or the beginning of February.

[17] In states that do not expand Medicaid, the lower end of financial eligibility for subsidies drops to 100 percent of FPL. In all states, non-citizens who are lawfully present in the U.S. but are not qualified aliens eligible for federal Medicaid funding can qualify for QHP subsidies with incomes below otherwise applicable minimums.

[18] Overall employment and wage levels for non-supervisory and production workers are also slightly higher in the spring than during the final months of the year, as shown in table 2, below.

[19] Of all existing home sales in the Census Bureau's Western Region during 2010 through 2010, 45 percent, 12 percent, and 2 percent took place in California, Arizona, and Hawaii, respectively. Author's calculations, National Association of Realtors, Washington, DC, *Real Estate Outlook; Market Trends & Insights*, "Table 979. Existing Home Sales by State: 2000 to 2010," https://www.census.gov/compendia/statab/2012/tables/12s0979.xls. The Census Bureau does not publish state-level data about new home sales.

[20] Author's calculations, U.S. Census Bureau, Monthly Retail Trade and Food Services. Not Seasonally Adjusted Sales - Monthly [Millions of Dollars], 1992–2014. "443: Electronics and Appliance Stores: U.S. Total," https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=443&dataType=SM&geoLevel=US¬Adjusted=1&submit=GET+DATA; "4481: Clothing Stores: U.S. Total," https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=4481&dataType=SM&geoLevel=US¬Adjusted=1&submit=GET+DATA; "451: Sporting Goods, Hobby, Book, and Music Stores: U.S. Total," https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=4541&dataType=SM&geoLevel=US¬Adjusted=1&submit=GET+DATA; "45322: Gift, Novelty, and Souvenir Stores: U.S. Total," https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=45322&dataType=SM&geoLevel=US¬Adjusted=1&submit=GET+DATA; "4541: Electronic Shopping and Mail-order Houses: U.S. Total," https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=4541&dataType=SM&geoLevel=US¬Adjusted=1&submit=GET+DATA.

[21] Author's calculations. IRS. "Table 3.3 All Returns: Tax Liability, Tax Credits, and Tax Payments, by Size of Adjusted Gross Income, Tax Year 2012." *SOI Tax Stats - Individual Income Tax Returns Publication 1304.* Washington, DC: IRS, 2014. http://www.irs.gov/file_source/pub/irs-soi/12in33ar.xls.

[22] Author's calculations, Federal Reserve Board, "Revolving consumer credit owned and securitized, not seasonally adjusted level," *The G.19 Statistical Release,*

http://www.federalreserve.gov/releases/g19/HIST/cc_hist_r_levels.htmlhttp://www.federalreserve.gov/releases/g19/HIST/cc_hist_r_levels.html.

[23] http://www.irs.gov/uac/2014-and-Prior-Year-Filing-Season-Statistics.

[24] 26 CFR 1.6011–8(a).

[25] Author's calculations, U.S. Census Bureau, "5242: Agencies, Brokerages, and Other Insurance Related Activities: U.S. Total, Not Seasonally Adjusted Total Revenue [Millions of Dollars], 2003–2014," https://www.census.gov/econ/currentdata/dbsearch?program=QSS&startYear=2003&endYear=2014&categories=5241T&dataType=QREV&geoLevel=US¬Adjusted=1&submit=GET+DATA.

[26] Author's calculations, U.S. Census Bureau, "Monthly Retail Trade and Food Services, 4411,4412: Auto and Other Motor Vehicles: U.S. Total, Not Seasonally Adjusted Sales - Monthly [Millions of Dollars], 1992-2014," https://www.census.gov/econ/currentdata/dbsearch?program=MRTS&startYear=1992&endYear=2014&categories=441X&dataType=SM&geoLevel=US¬Adjusted=1&submit=GET+DATA.

[27] Author's calculations, U.S. Census Bureau, "New Single-family Houses Sold: United States — Not Seasonally Adjusted All Houses [Thousands of Units], 1963-2014," "https://www.census.gov/econ/currentdata/dbsearch?program=RESSALES&startYear=1963&endYear=2014&categories=SOLD&dataType=TOTAL&geoLevel=US¬Adjusted=1&submit=GET+DATA.

[28] Laibson D, "Impatience and Savings," *NBER Reporter Online* (2005). http://www.nber.org/reporter/fall05/laibson.html; Laibson D, "Golden Eggs and Hyperbolic Discounting," *The Quarterly Journal of Economics* 112, no. 2 (1997): 443–78; Thaler R, "Mental Accounting and Consumer Choice," *Marketing Science* 4, no. 3 (1985): 199–214; O'Donoghue T and Rabin R, "Procrastination in Preparing for Retirement," in *Behavioral Dimensions of Retirement Economics*, edited by Aaron H (Washington, DC: Brookings Institution and Russell Sage, 1998): 125–56; Baicker K,. Congdon W J, and Mullainathan S, "Health Insurance Coverage and Take-Up: Lessons from behavioral economics," *The Milbank Quarterly* 90, no. 1 (2012): 107–34; Choi J J, Laibson D, and B C Madrian. $100 Bills on the Sidewalk: Suboptimal Investment in 401(K) Plans. *NBER Working Paper 11554*. August. 2005. http://www.nber.org/papers/w11554.pdf?new_window=1; Beshears J, Choi J J , Laibson D, and Madrian B C, "The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States," *National Bureau of Economic Research Working Paper Series* (Cambridge, MA: NBER, 2006); Madrian B C and Shea D F, "The Power of Suggestion: Inertia in 401(k) participation and savings behavior," *The Quarterly Journal of Economics* 116, no. 4 (2001): 1149–87; Dorn S, Wilkinson M, and Benatar S. "Case Study of Louisiana's Express Lane Eligibility: Final Report." *CHIPRA Express Lane Eligibility Evaluation*. Washington, DC: Urban Institute, January 2012; Johnson, E.J., and D.G. Goldstein. "Defaults and Donation Decisions." *Transplantation*. 78 (12): 1713–1716. December 27, 2004.

[29] Congdon W, Kling JR, and Mullainathan S. "Behavioral Economics and Tax Policy." *National Bureau of Economic Research Working Paper 15328.* September 2009.

[30] Such assistance played an important role in the success achieved by Massachusetts's 2006 reforms; more than half of successful applications came, not from consumers themselves, but from providers and community organizations acting on consumers' behalf. Dorn S, Hill I, and Hogan S. *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, November 2009, Washington, DC: Urban Institute, http://www.urban.org/uploadedpdf/411987_massachusetts_success.pdf. Along similar lines, a randomized, controlled experiment involved the tax preparation firm H&R Block, which used tax return data and interviews to complete and submit SNAP application forms on behalf of low-income clients. Among those in that group, 80 percent more SNAP applications were filed than with a control group that received only basic SNAP information and a blank SNAP form. By contrast, no statistically significant effects were observed, compared to the control group, when H&R Block completed SNAP forms, handed them to families, and explained where and how to file them. Schanzenbach W D. "Experimental Estimates of the Barriers to Food Stamp Enrollment." Institute for Research on Poverty, Discussion Paper no. 1367-09. Sept. 2009. A comparable H&R Block experiment involving applications for college student aid found similar results. Bettinger, EP, Long BT, Oreopoulos P, and Sanbonmatsu L, "The Role of Simplification And Information In College Decisions: Results From The H&R Block FAFSA Experiment," National Bureau of Economic Research Working Paper 15361 (September 2009). As another example, a randomized, controlled experiment in a low-income, predominantly Latino community in Boston compared Massachusetts's normal Medicaid outreach methods with having case managers from a community-based organization file applications for children, then following up over time to address emerging problems. The state's normal outreach methods involved mailings, door-to-door canvassing, radio advertisements in Spanish, grants to community organizations, and a toll-free call center. Among the children who received assistance from community-based case managers, 96 percent enrolled in Medicaid, and 78 percent retained coverage continuously

throughout the study's one-year follow-up period. By contrast, only 57 percent of the children receiving the state's standard outreach enrolled, and just 30 percent retained coverage continuously throughout the following year. Flores G, et al. "A randomized, controlled trial of the effectiveness of community-based case management in insuring uninsured Latino children." *Pediatrics*. 2005; 116: 1433–41. http://pediatrics.aappublications.org/content/116/6/1433.full.pdf.

[31] Baron Z. *In-Person Assistance Maximizes Enrollment Success*. March 2014, Washington, DC: Enroll America, https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[32] Dorn S. *Public Education, Outreach and Application Assistance*. November 2014, Washington, DC: Urban Institute. HRMS is funded by the Robert Wood Johnson Foundation, the Ford Foundation, and others.

[33] Marketplaces typically fund administration through QHP surcharges, which increase QHP premiums. If administrative costs, hence surcharges, rise, the resulting premium increase could disadvantage QHPs in competing against individual plans outside the Marketplace. Both competitive dynamics and worries about Marketplaces' sustainable financing of ongoing operations pressure Marketplaces to limit administrative costs, including for application assistance. See KPMG Government Institute, "The Market Model for Sustainable ACA State Exchanges," *KPMG Government Institute Issue Brief*, January 2014, http://www.kpmg-institutes.com/content/dam/kpmg/governmentinstitute/pdf/2014/market-model-for-sustainable-aca-state-exchanges-1.pdf.

[34] Dorn S., Public Education, *Outreach and Application Assistance*, December 2014, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/2000037-Public-Education-Outreach-and-Application-Assistance.pdf; author's calculations, Covered California, "Ethnic Race by Service Channel - Subsidized Only," *2014 Open Enrollment Data Book,* June 18, 2014 (enrollment data from October 1, 2013, through April 15, 2014), http://hbex.coveredca.com/data-research/2014-Open-Enrollment-Data-Book/Income%20Category%20by%20Service%20Channel.xlsx.

[35] Blavin F, Zuckerman S, and Karpman M. *Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources*. June 9, 2014, Washington, DC: Urban Institute, http://hrms.urban.org/briefs/obtaining-information-on-marketplace.html.

[36] Dorn S, Buettgens M, and Dev J. *Tax Preparers Could Help Most Uninsured Get Covered*. Feb. 2014, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/413029-Tax-Preparers-Could-Help-Most-Uninsured-Get-Covered.pdf.

[37] Agency for Healthcare Research and Quality. Total Health Services-Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2012. Medical Expenditure Panel Survey Household Component Data. Generated interactively. (December 11, 2014) http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug=

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[39] Dorn, Buettgens, and Dev 2014, Tax Preparers Could Help Most Uninsured Get Covered.

[40] Marcuss R, Dubois A, Hedemann H, Risler M-H, and Leibel K. August 2014. *Compliance Estimates for the Earned Income Tax Credit Claimed on 2006–2008 Returns,* Research, Analysis, and Statistics Report, *P*ublication 5162, Washington, DC: Internal Revenue Service.

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[42] Karen Pollitz, Jennifer Tolbert, and Rosa Ma. *Survey of Health Insurance Marketplace Assister Programs: A First Look at Consumer Assistance under the Affordable Care Act*, July 2014, Washington, DC: Kaiser Family Foundation, http://files.kff.org/attachment/survey-of-health-insurance-marketplace-assister-programs-report.

[43] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period,* For the period: October 1, 2013 – March 31, 2014 (Including Additional Special Enrollment Period Activity Reported through 4-19-14), May 1, 2014.

[44] Unpublished tabulations from Dorn, Buettgens, and Dev 2014, Tax Preparers Could Help Most Uninsured Get Covered.

[45] Brian Haile, 2014.

[46] Covered California. *All Certified Enrollment Counselors (CEC) Production (Data from Oct. 1, 2013 – April 15, 2014)*, June 5, 2014, http://hbex.coveredca.com/data-research/library/CEC%20ID%20Number%20Production%20Report%20Final.pdf.

[47] Kelly Rolfe Financial Services, for example, California's top-ranked tax preparer is a certified enrollment counsellor. See http://krfs.org/.

[48] In many states, QHP plan selection was the most time-consuming part of the enrollment process for subsidy-eligible consumers. Dorn, Public Education, Outreach and Application Assistance.

[49] Brian Haile, 2014. Typically, Medicaid and CHIP agencies contract with private vendors to help newly enrolling consumers select a managed care plan. In many states, those who fail to choose a plan within a specified period of time are assigned to a plan that is selected automatically.

[50] IRS. "IRC § 7216 Questions and Answers Related to the Affordable Care Act," February 3, 2014, http://www.irs.gov/uac/IRC-%C2%A7-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act.

[51] Government Accountability Office. *Paid Tax Return Preparers: In a Limited Study, Preparers Made Significant Errors*, April 8, 2014, GAO-14-467T, http://gao.gov/assets/670/662356.pdf.

[52] Marcus, et al., Compliance Estimates for the Earned Income Tax Credit Claimed on 2006–2008 Return.

[53] IRS National Taxpayer Advocate. "Most Serious Problem #5: Regulation of Return Preparers: Taxpayers and Tax Administration Remain Vulnerable to Incompetent and Unscrupulous Return Preparers While the IRS Is Enjoined From Continuing its Efforts to Effectively Regulate Unenrolled Preparers," *2013 Annual Report to Congress, Volume I*, December 31, 2014, http://www.taxpayeradvocate.irs.gov/userfiles/file/2013FullReport/Volume-1.pdf.

[54] The IRS has developed a voluntary Annual Filing Season Program designed to encourage tax return preparers who are not attorneys, CPAs, or enrolled agents to complete continuing education courses and to agree to abide by requirements that govern representation of taxpayers before the IRS. Such non-enrolled preparers can receive an Annual Filing Season Program Record of Completion by meeting specified education requirements and agreeing to comply with various provisions within Treasury Department Circular No. 230, including 31 CFR § 10.51. The latter prohibits, among other things, "[g]iving false or misleading information, or participating in any way in the giving of false or misleading information" on "Federal tax returns;" "willfully evading, attempting to evade, or participating in any way in evading or attempting to evade any assessment or payment of any Federal tax;" "[w]illfully assisting, counseling, encouraging a client or prospective client in violating, or suggesting to a client or prospective client to violate, any Federal tax law, or knowingly counseling or suggesting to a client or prospective client an illegal plan to evade Federal taxes or payment thereof;" or "[g]iving a false opinion, knowingly, recklessly, or through gross incompetence, including an opinion which is intentionally or recklessly misleading, or engaging in a pattern of providing incompetent opinions on questions arising under the Federal tax laws." For a more detailed explanation of the Annual Filing Season Program, see IRS, *Annual Filing Season Program,* Rev. Proc. 2014-42, July 1, 2014, http://www.irs.gov/pub/irs-drop/rp-14-42.pdf.

