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COVERED CALIFORNIA

Report to the Governor and the Legislature

FISCAL YEAR

2015-2016



**COVERED
CALIFORNIA**

JANUARY 2017



January 24, 2017

On behalf of the governing board of Covered California, and pursuant to Government Code section 100503, I am pleased to present this year's annual report to the Governor and the Legislature. This report primarily focuses on the progress Covered California made during Fiscal Year 2015-16 toward establishing and maintaining a competitive marketplace for consumers, improving access to care and lowering costs.

Fiscal Year 2015-16 was marked by a number of important milestones for Covered California and its consumers. Covered California concluded its third-ever open-enrollment period, and second-ever renewal period, resulting in a robust enrollment of approximately 1.4 million enrollees as of March 2016. Additionally, through prudent financial management, Covered California operated with a budget of \$335 million, maintained a solid funding reserve and made the transition from using remaining federal establishment funding to becoming entirely self-sustainable through fees assessed on its carriers.

During the last fiscal year, Covered California continued its commitment toward consumer-focused initiatives that help ensure consumers have access to the right care at the right time while keeping an eye toward lowering costs. Leveraging our role in creating a competitive marketplace, we launched successful efforts to improve quality, value and access to care for consumers. We also continued to grow and maintain valuable partnerships with agents, community organizations, consumer advocates, plans, providers, government entities and others who help support us in achieving our mission.

Through Covered California's work, as well as the expansion of Medi-Cal in our state, California has reduced its uninsured rate by more than half — from 17 percent in 2013 to 7.4 percent in 2016 — bringing it to its lowest level on record. Looking ahead to 2017, Covered California continues its commitment to enrolling consumers into health coverage, and implementing initiatives that improve the consumer experience and advance competition in the marketplace. Additionally, I look forward to sharing our insights and lessons learned as policy discussions take place at the federal level with regard to health reform.

Sincerely,

Peter V. Lee
Executive Director

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EXECUTIVE SUMMARY

This report focuses primarily on fiscal year (FY) 2015-16, during which Covered California continued making progress toward establishing a competitive marketplace for consumers, improving access to care and lowering costs.

Covered California continues to build on its progress: Since opening its doors in 2014, the state health exchange has insured more than 2.5 million people, with nine out of 10 of these consumers receiving federally funded financial assistance to lower premiums, and in some instances, lower out-of-pocket costs. On Jan. 31, 2016, Covered California concluded its third open-enrollment period, adding more than 439,000 new enrollees, and completed its second-ever renewal period. Through renewal and open enrollment, Covered California maintained a robust enrollment of approximately 1.4 million actively enrolled consumers as of March 2016.

Recent data from the U.S. Census Bureau indicates that California has cut its uninsured rate down to the lowest level on record, from 17 percent in 2013 to 7.4 percent in the first half of 2016, a figure that is largely attributed to the success of Covered California and the expansion of Medi-Cal. Those numbers highlight California's commitment to health care and the state's achievement in closing coverage gaps for low-to-middle-income families.

A number of significant milestones were achieved during FY 2015-16, including:

- **Self-sustainability** — FY 2015-16 marks Covered California's transition from using federal establishment funding to being entirely self-sustaining, with operating funds generated from plan assessments. With a FY 2015-16 budget of \$335 million and a solid reserve, Covered California fulfills the legislative intent to build an independent and financially self-sustaining state-based marketplace that does not rely on any state general funds.
- **Working to maintain affordability for consumers** — Covered California continues to use its authority to negotiate affordable premium rates and create a competitive market that works for consumers. During FY 2015-16, Covered California negotiated with 12 participating carriers to achieve a statewide average rate increase of 4 percent for the 2016 plan year, lower than the previous year's increase of 4.2 percent. While negotiating with health insurance companies, Covered California uses data from its enrollment profile. For the past few years, Covered California has provided strong evidence that its enrollees are healthier and present less risk to health plans — factors which helped drive down the cost of premiums. It is estimated that in 2015 and 2016, data-driven negotiation saved consumers more than \$300 million in premium dollars.
- **Improving access, quality and value** — Covered California leverages its role in creating a competitive marketplace to improve quality, value and access to care for its enrollees and those who choose mirrored plans in the individual market. More than 300,000 people have purchased mirrored plans, which are plans that offer the same benefits at the prices we negotiate. For the 2016 plan year, Covered California became the first health exchange in the nation to adopt benefit design changes that cap the cost of high-cost specialty drugs. These

cost caps — which were a result of extensive collaboration with consumer organizations, stakeholders, health plans and regulators — provide an important consumer protection that ensures that consumers have access to the medication they need.

Additionally, in April 2016, Covered California’s board adopted plan contract requirements that require Covered California plans in future years to reduce health disparities, promote health equity, implement payment reform that promotes quality and value, and give consumers tools to participate more actively in their health care. You can access the model plan contract at <http://bit.ly/2hW8pXd>.

- **Expanding access to dental and vision coverage** — During FY 2015-16, Covered California launched the offering of standalone, unsubsidized family dental HMO and PPO plans as an optional purchase for consumers signing up for health coverage. In addition, Covered California partnered with two vision carriers, Vision Service Plan (VSP) and EyeMed Vision Care, to provide a website link to Covered California consumers to view vision plan offerings.
- **Effective marketing, outreach, partnerships and consumer service** — The work we do could not be possible without the steadfast commitment of Covered California staff, stakeholders and partners who strive to promote and maintain enrollment in health coverage. During FY 2015-16, more than 900 staff members in three Covered California service centers processed more than 2.5 million calls in 14 different languages to assist consumers. On the ground, more than 20,000 certified enrollers, including Certified Insurance Agents, Certified Application Counselors and Certified Enrollment Counselors, provided enrollment and post-enrollment support services in their local communities. Covered California’s partners from local district offices, county social services offices and community-based organizations provided invaluable support in informing Californians of their health care options. Additionally in FY 2015-16, Covered California implemented a successful multiethnic, multichannel marketing campaign crafted to retain and renew existing members and reach new consumers. These marketing efforts helped retain and bolster enrollment.

Over the years, we have worked closely with the California Legislature and have established a competitive marketplace through which many Californians now have health insurance for the first time. Throughout the process, we have established a solid foundation for maintaining strong enrollment, expanding access to health coverage, lowering costs and improving the consumer experience.

While this report is focused on FY 2015-16, Covered California is currently in the midst of its fourth open-enrollment period, during which California consumers are renewing their plans and enrolling into coverage for the 2017 year. The section of this report titled “Looking Ahead to the Future” contains more information about the work we are currently engaged in and what changes are forthcoming for the 2017 plan year.

Many questions have been asked about what changes to Congress and the federal administration may mean for Covered California and its consumers. We remain focused on enrolling and renewing consumers into health coverage through Covered California. We want to make sure they are aware that the 2017 health plan rates announced in July 2016 will not change, that financial assistance is still available, and that the penalty for not maintaining coverage is still intact. We will continue to communicate these important messages to consumers. In the weeks and months ahead, we look forward to sharing our lessons learned in order to help inform policy changes that may take place nationally.

COVERED CALIFORNIA LEADERSHIP

COVERED CALIFORNIA BOARD

Covered California is an independent public entity in state government. It is governed by a Board of Directors that consists of five members who are residents of California and who are appointed by either the governor, Senate Committee on Rules or the Speaker of the Assembly. The board sets Covered California's major policies, including policy related to eligibility and enrollment, qualified health plans, benefit design, marketing, outreach and service to consumers.

The Covered California board meets regularly, usually 10 months out of the year, in an open forum that gives the public the opportunity to participate in Covered California's policymaking process. The secretary of the California Health and Human Services Agency, or his or her designee, serves as a voting, ex-officio member of the board. The board elects the chair and provides overall direction for the organization. Two of the board members are appointed by the governor, one by the Senate Committee on Rules and one by the Speaker of the Assembly. These four members must have competency in at least two of the following areas:

- Individual health coverage.
- Small-employer health coverage.
- Health benefits plan administration.
- Health care finance.
- Administering a public or private health care delivery system.
- Purchasing health coverage.
- Marketing of health insurance products.
- Information technology system management.
- Management of information systems.
- Enrollment counseling assistance, with priority to cultural and linguistic competency.

2015-2016 BOARD MEMBERS



Diana S. Dooley – Chair (elected by the Board)
Ex-Officio Member

Appointed by Governor Edmund G. Brown Jr. in January 2011, Diana S. Dooley serves as the Secretary of the California Health and Human Services Agency. Secretary Dooley began her professional career as an analyst at the State Personnel Board and in 1975 was appointed to the staff of Governor Brown, for whom she served as Legislative Director and Special Assistant until the end of his term in January 1983. Secretary Dooley owned a public relations and advertising agency prior to becoming an attorney in 1995. In December 2000, she became General Counsel and Vice President at Valley Children’s Hospital, and later served as President and Chief Executive Officer of the California Children’s Hospital Association.



Art Torres – Board Member

Appointed by the Senate Rules Committee in 2015 – Term expires in 2020

Former Senator Torres currently serves as the Vice Chair of the Governing Board of the California Institute for Regenerative Medicine (CIRM). He served in the California State Senate from 1982 to 1994, where he chaired the Senate Insurance Committee. He also served in the California State Assembly from 1974 to 1982, during which he overhauled the Medi-Cal program as Chair of the Assembly Health Committee. Former Senator Torres has written bipartisan initiatives in the fields of health care, education, the environment and human rights.



Genoveva Islas – Board Member

Appointed by the Governor in 2014 – Term expires in 2019

Since 2006, Ms. Islas has served as Program Director of Cultiva La Salud, formerly the Central California Regional Obesity Prevention Program. She was an area field representative for the California Department of Public Health’s California Diabetes Program from 2004 to 2005. Ms. Islas was an adjunct faculty member at Bakersfield College from 1997 to 2005 and was a health education-cultural linguistics supervisor at Kern Health Systems from 1993 to 1999. She earned a Master of Public Health degree from Loma Linda University.

2015-2016 BOARD MEMBERS

Paul E. Fearer – Board Member

Appointed by the Speaker of the Assembly in 2016 – Term expires in 2021

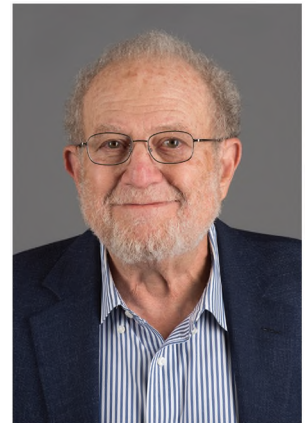
From 1997 to 2012, Mr. Fearer chaired the Board of Directors of the Pacific Business Group on Health (PBGH), an organization of approximately three dozen large employers committed to improving the quality and efficiency of the health care delivery system in the western states, as well as moderating price increases for employers and employees. He also served from 2000 to 2007 as Chair and board member of PacAdvantage, a small-business health benefit exchange and subsidiary of PBGH.



Marty Morgenstern – Board Member

Appointed by the Governor in 2015 – Term expires in 2019

Before retiring in 2012, Mr. Morgenstern served as the Secretary of the California Labor and Workforce Development Agency. Mr. Morgenstern has served in state government in other leadership positions, including as Director of the Governor's Office of Employee Relations, and its successor, the Department of Personnel Administration. He also served as a board member on the Public Employment Relations Board (PERB). Following his service on PERB, Mr. Morgenstern was Chair of the Center for Labor Research and Education at the UC Berkeley Institute for Research on Labor and Employment, and was a human resources advisor at the University of California Office of the President and was senior advisor to the governor. He also serves on the Secure Choice Retirement Savings Investment board and the Cal Humanities board.



EXECUTIVE DIRECTOR AND LEADERSHIP TEAM

Covered California's executive board is responsible for hiring executive staff, including Executive Director Peter V. Lee, who began his tenure as Covered California's first permanent executive director in 2011 and continues to serve in that capacity today. Mr. Lee oversees all aspects of Covered California's operations, guided by the direction of the board. Below is Covered California's organizational chart, which reflects its executive director and executive leadership for FY 2015-16.