[55] George Brandes, formerly of Jackson-Hewitt, personal communication, 2014.

[56] 26 CFR 1.6011–8(a) provides: "A taxpayer who receives advance payments of the premium tax credit under section 36B must file an income tax return for that taxable year on or before the fifteenth day of the fourth month following the close of the taxable year." According to 45 CFR 155.305 (f)(4), "The Exchange may not determine a tax filer eligible for advance payments of the premium tax credit if HHS notifies the Exchange … that advance payments of the premium tax credit were made on behalf of the tax filer or either spouse … and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period."

[57] Most QHP subsidy beneficiaries are unaware even of the more basic requirement that they must reconcile ATPCs on annual federal income tax returns. Dorn S. *Public Education, Outreach and Application Assistance*, November 2014, Washington, DC: Urban Institute.

[58] Among taxpayers who qualify for EITCs, childless adults are much less likely to file returns and claim credits, compared to families with children. Plueger, D, "Earned Income Tax Credit Participation Rate for Tax Year 2005," Internal Revenue Service, 2009, http://www.irs.gov/pub/irs-soi/09resconeitcpart.pdf.

[59] The New Mexico Marketplace arranged referrals to Jackson Hewitt, which offered discounts to help consumers with income tax-filing, and which helped interested taxpayers apply for IAPs.

[60] ACA §1411(h)(1)(A)(i)(I), cross-referencing §1411(b); ACA §1411(b)(c)(B), cross-referencing §1412(b)(2).

[61] 26 CFR 1.162(l)-1T.

[62] It is also possible that if the OEP begins in February, the current year's FPL guidelines, rather than guidelines for the previous year, would determine subsidy eligibility. Eligibility for premium tax credits and cost-sharing reductions is based on federal poverty level (FPL) guidelines in effect at the start of open enrollment. Internal Revenue Code § 36B(d)(3)(B), 45 CFR §155.300(a). Each January, HHS releases an updated set of FPL guidelines, reflecting changes in the Consumer Price Index since the previous calendar year. When OEPs begin in October, QHP subsidy eligibility reflects FPL guidelines from the previous calendar year. If the OEP starts in February, the higher, current-year FPL guidelines may apply, which would lower each household's FPL level. If inflation remains low, tax credit amounts would not change much. However, consumers with incomes that would otherwise be slightly above 150, 200, or 250 percent of FPL could move into a different category that qualifies for additional cost-sharing reductions. Particularly for those slightly above the two lowest thresholds, a small drop in family FPL could significantly lower their out-of-pocket costs, thus improving their access to care. Cost-sharing reductions raise actuarial value in silver plans from 70 percent to 94 percent for consumers with incomes at or below 150 percent of FPL; to 87 percent for those with incomes between 151 and 200 percent of FPL; and to 73 percent for those with incomes between 201 and 250 percent of FPL.

[63] In fact, such a consumer would receive additional credits at reconciliation, as the tax return for the year would show lower income than was projected in determining APTC eligibility. 26 CFR 1.36B-2(b)(7).

[64] Pollack R and Klein R. *Accelerating the Affordable Care Act's Enrollment Momentum: 10 Recommendations for Future Enrollment Periods*. April 2014, Washington, DC: Families USA, http://familiesusa.org/product/10-enrollment-fixes.

[65] Jost 2014. Implementing Health Reform: New HHS 2015 Marketplace Enrollment Estimates.

[66] See the "exceptional circumstances" SEP in 45 CFR 155.420(d)(9).

[67] CMS explained the following in a regulatory preamble: ""[Our] final rules do not preclude the application of stronger consumer protections provided by state law including, for example, open enrollment periods that allow individuals to purchase coverage more frequently than the federal standards…. We note that states may create special enrollment periods or limited open enrollment periods in addition to those established by this final rule." Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule. 78 Fed. Register 13406, 13417-13418 (February 27, 2013). By July 2014, eight states (including D.C.) had created new SEPs or extended federally-created SEPs beyond parameters established by federal regulations. To illustrate the latter, some states lengthened federally-defined SEPs or required additional notices beyond those mandated by federal regulations. Giovannelli J, Lucia KW, and Corlette S. "Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market." New York, New York: The Commonwealth Fund (July 2014), Center on Health Insurance, Reforms Georgetown University Health Policy Institute.

[68] *Kaiser Health Tracking Poll,* November 2014, http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2014/.

[69] Unpublished data from Dorn, Public Education, Outreach and Application Assistance.

[70] Jost, Implementing Health Reform: New HHS 2015 Marketplace Enrollment Estimates.

[71] Centers for Disease Control and Prevention. National Center for Health Statistics. Health Indicators Warehouse. www.healthindicators.gov. Rates of non-fatal auto accidents per 100,000 are available by age group for 2011 at http://www.healthindicators.gov/Indicators/Motor-vehicle-injuries-nonfatal-per-100000_1078/Profile/ClassicData. The two-month estimates in the text divided these annual totals by six.

[72] DevCan 6.8.0, August 2014, National Cancer Institute (http://surveillance.cancer.gov/devcan/), "Table 2.12. All Cancer Sites (Invasive), Risk of Being Diagnosed With Cancer in 10, 20 and 30 Years, Lifetime Risk of Being Diagnosed with Cancer Given Alive and Cancer-Free at Current Age, and Lifetime Risk of Dying from Cancer Given Alive at Current Age, Both Sexes, 2009-2011 By Race/Ethnicity."
http://seer.cancer.gov/csr/1975_2011/results_merged/topic_lifetime_risk.pdf. The estimates of being diagnosed with cancer during each 10-year period from ages 20 through 60 were divided by 60 to develop estimates of being diagnosed with cancer during a two-month period. An estimated risk of cancer diagnosis between ages 60 and 65 was developed

using Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) DevCan database: "SEER 18 Incidence and Mortality, 2000–2011, with Kaposi Sarcoma and Mesothelioma". National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released August 2014, based on the November 2013 submission. Underlying mortality data provided by NCHS (www.cdc.gov/nchs). Results are available at http://canques.seer.cancer.gov/cgi-bin/cq_submit?dir=devcan2011&db=1&rpt=TAB&sel=1^4^1^1^59^12^13&dec=2&template=null. That six-year estimate was then divided by 36 to yield a two-month estimate for the likelihood of a new cancer diagnosis among 60-65 year olds. The estimates in the text combine the risks of each applicable age group into larger age bands.

[73] Dorn, Public Education, Outreach and Application Assistance.

[74]The Government Accountability Office thus explained as follows: "The extent to which individual taxpayers accurately report their income is related to the extent to which the income is reported to them and IRS by third parties or taxes on the income are withheld. For example, for types of income for which there is little or no information reporting, such as business income, individual taxpayers tend to misreport over half of their income. In contrast, employers report most wages, salaries, and tip compensation to employees and IRS through Form W-2. Also, banks and other financial institutions provide information returns (Forms 1099) to account holders and IRS showing the taxpayers' annual income from some types of investments. Findings from IRS's study of individual tax compliance indicate that nearly 99 percent of these types of income are accurately reported on individual tax returns." Government Accountability Office. *Tax Gap: Sources of Noncompliance and Strategies to Reduce It*. GAO-12-651T, Apr 19, 2012. http://www.gao.gov/products/GAO-12-651T.

[75] For example, the SEP could expand to include people who were uninsured in 2014 but not penalized based on exemptions that may not continue in 2015, such as income below federal income tax filing requirements or health insurance costs exceeding 8 percent of income.

[76] As noted earlier, the legal basis for a national SEP could be "exceptional circumstances." The circumstances discussed here could be exceptional in the sense that they could be characterized as highly unfair, denying an opportunity for those who have rectified a past period of uninsurance to sign up for coverage in time to avoid a new and more severe penalty of which they were unaware during the first year of the penalty's application. That said, if most who want to enroll into QHPs can do so under a particular SEP, one could argue that, by definition, the SEP is not "exceptional."

[77] During the past two years, 69 percent of all returns filed by April 15 were filed by the end of March; but among those that claimed refunds, which are more likely to be submitted by low- and moderate-income taxpayers, 77 percent were filed by the end of March (figure 1). Author's calculations, Internal Revenue Service, 2013 and 2014 Filing Season Statistics, http://www.irs.gov/uac/2014-and-Prior-Year-Filing-Season-Statistics.

[78] Author's calculations, CPS-ASEC data for 2013, http://www.census.gov/hhes/www/cpstables/032014/pov/pov01_400_1.xls.

[79] Limiting the analysis to non-elderly *adults*, rather than *all non-elderly residents*, those ages 45–64 are 50 percent of people with incomes above 400 percent of FPL but 37 percent of adults with incomes at or below 400 percent of FPL. Author's calculations, CPS-ASEC data for 2013, http://www.census.gov/hhes/www/cpstables/032014/pov/pov01_400_1.xls.

[80] A QHP plan year that begins in June, leaving a two-month gap between the end of the OEP and the start of the QHP plan year, would further reduce the odds of enrollment "snafus" and lessen selection risks. However, such a prolonged delay could prove unacceptable to much of the public, given our culture of increasingly brief periods between order and delivery of consumer goods. It could also reduce plans' ability to price products effectively, since fewer claims would be available from one QHP plan year by the time QHP bids must be submitted for the following year.

[81] Brian Haile, a respected analyst who has thought deeply about this issue, suggests that the QHP plan year could begin in January even if the OEP overlapped with tax filing. It is hard to see how such an alternative could work effectively in practice, however. If the OEP runs from February through April, for example, existing enrollees would need the opportunity to change plans during November or December, before the QHP plan year begins. Otherwise, they could wait to see whether health problems develop in January through March, after which they could switch to a comprehensive plan, creating significant selection problems. But if enrollees could switch plans during November or December, plans would need to prepare QHP bids at roughly the same time as for Medicare Advantage and Medigap open enrollment, which begins in October, forfeiting important administrative advantages of a late winter-early spring OEP. If the QHP calendar year begins in January and the OEP starts in December, existing enrollees would need to change plans by December 15, which would place a tremendous stress on carrier enrollment staff and brokers during

the final days of Medicare open enrollment, again forfeiting important administrative advantages of a changed QHP OEP. Moreover, to gain the participation advantages of a late winter/early spring OEP, an OEP that starts in November or December would need to last until March or April; such an OEP would be quite lengthy, potentially created opportunities for serious adverse selection that could raise serious objections from some carriers.

[82] One other factor could lessen reconciliation risks if open enrollment beginning in February resulted in the use of current-year FPL guidelines, thereby lowering consumers' FPL levels, as explained earlier. For APTC beneficiaries whose annual income would otherwise be slightly above 200, 300, or 400 percent of FPL, this would reduce their maximum reconciliation-based tax liability, because they would move from slightly above to slightly below those FPL levels. Reconciliation liability is capped, for single adults and other filers, at $300 and $600, respectively, if income is below 200 percent of FPL; at $750 and $1,500 if income is between 200 and 299 percent of FPL; and at $1,250 and $2,500 if income is between 300 and 399 percent of FPL. 25 CFR 1.36B-4(a)(3).

[83] See 45 CFR §155.320.

[84] Buettgens M, Nichols A, and Dorn S. *Churning Under the ACA and State Policy Options for Mitigation.* Prepared by the Urban Institute for the Robert Wood Johnson Foundation. June 2012. http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf; Curtis R and Graves J. "Open Enrollment Season Marks the Beginning (Not the End) of Exchange Enrollment." *Health Affairs Blog.* November 26th, 2013. http://healthaffairs.org/blog/2013/11/26/open-enrollment-season-marks-the-beginning-not-the-end-of-exchange-enrollment/.

[85] Only during an OEP that overlaps with tax filing would the prospective APTC amount be relevant to a decision that clients face at tax time. If QHP enrollment is not taking place during tax filing, tax preparers' ACA-related services are likely to be limited to (1) showing compliance with, making a case for falling within exceptions to, or completing forms and calculating penalties for violating the coverage mandate; and (2) reconciliation. Both of these topics arise in the context of preparing the tax return. Brian Haile, op cit. Determining APTC amounts, by contrast, would be comparable to revising withholding on W-4 forms, which is not typically undertaken by tax preparation services during tax filing season.

[86] Massachusetts officials reported that applications filed on consumers' behalf by trained and certified providers and consumer groups contained many fewer errors than those filed by consumers themselves. Dorn S, et al., The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage.

[87] One illustration is provided by the National School Lunch Program (NSLP), which, before 2004 legislation, required participants to report all income changes of $50 or more; few met those requirements. Families applied in August, without documenting income. A small sample of applications would be selected for verification in December. Unreported income changes and other differences from household circumstances reported at the time of application would frequently result in findings of error. Ralston K et al. *The National School Lunch Program: Background, Trends, and Issues*. July 2008. Economic Research Report Number 61. Economic Research Service, U.S. Department of Agriculture (ERS/USDA), http://www.ers.usda.gov/media/205594/err61_1_.pdf. Notably, this even occurred with NSLP applications where eligibility was granted, not based on parents' unverified income attestations, which were sometimes erroneous, but when eligibility resulted from receipt of benefits like food stamps or cash assistance, for which other public agencies had verified income. One analysis of verification outcomes in large metropolitan school districts found that, among sampled NSLP children granted benefits in August based on receipt of other benefits, 10 percent were found to qualify for fewer benefits and 24 percent were eligible for additional benefits based on their circumstances in December. Author's calculation, table III 3, bottom panel, Burghardt J, Silva T, and Hulsey L. "Case Study of National School Lunch Program Verification Outcomes in Large Metropolitan School Districts." *Special Nutrition Program Report Series, No. CN-04-AV3.* Prepared by Mathematica Policy Research, Inc., for USDA Food and Nutrition Service, April 2004, http://www.fns.usda.gov/sites/default/files/NSLPcasestudy.pdf. Children in the latter category could have had their parents report current circumstances that qualified them for additional assistance, such as a change in benefits granted by the other program on which NSLP eligibility was originally granted.

[88] Regardless of when the OEP is scheduled, tax reconciliation risks could be mitigated if, during the OEP, consumers can adjust their APTC claims for the final months of the QHP plan year. However, such adjustments are limited by consumers' inability to change QHPs at that point in the plan year, unless a special enrollment period is triggered by a change in eligibility for cost-sharing subsidies. See 45 CFR 155.420(d)(6)(i) and (ii). An APTC reduction may not be feasible if it would leave the consumer exposed to an unaffordable premium payment. By contrast, an APTC adjustment made during the OEP, which takes effect at the start of the QHP plan year, can be accompanied by a choice of plan that fits the modified APTC.

[89] 45 CFR 155.330 (e)(2)(ii)(C).

[90] 45 CFR 155.420(d)(6).

[91] In the past, inertia has often prevented enrollees in various health coverage systems (including Medicare) from changing plans even when such changes would have been favorable. Neuman T. Open Enrollment: Insights from Medicare for Health Insurance Marketplaces. October 23, 2014, Washington, DC: Kaiser Family Foundation, http://kff.org/health-reform/perspective/open-enrollment-insights-from-medicare-for-health-insurance-marketplaces/. That said, reporting income changes to Marketplaces would take much less work than would be required to change health plans. However, as suggested by the above NSLP findings, families do not always report changed circumstances that qualify them for additional benefits.

[92] See 45 CFR 147.104(b)(1)(ii).

[93] Herman B. "Insurers Ramp Up Staffing ahead of Obamacare Open Enrollment," *Modern Healthcare,* November 5, 2014, http://www.modernhealthcare.com/article/20141105/NEWS/311059984/insurers-ramp-up-staffing-ahead-of-obamacare-open-enrollment.

[94] IRS. Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055), Page Last Reviewed or Updated: 09-Dec-2014, http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055; IRS, Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056), Page Last Reviewed or Updated: 09-Dec-2014, http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056.

[95] CMS. "Appendix A: Health Coverage from jobs," *Application for Health Coverage & Help Paying Costs*, Family Application Form (English), https://Marketplace.cms.gov/applications-and-forms/Marketplace-application-for-family.pdf.

[96] See 45 CFR 155.320(d)(3)(iii).

[97] Tax preparation services may also be able to find the current employer's EIN and use it on the consumer's IAP application, even if the consumer recently changed jobs and the previous year's tax form is no longer timely for this purpose.

[98] Copeland CW. *Length of Rule Reviews by the Office of Information and Regulatory Affairs*. December 2, 2013, draft report for the Administrative Conference of the United States, https://www.acus.gov/sites/default/files/documents/Draft%20OIRA%20Report%20120213.pdf.

[99] Attkisson S. "Did White House Obamacare guidance stop ahead of 2012 election?" *CBS News*, October 24, 2013, 8:56 PM, http://www.cbsnews.com/news/did-white-house-obamacare-guidance-stop-ahead-of-2012-election/.

[100] 79 Fed. Reg. 70674 (Nov. 26, 2014).

[101] HHS, "Patient Protection and Affordable Care Act: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Final Rule)," 77 *Fed. Register* 17220, 17223 (March 23, 2012).

[102] CCIIO. *DRAFT 2016 Letter to Issuers in the Federally-facilitated Marketplaces.* Dec. 19, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf.

[103] See Hartman M., et al., "National Health Spending In 2013: Growth Slows, Remains In Step With The Overall Economy," *Health Affairs. January 2015 34:150-160;*

[104] CMS. "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule." *Federal Register.* July 15, 2011, Vol. 76, No. 136: 41866- 41927, http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf.

[105] Federal regulations of the individual market include many explicit and implicit references to the January start date of QHP coverage. States with unified small group and individual markets are currently required to have plan years that coincide with the calendar year. 45 CFR 147.104 (b)(2). Also, current regulations forbid insurers, from November 15 through December 15 of each year, from denying offers to small firms based on failure to meet minimum participation requirements. 45 CFR 147.104 (b)(1)(i)(B). The policy judgment underlying the choice of the latter dates presumably reflected the open enrollment period for individual coverage. Accordingly, federal policymakers may need to reconsider

the period during which the regulation requires the effective suspension of non-participation requirements for small group coverage.

[106] Brian Rossman, Massachusetts Health Care for All, personal communication, 2014; Katherine Swartz, Harvard School of Public Health, personal communication, 2015.

[107] See 45 CFR § 156.430 for a description of how CMS provides QHPs with advance payments to cover the estimated cost of CSRs the plans provide to eligible consumers; how QHPs report CSRs' actual cost; and how those advance payments are reconciled with actual costs. For examples of the detailed calculations that apply, see Center for Consumer Information and Insurance Oversight, CMS. Cost-Sharing Reductions Reconciliation, March 2013, https://www.cms.gov/CCIIO/Resources/Files/Downloads/pages_from_csr_recon_cleared-a.pdf.

[108] For example, a healthy consumer already enrolled in a plan from the prior calendar year could stop paying premiums in January and wait to see whether he or she gets sick by March. If so, the consumer could make back-payments of premiums to the start of the year and remain insured through the end of April. If the consumer does not get sick, he or she could avoid paying premiums for the four-month bridge plan. Such a healthy consumer would simply enroll into coverage that starts in May. CCIIO. *Revised Bulletin #10 on Grace Periods Related to Terminations for Non-Payment of Premiums and Enrollment through the Federally-facilitated Marketplace across Benefit Years.* September 12, 2014. https://www.regtap.info/uploads/library/REVISED_Bulletin10GracePeriods_5CR_091214.pdf.

[109] Karen Pollitz, Kaiser Commission on Medicaid and the Uninsured, personal communication, 2014; Judy Solomon and January Angeles, Center on Budget and Policy Priorities, personal communication, 2014.

[110] When death, divorce, or marriage occurs mid-year, special rules determine household size for purposes of calculating FPL and the annual tax credit. See, 26 CFR 1.36B–4(b).

[111] 26 CFR §§1.36B–4(a)(2), 1.36B–4T(a)(4), Example 4.

[112] In a related point, if an employer's open enrollment period overlaps with QHP open enrollment, workers who move from ESI into QHPs will do so at the start of the employer's plan year. By contrast, if QHP open enrollment is at a different time, such workers could leave ESI in the middle of the employer's plan year. That would not be unprecedented; employees leave or begin ESI mid-year for many reasons, including job changes. Nevertheless, coverage changes initiated mid-year could be more disruptive to employers than changes at the start of the employer's plan year. This problem could be prevented if CMS established a SEP allowing QHP enrollment when an employer's OEP differs from the Marketplace OEP. Such an SEP would be analogous to the existing SEP for consumers whose individual coverage ended in 2014 at a time that was off-cycle for QHP open enrollment. 45 CFR 155.420 (d)(1)(ii).

[113] Urban Institute Health Insurance Policy Simulation Model 2014.

[114] Buettgens M, et al., Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches.

[115] Blue Cross and Blue Shield of Massachusetts Foundation. *Health Reform in Massachusetts Expanding Access to Health Insurance Coverage: Assessing the Results*, March 2014, Boston, MA, http://bluecrossmafoundation.org/sites/default/files/download/publication/Monitoring%20MA%20Reform%20March%202013_0.pdf.

[116] The text is consistent with IRS regulations, although the latter are framed in terms of annual rather than monthly premiums. Such regulations provide that the annual benchmark premium is calculated using an average of the different annual benchmark premiums that were charged during the year. The latter premiums are weighted based on the number of months to which they applied. For example, if a $6,000 annual benchmark premium applied to one-third of the year, and a $9,000 annual benchmark premium applied to the other two-thirds, an $8,000 benchmark premium would be used to determine the year's premium tax credit (1/3 x $6,000 + 2/3 x $9,000 = $8,000). See Example 7 in 26 CFR §1.36B-4(a)(4). Translating this example into monthly terms, if a monthly $500 benchmark premium (the monthly equivalent to a $6,000 annual premium) is charged for 4 months (one-third of the year) and a $750 benchmark premium (the monthly equivalent to an $8,000 annual premium) is charged for 8 months (two-thirds of the year), the annual benchmark premium is calculated as follows: ($500 x 4) + ($750 x 8) = $8,000.

[117] According to the IRS, "You may receive more than one Form 1095-A if members of your household were not all enrolled in the same health plan, you updated your family information during the year, you switched plans during the year, or you had family members enrolled in different states." IRS. *Health Insurance Marketplace Statements*. Page Last Reviewed or Updated: 06-Feb-2015, http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Health-Insurance-Marketplace-Statements.

[118] Under the schedule discussed here, another factor would lessen consumer confusion if a February rather than October start to the OEP would result in the use of current-year FPL guidelines, rather than prior-year FPL guidelines, to determine eligibility for QHP subsidies. This change would better align QHP subsidies with Medicaid and CHIP, which use current-year rather than prior-year FPL guidelines. See 42 CFR 435.4 (definition of "Federal poverty level (FPL)"). Such alignment would prevent confusion that otherwise results when consumers learn, in some cases as they shift between programs, that they have one FPL level for purposes of QHP subsidies but a different FPL level for Medicaid purposes. Unlike the theoretical alignment of QHP subsidies and Medicare/ESI, which affects very few consumers, aligning Medicaid and QHP subsidies would affect numerous consumers. Among consumers who qualify for QHP subsidies in a two-year period, 38 percent qualify for Medicaid during one of those years. Buettgens M, Nichols A, and Dorn S. *Churning Under the ACA and State Policy Options for Mitigation,* June 2012, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf.

ISSUE BRIEF
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How Will the Affordable Care Act Affect the Use of Health Care Services?

Sherry Glied and Stephanie Ma

Abstract In January 2014, the Affordable Care Act extended access to health insurance coverage to an estimated 30 million previously uninsured people. This issue brief provides state-level estimates of the increased demand for physician and hospital services that is expected to result from expanded access and assesses the sufficiency of the existing supply of providers to accommodate the anticipated increase in demand. We project that primary care providers will see, on average, 1.34 additional office visits per week, accounting for a 3.8 percent increase in visits nationally. Hospital outpatient departments will see, on average, 1.2 to 11.0 additional visits per week, or an average increase of about 2.6 percent nationally. Increases of the magnitude likely to be generated by the Affordable Care Act will have modest effects on the demand for health services, and the existing supply of providers should be sufficient to accommodate this increased demand.

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OVERVIEW

Since January 2014, some 11 million formerly uninsured Americans have gained health insurance coverage under the Affordable Care Act (ACA).[1] In addition to providing financial protection against high health care costs, the law should improve access to care, though this will depend partly on the availability of health services. This issue brief examines the expected new demand for health services in each state as a result of the ACA's coverage expansion and draws inferences about the capacity of the health care workforce to meet the new demand.

Most analysts anticipate that the insurance expansions will not lead, in the aggregate, to substantial strains on the health care delivery system. The Centers for Medicare and Medicaid Services' Office of the Actuary projects an increase of about 2.1 percent in aggregate health spending, with larger increases in prescription drug spending and smaller increases in inpatient care spending.[2] Studies of the impact on use of certain services, mainly primary care, indicate that the coverage expansions are likely to lead to between 15 million and 26 million additional primary care visits annually and these studies project that between 4,300 and 7,200 additional primary care physicians will be needed to meet these new demands.[3,4,5] The health law's effects on demand will likely vary substantially by state, as the number of people gaining health coverage and the supply of physicians both vary by state.

Most earlier analyses assumed that the primary care physician supply is currently fully utilized, so that new demand would require new resources to maintain

access to care. But newer research demonstrates that the intensity of health service use varies considerably across the United States. The Dartmouth Atlas of Health Care shows, for example, that only 60 percent of Medicare beneficiaries in the Bronx, N.Y., saw a primary care physician in the preceding year, compared with about 90 percent of beneficiaries in Florence, S.C.[6] Moreover, provider supply is not correlated with consumers' access to care, as evidenced by the large and persistent variations in waiting times for physician appointments among U.S. cities.[7]

Part of the reason for this disconnect between supply and access is that differences in how health care systems are organized across localities and regions substantially mediate variations in physician supply. For example, compared with a solo practitioner, a physician working in a group practice can see 12.2 percent more patients, in part by utilizing nonphysician health professionals on staff or electronic health record–enabled communication.[8,9] Patient-centered medical homes and nurse-managed health centers also can offer expanded access to care, holding physician supply constant.[10]

Our study, which draws from the Medical Expenditure Panel Survey and findings from previously published studies, provides new estimates of the ACA's likely impact on utilization of health services, including primary care, medical and surgical specialty services, pharmaceuticals, and inpatient and outpatient hospital services. We then compare these demand estimates with measures of supply and compute the likely rates of new patient visits per provider. Finally, we assess the relationship between the supply of physicians and access to care. (For more about the study's design, see the box on the opposite page and "Appendix. Study Methodology in Detail" on page 7.)

FINDINGS

Impact on Utilization Will Be Nominal

Our analysis indicates that the ACA is expected to result in roughly 20.3 million additional primary care visits nationally, with people newly insured through the marketplaces accounting for more than a third of these visits, or about 3.8 percent above base (Table A). Emergency room visits by the newly insured are predicted to increase by 1.1 million, with those gaining Medicaid coverage accounting for more than two-thirds of these visits (Table C).

Overall, our projected increases in health care utilization are small. Only 17 states are expected to experience increases in primary care visits that exceed 4 percent, and only seven states are expected to see increases of greater than 5 percent; the U.S. average is expected to be 3.8 percent (Table A). The ACA's impact on medical and surgical specialty services is projected to be even more modest, with increases in medical and surgical specialty use projected to range from less than one-half of 1 percent in Massachusetts to just under 2 percent in New Mexico (Table B). Projected increases in outpatient service use are similar to those for primary care services. With the exception of six states, the vast majority of the country is expected to experience increases in outpatient care utilization of no more than 4 percent (Table C).

The ACA is also expected to bring about very modest increases in prescription drug use. In all but two states (New Mexico and Oregon) increases in prescription drug use are expected to be below 2.5 percent. Increases in inpatient service use will likely vary considerably across states, with the West experiencing a 4 percent average increase, compared with a 3.4 percent increase in the South and a 2 percent increase in the Northeast (Table C).

HOW WE DESIGNED THIS STUDY

Our findings on the impact of the ACA expansion on health care use and resource supply are best understood in light of how we structured our study. We conducted separate analyses for the newly insured who gained coverage under the ACA's Medicaid expansion and those who gained coverage in the ACA's health insurance marketplaces, as these populations differ demographically and in their use of care. (We assumed that all states participate in the Medicaid expansion, even though several states have not moved forward with this expansion. Therefore, our estimates incorporate a larger increase in service utilization than is currently likely.) Our projections are based on analyses of the experience of previously uninsured people who obtained coverage at some point between 2006 and 2010.