Covered California 2015-2016 Leadership Team¹

Peter V. Lee
Executive Director

Yolanda R. Richardson
Chief Deputy Executive Director

LaVonne Coen
Administrative Services
Division Director/
Deputy Chief Operations
Officer

Kelly Green
External Affairs
Division Director

Kathleen Keeshen
General Counsel

Thien Lam
Program Integrity
Division Director

Jim Lombard
Financial Management
Division Director and
Chief Financial Officer

Amy Palmer
Communications
and Public Relations
Division Director

Anne Price
Plan Management
Division Director

Katie Ravel
Program Policy,
Evaluation and Research
Division Director

Karen Ruiz
Information Technology
Division Director/
Chief Technology Officer

Mavilla Safi
Service Center
Division Director

Colleen Stevens
Marketing
Division Director

Kirk Whelan
Individual and
Small Business
Outreach and Sales
Division Director

¹ Note: Ms. Richardson left Covered California in June of 2016. On Nov. 21, 2016, Covered California announced the hiring of Doug McKeever as chief deputy executive director of Programs. Additionally, on Dec. 23, 2016, Covered California announced the hiring of Karen Johnson as chief deputy executive director of Operations. Anne Price left Covered California in July 2016 and James DeBenedetti currently serves as acting director of Plan Management.

BUDGET AND FINANCE

On June 18, 2015, Covered California adopted the budget for fiscal year 2015-16. The budget authorized \$335 million and 1,399 positions to ensure Covered California has the right tools, processes and resources to deliver on its mission. This was the final year that Covered California relied on federal establishment grant funding. The 2015-16 budget was balanced with both the remainder of the federal establishment funds and plan assessment fees.

In order to use the remaining \$157 million in grant funds, an extension from the federal government was requested and approved. The remaining balance of grant funds spent in FY 2015-16 was used in accordance with federal guidance, which allowed state-based marketplaces to use remaining grant funds for design, development and implementation, as long as costs did not support ongoing operations.

With the end of federal establishment funds, Covered California transitioned to relying solely on fees it collects from health plans (a flat rate of \$13.95 per member, per month during FY 2015-16), as well as from extensive reserves saved while using federal funds for establishment. This transition reflects California’s legislative intent for Covered California to be an independent and financially self-sufficient state-based marketplace.

The budget for FY 2015-16 included funding for a number of important activities supporting Covered California’s mission. Substantial investments were made in outreach, marketing and enrollment. Service center funding levels were comparable to the previous fiscal year to accommodate the workload associated with consumer inquiries and appeals. Additionally, funding for CalHEERS supported system and program requirements during the year.

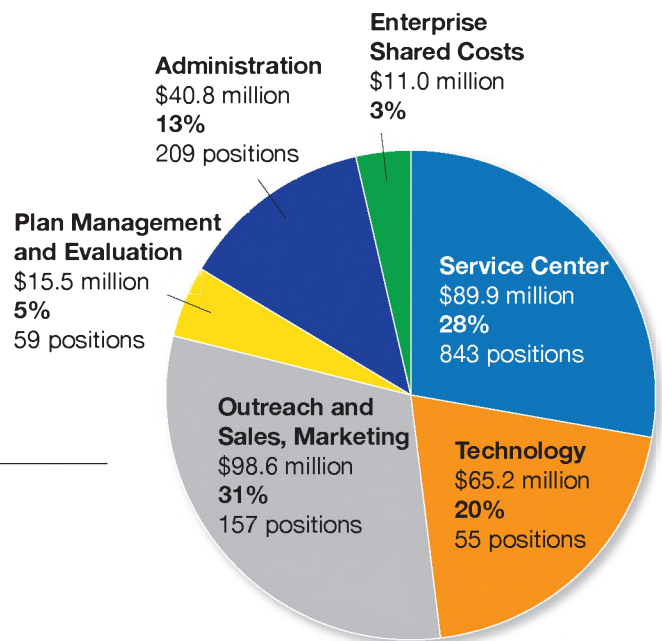


FIGURE 1
Revised FY 2015-16 Budget: \$335.0 Million



For more detailed information about Covered California’s budget and financing, please see Covered California’s budget book for FY 2015-16 at <http://bit.ly/2iH5Nvc>.

Fiscal Year-End Update for FY 2015-16

As displayed in Table 1 below, Covered California achieved revenues that were higher than forecasted and budget expenditures that were lower than anticipated in FY 2015-16. Covered California ended the fiscal year with an operating cash reserve of approximately \$318 million.

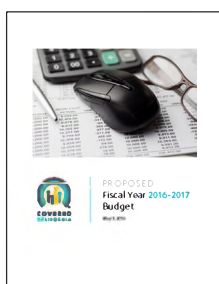
TABLE 1 — FY 2015-16 Budget vs. Actuals

\$ millions	2015-16 Budget	2015-16 Actual	Variance to Budget
Opening Balance	\$ 297.9	\$ 320.2	\$ 22.3
Plan Assessments (cash basis)	\$ 234.4	\$ 266.0	\$ 32.2
Expenditures*	\$ 355.0	\$ 269.3	\$ (65.7)
Gain/Loss	\$ (100.6)	\$ (2.7)	\$ 97.9
Ending Balance	\$ 197.3	\$ 317.5	\$ 120.2

* Includes adjustments to prior year expenditures.

Highlights from Covered California’s FY 2015-16 revenue and expenditures include:

- Higher-than-projected revenues.** The actual number of enrollments was very close to forecasts, and Covered California’s enrollment following its second renewal period and third open-enrollment period fell within the range of forecasts used to develop the FY 2015-16 budget. Actual revenues generated from plan assessments during the fiscal year were \$267 million, approximately \$32 million higher than budgeted. This is largely the result of streamlining the reconciliation process, which allowed plans to remit payment sooner than expected.
- Lower-than-projected expenditures.** Expenditures in FY 2015-16 were \$269.3 million, approximately \$66 million lower than budgeted. Lower expenditures are attributable to a variety of factors, including lower-than-expected contract expenditures, position vacancies, lower-than-expected costs relating to Covered California’s portion of statewide allocated costs, strategic initiatives and contingencies for unplanned expenditures. Covered California made significant strides to make reductions and align the FY 2016-17 budget with prior year expenditures.
- Year-end reserve of \$318 million.** FY 2015-16 ended with a \$318 million reserve, approximately \$40 million higher than initially projected. This amount gives Covered California an 11.9-month reserve. Consistent with state law, Covered California is charged with reducing rates should reserves exceed 12 months. The conscious decision to establish and maintain appropriate reserves allows Covered California to maintain its momentum, remain nimble and make adjustments from year to year, if necessary.



For more detailed information about Covered California’s budget and financing, please see Covered California’s budget book at <http://bit.ly/2iGYLqk>.

LOOKING AHEAD TO FY 2016-17 AND BEYOND

Covered California receives its revenues from an assessment, or fee, on each plan purchased through Covered California. The current outlook reflects a change in the assessment from a flat \$13.95 per-member, per-month (PMPM) rate to a percentage of gross premiums paid beginning in 2017 with the rate set initially at 4 percent.

Table 2 summarizes the revenue outlook for the individual market and Covered California for Small Business (CCSB) forecasts described below.

TABLE 2 — Covered California Revenue Outlook Summary: Medium Forecast Alternatives

Market	PMPM Revenue (\$millions)			
Fiscal Year	2016-17	2017-18	2018-19	2019-2020
Individual Market – Medical	\$255.9	\$315.3	334.3	\$341.2
Individual Market – Dental	\$0.9	\$1.1	\$1.1	\$1.1
CCSB	\$9.8	\$15.6	\$22.8	\$31.1
Total Revenue	\$266.6	\$332.0	\$358.2	\$373.7

<i>Individual Market Revenue Cash Basis Adjustment</i>				
<i>Individual Market – Medical</i>	<i>\$255.9</i>	<i>\$315.3</i>	<i>\$334.3</i>	<i>\$341.2</i>
<i>Adjustment for Payment Receipt Lag</i>	<i>-\$28.3</i>	<i>-\$5.0</i>	<i>-\$1.6</i>	<i>-\$1.7</i>
<i>Cash Basis</i>	<i>\$227.6</i>	<i>\$310.3</i>	<i>\$332.8</i>	<i>\$340.5</i>
<i>Total Revenue (Cash Basis)</i>	<i>\$238.3</i>	<i>\$327.0</i>	<i>\$356.7</i>	<i>\$373.0</i>

Covered California projects that it will achieve a balance between revenues and expenditures in FY 2017-18. In FY 2014-15, Covered California expenditures equaled roughly 6.6 percent of gross health insurance premiums. This proportion is projected to drop to 4 percent in FY 2017-18. The \$13.95 PMPM assessment, which will equal only 3.3 percent of premiums during FY 2016-17, is well below the comparative rate for expenditures. While the initial 4 percent assessment rate is effectively higher than the current \$13.95 flat rate charged, it puts Covered California in a position in which revenues will equal expenditures by FY 2017-18 and sets Covered California on the path to reducing the assessment in coming years.

As of 2017, 4 percent of the premium fee is assessed on those currently enrolled in Covered California plans. In addition to Covered California enrollees, there are also approximately 700,000 people in the individual market who benefit from the rates negotiated by Covered California, even though they are not directly enrolled through the exchange, because the rates for these products (both on and off exchange) are required to be the same. Since the health plans offered by Covered California represent approximately 66 percent of the total enrollment in individual coverage, the assessment essentially requires the health plans to spread the assessment fee across the entire individual market. Covered California estimates that the actual average effective assessment rate for 2017 will be approximately 2.6 percent across the entire individual market. Covered California currently projects its assessment to decrease to 3.5 percent by 2020, which equates to 2.3 percent across the entire market.

The FY 2016-17 Covered California budget, presented in Figure 2, supports activities for the organization’s first year operating solely on plan assessments and reserves. Covered California anticipates expending all federal funding by the end of FY 2015-16. The budget framework is informed by Covered California’s financial guiding principles and strategic pillars, FY 2015-16 expenditures, the enrollment and revenue forecasts described above and the multi-year forecast discussed below. The budget provides 1,323 positions and \$320.9 million to fund program operations, which is \$14 million, or 4 percent, less than the FY 2015-16 approved budget.

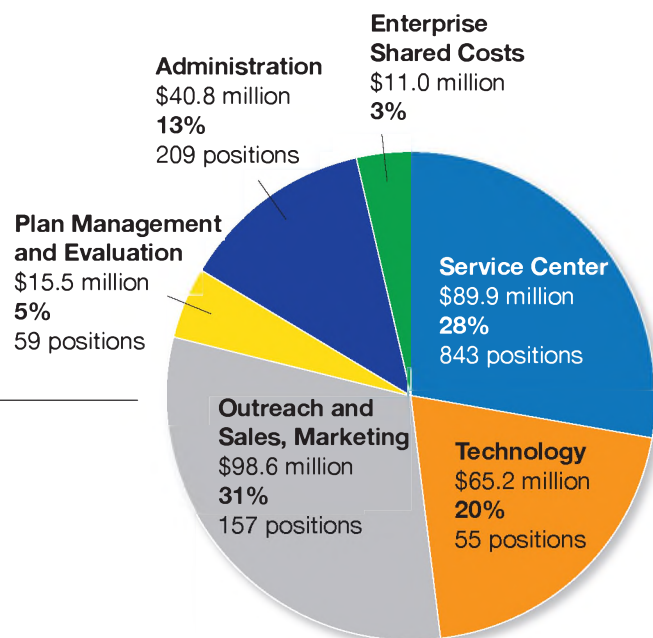


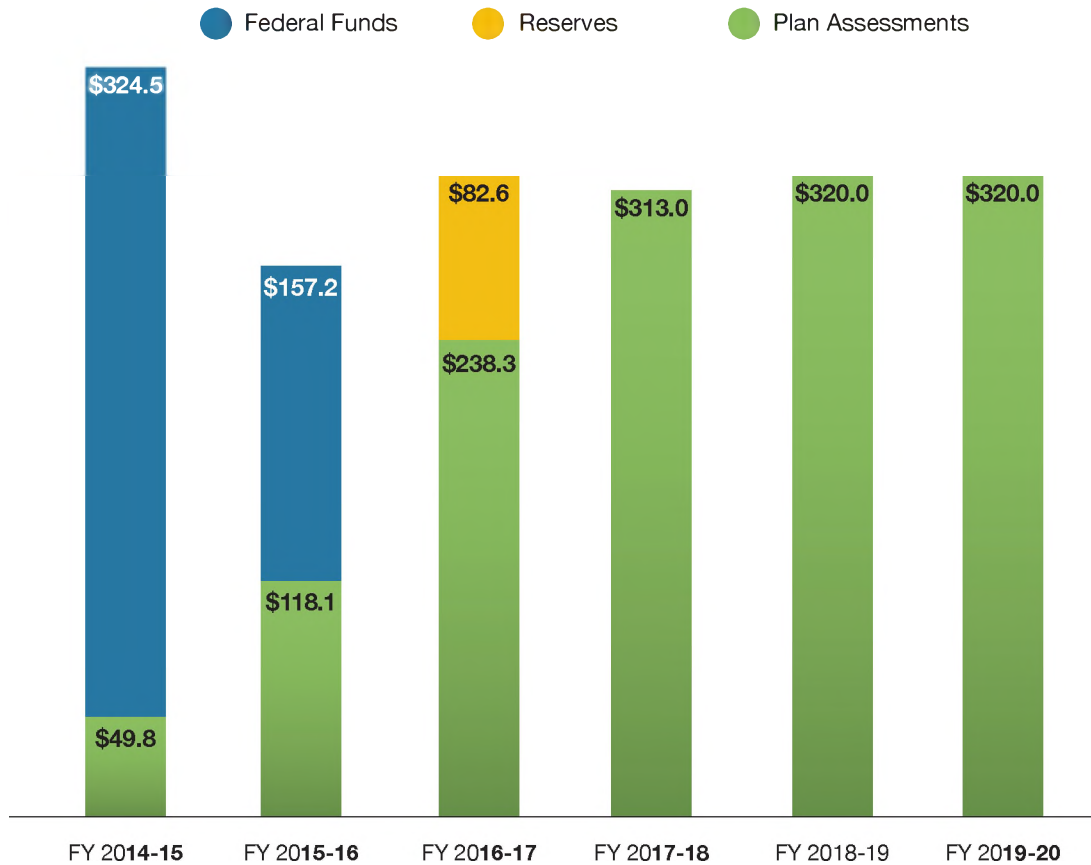
FIGURE 2
FY 2016-17 Budget: \$320.9 Million

MULTI-YEAR FORECAST

Covered California has used two main funding sources, federal establishment funds and assessments on plans. It can also use year-end reserves to meet program expenditures. Figure 3 illustrates Covered California’s multi-year budget by funding source. Federal funds decrease from more than 80 percent of the budget in 2014-15 to zero by 2016-17. In 2016-17, Covered California projects that it will use just over \$82.6 million, approximately 26 percent, of its reserves to fund a portion of program operations, leaving \$235 million in reserve at year’s end.

Since its inception, Covered California has recognized that the budget planning process involves consideration of several key variables over a multi-year period, including revenue, expenditures and reserves. As such, the FY 2016-17 budget is one component of a multi-year plan that will ensure that Covered California has a strong fiscal foundation for the foreseeable future.

FIGURE 3 — Budget and Sources of Funding: FY 2014-15 through 2019-20
(Dollars in Millions)



The current multi-year forecast is displayed in Table 3, below. Revenues that include both the individual and Covered California for Small Business markets are calculated on a cash basis that more accurately reflects the timing of the collection of revenue.

TABLE 3 — Multi-Year Forecast (Dollars in Millions)

Fiscal Year	2015-16	2016-17	2017-18	2018-19	2019-2020
Effectuated Enrollment	1,320,581	1,344,087	1,409,724	1,472,852	1,522,081
Opening Balance	\$ 320.2	\$ 317.5	\$ 234.9	\$ 248.9	\$ 285.5
Plan Assessments – Cash Basis	\$ 266.6	\$ 238.3	\$ 327.0	\$ 356.7	\$ 373.0
Expenditures 2015-16 Projected	\$ (269.3)	\$ (321.0)	\$ (313.0)	\$ (320.0)	\$ (320.0)
Year-End Operating Reserve	\$ 317.5	\$ 234.9	\$ 248.9	\$ 285.5	\$ 338.5
Months Covered by Reserve	14	9	10	11	13

In addition to the \$321 million budget in FY 2016-17, the forecast assumes budgets of between \$313 million and \$320 million for FY 2017-18 through FY 2019-20, and is designed to balance revenues and expenditures by FY 2017-18. The plan will provide a nine-month operating reserve throughout FY 2016-17 with a fiscal year-end position of more than \$230 million. Covered California does not expect its fiscal year-end reserve level to be less than nine months at any time throughout the outlook. The forecast reflects modest increases in operating expenses over the next few fiscal years to allow programs to maintain service levels necessary to maintain and expand membership.

ENROLLMENT

COVERED CALIFORNIA'S THIRD OPEN ENROLLMENT

During Covered California's third open-enrollment period, which ran from Nov. 1, 2015 to Jan. 31, 2016, more than 439,400 people newly enrolled and selected a Covered California health plan for the 2016 plan year. Along with consumers who renewed their plans, this brings current enrollment to approximately 1.4 million members as of July 2016. Below are tables that show Covered California's enrollees from the third open enrollment by demographic, subsidy and plan choice.

TABLE 4 — New Enrollment in the Third Open-Enrollment Period, Enrollment Total by Age

Age Bracket	Subsidy Eligible		Unsubsidized		Total	
	Enrollees	Percentage	Enrollees	Percentage	Enrollees	Percentage
17 and under	18,930	4.9%	9,360	16.7%	28,290	6.4%
18 to 25	67,880	17.7%	6,630	11.8%	74,510	17.0%
26 to 34	78,230	20.4%	14,090	25.2%	92,320	21.0%
35 to 44	61,330	16.0%	10,080	18.0%	71,410	16.3%
45 to 54	82,560	21.5%	8,920	15.9%	91,480	20.8%
55 to 64	72,390	18.9%	6,530	11.7%	78,920	18.0%
65 and older	2,100	0.5%	350	0.6%	2,450	0.6%
Grand Total	383,430	100.0%	55,970	100.0%	439,400	100.0%

For its third open enrollment, Covered California was able to increase its share of younger enrollees. The percentage of consumers between the ages of 18 and 34 who signed up for coverage was 29 percent during the first open-enrollment period, 34 percent in the second and 38 percent during the third. Having younger enrollees in the pool improves the enrollee profile and helps reduce overall premium rates for all consumers.

TABLE 5 — New Enrollment in the Third Open-Enrollment Period by Metal Tier

Metal Tier	Subsidy Eligible		Unsubsidized		Total	
	Enrollees	Percentage	Enrollees	Percentage	Enrollees	Percentage
Minimum Coverage	3,680	1.0%	4,860	8.7%	8,540	1.9%
Bronze	118,530	30.9%	21,670	38.7%	140,200	31.9%
Silver	40,620	10.6%	18,460	33.0%	59,080	13.4%
Silver - Enhanced 73	35,440	9.2%	0	0.0%	35,440	8.1%
Silver - Enhanced 87	101,210	26.4%	0	0.0%	101,210	23.0%
Silver - Enhanced 94	60,380	15.7%	0	0.0%	60,380	13.7%
Gold	14,190	3.7%	6,120	10.9%	20,310	4.6%
Platinum	9,370	2.4%	4,860	8.7%	14,230	3.2%
Grand Total	383,430	100.0%	55,970	100.0%	439,400	100.0%

More than half (51 percent) of subsidized consumers are enrolled in an Enhanced Silver plan. Under this metal tier, Covered California enrollees are not only getting a comprehensive set of benefits, but are also receiving financial help to lower out-of-pocket costs for medical services. For example, a consumer enrolled in an Enhanced Silver 94 plan would pay \$5 for a primary care visit and \$8 for a specialty visit. The support for out-of-pocket expenses is funded through cost-sharing reduction payments made by the federal government directly to Covered California’s qualified health plans.

TABLE 6 — New Enrollment in the Third Open-Enrollment Period as of June 2016, by Income

FPL	Subsidy Eligible		Unsubsidized		Total	
	Enrollees	Percentage	Enrollees	Percentage	Enrollees	Percentage
138% or less	27,290	2.4%	6,390	4.9%	33,680	2.6%
138% to 150%	190,390	16.5%	570	0.4%	190,960	14.9%
150% to 200%	424,940	36.9%	2,440	1.9%	427,380	33.4%
200% to 250%	213,090	18.5%	2,410	1.9%	215,500	16.8%
250% to 400%	290,550	25.2%	7,760	6.0%	298,310	23.3%
400% or greater	210	0.0%	41,290	31.8%	41,500	3.2%
FPL Unavailable	4,210	0.4%	0	0.0%	4,210	0.3%
Unsubsidized Application	570	0.0%	68,930	53.1%	69,500	5.4%
Grand Total	1,151,240	100.0%	129,790	100.0%	1,281,030	100.0%

Approximately 72 percent of Covered California enrollees are between 138 percent and 250 percent of the federal poverty level, and are receiving federally funded financial assistance that covers a significant portion of premium costs and, in some instances, out-of-pocket costs for medical services. As noted earlier, more than 300,000 additional Californians receive individual coverage outside of Covered California.

RENEWAL ENROLLMENT

Fiscal year 2015-16 marked Covered California's second renewal effort. The open-enrollment period offers an opportunity to both enroll new consumers and retain existing consumers who can change their plan during this time. Similar to the previous year, consumers could choose to automatically renew their current plan or visit the "Shop and Compare Tool" on the consumer website to consider the potential benefits of changing plans.

Renewal Process — Most consumers did not need to take any action to be automatically renewed. Consumers were eligible for automatic renewal if they previously consented to having Covered California verify their tax filing information with the IRS. If consumers filed their taxes and did not choose to change plans, they were re-enrolled into the same plan with the appropriate tax credits. Consumers were also notified by their health plan about automatic renewal and sent billing statements with the updated 2016 rate for that plan.

An overwhelming majority of consumers — 96 percent, in fact — who enrolled in 2015 renewed their coverage for 2016. Of those who renewed, the majority were passively renewed and made no changes. Other consumers actively renewed, and about 8 percent of those who actively renewed chose a new health insurer.

Consumers were also notified by Covered California that they could shop for a new plan during open enrollment, and if their income or family size changed, re-determine their eligibility. Consumers could use the Shop and Compare Tool available on CoveredCA.com to learn about their 2016 options and then change plans through their Covered California online account or with help from a certified enroller.

The Shop and Compare Tool allows consumers to estimate what level of financial assistance they may receive and which plans are available to them, anonymously, before they start an application. They only need to enter their household income, ZIP code, age, the number of people enrolling and the number of people in their household. The tool will tell them whether they qualify for Medi-Cal, federal subsidies or no subsidies.

The screenshot shows the "2016 Covered California Shop and Compare Tool" interface. At the top, there is a navigation bar with the Covered California logo and social media links. Below the navigation bar is a banner with the title "The 2016 Covered California Shop and Compare Tool" and a row of images showing diverse people. The main content area contains an "Important" notice about the January 1, 2016 coverage start date and a link to a page for pregnant women. Below this is the "Household Information" section, which includes a form for "Household income" (with an "Annual" dropdown), "ZIP Code", and a table for "Age" and "Enrolling" information for household members. The "Total Enrolling" and "Number of people in the household" are both set to 0. At the bottom, there is a "Breaking Down the Monthly Cost" section and a "Clear" button.

Important: The health insurance plans and premiums displayed are for coverage starting **January 1, 2016**. These results provide an estimate only, you will see your actual rate once you complete the application. You'll need to re-enter your information during the enrollment process. If you're currently receiving affordable health insurance through an employer or a public program, you won't receive premium assistance for insurance purchased via Covered California.

Different health insurance plans and rates may be available for pregnant women. See <https://www.coveredca.com/individuals-and-families/special-circumstances/pregnant-women/>. Contact Covered California or your county Medi-Cal office for more information.

Household Information

Household income * Annual

ZIP Code *

Enter the **AGE** of each person, whether they are enrolling or not. Uncheck the **ENROLLING** box next to the age for those household members not enrolling. Note: Premium estimates assume same age for each member as of coverage effective date.

	Age	Enrolling	
Person 1	<input type="text" value="Age"/>	<input checked="" type="checkbox"/>	<input type="button" value="Remove"/>

Total Enrolling:

Number of people in the household

Breaking Down the Monthly Cost

* Indicates required field

CARRIERS, RATES, AND BENEFIT DESIGN FOR 2016

Covered California works to ensure consumers benefit from shopping in a competitive marketplace. Consumers can compare plans with standard patient-centered benefit designs that are structured to help them get the right care at the right time. Covered California actively negotiates and contracts with the qualified health plans offered through the exchange. All of Covered California’s health plans provide the same patient-centered benefit designs for each metal tier, thus requiring the plans to compete with one another based on premium, networks, quality and service to consumers.

Covered California health plans must meet high standards of quality and affordability as they compete in the marketplace, and must commit to improve care delivery. The result of Covered California’s efforts to create competition in the marketplace has resulted in a strong foundation of consistent plan offerings for consumers. Competition among plans has stimulated strategies for providing high-quality, affordable health care, promoting prevention and wellness and reducing health disparities.