We also account for the likely difference in utilization between people who moved from uninsurance to insurance in the past and those who gain eligibility under the ACA. Many people who formerly gained access to Medicaid did so because they were already ill and had been admitted to a hospital that then enrolled them in coverage; many women gained coverage because of pregnancy. The population gaining coverage under the Affordable Care Act is likely to be relatively healthier and to use less inpatient care than previously. To account for this potential bias, we calibrated our estimates against the estimates of Finkelstein et al. from the Oregon Medicaid experiment.[11] It is less clear how the marketplace population differs from those who gained coverage in the past. Historically, some people who gained access to group insurance may have done so in anticipation of future health needs, resulting in a less healthy population of newly insured individuals compared with those enrolled under the ACA because of the mandate to enroll and subsidies provided. At the same time, some of those who will be eligible under the ACA for nongroup coverage would have been denied such coverage in the prior unregulated market, making the new nongroup risk pool sicker than in the past.

Additionally, our projections of increased visits are aggregated by type of services and settings: primary care, including internal medicine, family practice, and pediatric care (Table A); specialty care, including ob/gyn, psychiatric, medical specialty, and surgical services (Table B); and other services (emergency room, outpatient, inpatient, and prescription drugs) (Table C).

Projected Additional Visits per Doctor Will Vary Across States

Exhibit 1 illustrates how the ACA will affect the average number of primary care visits per primary care physician (including doctors in community health centers) across the states. The map on the left shows these ratios in 2010 before ACA's implementation, while the map on the right, which combines pre-ACA figures with figures for the projected visit increase, shows the ratios following ACA implementation.

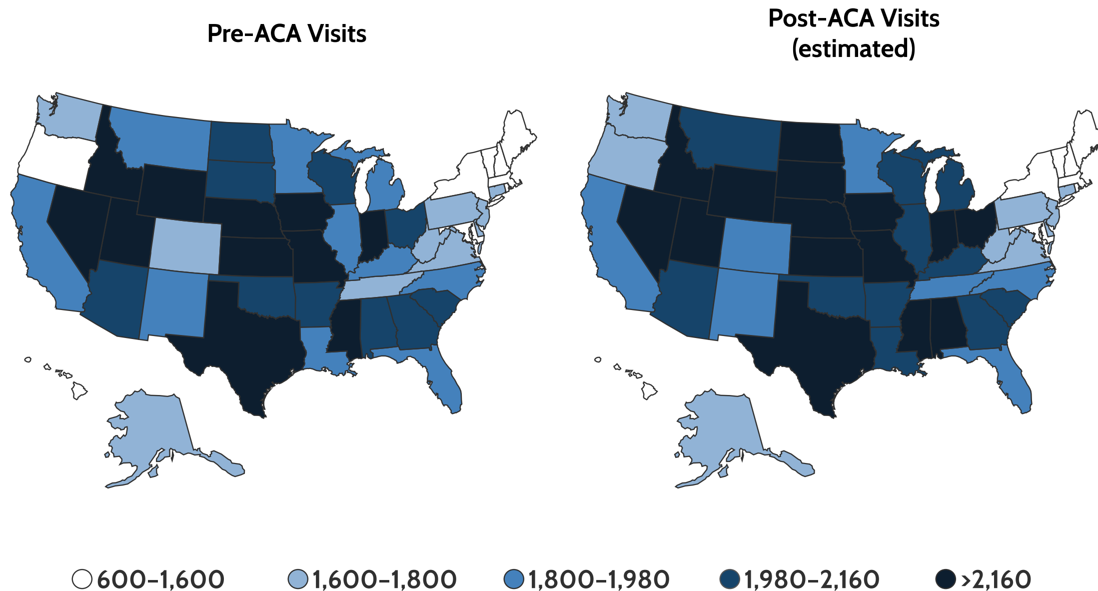
Baseline visit rates vary substantially across regions. States in the Northeast (including Maine, Massachusetts, New York, and Vermont) have the fewest visits per primary care doctor, with doctors averaging around 1,500 visits annually. Colorado and California, with about 1,800 visits a year, also have relatively low visit-per-doctor ratios. States in the South and Midwest and in the West and Southwest have higher visit-per-doctor ratios. Utah's visit-per-doctor ratio prior to ACA implementation was the highest, at 2,488; this is projected to rise to nearly 2,600, once the law is fully implemented.

A comparison of states pre- and post-ACA suggests that only a few will see noticeable increases in visits after the ACA expansions take full effect. The law's impact on primary care visits is projected to vary substantially by region, with states in the Northeast expected to experience the smallest rise. Seven states are projected to experience increases in primary care visits per doctor per year that exceed 100, or between 2.1 and 2.7 additional visits per week.

Table D details, by physician and service type, the anticipated number of new visits per provider per week across types of providers. On average, the expansion forecast is for roughly 70 additional visits annually for a primary care physician, or 1.34 visits a week.

Most specialties will see much smaller weekly increases in use by comparison. Some new utilization is expected to occur in hospital outpatient departments. The largest increases are expected in the South and West, where these regions' outpatient departments are expected to see growth of about 5.7 and 7.3 visits a week per outpatient department, respectively.

Exhibit 1. Visits per Primary Care Physician, Pre- and Post-Affordable Care Act



Notes: Ratios calculated by dividing the number of visits (pre-ACA and estimated post-ACA from MEPS) by the supply of doctors in each state (denominator reflects number of total primary care physicians, not full-time equivalents).
Source: Physician supply data from AHRQ, "The Number of Practicing Primary Care Physicians in the United States," and primary care visit data calculated from the Medical Expenditure Panel Survey (MEPS).

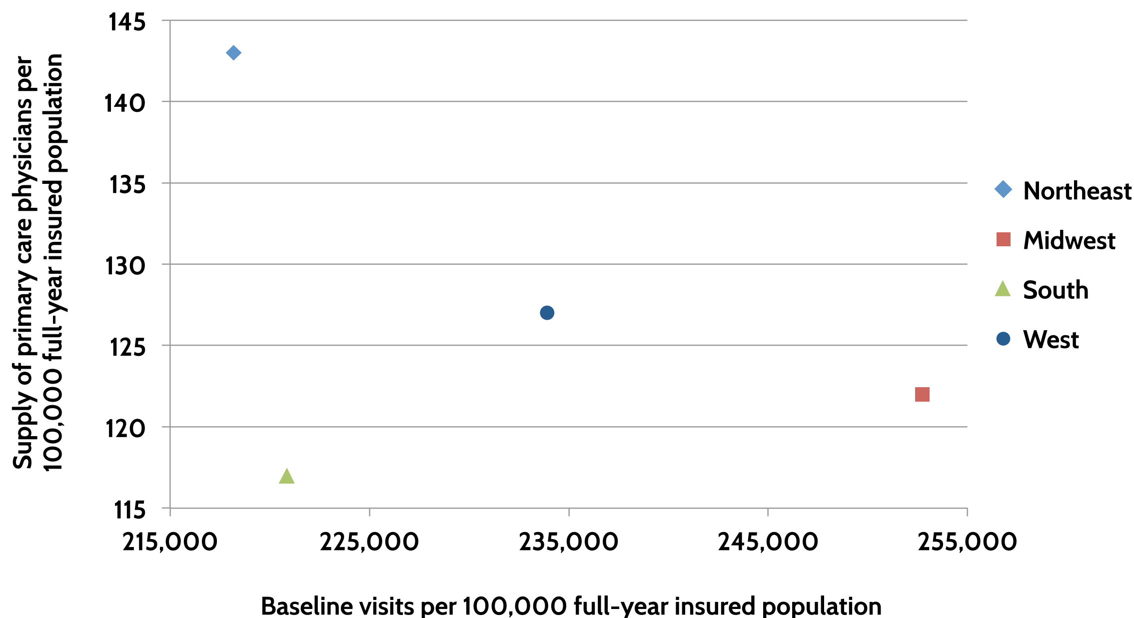
Physician Supply Does Not Predict Primary Care Access

Increases in visits per provider, such as those projected above, may not lead to worse access to care. As Exhibit 1 shows, rates of primary care visits per physician varied considerably before implementation of the ACA. Across states, however, high rates of primary care visits per physician did not always reflect low physician supply, since utilization rates depend on both the supply of doctors and the rate at which people use their services (Exhibit 2). Visits per doctor are lowest in the Northeast, both because this region has the highest supply of primary care doctors (though many may be part-time) and because insured residents of these states make the fewest visits to primary care doctors annually.

The high ratios of visits per primary care doctor observed in Midwestern states, such as Indiana, by contrast, occur both because people in this region use more primary care and because primary care supply is relatively low.

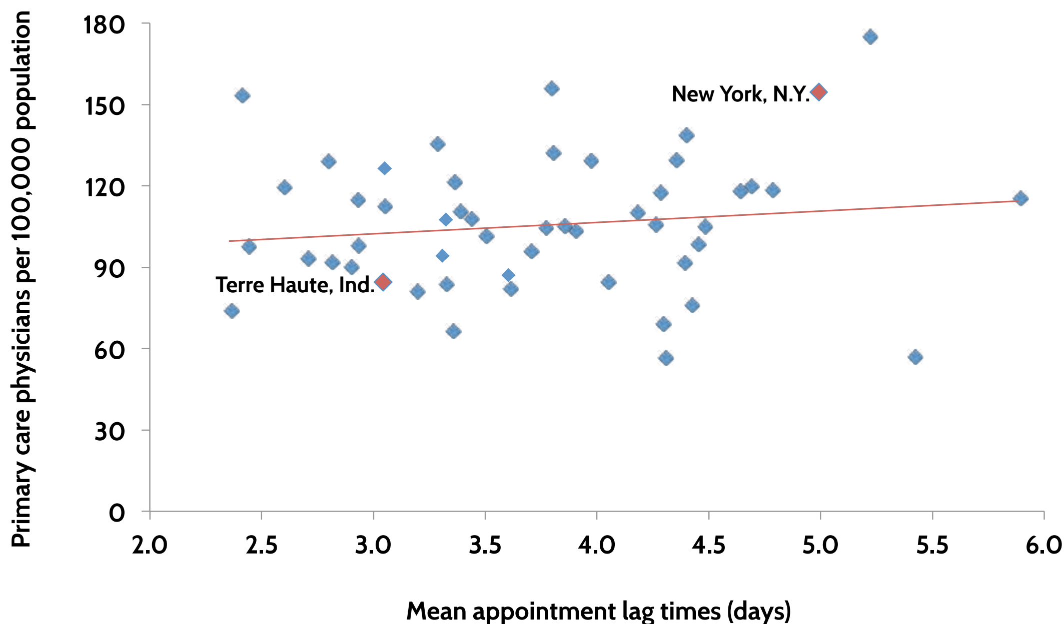
Visits per primary care physician, in turn, do not translate directly into variations in access to care, because of differences in utilization patterns and in the organization of medical practice. Paradoxically, delays in gaining access to primary care are systematically greater, not fewer, in areas with more primary care doctors. The delay between seeking care and getting an appointment is generally shorter in the South than in the Northeast or West, and substantially shorter in Indiana than in New York (Exhibit 3). These results, drawn from a large dataset in 2003, are consistent with a more recent study examining waiting times and physician supply in 2012.[12]

Exhibit 2. Regional Variation Pre-Affordable Care Act in the Ratio of Baseline Visits per Primary Care Physician and the Per Capita Supply of Primary Care Physicians, 2010



Source: 2010 Medical Expenditure Panel Survey (MEPS); AHRQ "Number of Practicing Primary Care Physicians in the United States."

Exhibit 3. Variation in Mean Appointment Lag Times and the Supply of Primary Care Physicians per 100,000 Population, 2003



Notes: Analysis at the county level. Wait-time data are truncated at 21 days.
Source: The 2003 Community Tracking Study's Household Survey, Physicians Characteristics and Distribution in the United States.

POLICY IMPLICATIONS

One of the principal reasons for extending health insurance coverage is to increase people's access to needed health services. Although analysts have expressed concern that greater access to care will strain the service delivery system, our projections suggest that increased use of health services by the newly insured will be relatively modest for most services. The greatest increases will be in primary care, followed by inpatient and outpatient care.

The U.S. health system is likely to be able to absorb these increases. Use of primary, emergency, inpatient, and outpatient care varies substantially across the country, and these variations do not appear to be correlated with delays in access to care. The variation in use patterns supports the idea that anticipated increases in doctor's visits by the newly insured can be accommodated through organizational changes and changes in practice patterns.[13] Plausible structural changes, some of which have already occurred, include physician pooling and greater use of nonphysician health professionals, such as nurses and physician assistants, as part of a team-based approach.[14] In addition, technological advances are also likely to play an important role in improving the efficiency of health care delivery. Notably, the use of telemedicine—the exchange of medical information via electronic communication—has already shown promising results in managing common chronic illnesses at home and reducing time spent at physician offices to manage these diseases.[15]

It is critical that the expansion of health insurance coverage leads to improved access to care for those who were previously uninsured and does not limit access for those who already have coverage. Our results suggest that the current supply of primary care physicians and physicians in most specialties is sufficient to ensure this result will hold.

APPENDIX. STUDY METHODOLOGY IN DETAIL

Overview

We used the Medical Expenditure Panel Survey (MEPS) to estimate current utilization rates of specific health services at the national and regional level. We allocated this utilization to states within each region.

Next, we used MEPS to project additional use of health services under the Affordable Care Act (ACA) by income eligibility group. Projected increases in service utilization were calculated by taking the number of projected additional visits and dividing it by the baseline current utilization rates. We then estimated the current supply of specific health service resources such as physicians and hospital beds by state. We combined these sources to calculate the number of current and additional visits per provider.

Current Annual Health Service Utilization

The 2010 MEPS data were used to estimate the total number of medically related visits made by the entire population in 2010 by geographic region for the following provider or service categories: internal medicine, family practice, pediatrics, all primary care, obstetrics and gynecology, psychiatric, medical specialties, surgical specialties, emergency room, outpatient services, and prescription drugs. The MEPS data include both visits to clinics and community health centers in their office-based visit calculation; thus, these types of visits are included in our estimates of increases in office visit demand.

We allocated regional health services to each state according to that state's population (from the U.S. Census Bureau) as a proportion of the region's total population.

Projected Health Service Utilization

To determine utilization patterns of individuals who will gain insurance under the ACA, we combined yearly data from MEPS for 2006 to 2010. We selected a sample of individuals who were uninsured for the first year they were in the sample. We divided this sample according to income eligibility for Medicaid or the health care marketplaces. We then examined the service use of these populations in the second year of the sample, when some of them had gained insurance. For each of these subsamples, we ran negative binomial regression to predict utilization patterns for each category of service or provider. To predict utilization patterns of the newly insured, we turned to two reports released by the PricewaterhouseCoopers Health Research Institute, *Medicaid Expansion: New Patients, New Challenges*[16] and *Health Insurance Exchanges: Long on Options, Short on Time,*[17] which report the predicted demographic makeup of the newly insured Medicaid and marketplace-eligible populations. Results from the regression were then multiplied by each state's projected newly insured Medicaid and marketplace-eligible population size to obtain projected additional visits under the ACA by state. Projected expansions in insurance coverage by state were taken from the reports *Health Reform Across the States: Increase Insurance Coverage and Federal Spending on the Exchanges and Medicaid*[18] and *A Profile of Health Insurance Exchange Enrollees.*[19] All regression analyses were conducted using STATA (version 12).

Number of Primary Care Physicians

The 2010 supply of primary care, internal medicine, family practice, general practice, and pediatric physicians were obtained from the Agency for Healthcare Research and Quality (AHRQ) publication, *The Number of Practicing Primary Care Physicians in the United States.*[20] The supply of active primary care physicians by state were taken from the Association of American Medical Colleges (AAMC) publication, *2011 State Physician Workforce Data Book.*[21] We calculated the number of active primary care physicians in each state as a proportion of the nation's total supply of active primary care physicians. State-level estimates of physician supply were computed for each primary care category by taking each state's calculated proportion and multiplying this by the nation's total supply of physicians reported by AHRQ. Our supply estimates for primary care providers include physician assistants and nurse practitioners. The number of physician assistants and nurse practitioners working in primary care was obtained from AHRQ's "The Number of Nurse

Practitioners and Physician Assistants Practicing Primary Care in the United States,"[22] and is included to supplement our primary care visits to clinics and community health centers. Likewise, psychologists were included with physicians in our supply estimates of mental health. Using AAMC's *2012 Physician Specialty Data Book,*[23] the supply of medical and surgical specialty physicians, as well as the supply of physicians specializing in psychiatry and obstetrics/gynecology, was obtained at the national level and state level estimates were calculated using similar methods described above. It is important to note that all physician supply estimates indicate the number of all physicians, both full-time and part-time, and do not report the number of full-time-equivalent physicians.

Last, the existing supply for inpatient, outpatient, and emergency room services were calculated using data from the 2010 Area Resource File.[24] Inpatient values reflect the supply of inpatient beds in each state; emergency room and outpatient estimates reflect the number of hospitals with emergency departments or outpatient services in each state.

Number of Visits per Physician

We first took the current number of visits for each service category and divided the number of these visits by the current supply in each state. The same method was repeated using projected additional visits and total visits (current visits + projected additional visits) to obtain state averages of the number of visits per doctor annually.

Wait Times and Physicians per 100,000 People

We compared the average appointment wait times for primary care visits to the ratio of the local supply of primary care physicians per 100,000 people in 2003 and 2012 at the county, city, and state levels. Select wait-time data were obtained from three data sources: the 2003 Community Tracking Study (CTS) Household Survey,[25] the 2013 Merritt Hawkins Physician Appointment Wait Times Study,[26] and a 2012 simulated patient study conducted by Rhodes et al.[27] The 2003 county data from the CTS were supplemented by physician supply data from the Physicians Characteristics and Distribution in the U.S. and population data from the U.S. Census Bureau. The CTS data capture wait-time data for sick visits to primary care physicians by adult insured patients. The 2013 mean wait-time data for primary care conducted at the city level were supplemented with 2011 county physician supply data and population counts from the Area Resource File. The 2012 median wait-time data for primary care conducted at the state level were supplemented with 2012 supply figures of primary care physicians from AAMC's *State Physician Workforce Data Book.* All physician supply ratios were calculated by taking the supply of physicians at the city or county level and dividing by the population per 100,000 people.

Notes

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Table A. Projected Number of Additional Primary Care Services Visits by the Newly Insured, by Insurance Coverage and Type of Doctor/Service

	All Primary Care				Internal Medicine				Family Practice				Pediatrics			
	Newly insured visits			%	Newly insured visits			%	Newly insured visits			%	Newly insured visits			%
State	Medicaid*	Exchange*	Total	Increase from base	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base
Northeast	**1,704,794**	**801,581**	**2,506,375**	**2.59**	**11,378**	**49,984**	**61,362**	**0.43**	**407,066**	**547,920**	**954,986**	**2.03**	**5,660**	**3,288**	**8,947**	**0.04**
CT	123,878	50,458	174,335	2.79	827	3,146	3,973	0.44	29,579	34,490	64,070	2.11	411	207	618	0.05
ME	37,079	20,101	57,180	2.46	247	1,253	1,501	0.44	8,854	13,740	22,594	2.00	123	82	206	0.04
MA	80,900	60,713	141,613	1.24	540	3,786	4,326	0.26	19,317	41,501	60,818	1.09	269	249	518	0.02
NH	42,135	19,486	61,621	2.67	281	1,215	1,496	0.44	10,061	13,319	23,380	2.09	140	80	220	0.04
NJ	347,195	122,452	469,647	3.05	2,317	7,636	9,953	0.44	82,902	83,702	166,604	2.23	1,153	502	1,655	0.05
NY	478,657	290,235	768,891	2.27	3,195	18,098	21,293	0.43	114,292	198,390	312,682	1.90	1,589	1,190	2,780	0.04
PA	546,916	211,266	758,182	3.41	3,650	13,174	16,824	0.52	130,591	144,411	275,002	2.55	1,816	867	2,682	0.06
RI	38,764	17,024	55,789	3.03	259	1,062	1,320	0.49	9,256	11,637	20,893	2.34	129	70	199	0.05
VT	9,270	9,845	19,115	1.75	62	614	676	0.42	2,213	6,730	8,943	1.68	31	40	71	0.03
Midwest	**4,661,820**	**2,190,914**	**6,852,734**	**5.19**	**19,899**	**67,852**	**87,751**	**0.73**	**711,912**	**743,786**	**1,455,699**	**1.97**	**9,898**	**4,463**	**14,361**	**0.09**
IL	868,327	395,232	1,263,558	4.99	3,706	12,240	15,947	0.69	132,603	134,176	266,779	1.88	1,844	805	2,649	0.09
IN	552,092	167,674	719,766	5.62	2,357	5,193	7,549	0.65	84,311	56,923	141,234	1.97	1,172	342	1,514	0.10
IA	135,717	104,074	239,791	3.99	579	3,223	3,802	0.69	20,726	35,332	56,057	1.67	288	212	500	0.07
KS	204,235	102,422	306,656	5.45	872	3,172	4,044	0.79	31,189	34,771	65,960	2.09	434	209	642	0.09
MI	623,245	327,088	950,333	4.87	2,660	10,130	12,790	0.72	95,177	111,042	206,219	1.89	1,323	666	1,990	0.08
MN	209,505	175,934	385,439	3.68	894	5,449	6,343	0.66	31,994	59,727	91,721	1.57	445	358	803	0.06
MO	523,104	218,059	741,163	6.27	2,233	6,753	8,986	0.83	79,884	74,028	153,912	2.33	1,111	444	1,555	0.11
NE	118,588	71,860	190,448	5.28	506	2,225	2,732	0.83	18,110	24,396	42,505	2.11	252	146	398	0.09
ND	39,529	31,387	70,917	5.34	169	972	1,141	0.94	6,037	10,656	16,692	2.25	84	64	148	0.09
OH	943,432	388,624	1,332,056	5.85	4,027	12,036	16,063	0.77	144,073	131,933	276,005	2.17	2,003	792	2,795	0.10
SD	63,247	33,865	97,112	6.04	270	1,049	1,319	0.90	9,659	11,497	21,155	2.35	134	69	203	0.10
WI	380,799	174,695	555,494	4.95	1,625	5,410	7,036	0.69	58,152	59,307	117,459	1.87	809	356	1,164	0.08
South	**4,357,881**	**2,648,348**	**7,006,229**	**3.81**	**43,471**	**105,302**	**148,773**	**0.64**	**1,555,221**	**1,154,306**	**2,709,527**	**2.68**	**21,623**	**6,927**	**28,549**	**0.09**
AL	161,257	88,461	249,717	3.25	1,609	3,517	5,126	0.53	57,549	38,556	96,105	2.28	800	231	1,031	0.08
AR	124,608	69,482	194,089	4.15	1,243	2,763	4,006	0.67	44,469	30,284	74,754	2.91	618	182	800	0.10
DE	15,224	19,622	34,846	2.42	152	780	932	0.51	5,433	8,552	13,985	1.77	76	51	127	0.05
DC	11,841	15,762	27,603	2.86	118	627	745	0.61	4,226	6,870	11,096	2.09	59	41	100	0.06
FL	761,177	487,659	1,248,836	4.14	7,593	19,390	26,983	0.70	271,646	212,550	484,196	2.92	3,777	1,275	5,052	0.09
GA	405,961	202,655	608,616	3.91	4,050	8,058	12,107	0.61	144,878	88,329	233,207	2.73	2,014	530	2,544	0.09
KY	173,097	98,432	271,530	3.90	1,727	3,914	5,640	0.64	61,774	42,903	104,677	2.74	859	257	1,116	0.09
LA	219,896	101,971	321,867	4.42	2,194	4,054	6,248	0.68	78,475	44,445	122,920	3.08	1,091	267	1,358	0.11
MD	123,480	130,278	253,758	2.74	1,232	5,180	6,412	0.55	44,067	56,783	100,850	1.98	613	341	953	0.06
MS	128,554	65,300	193,854	4.07	1,282	2,596	3,879	0.64	45,878	28,462	74,339	2.84	638	171	809	0.10
NC	333,790	205,872	539,662	3.52	3,330	8,186	11,515	0.59	119,122	89,731	208,853	2.49	1,656	538	2,195	0.08
OK	103,746	83,314	187,059	3.11	1,035	3,313	4,348	0.57	37,024	36,313	73,337	2.22	515	218	733	0.07
SC	182,119	99,397	281,516	3.79	1,817	3,952	5,769	0.61	64,994	43,323	108,317	2.66	904	260	1,164	0.09
TN	211,438	137,355	348,793	3.42	2,109	5,461	7,571	0.59	75,457	59,867	135,325	2.42	1,049	359	1,408	0.08
TX	1,155,298	637,238	1,792,536	4.44	11,524	25,337	36,862	0.72	412,298	277,746	690,043	3.11	5,732	1,667	7,399	0.10
VA	175,353	175,634	350,987	2.73	1,749	6,983	8,733	0.54	62,579	76,552	139,131	1.97	870	459	1,329	0.06
WV	71,043	29,916	100,959	3.39	709	1,189	1,898	0.50	25,354	13,039	38,393	2.35	352	78	431	0.08
West	**2,272,203**	**1,643,705**	**3,915,908**	**3.17**	**21,885**	**81,717**	**103,601**	**0.79**	**782,943**	**895,768**	**1,678,711**	**2.56**	**10,885**	**5,375**	**16,261**	**0.08**
AK	24,526	15,694	40,220	3.30	236	780	1,016	0.79	8,451	8,552	17,004	2.63	117	51	169	0.09
AZ	136,648	129,407	266,055	2.45	1,316	6,433	7,750	0.67	47,085	70,523	117,608	2.04	655	423	1,078	0.06
CA	1,253,186	883,726	2,136,912	3.34	12,070	43,934	56,004	0.82	431,816	481,603	913,419	2.69	6,004	2,890	8,894	0.09
CO	140,151	124,005	264,156	3.06	1,350	6,165	7,515	0.82	48,293	67,579	115,871	2.53	671	406	1,077	0.08
HI	31,534	16,465	47,999	2.06	304	819	1,122	0.45	10,866	8,973	19,839	1.60	151	54	205	0.06
ID	54,893	43,736	98,629	3.66	529	2,174	2,703	0.95	18,915	23,835	42,749	2.99	263	143	406	0.10
MT	35,622	28,557	64,179	3.78	343	1,420	1,763	0.98	12,274	15,563	27,837	3.09	171	93	264	0.10
NV	84,675	50,940	135,614	2.92	816	2,532	3,348	0.68	29,177	27,761	56,937	2.31	406	167	572	0.08
NM	107,449	45,537	152,986	4.33	1,035	2,264	3,299	0.88	37,024	24,816	61,841	3.30	515	149	664	0.12
OR	175,773	87,987	263,760	4.01	1,693	4,374	6,067	0.87	60,567	47,950	108,517	3.11	842	288	1,130	0.11
UT	82,923	64,318	147,241	3.10	799	3,198	3,996	0.79	28,573	35,051	63,624	2.53	397	210	608	0.08
WA	129,640	138,412	268,052	2.32	1,249	6,881	8,130	0.66	44,671	75,430	120,101	1.96	621	453	1,074	0.06
WY	15,183	14,922	30,105	3.11	146	742	888	0.86	5,232	8,132	13,364	2.60	73	49	122	0.08
Total	**12,996,697**	**7,284,548**	**20,281,245**	**3.78**	**96,633**	**304,854**	**401,487**	**0.64**	**3,457,142**	**3,341,781**	**6,798,923**	**2.37**	**48,066**	**20,053**	**68,118**	**0.08**

Notes: The Medicaid and Exchange columns show the projected number of additional visits by the population expected to gain insurance coverage under the Affordable Care Act. The Total column calculates the number of projected visits as a percentage of the baseline number of visits made by the entire population in 2010.

* Regression analyses carried out at the regional level, not national.

Source: 2006–2010 Medical Expenditure Panel Survey (MEPS); PricewaterhouseCoopers, "Medicaid Expansion: New Patients, New Challenges" and "Health Insurance Exchanges: Long on Options, Short on Time."