CARRIERS

All 10 health insurance plans offered in 2015 continued to be offered in 2016. Additionally, Oscar Health Plan of California and United Healthcare were added for 2016 in certain areas of the state. In 2016, in every ZIP code in the state, consumers had the choice of two health plans. And, in greater than 99 percent of ZIP codes, consumers had three plans to choose from.

RATES

In July 2015, Covered California announced its negotiated rates for the 2016 plan year, which continued a downward trend of rate increases in the state. The statewide average increase for the 2016 plan year was 4 percent, lower than the previous year’s increase of 4.2 percent. This represented a dramatic change from the trends that individuals faced in the three years prior to the implementation of the ACA.

COVERED CALIFORNIA HEALTH INSURANCE COMPANIES OFFERED TO CONSUMERS IN 2016

Anthem Blue Cross of California
Blue Shield of California
Chinese Community Health Plan
Health Net
Kaiser Permanente
L.A. Care Health Plan
Molina Healthcare
Oscar Health Plan of California (new for 2016)
Sharp Health Plan
United Healthcare Benefits Plan of California (new for 2016)
Valley Health Plan
Western Health Advantage

TABLE 7 — New Covered California Members by Plan After the Third Open Enrollment, as of May 18, 2016²

Health Plan	Subsidy Eligible		Unsubsidized		Total	
	Enrollees	Percentage	Enrollees	Percentage	Enrollees	Percentage
Anthem Blue Cross of California	88,290	23.0%	15090	27.0%	103,380	23.5%
Blue Shield of California	102,540	26.7%	15250	27.2%	117,790	26.8%
Chinese Community Health Plan	2,670	0.7%	220	0.4%	2,890	0.7%
Health Net	41,020	10.7%	4740	8.5%	45,760	10.4%
Kaiser Permanente	85,060	22.2%	13980	25.0%	99,040	22.5%
L.A. Care Health Plan	2,790	0.7%	430	0.8%	3,220	0.7%
Molina Healthcare	47,540	12.4%	3310	5.9%	50,850	11.6%
Oscar Health Plan of California	1,310	0.3%	250	0.4%	1,560	0.4%
Sharp Health Plan	7,530	2.0%	1820	3.3%	9,350	2.1%
UnitedHealthcare	800	0.2%	290	0.5%	1,090	0.2%
Valley Health Plan	1,240	0.3%	160	0.3%	1,400	0.3%
Western Health Advantage	2,630	0.7%	420	0.8%	3,050	0.7%
Grand Total	383,430	100.0%	55,970	100.0%	439,400	100.0%

In addition to the statewide weighted average increase, the respective average rate increases for the lowest-priced Bronze and Silver plans were 3.3 percent and 1.5 percent. These two tiers had the vast majority of Covered California’s enrollment. The lower increase indicated that consumers who wanted to shop and change plans could experience an even smaller increase in their premium costs.

The majority of Covered California consumers saw a decrease in their health insurance premiums or an increase of less than 5 percent if they chose to renew their current plan. In addition, consumers were able to reduce their premiums by an average of 4.5 percent, and more than 10 percent in some regions, if they shopped for other coverage and switched to a lower-cost plan within the same metal tier. However, the majority of renewing consumers — approximately 88 percent — kept their plan, indicating satisfaction with price, quality and coverage level.

For the 2016 plan year, the weighted average premium increase was limited to 4 percent due in part to the healthy enrollment profile of Covered California’s enrollees. This enrollment profile helped lower proposed rates during negotiations with carriers. Additionally, Covered California health plans received more than \$1.1 billion in reinsurance payments and more than \$600 million in risk-adjustment transfers, pursuant to the federal reinsurance and risk-adjustment programs.

² This table illustrates statewide averages, but local market share by carrier varies widely by region. For example, in Region 1, covering the northernmost region of California, Anthem Blue Cross’ PPO plan accounted for 91.7 percent of enrollment in 2016. And in Region 4, covering San Francisco County, Chinese Community Health Plan accounted for 27 percent of enrollment.

TABLE 8 — Covered California Rate Changes, 2015 to 2016

Rate Change	2014-2015	2015-2016
Weighted average Increase	4.2%	4.0%
Lowest-price Bronze plan (unweighted)	4.4%	3.3%
Lowest-price Silver plan (unweighted)	4.8%	1.5%
If a consumer shopped and switched to the lowest-cost plan in the same metal tier	—	- 4.5%

BENEFIT DESIGN

Covered California is leading the way for consumers by using a patient-centered benefit design. Patient-centered benefit designs allow consumers to shop across Covered California’s different health insurance companies knowing that the benefits are the same, depending on metal tier, no matter which company they choose. Consumers can make apples-to-apples comparisons among plans’ copays, deductibles and other out-of-pocket costs up front so there are no surprises when they use their coverage. Consumers have their choice of coverage level based on a metal-tier system to select a plan that best fits their needs.

Specifically, under this drug benefit design, drug-cost caps range from \$150 to \$500 per month, per prescription — depending on metal tier — with the vast majority of Covered California consumers having their specialty drugs capped at \$250 per month, per prescription. This drug-cost cap helps consumers who would otherwise be required to spend their entire maximum out-of-pocket costs in their first few months of coverage in order to access needed high-cost medications.

Other consumer-focused benefit design changes related to prescription drug coverage adopted by the Covered California board in 2015 and taking effect in 2016 included:

- Requiring plan formularies to include at least one Food and Drug Administration-approved drug in tiers one, two or three under certain conditions.
- Requiring plans to have an “opt-out” retail option for mail order.
- Requiring plans to provide consumers an estimate of the out-of-pocket costs for specific drugs and to include a statement on the availability of drugs not listed in the formulary.
- Requiring plans to include an exception process written clearly in their formulary and a dedicated pharmacy customer service line where advocates and prospective consumers can call for assistance.

Additionally in 2015, the Covered California board approved other benefit design changes to take effect in 2016 that are designed to increase affordability and access to medical services. Specifically, the 2016 standard benefit design:

- Exempts the first three office visits from the deductible for Bronze plans. The visits could include a specialist visit in addition to primary care, mental health and urgent care visits.
- Removes the application of a deductible for certain Silver services, such as laboratory tests and rehabilitation.
- Combines copay and coinsurance into a single product for Silver plans. Doctor visits, lab tests and prescriptions are not subject to a deductible in this single product.

Below is Covered California’s 2016 Standard Benefit Designs and Medical Cost Shares, which lays out what consumers can expect to pay for each service. And more importantly, it lays out in blue which services consumers can access without having to first meet their deductible. (In other words, consumers have access to every service highlighted in blue, including primary care visits, and only pay the copay without having to first pay a deductible.)

TABLE 9 — 2016 Standard Benefit Designs and Medical Cost Shares

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	\$23,451 to \$29,425 (>200% to ≤250% FPL)	\$17,656 to \$23,450 (>150% to ≤200% FPL)	up to \$17,655 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	after first 3 non-preventive visits, pay negotiated carrier rate per instance until out-of-pocket maximum is met	\$70*	\$45	\$40	\$15	\$5	\$35	\$20
Specialist Visit	pay negotiated carrier rate per service until out-of-pocket maximum is met	\$90*	\$70	\$55	\$25	\$8	\$55	\$40
Urgent Care		\$120*	\$90	\$80	\$30	\$6	\$60	\$40
Emergency Room		Full cost until deductible is met	\$250	\$250	\$75	\$30	\$250	\$150
Laboratory Tests		\$40	\$35	\$35	\$15	\$8	\$35	\$20
X-Rays and Diagnostics	Full cost until deductible is met	Full cost until deductible is met	\$65	\$50	\$25	\$8	\$50	\$40
Imaging			\$250	\$250	\$100	\$50	\$250 copay 20% coinsurance***	\$150 copay 10% coinsurance***
Tier 1 (Generic Drugs)	pay negotiated carrier rate per script until out-of-pocket maximum is met	Full cost up to \$500 after drug deductible is met	\$15	\$15	\$5	\$3	\$15	\$5
Tier 2 (Preferred Drugs)			\$50**	\$45**	\$20**	\$10	\$50 or less	\$15 or less
Tier 3 (Non-preferred Drugs)			\$70**	\$70**	\$35**	\$15	\$70 or less	\$25 or less
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150** per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual \$6,000 Family \$12,000	Individual \$2,250 Family \$4,500	Individual \$1,900 Family \$3,800	Individual \$550 Family \$1,100	Individual \$75 Family \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual \$500 Family \$1,000	Individual \$250 Family \$500	Individual \$250 Family \$500	Individual \$50 Family \$100	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$6,850 individual only	\$6,500 individual \$13,000 family	\$6,250 individual \$12,500 family	\$5,450 individual \$10,900 family	\$2,250 individual \$4,500 family	\$2,250 individual \$4,500 family	\$6,200 individual \$12,400 family	\$4,000 individual \$8,000 family

Drug prices are for a 30 day supply
 * Copay is for any combination of the first three visits. After three visits, future visits will be at full cost until the medical deductible is met
 ** Price is after pharmacy deductible amount is met *** See plan Evidence of Coverage for imaging cost share

DENTAL AND VISION COVERAGE

DENTAL COVERAGE

All Covered California health insurance plans in the individual market offer embedded pediatric dental plans. Dental coverage for children is included in the price of all health plans purchased through Covered California.

In an effort to expand dental coverage among adults and families, Covered California began offering standalone family dental plans. Beginning Jan. 1, 2016, family dental HMO and PPO plans are available as an optional purchase for consumers who have a health plan through Covered California.

The dental insurance companies offering plans through Covered California in 2016 are:

- Access Dental/Premier Access.
- Anthem Dental (Individual only).
- Delta Dental.
- Dental Health Services.
- Liberty Dental (Covered California for Small Businesses only).
- MetLife/Safeguard Dental (Covered California for Small Businesses only).

Dental plans sold through Covered California must adhere to patient-centered benefit designs, making dental benefits available to single adults, married adults, families and children. All dental plans include comprehensive coverage and free preventive and diagnostic care, such as cleanings, X-rays and exams. Depending on where they live, adult consumers can choose from monthly premiums of approximately \$11 to \$21 for dental HMO plans, and \$47 to \$65 for dental PPO plans.

There are no federal subsidies available to consumers for the purchase of family dental plans. Additionally, Covered California receives revenue from the dental plans in a similar method used for health plans. For plan year 2016, each dental plan gave Covered California \$0.83 per monthly premium paid by each enrollee.

TABLE 10 — Standalone Dental Plans Types and Enrollee Cost Sharing for 2016

DHMO – ENROLLEE PAYS

Coverage category	Child	Adult
Diagnostic and preventive (includes X-rays, exams and cleanings)	\$ 0	\$ 0
Amalgam filling – one surface	\$ 25	\$ 25
Root canal – molar	\$ 300	\$ 300
Gingivectomy per quad	\$ 150	\$ 150
Extraction – single tooth, exposed root or erupted	\$ 65	\$ 65
Extraction – complete bony	\$ 160	\$ 160
Crown – porcelain with metal	\$ 300	\$ 300
Medically necessary orthodontia	\$ 350	not covered

As of March 1, 2016, Covered California reported that 115,200 members have enrolled in individual marketplace family dental plans.

Enrollee costs		
Deductible (waived for diagnostic and preventive)	\$ 0	\$ 0
Annual benefit limit	none	none
Individual out-of-pocket maximum	\$ 350	N/A
Family out-of-pocket maximum (two or more children)	\$ 700	N/A
Office copay	\$ 0	\$ 0
Waiting period	none	none

DPPO – ENROLLEE PAYS

Coverage category	Child	Adult
Diagnostic and preventive (includes X-rays, exams and cleanings)	0%	0%
Amalgam filling – one surface	20%	20%
Root canal – molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction – single tooth, exposed root or erupted	50%	50%
Extraction – complete bony	50%	50%
Crown – porcelain with metal	50%	50%
Medically necessary orthodontia	50%	not covered

Enrollee costs		
Deductible (waived for diagnostic and preventive)	\$ 65	\$ 50
Annual benefit limit	none	\$ 1,500
Individual out-of-pocket maximum	\$ 350	N/A
Family out-of-pocket maximum (two or more children)	\$ 700	N/A
Office copay	\$ 0	\$ 0
Waiting period	none	6 months* for major services

* Waived with proof of prior coverage.

VISION COVERAGE

Similar to pediatric dental coverage, pediatric vision coverage is an essential health benefit under the Affordable Care Act. As such, vision benefits for children are embedded in all Covered California health insurance plans. However, vision care for adults is not considered an essential health benefit and is not a covered benefit in Covered California health plans.