Table B. Projected Number of Additional Specialty Services Visits by the Newly Insured, by Insurance Coverage and Type of Doctor/Service

	Obstetrics and Gynecology				Psychiatry				Medical Specialties				Surgical Specialties			
	Newly insured visits			%	Newly insured visits			%	Newly insured visits			%	Newly insured visits			%
State	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base
Northeast	**90,725**	**117,649**	**208,374**	**1.58**	**16,405**	**7,147**	**23,552**	**0.12**	**129,459**	**212,988**	**342,447**	**0.86**	**118,309**	**160,800**	**279,109**	**0.79**
CT	6,592	7,406	13,998	1.64	1,192	450	1,642	0.13	9,407	13,407	22,814	0.88	8,597	10,122	18,719	0.82
ME	1,973	2,950	4,924	1.55	357	179	536	0.11	2,816	5,341	8,157	0.85	2,573	4,032	6,606	0.78
MA	4,305	8,911	13,216	0.85	779	541	1,320	0.06	6,143	16,132	22,276	0.47	5,614	12,179	17,794	0.43
NH	2,242	2,860	5,102	1.63	405	174	579	0.12	3,200	5,178	8,377	0.88	2,924	3,909	6,833	0.82
NJ	18,477	17,973	36,449	1.74	3,341	1,092	4,433	0.14	26,365	32,537	58,902	0.93	24,095	24,564	48,659	0.87
NY	25,473	42,598	68,071	1.47	4,606	2,588	7,194	0.10	36,348	77,118	113,467	0.81	33,218	58,222	91,440	0.74
PA	29,106	31,008	60,113	1.99	5,263	1,884	7,147	0.16	41,532	56,136	97,667	1.07	37,955	42,381	80,335	1.00
RI	2,063	2,499	4,562	1.82	373	152	525	0.14	2,944	4,524	7,467	0.98	2,690	3,415	6,105	0.91
VT	493	1,445	1,938	1.30	89	88	177	0.08	704	2,616	3,320	0.74	643	1,975	2,618	0.66
Midwest	**158,668**	**159,706**	**318,373**	**2.28**	**28,691**	**9,702**	**38,393**	**0.22**	**226,409**	**289,125**	**515,534**	**1.39**	**206,909**	**218,281**	**425,190**	**1.21**
IL	29,554	28,810	58,364	2.18	5,344	1,750	7,094	0.21	42,172	52,157	94,329	1.33	38,540	39,377	77,917	1.16
IN	18,791	12,223	31,013	2.29	3,398	743	4,140	0.24	26,813	22,127	48,941	1.37	24,504	16,705	41,209	1.21
IA	4,619	7,586	12,206	1.92	835	461	1,296	0.16	6,591	13,734	20,325	1.21	6,024	10,369	16,393	1.02
KS	6,951	7,466	14,417	2.42	1,257	454	1,711	0.23	9,919	13,516	23,435	1.49	9,065	10,204	19,269	1.29
MI	21,212	23,843	45,055	2.18	3,836	1,448	5,284	0.20	30,269	43,164	73,433	1.35	27,662	32,588	60,250	1.16
MN	7,131	12,825	19,955	1.80	1,289	779	2,068	0.15	10,175	23,217	33,392	1.14	9,299	17,528	26,827	0.96
MO	17,804	15,895	33,699	2.69	3,219	966	4,185	0.27	25,405	28,776	54,182	1.64	23,217	21,725	44,943	1.43
NE	4,036	5,238	9,274	2.43	730	318	1,048	0.22	5,759	9,483	15,243	1.51	5,263	7,159	12,423	1.29
ND	1,345	2,288	3,633	2.58	243	139	382	0.22	1,920	4,142	6,062	1.63	1,754	3,127	4,882	1.38
OH	32,110	28,329	60,439	2.51	5,806	1,721	7,527	0.25	45,819	51,285	97,104	1.52	41,873	38,719	80,592	1.33
SD	2,153	2,469	4,621	2.72	389	150	539	0.25	3,072	4,469	7,541	1.68	2,807	3,374	6,181	1.45
WI	12,961	12,734	25,695	2.16	2,344	774	3,117	0.21	18,494	23,054	41,548	1.32	16,901	17,405	34,306	1.15
South	**346,620**	**247,853**	**594,473**	**2.60**	**62,678**	**15,057**	**77,734**	**0.41**	**494,607**	**448,703**	**943,309**	**1.26**	**452,007**	**338,758**	**790,764**	**1.43**
AL	12,826	8,279	21,105	2.21	2,319	503	2,822	0.36	18,302	14,988	33,290	1.07	16,726	11,315	28,041	1.21
AR	9,911	6,503	16,414	2.82	1,792	395	2,187	0.45	14,143	11,772	25,915	1.36	12,924	8,888	21,812	1.55
DE	1,211	1,836	3,047	1.70	219	112	331	0.22	1,728	3,325	5,052	0.86	1,579	2,510	4,089	0.94
DC	942	1,475	2,417	2.01	170	90	260	0.26	1,344	2,671	4,014	1.02	1,228	2,016	3,244	1.12
FL	60,543	45,639	106,182	2.83	10,948	2,773	13,720	0.44	86,391	82,623	169,014	1.38	78,951	62,378	141,328	1.56
GA	32,290	18,966	51,256	2.65	5,839	1,152	6,991	0.44	46,075	34,335	80,411	1.27	42,107	25,922	68,029	1.45
KY	13,768	9,212	22,980	2.65	2,490	560	3,049	0.42	19,646	16,677	36,323	1.28	17,954	12,591	30,545	1.46
LA	17,490	9,543	27,033	2.99	3,163	580	3,742	0.50	24,958	17,277	42,234	1.43	22,808	13,043	35,851	1.64
MD	9,821	12,192	22,014	1.91	1,776	741	2,517	0.26	14,015	22,073	36,087	0.96	12,808	16,664	29,472	1.06
MS	10,225	6,111	16,336	2.76	1,849	371	2,220	0.45	14,591	11,064	25,654	1.33	13,334	8,353	21,687	1.51
NC	26,549	19,267	45,816	2.41	4,801	1,170	5,971	0.38	37,884	34,880	72,765	1.17	34,621	26,334	60,955	1.32
OK	8,252	7,797	16,049	2.14	1,492	474	1,966	0.32	11,775	14,116	25,890	1.06	10,761	10,657	21,418	1.18
SC	14,485	9,302	23,788	2.58	2,619	565	3,184	0.42	20,670	16,841	37,511	1.24	18,890	12,714	31,604	1.41
TN	16,818	12,855	29,672	2.34	3,041	781	3,822	0.36	23,998	23,272	47,269	1.14	21,931	17,569	39,500	1.29
TX	91,891	59,638	151,528	3.02	16,616	3,623	20,239	0.49	131,123	107,965	239,088	1.46	119,829	81,511	201,340	1.66
VA	13,947	16,437	30,385	1.90	2,522	999	3,521	0.27	19,902	29,757	49,659	0.95	18,188	22,466	40,654	1.05
WV	5,651	2,800	8,450	2.28	1,022	170	1,192	0.39	8,063	5,069	13,132	1.09	7,369	3,827	11,195	1.25
West	**174,499**	**192,339**	**366,838**	**2.79**	**31,554**	**11,684**	**43,238**	**0.25**	**248,999**	**348,204**	**597,203**	**1.53**	**227,553**	**262,884**	**490,437**	**1.45**
AK	1,884	1,836	3,720	2.87	341	112	452	0.27	2,688	3,325	6,012	1.56	2,456	2,510	4,966	1.48
AZ	10,494	15,143	25,637	2.22	1,898	920	2,818	0.19	14,975	27,414	42,388	1.23	13,685	20,697	34,381	1.15
CA	96,241	103,410	199,651	2.93	17,403	6,282	23,685	0.27	137,330	187,209	324,539	1.61	125,502	141,338	266,840	1.52
CO	10,763	14,510	25,274	2.75	1,946	882	2,828	0.24	15,358	26,269	41,628	1.53	14,036	19,833	33,868	1.43
HI	2,422	1,927	4,348	1.75	438	117	555	0.17	3,456	3,488	6,944	0.94	3,158	2,633	5,791	0.90
ID	4,216	5,118	9,333	3.26	762	311	1,073	0.29	6,015	9,265	15,280	1.80	5,497	6,995	12,492	1.69
MT	2,736	3,342	6,077	3.36	495	203	698	0.30	3,904	6,050	9,953	1.85	3,567	4,567	8,135	1.74
NV	6,503	5,961	12,464	2.53	1,176	362	1,538	0.24	9,279	10,791	20,070	1.37	8,480	8,147	16,627	1.31
NM	8,252	5,329	13,580	3.61	1,492	324	1,816	0.37	11,775	9,647	21,421	1.92	10,761	7,283	18,044	1.86
OR	13,499	10,296	23,795	3.40	2,441	625	3,066	0.34	19,262	18,639	37,901	1.82	17,603	14,072	31,675	1.75
UT	6,368	7,526	13,894	2.75	1,152	457	1,609	0.25	9,087	13,625	22,712	1.52	8,304	10,287	18,591	1.43
WA	9,956	16,196	26,152	2.13	1,800	984	2,784	0.17	14,207	29,321	43,528	1.19	12,983	22,137	35,120	1.11
WY	1,166	1,746	2,912	2.83	211	106	317	0.24	1,664	3,161	4,825	1.58	1,521	2,386	3,907	1.47
Total	**770,511**	**717,547**	**1,488,058**	**2.36**	**139,328**	**43,590**	**182,918**	**0.25**	**1,099,474**	**1,299,019**	**2,398,493**	**1.26**	**1,004,778**	**980,723**	**1,985,501**	**1.24**

Notes: The Medicaid and Exchange columns show the projected number of additional visits by the population expected to gain insurance coverage under the Affordable Care Act. The Total column calculates the number of projected visits as a percentage of the baseline number of visits made by the entire population in 2010. Medical specialties = allergy and immunology, anesthesiology, cardiology, dermatology, endocrinology, diabetes and metabolism, gastroenterology, hematology and oncology, nephrology, neurology, physical medicine and rehabilitation, pulmonary, radiology, and rheumatology. Surgical specialties = general surgery, ophthalmology, orthopedics, otolaryngology, plastic surgery, thoracic surgery, and urology.
Source: 2006–2010 Medical Expenditure Panel Survey (MEPS); PricewaterhouseCoopers, "Medicaid Expansion: New Patients, New Challenges" and "Health Insurance Exchanges: Long on Options, Short on Time."

Table C. Projected Number of Additional Visits for Other Health Services by the Newly Insured, by Insurance Coverage and Type of Doctor/Service

	Emergency Room				Outpatient Visits				Inpatient Stays				Prescription Drug Use			
	Newly insured visits			%	Newly insured visits			%	Newly insured visits			%	Newly insured drug use/refills			%
State	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base	Medicaid	Exchange	Total	Increase from base
Northeast	**89,147**	**61,340**	**150,487**	**1.50**	**262,008**	**151,799**	**413,807**	**1.43**	**76,390**	**72,452**	**148,842**	**2.00**	**4,043,659**	**2,949,871**	**6,993,530**	**1.21**
CT	6,478	3,861	10,339	1.59	19,039	9,555	28,594	1.53	5,551	4,561	10,112	2.10	293,830	185,688	479,518	1.28
ME	1,939	1,538	3,477	1.44	5,699	3,807	9,505	1.37	1,661	1,817	3,478	1.94	87,949	73,973	161,922	1.16
MA	4,230	4,646	8,876	0.75	12,433	11,498	23,931	0.70	3,625	5,488	9,113	1.03	191,889	223,429	415,318	0.60
NH	2,203	1,491	3,694	1.54	6,476	3,690	10,166	1.47	1,888	1,761	3,649	2.06	99,942	71,709	171,651	1.24
NJ	18,155	9,371	27,526	1.72	53,360	23,189	76,549	1.66	15,557	11,068	26,626	2.25	823,523	450,633	1,274,156	1.38
NY	25,030	22,210	47,240	1.34	73,564	54,963	128,527	1.27	21,448	26,233	47,682	1.83	1,135,343	1,068,083	2,203,426	1.08
PA	28,599	16,167	44,766	1.94	84,055	40,008	124,064	1.86	24,507	19,096	43,602	2.55	1,297,249	777,474	2,074,723	1.56
RI	2,027	1,303	3,330	1.74	5,958	3,224	9,182	1.66	1,737	1,539	3,276	2.31	91,947	62,651	154,598	1.40
VT	485	753	1,238	1.09	1,425	1,864	3,289	1.00	415	890	1,305	1.55	21,987	36,232	58,219	0.89
Midwest	**155,908**	**83,268**	**239,175**	**1.93**	**458,223**	**206,063**	**664,286**	**1.86**	**133,597**	**98,352**	**231,950**	**2.91**	**7,071,907**	**4,004,367**	**11,076,273**	**1.37**
IL	18,464	6,373	24,837	2.07	54,267	15,770	70,037	2.02	15,822	7,527	23,349	3.02	837,515	306,460	1,143,976	1.46
IN	29,040	15,021	44,061	1.86	85,350	37,173	122,523	1.78	24,884	17,742	42,627	2.79	1,317,238	722,371	2,039,609	1.32
IA	4,539	3,955	8,494	1.51	13,340	9,788	23,128	1.42	3,889	4,672	8,561	2.36	205,881	190,217	396,098	1.08
KS	6,830	3,893	10,723	2.03	20,075	9,633	29,708	1.95	5,853	4,598	10,451	3.07	309,821	187,198	497,018	1.44
MI	20,844	12,431	33,275	1.82	61,261	30,764	92,024	1.74	17,861	14,683	32,544	2.76	945,453	597,824	1,543,277	1.29
MN	7,007	6,687	13,693	1.40	20,593	16,547	37,140	1.31	6,004	7,898	13,902	2.20	317,816	321,557	639,373	1.00
MO	17,494	8,288	25,782	2.33	51,417	20,509	71,927	2.24	14,991	9,789	24,780	3.47	793,541	398,550	1,192,090	1.65
NE	3,966	2,731	6,697	1.99	11,656	6,759	18,415	1.88	3,398	3,226	6,624	3.04	179,896	131,340	311,236	1.41
ND	1,322	1,193	2,515	2.02	3,885	2,952	6,838	1.90	1,133	1,409	2,542	3.17	59,965	57,367	117,332	1.45
OH	31,552	14,770	46,322	2.17	92,733	36,551	129,284	2.09	27,037	17,446	44,482	3.24	1,431,172	710,294	2,141,465	1.54
SD	2,115	1,287	3,402	2.26	6,217	3,185	9,402	2.16	1,813	1,520	3,333	3.44	95,944	61,896	157,840	1.61
WI	12,735	6,639	19,375	1.84	37,430	16,431	53,860	1.77	10,913	7,842	18,755	2.77	577,666	319,293	896,958	1.31
South	**340,592**	**129,226**	**469,817**	**2.44**	**1,001,020**	**319,795**	**1,320,815**	**3.52**	**291,852**	**152,636**	**444,488**	**3.38**	**15,449,058**	**6,214,505**	**21,663,563**	**1.71**
AL	12,603	4,316	16,919	2.11	37,041	10,682	47,723	3.05	10,800	5,098	15,898	2.90	571,669	207,578	779,247	1.47
AR	9,739	3,390	13,129	2.68	28,623	8,390	37,013	3.88	8,345	4,005	12,350	3.69	441,744	163,043	604,787	1.87
DE	1,190	957	2,147	1.42	3,497	2,369	5,866	2.00	1,020	1,131	2,150	2.09	53,969	46,045	100,013	1.01
DC	925	769	1,695	1.68	2,720	1,903	4,623	2.35	793	908	1,701	2.46	41,976	36,987	78,962	1.19
FL	59,490	23,795	83,285	2.64	174,845	58,886	233,731	3.80	50,977	28,106	79,083	3.66	2,698,438	1,144,320	3,842,758	1.85
GA	31,728	9,889	41,617	2.56	93,251	24,471	117,722	3.71	27,188	11,680	38,868	3.50	1,439,167	475,542	1,914,709	1.79
KY	13,528	4,803	18,331	2.51	39,761	11,886	51,647	3.64	11,593	5,673	17,266	3.47	613,645	230,978	844,622	1.76
LA	17,186	4,976	22,162	2.91	50,511	12,313	62,824	4.23	14,727	5,877	20,604	3.96	779,549	239,281	1,018,829	2.03
MD	9,651	6,357	16,008	1.65	28,364	15,731	44,095	2.33	8,270	7,509	15,778	2.38	437,747	305,706	743,452	1.16
MS	10,047	3,186	13,234	2.65	29,529	7,885	37,415	3.85	8,609	3,764	12,373	3.63	455,736	153,230	608,966	1.85
NC	26,087	10,045	36,133	2.26	76,673	24,860	101,532	3.25	22,354	11,865	34,220	3.13	1,183,315	483,090	1,666,405	1.58
OK	8,108	4,065	12,174	1.93	23,831	10,060	33,891	2.76	6,948	4,802	11,750	2.73	367,787	195,501	563,288	1.36
SC	14,234	4,850	19,084	2.46	41,833	12,003	53,836	3.56	12,197	5,729	17,925	3.38	645,626	233,242	878,868	1.72
TN	16,525	6,702	23,227	2.18	48,568	16,586	65,154	3.14	14,160	7,916	22,077	3.03	749,566	322,312	1,071,878	1.53
TX	90,293	31,094	121,387	2.87	265,376	76,948	342,324	4.16	77,372	36,727	114,098	3.95	4,095,629	1,495,316	5,590,945	2.01
VA	13,705	8,570	22,275	1.66	40,279	21,208	61,487	2.35	11,744	10,123	21,866	2.38	621,640	412,137	1,033,777	1.17
WV	5,552	1,460	7,012	2.25	16,319	3,612	19,931	3.29	4,758	1,724	6,482	3.05	251,854	70,199	322,053	1.57
West	**171,464**	**100,282**	**271,746**	**2.79**	**503,942**	**248,169**	**752,111**	**3.65**	**146,927**	**118,449**	**265,376**	**4.08**	**7,777,498**	**4,822,601**	**12,600,099**	**2.10**
AK	1,851	957	2,808	2.92	5,440	2,369	7,809	3.84	1,586	1,131	2,717	4.23	83,951	46,045	129,996	2.19
AZ	10,312	7,895	18,207	2.13	30,306	19,538	49,845	2.75	8,836	9,325	18,161	3.17	467,729	379,679	847,408	1.60
CA	94,567	53,916	148,483	2.94	277,939	133,426	411,365	3.85	81,034	63,683	144,718	4.30	4,289,517	2,592,837	6,882,354	2.21
CO	10,576	7,565	18,142	2.67	31,084	18,722	49,806	3.46	9,063	8,936	17,999	3.96	479,722	363,827	843,550	2.01
HI	2,380	1,005	3,384	1.84	6,994	2,486	9,480	2.43	2,039	1,187	3,226	2.62	107,938	48,309	156,247	1.38
ID	4,142	2,668	6,811	3.21	12,174	6,603	18,778	4.18	3,550	3,152	6,701	4.73	187,891	128,321	316,212	2.42
MT	2,688	1,742	4,430	3.31	7,900	4,312	12,212	4.31	2,303	2,058	4,361	4.88	121,929	83,786	205,715	2.49
NV	6,390	3,108	9,497	2.60	18,780	7,691	26,471	3.42	5,475	3,671	9,146	3.75	289,832	149,456	439,288	1.95
NM	8,108	2,778	10,886	3.91	23,831	6,875	30,706	5.20	6,948	3,281	10,229	5.50	367,787	133,605	501,392	2.92
OR	13,264	5,368	18,632	3.59	38,984	13,284	52,268	4.76	11,366	6,341	17,706	5.11	601,652	258,151	859,803	2.69
UT	6,257	3,924	10,181	2.72	18,391	9,711	28,102	3.55	5,362	4,635	9,997	4.00	283,836	188,707	472,543	2.05
WA	9,783	8,444	18,227	2.00	28,752	20,898	49,650	2.58	8,383	9,974	18,357	3.02	443,743	406,098	849,841	1.51
WY	1,146	910	2,056	2.70	3,367	2,253	5,620	3.48	982	1,075	2,057	4.04	51,970	43,780	95,750	2.03
Total	**757,110**	**374,115**	**1,131,225**	**2.20**	**2,225,194**	**925,826**	**3,151,019**	**2.56**	**648,767**	**441,890**	**1,090,656**	**3.11**	**34,342,122**	**17,991,344**	**52,333,466**	**1.61**