In an effort to help consumers connect with and obtain coverage from quality vision plans, Covered California partnered with two vision carriers, Vision Service Plan (VSP) and EyeMed Vision Care, to offer individual and family vision coverage to Covered California consumers. Interested consumers can enroll directly on the vision carrier's website, and can call for enrollment assistance or use a Certified Insurance Agent to obtain coverage. Covered California provides a link to both vision carrier websites. The carrier websites provide consumers with information on vision coverage, coverage options and provider networks.

Beginning in February 2016, visitors to CoveredCA.com can access VSP through a link that takes them to VSP's website. Once on the VSP website, consumers work directly with VSP to shop for vision benefits and see which coverage options are best for them. VSP currently offers Covered California consumers one plan option, which is VSP's most popular plan.

In April 2016, EyeMed Vision Care became the second pathway to vision coverage for Covered California consumers. EyeMed Vision Care currently offers consumers three plan options with different levels of coverage.

As part of their agreements with Covered California, both VSP and EyeMed Vision Care are required to conduct annual consumer surveys to ensure a positive consumer experience. In addition, they will provide quarterly enrollment reports to Covered California based on those who have accessed their respective websites through CoveredCA.com. VSP and EyeMed Vision Care pay Covered California a commission of 5 percent of the quarterly premiums they earn from each enrollee who signed up through Covered California.

MARKETING AND MEDIA

Covered California's diverse and healthy enrollee population did not occur by chance. Rather, it is the product of making significant investments in marketing and outreach. Grounded in research and anchored in an ongoing effort to reach California's diverse population, marketing and outreach are key components of Covered California's mission and operations.

In FY 2015-16, approximately \$68 million was allocated to marketing for advertising, collateral materials, research and other efforts to:

- Build brand awareness and engagement by emphasizing the value and benefits of health insurance, positioning Covered California as the place to get quality health coverage and presenting solutions to address barriers to enrollment such as promoting federal financial assistance and free, in-person enrollment assistance.
- Drive enrollment in health coverage through Covered California with a multi-touch, tailored communication effort designed to engage consumers at key decision points in the enrollment journey from initial consideration, to information gathering and evaluation, to application, plan selection and effectuation.
- Drive retention and renewal of existing membership through continuous, timely and relevant communication with consumers that is designed to provide key information about their coverage, changes in status and the steps to renewing coverage.

OPEN ENROLLMENT CAMPAIGN

Covered California's open enrollment marketing campaign complemented extensive community outreach campaigns launched throughout the state. It was organized around specific market segments: general market (multi-segment), Latino, Asian/Pacific Islander, African-American, and Lesbian, Gay, Bisexual and Transgender (LGBT) audiences.

General Market (Multi-Segment) Marketing

Covered California's general market campaign for the third open-enrollment period was designed to cast the widest net, reaching English-speaking, subsidy-eligible Californians of multiple ethnic and cultural backgrounds, from rural to urban areas. The campaign was also designed to reach the millennial generation (ages 26 to 34) through social and digital media.

Covered California launched the "It's more than just health care; it's life care" campaign in late October 2015, which emphasized the overarching importance of health insurance in everyday life with the goal of improving the perceived value of health insurance and motivating the uninsured to get covered. When open enrollment began on Nov. 1, 2015, the campaign was rolled out in all 12 media markets in the state and included brand television, direct-response television (DRTV), cable television, radio, online banners, social media and paid search advertising.

Other key components to the general market campaign strategy included:

- Mobile advertising that complemented the digital ad buy and promoted Covered California to on-the-go consumers. Tactics included location-based targeting to reach users as they move around town and connect them to a Covered California storefront nearby.
- An extensive social media campaign designed to increase awareness and enthusiasm for open enrollment and renewal among prospective and current enrollees. The social media campaign resulted in 135 million impressions, 12,000 new Facebook friends and 1,500 new Twitter followers across all segments.

African-American Market Segment

During the third open enrollment, efforts were enhanced to better reach the African-American population. Reach to African-Americans was expanded by leveraging known talents and DJs who are well liked and trusted within this community to deliver Covered California's message. The marketing campaign focused on community-based and culturally focused media outlets. Specifically, Covered California used in-culture African-American radio, print publications and out-of-home media placements in select areas with a high concentration of African-Americans. Covered California also used African-American-targeted television programming from the general-market campaign to extend the reach to African-Americans. Overall, Covered California reached African-Americans in key markets such as Los Angeles, San Francisco and Oakland, San Diego and Sacramento, as well as through digital media statewide.

Asian/Pacific Islander Market Segment

Covered California's Asian-language marketing campaign reached Asian-American audiences in regions with high concentrations of this population, including Los Angeles, San Francisco, Sacramento, Fresno and San Diego. Since its inception, the campaign has been designed to reach Asian-Americans in specific languages, including Chinese (Cantonese and Mandarin), Vietnamese and Korean through select media channels such as television, radio, print and digital. Print advertising targeting Filipinos and radio advertising reaching Hmong, Cambodian and Laotian communities were also included in select markets with high concentration of these populations. In addition, the campaign reached bilingual Asian-Americans through general-market media placements with advertisements featuring Asian-American consumers.

Latino Market Segment

To motivate enrollment in the Latino community, Covered California maintained a robust enrollment effort aimed at both Spanish-speaking Latinos through Spanish-language media and English-speaking Latinos through targeted general-market media statewide. As in previous open-enrollment periods, the Spanish-language marketing campaign for the third open-enrollment period covered all 12 media markets in the state, with the heaviest penetration in areas of the state with the highest Latino populations: Los Angeles, San Diego, the San Francisco Bay Area, Sacramento, Fresno and Bakersfield.

Similar to the multi-segment campaign, Spanish-language ads for the "*Es más que cuidado médico; es cuidado para la vida*" campaign ran from November 2015 through January 2016 in multiple media channels. Specifically, Covered California aired ads on Spanish-language brand television, direct-response television and radio. In select areas with a high concentration of Latinos, print publications, out-of-home ads and direct mail were also used. There was Spanish-language digital, mobile and social media advertising statewide.

LGBT Market Segment

As in previous years, Covered California continued to reach out to the LGBT population during open enrollment, focusing on key markets (Los Angeles, San Francisco and San Diego) and using select print publications. The LGBT audience was also reached statewide through contextually relevant television shows, social media channels and digital media using banner and video ads.

SPECIAL ENROLLMENT CAMPAIGN

Covered California's special-enrollment period is an opportunity to sign up outside the open-enrollment period for individuals who have experienced life-changing events that make them newly eligible for Covered California. Ensuring proper enrollment during the special-enrollment period remains a priority for Covered California, and during FY 2015-16, Covered California maintained a special-enrollment marketing campaign that included outreach via radio, digital media, social media and paid search advertising to reach Latinos, African-Americans, Asian/Pacific Islanders and the general market.

Additionally, Covered California partnered with the Employment Development Department (EDD) on a direct-mail insert to reach the recipients of unemployment benefits, highlighting Covered California as an alternative to COBRA. This cost-effective effort of sending six direct-mail inserts generated approximately 10,000 leads or calls annually.

Other special-enrollment campaign partnerships include:

- With its health plans, Covered California works to facilitate conversion to Covered California for people who lose their employer-sponsored health plan or their prenatal coverage, or lose coverage through a parent's health plan when they turn 26 years old.
- In partnership with private-sector consulting groups that serve large employers, Covered California provides information about its offerings to people who are losing their employer-sponsored coverage.
- The Employment Development Department includes mail inserts in both English and Spanish to reach more than 800,000 recipients of EDD's monthly benefit mailer.
- California Courts provides information about Covered California on several of the agency's webpages, including Families & Children, Divorce or Separation, Child Support and Domestic Violence.
- The State Workforce Investment Board's Rapid Response teams give out information about Covered California to consumers who are being terminated from employment and will lose their employer-sponsored coverage.
- The California Department of Veterans Affairs provides information about Covered California on the CalVet website for veterans and their families when a veteran is returning from service and will be a resident of California.

Building Consumer Relationships

In late 2015, Covered California launched new message-automation software, Eloqua, which strategically sends personalized messages to consumers to support their purchase or renewal of coverage. For example, Covered California was able to target consumers at various stages of the application process and provide them with information about deadlines as well as reminders to submit their application or to pick a plan.

Further, beginning in the spring of 2016, Covered California actively sent information about special enrollment to those consumers who did not complete their enrollment during the open-enrollment period. Information was also sent to those whose coverage was terminated after receiving an advanced premium tax credit (APTC), or whose coverage was canceled, meaning they ended their enrollment before any APTC was allocated or premiums were paid.

In an effort to increase retention and promote renewal, in the spring of 2016 Covered California began to provide information, education and direction to current Covered California enrollees on various topics,

including paying premiums, tax preparation, 1095 tax forms and how to report changes. Covered California also sought to improve member satisfaction and brand image by communicating other educational topics such as How to Reset Your Password, Using Your Plan and Health Care Terms Explained to nurture and continue to build a relationship with members. Finally, Covered California sent enrollees proactive consumer service messages and specific instructions on how to renew their coverage, in addition to information about deadlines, plan changes and the metal tiers.

Bus Tour

At the beginning of November 2015, Covered California embarked on its second statewide bus tour designed to draw attention to the open-enrollment period. Spanning more than 2,000 miles that stretched from San Diego to Eureka, the bus tour made 38 stops at hospitals, clinics and Covered California storefronts, and visited Certified Insurance Agents and community partners. The theme was “Spotlight on Coverage” in recognition of the millions of Californians who have received much-needed medical care due to the Affordable Care Act. Along the bus tour the “spotlight” theme was also celebrated through actual Covered California-themed spotlights that lit up iconic buildings, hospitals, medical centers and enrollment locations across the state. The tour resulted in 34 million impressions on Californians through media coverage, seeing the bus and participating in bus tour events.



ENROLLMENT ASSISTANCE, OUTREACH AND PARTNERSHIPS

Covered California’s marketing and media efforts are complemented by robust outreach and enrollment assistance strategies. Covered California has created a network of community partners, health organizations, insurance agents and other entities that help potential enrollees learn about their health insurance options and enroll in coverage.

By the end of 2015, Covered California had more than 560 insurance agent and navigator “storefronts”



throughout the state, the largest storefront program in the nation. Storefronts are brick-and-mortar locations where consumers can enroll in a health plan through Covered California with free, confidential help from a certified enroller in their community. Additionally, during the third open-enrollment period, Covered California promoted more than 3,000 enrollment events on its website, striving to ensure consumers were aware of these community-based events where they can learn about health insurance and get assistance enrolling.

ENROLLMENT ASSISTANCE

Covered California partners with thousands of certified enrollers who offer enrollment assistance to consumers free of charge. All certified enrollers must go through an application and training process to assist and enroll consumers into Covered California. During the 2016 open enrollment and renewal cycle, there were more than 20,000 certified enrollers across the state providing enrollment assistance, including:

- 14,676 insurance agents who are certified by Covered California to enroll consumers into coverage. Certified Insurance Agents receive a commission from the health plans. They cannot charge consumers for their services, and are not compensated by Covered California.
- 2,175 Certified Application Counselors (CACs) who work or volunteer for a Certified Application Entity and are certified to enroll. They are not compensated by Covered California.
- 2,217 Certified Enrollment Counselors who are volunteers or employees of a navigator organization. Navigators are embedded in the community and provide enrollment assistance and education to consumers. Covered California awards grants to navigators through a competitive grant process.
- 30 Medi-Cal Managed Care Individual Enrollers affiliated with local organizations and health plans that exclusively serve Medi-Cal beneficiaries.
- 12,000 county eligibility workers located in their respective counties who can enroll consumers in both Medi-Cal and Covered California plans.
- 1,431 Plan-Based Enrollers, who are enrollers employed by the health plans.

ENROLLMENT OUTREACH STRATEGIES

In recognition that California is a diverse state, Covered California created strategies to reach potential consumers where they are most likely to need it. In Oakland, for example, Covered California partnered with the local government to create an enrollment center in City Hall. In San Diego, Long Beach, Riverside, the Central Valley and Los Angeles, Covered California canvassed neighborhoods, going door to door to inform people about open enrollment. Maps were also used to identify ZIP codes with a large number of subsidy-eligible people living there, called “hot spots.” Covered California used that information to strategically place enrollment resources. For instance, an enrollment center was opened in a widely used community center in a hot-spot neighborhood in Inglewood.

Covered California also expanded its public-private partnerships, including establishing Covered California kiosks at Westfield Malls and working with the Workforce Investment Board to inform the recently unemployed that they can buy insurance on the exchange.

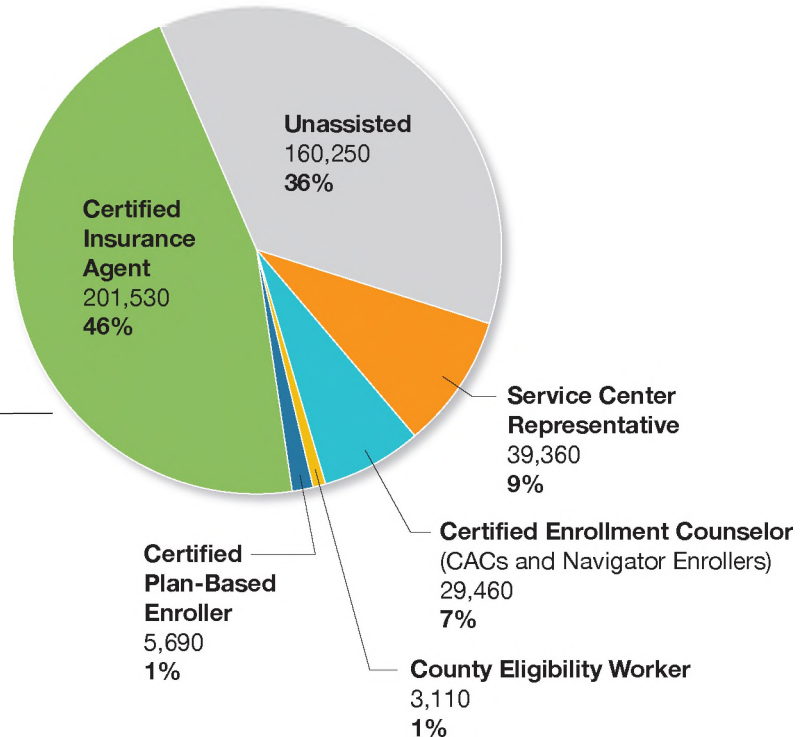


FIGURE 3

Number of Consumers Enrolled by Each Certified Enrollment Entity for the 2016 Plan Year

SPECIAL ENROLLMENT PERIOD OUTREACH

To prepare Covered California’s certified enrollers for the special-enrollment period, Covered California hosted a number of trainings and a statewide “Special-Enrollment Period Kickoff Tour.” The tour consisted of a series of meetings in 13 cities featuring a panel of speakers who shared best practices. Covered California staff members were there to answer questions and take feedback. The goal of these trainings was to ensure enrollers understand who qualifies for special enrollment and how to enroll them in a health plan outside of the peak open-enrollment time.

The outreach strategy also included the use of hot spots to identify areas with high special-enrollment-eligible residents and to build strategic partnerships with organizations that facilitate common qualifying life events, such as hospitals and employment agencies.

SERVING COVERED CALIFORNIA'S CONSUMERS

Covered California's service centers provide comprehensive pre- and post-enrollment education and support to consumers by responding to their inquiries, helping enroll them into coverage and promptly resolving challenges. The service centers also handle appeals, provide "warm transfers" to counties of individuals eligible for Medi-Cal or other programs and provide support to certified enrollers and health plans, among other duties.

During the 2015-16 fiscal year, more than 900 staff members were employed at Covered California's two service centers, in Rancho Cordova and Fresno. In FY 2015-16, Covered California continued its contract with the County of Contra Costa to operate a service center in Concord that was staffed by more than 120 county employees. Also in FY 2015-16, Covered California contracted with Faneuil, Inc. to provide call center services during "surge" periods when call volumes are at their peak during open enrollment, and to support systems for processing enrollment-related documents that cannot be handled automatically.

Key accomplishments of the Service Center division during FY 2015-16 include:

- Processed more than 2.5 million consumer assistance calls from July 2015 through March 2016.
- Service Center Representatives (SCRs) enrolled 15 percent of new enrollees during open enrollment.
- Completed more than one million "manual work streams," which is the system for processing documents that cannot be processed automatically.
- Processed 15,600 consumer appeals.
- Implemented a "live chat" function in Spanish.

Improvements to the Service Center Consumer Experience

Covered California is continuously working to make the service centers a helpful and consumer-friendly source of enrollment assistance through technology enhancements and SCR training.

When consumers call the service center, they encounter the Interactive Voice Response (IVR) system first. In FY 2015-16, the IVR system underwent a significant enhancement to increase consumer self-service and improve the consumer experience. The primary enhancements to the IVR system included:

- Skills-based routing so consumer calls are directed to the highest-skilled SCR.
- Medi-Cal messaging.
- Improvements and options for Covered California's Medi-Cal partners and consumers informing them that Medi-Cal coverage is available, and providing contact information for their local county office.
- Adding the Cantonese language to the full IVR call flow and self-service.
- Improving reporting capabilities so Covered California can make better data-driven decisions and improve consumers' experiences.

These enhancements have resulted in a dramatic reduction in average wait times for the third open-enrollment period in 2015-16, in comparison to the second open-enrollment period in 2014-15.

TABLE 11 — Service Center Calls in 2015-2016³

Calls to the IVR	4,754,902
Calls Offered to SCRs	3,344,312
Abandoned Percentage	9.16%
Average Speed of Answer	03:01
Average Handle Time	16:12
Calls Handled	2,555,920

Language Assistance

The service centers have strong language capabilities in order to maintain high-quality service to the diverse enrollee population. Through the service centers, consumers can receive assistance in 14 languages: English, Spanish, Cantonese, Hmong, Farsi, Russian, Lao, Tagalog, Vietnamese, Arabic, Korean, Armenian, Mandarin and Cambodian. If a bilingual SCR is not available to take a consumer’s call or a caller speaks another language, the SCR uses a language-interpreting service.

TABLE 12 — Service Center Calls Conducted in Languages Other Than English, FY 2015-16³

Arabic	8,784	1.8%
Armenian	3,064	0.6%
Cambodian	493	0.1%
Cantonese	18,421	3.7%
Farsi	5,524	1.1%
Hmong	501	0.1%
Korean	13,958	2.8%
Laotian	792	0.2%
Mandarin	29,869	6.1%
Russian	4,363	0.9%
Spanish	387,515	78.6%
Tagalog	6,518	1.3%
Vietnamese	13,445	2.7%

³ Calls logged from Sept. 1, 2015 to Sept. 30, 2016.

TECHNOLOGY TOOLS FOR CONSUMERS

Covered California’s consumer website, CoveredCA.com, and the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) are the consumer’s portal to health insurance through Covered California. CalHEERS and CoveredCA.com are overseen by the Information Technology division in partnership with the Communications and Public Relations division to ensure both have the technological capabilities and consumer friendliness necessary to achieve Covered California’s mission.

CoveredCA.com

CoveredCA.com is the one-stop shopping experience for Californians seeking affordable health insurance. Consumers can shop for a plan, and depending on their income level, can get help paying for their coverage through federal subsidies and cost-sharing reductions. Those who qualify for Medi-Cal can also learn about their health care options on the website and apply for coverage. It is also where the Shop and Compare Tool is located.

CalHEERS

CalHEERS is the information technology system that is used to support the application for Covered California and Medi-Cal. CalHEERS is overseen by the California Office of Systems Integration (OSI), and is jointly sponsored by Covered California and the Department of Health Care Services (DHCS), the agency that administers Medi-Cal. CalHEERS supports Covered California and DHCS through user account creation, implementation of the single streamlined application, determination of eligibility, interfacing with county IT systems and enrollment in health plans.

Improvements to CoveredCA.com During FY 2015-16

Covered California is committed to continuously improving the consumer experience with the online application. Enhancements are rolled out throughout each year, and FY 2015-16 was no exception. Numerous enhancements were made to CalHEERS prior to the third open-enrollment period to aid consumers as they enrolled in Covered California and Medi-Cal. These enhancements included:

- Refining the “business rules” that identify which consumers may be eligible for which financial assistance programs so that all applicants are informed of their health care options as quickly, easily and accurately as possible.
- Making the application more dynamic so that consumers are directed only to questions that apply to them and the insurance affordability programs for which they qualify.
- Offering consumers the choice to receive their notices by email if that is their preferred communication method.
- Providing more options to securely reset their password without having to speak to a Service Center Representative.
- Enhanced safeguards to prevent duplicate accounts and applications for one consumer. Multiple applications can result in delayed access to eligibility results and effectuation of coverage.

- Changes to help consumers more accurately report their income and ensure timely and accurate eligibility determinations.

New Consumer Tools

In FY 2015-16, CoveredCA.com underwent changes designed to provide a better user experience. In the fall of 2015, consumers were greeted with the option of using the Storefront Finder. This tool allows consumers to enter their ZIP code and find a certified enroller in their neighborhood. One-on-one meetings with knowledgeable Covered California representatives are helpful for consumers who wish to better understand the enrollment process.

Also in the fall of 2015, Covered California unveiled an enrollment-journey map that lets consumers see the steps of the enrollment process. This map can be accessed by clicking on the “About” button on the CoveredCA.com homepage. The map was designed to give the consumer a visual understanding of how the enrollment process works and what they can expect along the way. The map has information about shopping tools, how to apply, how to pay one’s bill and other steps in the process.

Interface Improvements

Prior to the 2015-16 open-enrollment period, Covered California refreshed CoveredCA.com with an upgrade to its “look and feel.” This enhancement was most notable on the homepage, which received an updated main photograph, a link within that photo that tells consumers more about Covered California and a button leading to the steps to apply. All of these upgrades were made while keeping consumers in mind.

Lastly, in May of 2016, Covered California launched a Google search bar on CoveredCA.com. The search bar is on the upper right-hand side of the website, and helps consumers more easily find the items they are seeking. This tool is especially useful for Service Center Representatives while they are fielding calls from consumers.

ASSURING PROGRAM INTEGRITY

Covered California's Program Integrity division was established during FY 2015-16. The division was formerly known as the Eligibility and Enrollment division. This division collaborates with all program areas to improve system and operational efficiencies throughout Covered California. It was also formed to help oversee program compliance with federal and state laws and regulations, and is a mission-critical section within Covered California.

The Program Integrity division administers the Consumer Protection and Fraud Risk Management Program, an integrated fraud prevention system within Covered California. This program drives improvement in policies, procedures, internal controls, compliance with whistleblower provisions and enterprise risk management. The focus on fraud prevention is centered on integrity and the expected behaviors from employees and others. Combating fraud before it occurs is a vital concern and priority for Covered California.

Additionally, the Program Integrity division administers the Oversight and Monitoring Program, which oversees and monitors financial and programmatic areas to ensure compliance with the Affordable Care Act. Covered California's Oversight and Monitoring Program fosters accountability and transparency, mitigates the risk of systematic vulnerabilities going undetected, and reduces the frequency of operational inconsistencies.

Key activities of the Program Integrity division during FY 2015-16 include:

- Managing, monitoring and reconciling program data to improve the accuracy of enrollment information and transactions sent between Covered California, health plans and federal partners.
- Coordinating and improving the testing and implementation protocols for CalHEERS in order to reduce the number of critical defects.
- Improving processes by which changes within Covered California programs are reviewed following implementation in order to improve operational efficiencies and compliance with business requirements and policies.
- Conducting and managing an independent audit function and risk assessment process to measure compliance with federal and state regulations and mandates.
- Administering consumer protection and fraud risk management.

IMPROVING THE IRS 1095-A FORM PROCESS

Every year, Covered California issues a Health Insurance Marketplace Statement, also called an Internal Revenue Service (IRS) Form 1095-A, to all Covered California enrollees for tax-filing purposes. A 1095-A form provides proof of insurance coverage for the previous year so the consumer does not have to pay the IRS penalty for not having coverage. In FY 2015-16, the Program Integrity division streamlined the process of generating and correcting 1095-A forms to ensure consumers received the right information at the right time.

Covered California issued 1.1 million 2015 IRS Form 1095-A forms by Jan. 31, 2016. Consumers received a hard copy of the 1095-A by mail and were also able to download a copy of the 1095-A form to their secure CalHEERS mailbox.

Most consumers received a correct 1095-A. However, some received an incorrect 1095-A for a variety of reasons, including but not limited to a change in consumer demographic information, a change in household composition or an update to the premiums paid by the consumer. As such, Covered California implemented the 1095-A dispute process that let consumers who received an incorrect 1095-A complete a standardized online form that was designed to efficiently categorize cases for research and resolution. The standardized form, coupled with a dedicated resolution team, allowed the vast majority of disputes to be resolved within 30 days. Table 13 below illustrates the number of corrected 1095-A forms Covered California issued this fiscal year, as well as how many 1095-A forms were disputed.