Notes: The Medicaid and Exchange columns show the projected number of additional visits by the population expected to gain insurance coverage under the Affordable Care Act. The Total column calculates the number of projected visits as a percentage of the baseline number of visits made by the entire population in 2010.
Source: 2006–2010 Medical Expenditure Panel Survey (MEPS); PricewaterhouseCoopers, "Medicaid Expansion: New Patients, New Challenges" and "Health Insurance Exchanges: Long on Options, Short on Time."

Table D. Average Additional Weekly Visits per Doctor by the Newly Insured

State	All primary care	Internal medicine	Family practice	Pediatrics	Ob/Gyn	Psychiatry	Medical	Surgical	Emergency room	Outpatient	Inpatient
Northeast	**0.76**	**0.08**	**0.95**	**0.02**	0.49	0.02	**0.18**	0.28	**5.88**	**4.23**	**0.02**
Connecticut	0.86	0.08	1.04	0.02	0.49	0.02	0.18	0.28	7.95	5.24	0.03
Maine	0.64	0.07	0.83	0.02	0.53	0.02	0.20	0.31	1.91	1.44	0.02
Massachusetts	0.30	0.04	0.42	0.01	0.23	0.01	0.09	0.13	3.22	2.28	0.01
New Hampshire	0.79	0.08	0.98	0.02	0.54	0.02	0.20	0.31	2.96	2.17	0.03
New Jersey	0.99	0.09	1.15	0.02	0.57	0.02	0.21	0.33	9.13	6.66	0.02
New York	0.65	0.07	0.86	0.02	0.43	0.01	0.17	0.25	6.40	4.37	0.02
Pennsylvania	1.10	0.10	1.31	0.03	0.67	0.02	0.25	0.39	6.47	4.92	0.02
Rhode Island	0.86	0.08	1.06	0.02	0.57	0.02	0.22	0.33	6.40	4.20	0.03
Vermont	0.46	0.07	0.70	0.01	0.44	0.01	0.17	0.26	1.98	1.44	0.02
Midwest	**2.06**	**0.11**	**1.43**	**0.03**	**0.81**	**0.03**	**0.30**	**0.47**	**3.92**	**3.25**	**0.02**
Illinois	1.89	0.10	1.30	0.03	0.78	0.03	0.29	0.45	5.50	4.28	0.02
Indiana	2.65	0.11	1.69	0.04	0.85	0.03	0.31	0.49	5.37	4.26	0.03
Iowa	1.75	0.11	1.33	0.02	0.86	0.03	0.33	0.50	1.37	1.16	0.02
Kansas	2.37	0.13	1.66	0.03	1.01	0.04	0.38	0.58	1.68	1.71	0.02
Michigan	1.82	0.10	1.29	0.02	0.73	0.03	0.27	0.42	5.20	3.85	0.03
Minnesota	1.29	0.09	1.01	0.02	0.60	0.02	0.23	0.35	2.80	2.38	0.02
Missouri	2.71	0.13	1.84	0.04	0.94	0.03	0.35	0.54	4.39	3.57	0.03
Nebraska	2.29	0.13	1.67	0.03	1.00	0.03	0.38	0.58	2.86	2.64	0.02
North Dakota	2.11	0.14	1.62	0.03	0.94	0.03	0.36	0.55	2.10	1.96	0.01
Ohio	2.33	0.11	1.57	0.03	0.85	0.03	0.31	0.49	6.85	5.25	0.03
South Dakota	2.49	0.14	1.77	0.03	1.04	0.04	0.39	0.60	1.56	1.67	0.01
Wisconsin	1.89	0.10	1.31	0.03	0.73	0.03	0.27	0.42	3.13	2.48	0.03
South	**1.38**	**0.12**	**1.75**	**0.04**	**0.89**	**0.03**	**0.33**	**0.51**	**6.01**	**5.67**	**0.03**
Alabama	1.35	0.11	1.69	0.04	0.88	0.03	0.32	0.50	3.62	3.61	0.02
Arkansas	1.61	0.14	2.02	0.04	1.26	0.05	0.46	0.72	3.77	3.77	0.03
Delaware	0.75	0.08	0.99	0.02	0.51	0.02	0.20	0.30	6.88	4.90	0.02
Dist. of Columbia	0.33	0.04	0.44	0.01	0.23	0.01	0.09	0.13	5.43	4.04	0.01
Florida	1.43	0.13	1.81	0.04	0.84	0.03	0.31	0.48	12.92	10.70	0.03
Georgia	1.53	0.12	1.91	0.04	1.01	0.04	0.37	0.58	7.48	6.70	0.03
Kentucky	1.48	0.13	1.86	0.04	0.96	0.04	0.35	0.55	4.35	3.93	0.02
Louisiana	1.68	0.13	2.09	0.05	1.00	0.04	0.36	0.58	6.00	5.81	0.03
Maryland	0.69	0.07	0.90	0.02	0.49	0.02	0.18	0.28	7.00	5.08	0.02
Mississippi	1.90	0.16	2.38	0.05	1.19	0.05	0.43	0.69	2.96	4.55	0.02
North Carolina	1.26	0.11	1.60	0.03	0.85	0.03	0.31	0.49	7.09	5.61	0.03
Oklahoma	1.22	0.12	1.57	0.03	0.87	0.03	0.32	0.50	2.52	2.61	0.02
South Carolina	1.46	0.12	1.83	0.04	0.92	0.04	0.33	0.53	6.55	5.78	0.03
Tennessee	1.18	0.10	1.49	0.03	0.78	0.03	0.29	0.45	5.88	5.62	0.02
Texas	1.87	0.16	2.35	0.05	1.17	0.05	0.43	0.67	6.24	6.44	0.04
Virginia	0.89	0.09	1.15	0.02	0.61	0.02	0.23	0.35	5.79	4.48	0.02
West Virginia	1.05	0.08	1.30	0.03	0.85	0.04	0.30	0.49	2.64	2.43	0.02
West	**1.12**	**0.12**	**1.57**	**0.03**	**0.84**	**0.03**	**0.32**	**0.49**	**8.26**	**7.26**	**0.04**
Alaska	1.03	0.11	1.42	0.03	0.90	0.03	0.33	0.52	6.00	5.36	0.03
Arizona	0.95	0.11	1.37	0.03	0.69	0.02	0.26	0.40	7.61	6.70	0.03
California	1.16	0.12	1.63	0.03	0.88	0.03	0.33	0.51	13.04	11.00	0.04
Colorado	1.04	0.12	1.48	0.03	0.75	0.03	0.29	0.44	5.63	5.07	0.04
Hawaii	0.58	0.06	0.78	0.02	0.47	0.02	0.17	0.27	5.01	5.36	0.02
Idaho	1.73	0.19	2.45	0.05	1.18	0.04	0.44	0.68	4.68	4.10	0.04
Montana	1.42	0.16	2.01	0.04	0.99	0.03	0.37	0.57	2.08	2.04	0.02
Nevada	1.32	0.13	1.81	0.04	0.91	0.03	0.34	0.52	10.15	8.93	0.03
New Mexico	1.50	0.13	1.99	0.04	1.33	0.05	0.48	0.77	7.75	6.79	0.05
Oregon	1.22	0.11	1.64	0.03	0.94	0.04	0.34	0.54	6.07	5.21	0.05
Utah	1.48	0.16	2.09	0.04	0.97	0.03	0.36	0.56	7.53	6.67	0.04
Washington	0.75	0.09	1.09	0.02	0.62	0.02	0.24	0.36	5.65	4.63	0.03
Wyoming	1.31	0.16	1.90	0.03	1.09	0.03	0.41	0.63	1.72	2.04	0.02
U.S. average	**1.34**	**0.11**	**1.46**	**0.03**	**0.77**	**0.03**	**0.29**	**0.45**	**5.72**	**4.93**	**0.03**

Source: 2006–2010 Medical Expenditure Panel Survey (MEPS); PricewaterhouseCoopers, "Medicaid Expansion: New Patients, New Challenges" and "Health Insurance Exchanges: Long on Options, Short on Time."

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ACA Implementation—Monitoring and Tracking

Insurance Brokers and the ACA: Early Barriers and Options for Expanding Their Role

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Sabrina Corlette, Linda J. Blumberg and Erik Wengle

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HEALTH POLICY CENTER

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in case study states. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

In-person assistance from navigators and other professionals has significantly facilitated individual and family enrollment into the health insurance marketplaces developed under the Affordable Care Act (ACA).[1] However, though enrollment in state and federally facilitated marketplaces was at 6.7 million by late 2014 and has exceeded 9.5 million thus far for 2015,[2] millions eligible for financial assistance through the marketplaces remain uninsured. As federal and state funding for navigators and other publicly funded assisters decreases in the coming years,[3] private insurance brokers and agents (hereafter referred to collectively as brokers) could play an increasingly important role in expanding coverage to the hard-to-reach uninsured and in ensuring that those already enrolled maintain coverage in the future.[4]

The ACA's drafters envisioned a continuing, significant role for brokers in the reformed nongroup insurance markets, but circumstances limited their active participation in the first year of marketplace enrollment. This analysis delineates the early barriers to brokers' full engagement with the marketplaces, highlights the main concerns with their having a more prominent role and offers options for making them more effective in enrolling the uninsured.

The information presented in this brief is based upon interviews conducted with stakeholders (e.g., providers, insurers, consumer advocates, navigators, assisters and brokers) in 21 states and the District of Columbia during the first half of 2014: California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont and Washington (states using state-based Marketplaces [SBMs]), as well as Arkansas, Delaware, Illinois, New Hampshire and West Virginia (states operating in partnership with the federally facilitated marketplace).