TABLE 13 — IRS 1095-A Forms Processed by Covered California, FY 2015-16

Type	Total
Original 1095-A Forms Issued	1,208,209
Corrected 1095-A Forms Issued	78,864
1095-A Form Disputes received, as of June 2016	33,901
1095-A Form Cases resolved, as of June 2016	33,612

COVERED CALIFORNIA FOR SMALL BUSINESS

Covered California is working to grow and enhance its small business health benefit exchange, known as Covered California for Small Business. Covered California for Small Business, formerly known as the Small Business Health Options (SHOP) program, allows small businesses throughout California to take advantage of a competitive marketplace while purchasing insurance for their employees. While offering health insurance to employees is mandatory only for businesses with more than 50 employees, small businesses with fewer than 50 employees may also purchase coverage through Covered California for Small Business. As such, Covered California for Small Business offers valuable advantages to small businesses, including:

- Help controlling their health care budget and limiting administrative overhead while offering employees a broader choice of health plans.
- Improving employee satisfaction by allowing employees to choose the health plan and physician network that work best for them.
- Offering employees a broad choice of physician networks and hospitals that might not be available to them otherwise.
- The convenience of one consolidated monthly bill even while purchasing coverage from multiple carriers.
- Offering tax credits for qualifying small business to help offset the cost of providing health insurance to employees.

Covered California for Small Business experienced positive growth last fiscal year. In July 2015, there were 18,476 members and 2,763 employer groups enrolled in Covered California for Small Business. As of June 30, 2016, 28,391 members and 3,838 employer groups were enrolled in Covered California for Small Business. In addition, six health plans and seven dental plans offered coverage during FY 2015-16 in the Covered California for Small Business marketplace in all four metal tiers:

- Blue Shield of California.
- Chinese Community Health Plan.
- Health Net.
- Kaiser Permanente.
- Sharp Health Plan.
- Western Health Advantage.

This coverage also includes Covered California's Dual Tier Choice program that allows employers to offer employees two plans instead of just one by selecting two adjoining metallic tiers: Bronze + Silver, Silver + Gold, or Gold + Platinum. Employees have the option to select any plan within those two levels. Dual Tier Choice gives employees a choice of multiple health plan options from private health insurance companies, allowing them to find one that fits their needs and budget.

Beginning on Jan. 1, 2016, CCSB opened its doors to businesses with up to 100 employees. The Protecting Affordable Coverage for Employees (PACE) Act is federal legislation that defines a small employer as an employer with an average of one to 50 employees on business days during the preceding calendar year. The legislation also gives states the option of extending the definition of small employer to include employers with up to 100 employees. California currently exercises this option pursuant to Assembly Bill 1083 (Monning, Chapter 852, Statutes of 2012) which defines a small employer as one with at least one but not more than 100 eligible employees.

LOOKING AHEAD TO THE FUTURE

Transition to a New Federal Administration

With the transition to a new federal administration taking place in 2017, Covered California will continue to pursue its mission to expand coverage for Californians by creating a consumer-focused health insurance marketplace.

Since its beginning, Covered California has been a learning organization, and has set the foundation to share its best practices as the health care landscape adapts to a new policy environment. As an example, Covered California commissioned an extensive study released in May 2016 that examined possible changes to the Affordable Care Act under numerous scenarios and their potential impacts on Californians.⁴

After the election, the Covered California board hosted a panel discussion in which health care marketplace experts analyzed the state of health reform implementation for 2017 and beyond.⁵ Covered California will use this input and the lessons learned from the past four years to adapt to possible changes to the federal law and help inform the larger conversation on health care reform.

These lessons include how Covered California:

- Built a competitive marketplace that puts consumers in the driver's seat, giving them a power that they did not previously have when it comes to the plans they pick and the providers they can access.
- Developed patient-centered benefit designs that offer good value for consumers and keep care affordable by including a wide variety of services not subject to the deductible.
- Fostered a healthy enrollment profile by promoting access to primary care in robust and extensive marketing and community outreach with partners that include insurance agents and members of communities across the state that number in the tens of thousands.
- Effectively managed the federal tax credits that have brought health coverage within reach of millions of Californians.
- Established an infrastructure to examine patient data to evaluate the relationship between consumers' income, benefit designs, health status and other factors related to the quality of care and costs of services. This Healthcare Evidence Initiative is just now collecting data to begin deep analysis.

Changes to Covered California Leadership

After 5 years of leadership, Yolanda Richardson, Chief Deputy Executive Director, left Covered California in June 2016. In January 2017, Covered California welcomed Doug McKeever as its new Covered California's Chief Deputy Executive Director, Program and Karen Johnson as its new Chief Deputy Executive Director, Administration. Each bring to their positions decades of leadership and experience in state service.

⁴ <http://bit.ly/2hWfHtL>

⁵ <http://bit.ly/2ihfOfF>

Additionally, in December 2016, Covered California announced the appointment of Darryl Lewis as the director of Covered California's new Office of the Ombudsman. These recent additions to the leadership team put Covered California in very good shape as we continue striving to meet our mission.

2017 Rates

The Covered California statewide weighted average rate increase for 2017 will be 13.2 percent, higher than the approximate 4 percent increase in prior years. However, nearly 80 percent of consumers will pay less or see a rate increase of no more than 5 percent if they switch plans during the renewal process.

Factors for higher rate increases for 2017 include:

- A one-year planned adjustment due to the end of a funding mechanism in the Affordable Care Act known as reinsurance, which was designed to moderate rate increases during the first three years while exchanges were being established. The American Academy of Actuaries estimates this will add between 4 percent and 7 percent to premiums for 2017.
- The rising cost of health care, especially specialty drugs.
- Pent-up demand for health care that is now being accessed by those who were locked out of the health care system before the Affordable Care Act was enacted.
- Higher health care costs associated with consumers who enroll in coverage during special enrollment has had a significant cost impact for two Covered California plans.

The three-year average increase since Covered California opened its doors is 7 percent, which is lower than pre-Affordable Care Act trends.

2017 Quality Initiatives

As part of the broader mission to improve health care quality in California, Covered California called for a number of requirements in the qualified health plan contract that increase accountability for the health outcomes of their enrollees. This section of the contract, known as Attachment 7, can be found at: <http://bit.ly/2ikhW6r>. These quality initiatives fall into four categories:

- **Primary Care:** In order to establish a primary source of care, health plans will ensure all enrollees either select or are assigned a primary care physician within 60 days of plan effectuation.
- **Quality and Value of Care:** Covered California will adopt a payment system for hospitals that will reward hospitals for quality performance. Health plan issuers will be required to identify and work to improve hospitals and providers that deliver poor-quality care or charge unreasonably high costs. Health plan issuers will also manage high-cost pharmaceuticals and help consumers better understand the effectiveness and cost of their drug treatments, as well as any alternatives.
- **Reducing Health Disparities:** Health plan issuers will track disparities among patients receiving care, identify trends in those disparities and aim to reduce disparities. This initiative will begin with four conditions: diabetes, hypertension, asthma and depression. Health plan issuers will also develop programs to proactively identify and manage at-risk enrollees.
- **Tools to Assist Consumers:** Health plan issuers will provide tools enabling consumers to view provider-specific cost shares (based on contracted rates) and quality information for prescription drugs and inpatient, outpatient and ambulatory services. In addition, these tools will allow members to see plan-specific accumulations toward deductibles and out-of-pocket maximums.

Marketing Campaign

Covered California uses an evidence-based marketing campaign based on focus groups and surveys. For the first time, in preparation for Covered California's fourth open enrollment, the Marketing division's research took into account the differing perspectives of both acculturated Latinos and Spanish-speaking-dominant Latinos. The research also included an LGBT focus group for the first time. This research is in addition to surveys and focus groups designed to get feedback from African-American, Latino, Asian/Pacific Islander and general-segment populations across income levels and insurance status.

With the transition to a new federal administration, Covered California is reminding consumers that Covered California continues to be open for business, and that individuals should renew or enroll into health coverage, with no changes expected in availability of coverage for 2017.

Covered California Consumer Website

For plan year 2017 Covered California invested in a significant update of CoveredCA.com. Taking consumer feedback into account, the website was redesigned to be more consumer friendly and informative. The website also features a new Shop and Compare Tool that allows consumers to view their insurance plan options and pick a plan in an anonymous format, but if they decide to apply, the plan choice will carry over into the application so the consumer does not need to "shop" for a plan again.

Special-Enrollment Period

Covered California is evaluating its special-enrollment application process to ensure that consumers are informed of their options and are applying appropriately. Currently, to apply for coverage during the special-enrollment period, applicants need to self-attest under penalty of perjury that they are experiencing a qualifying life event. However, due to new revelations about special enrollment's impact on premiums, Covered California is evaluating its special-enrollment process. Covered California is engaging in a verification program to review special-enrollment applications for their impact and accuracy.

Medi-Cal Transitions

Covered California works closely with its partners at the Department of Health Care Services to ensure Californians who qualify for Medi-Cal can access enrollment. Part of that partnership includes improving the process Covered California and Medi-Cal consumers experience when they must switch their coverage. An updated process is operational as of November 2016 that ensures consumers have access to health care while their eligibility is being determined. In the new process, when consumers report a change or when they renew their Covered California plan and find they are ineligible for Covered California, their case will be flagged as "Medi-Cal Pending." This status enables them to keep their Covered California plan while their case is reviewed by their local county. Once the county social services office has determined Medi-Cal eligibility, the Covered California plan will be terminated and the consumer will be enrolled into Medi-Cal. That way, there is no gap in coverage and the consumer has dual coverage until a final determination is made. If the county determines that the consumer is not eligible for Medi-Cal, their case will no longer be flagged and they will stay with Covered California. Covered California has shared these changes with consumers to ensure they are aware.

ADDITIONAL RESOURCES

For more information, please use the following websites and resources:

- **Covered California Website:** www.CoveredCA.com.
- **Covered California's Enabling Legislation:**
<http://bit.ly/2iNRHsJ>
<http://bit.ly/2iNSFVO>
- **Covered California Data Book:** <http://hbex.coveredca.com/data-research/>.
Book offers comprehensive data regarding Covered California enrollment broken down by region, age, income and other variables.



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Covered California | Sentiment Research

An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage

Topline Report | January 24, 2017





Covered California | Sentiment Research An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage

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Covered California | Sentiment Research An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage

Topline Report | January 24, 2017

Executive Summary

Background

With Open Enrollment 2016/2017 underway, Covered California conducted consumer research to understand attitudes toward obtaining health insurance, as it has during past Open Enrollments. This year, special emphasis was placed on understanding the impact of recent news about the future of the Affordable Care Act (ACA).

Covered California sought to understand how attitudes toward enrolling in and renewing health insurance coverage may have changed after the 2016 election. To support this goal, Covered California partnered with Greenberg, Inc., a strategic research consultancy, to conduct a study among key constituencies in December 2016.

Quantitative and qualitative research among insured and uninsured Californians was implemented to assess changes in attitudes. An online survey (n=500) primarily focused on sentiment and concerns, while focus groups with uninsured participants also included discussions on barriers. This enabled a statistically-significant assessment of sentiment, while also aiding understanding of the nuances of attitudes and emotions that drive decision-making.

These two sets of research inform an integrated narrative of key insights gained around sentiment toward enrolling in and renewing health insurance coverage in this new environment.

Current Attitudes Toward Health Insurance

Key findings of this integrated study include the following insights:

1. Concerns about health insurance affordability far outweigh concerns about future changes to health care.
2. The main enrollment barriers remain cost, product issues, and process complexity.
3. The changing discourse about the ACA has amplified existing barriers for those who expressed concerns.
4. The new uncertainty comes on top of deeper problems with the concept of health insurance.
5. Uncertainty among uninsured focus group participants adds to existing concerns. For some, this enhances motivation to enroll; for others, it seems to cause a "wait and see" attitude.
6. Despite uncertainty, trust in the "California brand" seems to be greater, reinforcing opportunities to overcome existing barriers.

Covered California | Sentiment Research

An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage

Topline Report | January 24, 2017

Section I. Research Overview

Background

Covered California was the first state health insurance exchange established following the federal health reform legislation enacted in 2010 (Patient Protection and Affordable Care Act). It is an independent part of the state government, the purpose of which is to make the health insurance marketplace work for California's consumers.

Objectives

With Open Enrollment 2016/2017 underway, recent news about the future of the Affordable Care Act (ACA) may be affecting attitudes toward health insurance. In light of this, Covered California sought to understand whether evolving sentiment is affecting intent to enroll in and renew coverage for 2017.