BARRIERS TO BROKER ENGAGEMENT IN THE HEALTH INSURANCE MARKETPLACES

An Evolving Partnership between Marketplaces and Brokers

Most broker respondents reported that the marketplaces did little to engage them or to adopt brokers as part of their marketing and enrollment strategy. The broker community was treated as "an afterthought," a broker in Washington reported, echoing a common theme, and brokers in Minnesota and New Hampshire sensed that state officials preferred to work with navigators for their outreach and enrollment efforts. Brokers in other states took umbrage at what they saw as the marketplaces' use of negative language to characterize brokers; a broker in Vermont

asserted that the SBM's ultimate goal was to "eliminate the role of brokers."

Despite inauspicious beginnings in many states, as the 2014 open enrollment period progressed and efforts to enroll people intensified, several marketplaces came to recognize the important role brokers were playing. For example, one broker in Vermont reported that the state formed a broker advisory group "late in the game" after "they realized they needed us." Other SBMs had no choice but to turn to the broker community after problems with information technology (IT) systems rendered online, unassisted enrollment too difficult. Brokers in Nevada, for example, reported that the marketplace initially rolled out without involving their community. But "now that things aren't going well," they said, "the Exchange is advising people to go to brokers." Oregon also came to rely heavily on brokers for enrollment because of a nonfunctioning IT system.

Brokers gave several marketplaces accolades for recognizing that brokers could spread the word about marketplace coverage and help people select a plan. Brokers in California, Connecticut, the District of Columbia, Illinois, New York and Rhode Island reported that the marketplaces made a concerted effort to communicate and work with them over the open enrollment period. In California, the marketplace found that brokers were driving a significant percentage of their non-Medicaid enrollment and became more proactive in their outreach to the broker community. "Fortunately, our partnership has solidified," one California broker reported, "and Covered California is now seeing the fruits of that [in robust enrollment numbers]." Ultimately, 39 percent of California's nongroup enrollment into 2014 marketplace plans was broker-assisted.[5] Brokers in Rhode Island and the District of Columbia applauded the marketplaces' efforts to partner with them: of the Rhode Island official responsible for liaising with brokers, they reported that "she has gone above and beyond" in supporting them. Idaho's marketplace received positive feedback for making it easy for consumers to find available brokers in their area. And brokers applauded marketplace directors in the District of Columbia and California for setting a positive tone and ensuring strong engagement of the broker community.

Barriers to Broker Participation in the Marketplaces: Information Technology, Customer Support and Compensation

Information Technology

Brokers almost universally panned marketplaces' IT systems. In the same way millions of consumers encountered frustrating glitches with IT systems in many marketplaces, brokers also found the eligibility and enrollment technologies clunky, time consuming, and in some cases impossible to use. In Nevada, for example, brokers had to print out marketplace applications and plan selections and then manually enter them into the insurers' systems to complete an enrollment. Because brokers are compensated by insurers per enrollee, their profit margins depend on their ability to enroll clients quickly. Yet it took considerably more time to use the marketplace IT systems, even when they functioned properly, than direct enrollment with the insurer. Consequently, many brokers were reluctant to work with subsidy-eligible applicants. One broker said of SBM states: "[Enrollment via the marketplaces] is just very commonly known as a very labor intensive thing—it is not nearly as seamless and simple…as non-[marketplace] plans." At the same time, brokers in Connecticut, though acknowledging the marketplace application was time-intensive, pointed out that it is less burdensome for consumers than insurers' pre-ACA applications, which required applicants to complete detailed health questionnaires. The marketplace requirement that assisters, including brokers, provide enrollment assistance solely through face-to-face transactions has also been a sore point for brokers: they feel it inconveniences their clients and significantly adds to the amount of time they are required to spend on each client.

Despite early problems, brokers in some states reported dramatic improvements over the course of the open enrollment period. For example, California brokers reported the time to process an application shrank from "up to eight hours" in the first three months to 15 minutes in the latter half of the open enrollment period. Brokers reported, however, that as the marketplaces implemented improvements they often communicated poorly about system changes affecting the eligibility and enrollment processes and work-arounds brokers had become accustomed to using. Brokers reported they would arrive at work and find that the marketplace had deployed new, midstream system changes without any advance notice or training.

Customer Support

Broker respondents in our study states also panned the marketplace call centers. "The call center has been horrendous," summarizes the common view. A "useless interaction," was how another broker characterized his effort to get help through the call center. Brokers reported wait times of 2–3 hours (particularly early in the open enrollment period) and found that call center workers generally lacked training and expertise. Several call centers did not have a dedicated broker call-in line, so brokers were relegated to the general consumer line. As one broker said, "We

are calling people who have less knowledge than we do." Others reported receiving different answers to the same question from different call center workers. In states that do offer a dedicated broker call-in line, such as Kentucky, brokers reported quicker responses but were still frustrated with the lack of expertise. Other states have created dedicated email addresses for brokers, but brokers reported slow response times. In Oregon, brokers reported receiving responses to their emailed questions only 20 percent of the time. Brokers in some states, such as Washington and Vermont, learned that there were some reliable staff within the SBMs they could turn to; brokers praised the assistance those staff are able to provide.

Compensation

Brokers in almost every state studied viewed the compensation structure as a barrier to assisting consumers with marketplace enrollment. For some, the primary concern was that they were not sufficiently paid for the amount of time it took to help someone through the enrollment process (although the length of time per client did decline as the open enrollment period progressed). "Brokers do double to triple the amount of work for less compensation than [they receive] outside the marketplace," reported one broker from West Virginia. For others, a major problem was that states do not compensate them for processing Medicaid enrollments. This means brokers often have to choose between turning away low-income people who might be Medicaid-eligible and providing assistance that will ultimately be unpaid. "Brokers might help with short, easy applications, but often direct [likely] Medicaid applicants to enrollment fairs or other assisters," a broker in Connecticut reported.

Brokers also noted that because of problems with the enrollment systems, they are often not credited for assisting a consumer with his or her health plan purchase. In most SBMs, when consumers start an application, they indicate whether a broker is assisting them and provide that broker's national identification number. In some cases, the marketplace had problems distinguishing between individual brokers and the agencies for which they work. Brokers in Nevada, for example, had trouble figuring out which broker within their agency should have received the commission because only the agency could be listed as the broker of record. Attribution problems were also reported in Colorado. In New York's open enrollment, consumers who started an application without a broker but sought their assistance later were unable to add the broker's identification number to their application.

Another problem brokers identified was the long lag time between when they assisted a client and when they received payment. Although interviewed several months after the start of open enrollment, brokers in Vermont reported that they had yet to receive any compensation for any marketplace enrollment assistance. "I haven't received a commission yet, and might not for a few more months," said one broker. Similarly, Illinois brokers reported that the traditional lag time between assisting a client and getting paid was two months; for one broker waiting on compensation for marketplace plan, however, "it's going on five months."

Despite these problems, some brokers were able to build a successful business model around nongroup marketplace enrollments. "Brokers need to learn how to turn [marketplace] enrollment into a volume game," said one broker from Kentucky. He reported generating significant revenue for his agency by targeting small businesses and enrolling their employees in individual marketplace qualified health plans. Brokers in Kentucky drove 44 percent of the marketplace's enrollment in 2014 nongroup plans.[6]

CONCERNS OVER GREATER BROKER INVOLVEMENT

Though insurance brokers are plentiful throughout the country and do not require public funds for enrolling individuals in nongroup coverage, there are at least two central concerns about using them to expand marketplace enrollment. First, brokers' financial incentives may not always be aligned with their clients' best interests. Second, many brokers lack experience working with low-income individuals and families, a group targeted under the ACA for marketplace enrollment and expanded coverage.

Potential Conflict of Interest

The health insurance marketplaces do not directly compensate brokers; they are compensated by the insurance companies that sell health plans through the marketplaces. Some companies pay brokers a flat amount per enrollee and some pay them a percentage of premiums for the policies they sell. Thus, different companies may compensate the same broker at different levels. Insurance companies may also have higher compensation levels for

brokers with a high sales volume, or they may compensate brokers more for selling higher premium plans. Insurers will also typically compensate brokers more for selling to large employer groups than to small groups and individuals.

Four SBMs sought to ensure that insurers compensate brokers equally regardless of whether they sell inside or outside the Marketplace.[7] But in general, variations in payments by insurer and broker volume can create distinct incentives for the brokers to encourage their clients to purchase particular plans or plans offered by specific insurers. In addition, brokers may have incentives to steer certain types of consumers to off-marketplace plans, particularly if they find the marketplace system to be time consuming and feel they can increase their business volume by avoiding it. Consequently, the plans most valuable for a particular broker to sell may not be the plan best suited for a particular client, creating a conflict of interest. Brokers do not have a legal responsibility to inform clients of the full array of plans available. In fact, brokers frequently do not have appointments with all insurance companies offering coverage through the state's marketplace, and thus may be unable to receive compensation for selling plans offered by companies with which they are not affiliated.

Navigators and in-person assisters are compensated in a substantially different way than are brokers. They are generally paid as hourly or salaried personnel of organizations receiving grants from the marketplace in their state. Consequently, publicly funded assisters do not have a financial interest in which plan an individual or family chooses, and they do not receive different compensation from different insurers. They also do not receive greater compensation for clients who enroll in coverage outside the marketplaces.

Lack of Expertise with Low-Income Population

Historically, brokers have had minimal experience working with a low-income population. Sources in the industry tell us that before ACA implementation, most low-income individuals who purchased nongroup insurance appeared to enroll without using brokers, who tended to focus on higher-income clients. Brokers may also lack relationships with communities with historically low levels of insurance, such as Hispanic and immigrant populations. Consequently, broker agencies may not have the infrastructure or staff capacity to meet these communities' linguistic or cultural needs. Conversely, many navigators and in-person assisters have a long history of working with low-income and other underserved populations, for example by helping individuals and families in those communities apply for public assistance programs, such as Medicaid, children's health insurance, food stamps, or heating assistance. Thus, they may have established relationships within low-income communities and more experience with an income-based government application process.

POTENTIAL FOR MORE EFFECTIVELY ENGAGING BROKERS IN MARKETPLACE ENROLLMENT

Broker respondents offered several ideas for increasing broker sales of marketplace-based coverage. First, many hope that the marketplaces will be more proactive in giving brokers visibility in their communications and advertising as well as a greater role in marketplace governance and decision-making. In particular, brokers would like to see easy-to-use, online broker directories that enable marketplace shoppers to easily identify a nearby participating broker. Though all SBMs have such directories at this time, their comprehensiveness and ease of use vary. To the extent that a broker facilitates the enrollment process for individuals, easier access to brokers could increase enrollment; however, this is not guaranteed because brokers often sell off-marketplace plans as well and may introduce shoppers to these alternative options.

Second, many brokers would like to see improved and ongoing training for enrollment procedures (as opposed to being taught ACA policy details), including hands-on training using individual scenarios and case-based training for complicated circumstances (e.g., immigrants and non-traditional family arrangements).

Third, brokers universally agreed that improved IT systems are needed to reduce the time necessary to enroll individuals and families in marketplace plans and effectively engage the broker community in selling these products. Many believed more efficient marketplace IT systems would increase incentives for brokers to sell marketplace plans. However, brokers may want to be careful what they wish for. Improved IT and better plan comparison tools could

allow more consumers to self-serve, lessening the need for broker-assisted enrollment.

Brokers also would like to see broker-facing portals that include the same functionality they find on insurers' sites for managing their business. This software allows brokers to track their clients as a group, see when payments are made, send communications to clients, and easily perform customer management tasks. If the marketplaces can integrate these types of case management software into their broker portals, selling marketplace products would become even more attractive to brokers.

Fourth, broker communities in several states asked that marketplaces fix several compensation issues. In particular, brokers cited the attribution challenges the marketplaces faced and the need to ensure that brokers are clearly identified on their clients' applications. If brokers do not trust they will be compensated for the work they perform, they will be less likely to sell marketplace products. In addition, if states begin to compensate brokers for enrolling low-income individuals and families in Medicaid, they may be able to improve the share of eligible individuals enrolling in public coverage. However, token payments alone are unlikely to entice brokers. Absent such payments, state and federal marketplaces can strongly encourage and even foster explicit partnerships between navigators and brokers, so that potential Medicaid enrollees and private purchasers with complex insurance needs can be best served without falling through the enrollment cracks after contact with one or the other type of assister. In some states, such partnerships have been discouraged. Federal regulators have said, however, that they will provide guidance on navigator-broker partnerships in the near future because of confusion over how much the two types of assisters can work together to enroll people through the federally facilitated marketplaces.

Fifth, state marketplaces that have hired brokers to work on staff have found that having those placements can significantly improve communication with the broker community and speed the resolution of problems hampering their ability to enroll clients in the plans.

Finally, marketplaces could do more to monitor broker participation to better understand whether and how they are facilitating enrollment. Many sources feel that regular surveys of brokers selling marketplace plans could be an effective way of providing feedback and informing state and federal governments of problems and barriers to increased participation. Others suggested that tracking broker volume of sales, the distribution of plans being sold by each broker and the characteristics of brokers' clients could provide important information for the marketplaces. For example, if individual brokers tend to sell a small number of plans or only plans offered by a single insurer, this could indicate either the need to increase awareness and understanding of broader marketplace options or strong financial incentives from a particular insurer and the possibility of a conflict of interest. If brokers tend to sell bronze plans as opposed to silver plans to subsidy-eligible enrollees, additional training on the value of available cost-sharing reductions (only available through silver plans) may be needed. If broker-mediated marketplace enrollments tend to skew toward older or less healthy individuals, this could signal adverse selection concerns.

CONCLUSION

Over time, marketplaces are unlikely to sustain the same levels of funding to support in-person enrollment assistance as they had during the initial rollout. Consequently, many may seek to leverage insurance brokers to conduct consumer education and help people enroll in marketplace plans. As evidenced here, sources interviewed have many concrete suggestions for increasing broker sales of marketplace plans, potentially increasing enrollment under the ACA. The amount that increased broker sales can reduce the number of uninsured, however, would be a function of whether brokers enroll more individuals previously uninsured or remain focused on those who previously had coverage through another source (e.g., the off-marketplace nongroup market).

Though increasing the size of the marketplaces is valuable for its own reasons (e.g., because it increases the base for financing the marketplace's administrative costs and potentially attracts more insurers to participate) ultimately, two of the ACA's primary objectives are to reduce the number of uninsured and increase affordable access to medical care regardless of health status or other characteristics. Achieving those objectives will require brokers to expand their reach into new populations and continue to provide effective counsel to their clients on the types of plans and plan structures (e.g., deductibles, co-payments, co-insurance, out-of-pocket maximums, benefits, provider networks) that will best meet their financial and medical care needs.

ENDNOTES

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