As part of its ongoing research program, Covered California, together with its advertising agency of record, Campbell Ewald, partnered with Greenberg, Inc., to conduct rapid response research among key constituencies in late December 2016. The specific objectives of this study were to:

- Evaluate whether recent events have affected attitudes toward enrolling in or renewing health insurance coverage
- Establish the primary barriers/motivators to enroll through Covered California, and whether they have changed

Methodology

Greenberg conducted an integrated – quantitative, then qualitative – study to gain a statistically significant assessment of sentiment, while also understanding the nuances of attitudes and emotions that drive decision-making.

The quantitative research – an online survey among insured and uninsured survey respondents conducted in both English and Spanish (noted in the next section) – secured the data to quantify opinions and reported behaviors to enroll in and renew health insurance, as well as to generalize results from a larger sample population. The results of the survey and analyses helped establish sentiment-related facts and inform the lines of inquiry in the qualitative research.

The qualitative research – in-person focus groups conducted in English and Spanish among uninsured participants – was used to gain a deeper understanding of barriers to obtaining health insurance along the lines of what was learned in the quantitative survey.¹

¹ Research findings about insured consumers are drawn from the quantitative survey. Qualitative focus groups included only uninsured participants, as the member renewal period had ended, and since the uninsured are Covered California's priority target.



Target – Quantitative Research

Greenberg conducted a survey among uninsured and insured Californians between the ages of 26–54 from December 14, 2016 to January 3, 2017. A total of 500 respondents completed the survey with the following breakout:

Insurance

Uninsured Subsidy Eligible	114
Uninsured Non-Subsidy Eligible (400%+ FPL)	49
Uninsured Medi-Cal Eligible	62
Insured – Covered California	175
Insured – Independently, Off Exchange*	50
Insured – Medi-Cal	50
Total Respondents	500

*Insured independently off exchange does not include those with employer-provided health insurance

Spanish-Dominant*

Uninsured Subsidy Eligible	22
Uninsured Medi-Cal Eligible	21
Insured – Covered California	41
Total Spanish-Dominant	84

*Spanish-Dominants must be Spanish-preferred and speak, read, and regularly utilize the Spanish language

Gender

Male	247
Female	250
Prefer not to say	3

Age

26–29	88
30–35	146
36–54	266

Race

White/Caucasian	216
Black/African American	26
Asian Pacific Islander/Asian American	71
Hispanic/Latino	162
Native American	5
Mixed Race	15
Other	3
I prefer not to say	2

Region

San Francisco	68
Sacramento	47
San Diego	106
Los Angeles	228
Other	51

Target – Qualitative Research

Greenberg conducted six 90-minute focus groups in Los Angeles on December 28 and 29, 2016 with uninsured Californians between the ages of 26–54. Each focus group included six or seven participants².

Of these groups:

- Three groups were made up of native English-speaking participants
- Two groups included Spanish-speaking participants, with Spanish as their dominant language (“Spanish-Dominant”)
- One group was Latino and/or Hispanic participants, identified as bilingual in Spanish and English
- Participants were screened to be 50%+ Subsidy Eligible (Federal Poverty Level (FPL) of 138% to 400%).

The same moderator conducted the four English and two Spanish-speaking focus groups. The Spanish discussion guide was translated and reviewed by Covered California’s Spanish-language agency, Casanova.

² In this report, those who took the survey are referred to as “respondents.” Focus group attendees are referred to as “participants.”



The Starting Point

The working hypothesis for this research was that the results of the November 2016 election may have affected attitudes toward obtaining or renewing health insurance through Covered California. Primary lines of inquiry were focused on understanding the scale, shape, and impact of these attitudes.

The sentiments that survey respondents and focus group participants expressed in this research reflect their knowledge and experiences as of the end of December 2016. These sentiments could change quickly given pending discussions and actions around health care coverage.

Bias Mitigation

Significant effort was made to avoid “biasing the witness.” The nomenclature used in both the quantitative and qualitative research excluded direct references to the political context. For example, the online survey and the qualitative research discussion guide excluded words such as “election,” “President-Elect Trump,” and “politics,” referring only to “recent events,” and used questions such as, “What have you heard about the future of the ACA?”

This Document

Across all research, findings were consistent in establishing a coherent understanding of consumer concerns and barriers to enrollment and renewal evident in the current marketplace. For this reason, we have chosen to present one narrative in this Topline Report, drawn from both the quantitative and qualitative research.



Covered California | Sentiment Research An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage

Topline Report | January 24, 2017

Section II. Current Attitudes Toward Health Insurance

Key Findings

This section highlights the primary *concerns* about the future of health coverage, as well as the top-level *barriers* to enrollment and renewal that emerged from the research. These are two distinct, yet overlapping aspects of the audience mindset, each vitally important in their own right to understanding enrollment dynamics.

Broadly speaking, the quantitative survey focused more on concerns only, while the focus groups addressed both barriers to enrollment and concerns. Six key findings are outlined in this section.

1. Concerns about health insurance affordability far outweigh concerns about future changes to health care.

“Despite whether things will get worse or not, affordability is not something you have to think a lot about. The cost is high, and that is exactly why [health] insurance is something that’s difficult for us.” ~Focus Group Participant, Uninsured

“We don’t know what’s going to happen in January and what new legislation will pass that will repeal Obamacare, who qualifies and who doesn’t, and how we’re going to pay for it.” ~Focus Group Participant, Uninsured

“I hope premiums do not increase and [that] there is an option to obtain affordable health care in the upcoming years.” ~Survey Respondent, Insured through Covered California

a. Survey respondents in quantitative research are aware of discussions about the future of health care and the ACA/Covered California, but levels of concern vary.

- i. 86% of survey respondents have at some point seen, heard, or read something about the future of the ACA/Covered California.³
- ii. Overall, 57% do not express concern for the future of the ACA/Covered California, while 43% say they are “concerned.” A third (32%) describe themselves as “confident,” while 25% are neutral.⁴

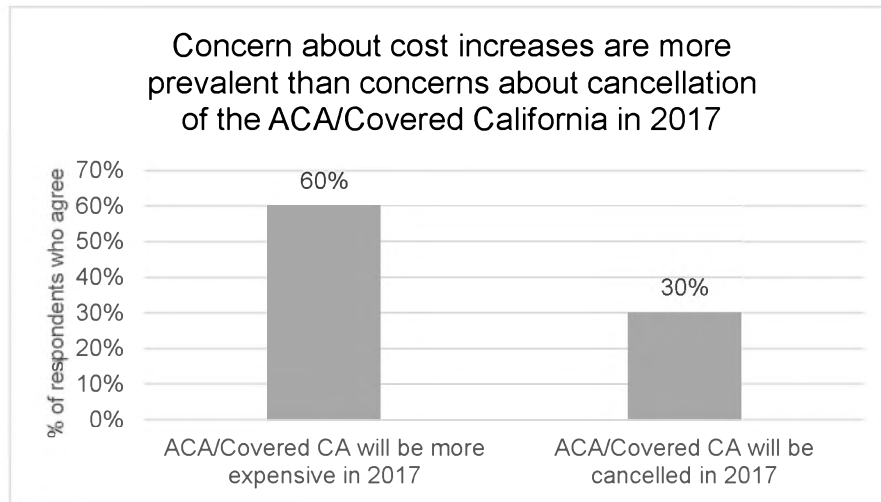
³ Which of the following have you seen, heard, and/or read about the future of the Affordable Care Act/Covered California?

⁴ How do you feel about the future of Covered California and/or the Affordable Care Act?



b. In both quantitative and qualitative research, concerns about costs rising are far more prevalent than concerns that the ACA/Covered California will be dismantled.

- i. Looking toward 2017, twice as many survey respondents expect costs to increase (60%) as those who expect the ACA/Covered California to be cancelled (30%).⁵
- ii. Concerns about cost increases in 2018 are more widespread than concerns that the ACA/Covered California will be cancelled that year (60% vs. 42%), although survey respondents are more likely to think the ACA/Covered California will be cancelled in 2018 (42%) than in 2017 (30%).⁶



c. Focus group participants express that if they could afford health coverage today, they would sign up for it, whether or not there is concern for the future of the ACA/Covered California. While they express significant apprehension that recent developments may affect the future of health care coverage, this is not foremost on their minds.

“If I have the money, I’ll get it [health insurance].” ~Focus Group Participant, Uninsured

“My employer doesn’t offer health insurance, which is rare. Most companies offer it. If they pay for part of it, I’ll pay for the rest; I can’t afford to do it all myself.” ~Focus Group Participant, Uninsured

- i. Uninsured **focus group** participants speak easily and freely of many other ongoing concerns and barriers they have to accessing health care coverage (see Finding #2).
- ii. It takes some probing to detect more recent concerns (e.g., asking participants what they have heard in the past couple of months).
- iii. Once the topic comes up, it is clear their concerns are heightened by recent events.

⁵What do you think? % of respondents who “strongly” or “somewhat” agree that: Health insurance through Covered California will become more expensive this year (2017) / Covered California/the Affordable Care Act will be cancelled and people will lose their health insurance this year (2017)

⁶What do you think? % of respondents who “strongly” or “somewhat” agree that: Health insurance through Covered California will become more expensive this year (2018) / Health insurance through Covered California will become more expensive this year (2017)



2. The main enrollment barriers remain cost, product issues, and process complexity.

“I realize [health insurance] is important, but it hasn’t seemed accessible, affordable, or an easy process, so the hassle has not been worth it.”
~Focus Group Participant, Uninsured

- a. **A majority of survey respondents believe that subsidies will be available and pre-existing conditions will be covered in 2017.**
- Most (62%) think Californians with pre-existing conditions will continue to be covered this year, and 90% think subsidies will continue to be available in 2017.⁷
- b. **For both uninsured and insured survey respondents, the cost of insurance is a higher enrollment barrier than concerns about the future of the ACA/Covered California. Regression analysis⁸ of the survey data shows this is a real obstacle:**
- Holding other factors constant – as one would assume, survey respondents who expect costs to rise in 2017 are less likely to enroll in or renew with Covered California.
 - In contrast, the belief that the program will be cancelled is not associated with hesitation to enroll/renew.*
- c. **In both English and Spanish focus groups, the barriers that prevent uninsured participants from enrolling in health insurance through Covered California are largely the same ones as four months ago in previous qualitative research, only heightened by recent events:**
- High premiums and overall affordability
 - The complexity inherent in evaluating insurance options, deductibles, subsidies, and risk
 - The perception that they are not eligible for subsidies
 - The perception (or experience) that enrolling is difficult (e.g., website usability, getting answers, etc.)
- d. **In focus groups, these barriers are compounded for most uninsured, Spanish-Dominant participants:**
- Focus group participants report low awareness of “financial help” (subsidies) available through Covered California.
 - Almost all Spanish-Dominant focus group participants know at least one person whose undocumented legal status and/or concern about privacy or deportation stops them from seeking insurance (even more so than cost).
 - Some understand that undocumented immigrants are not eligible for Covered California.
 - Some believe the cost of Covered California insurance is higher for undocumented immigrants.

“A lot of people are here illegally and are scared they’ll [Covered California] ask for legal documentation, so they don’t get health insurance.” ~Focus Group Participant, Uninsured

- e. **For some uninsured focus group participants, access to “workaround” coverage options and lack of perceived risk decrease the urgency of enrolling through Covered California, with examples including:**
- Accessing care through non-profit community-based organizations (e.g., Planned Parenthood or free clinics, especially for Spanish-Dominant)
 - However, during one focus group discussion, it was quickly realized that those “workarounds” could also be in jeopardy in the future.

⁷ What do you think? % of respondents who “strongly” or “somewhat” agree that: Those with a pre-existing condition will still be able to get health insurance through Covered California this year (2017) / Please fill in the blank with the answer option you think is most likely. Financial help (subsidies) to help pay for health insurance through Covered California will probably _____ in 2017. (% that filled in the blank with “be cancelled”)

⁸ A regression analysis is used to determine the strength of a relationship between a dependent variable and a series of independent variables. Here, it was used to find significant associations between perceptions of the future of Covered California/ACA and the likelihood to enroll, switch, and/or renew.



- ii. Opting not to purchase insurance for the young and healthy who don't see the point (see Finding #4), or for those who practice holistic medicine "as a form of health insurance"

- f. Finally, gaps in knowledge about health care is another significant ongoing barrier. In focus groups, many were highly conversant in current events, yet lacked key information and knowledge:**
- i. There was a general lack of understanding (including among Spanish-Dominants) of key aspects of how Covered California works, including health care terminology and the enrollment process.
 - ii. Some Spanish-Dominants are not aware of subsidies, or assume Covered California enrollment automatically comes with subsidies; alternatively, they see eligibility as a requirement for getting coverage, rather than a subsidy.
 - iii. To this end, focus group participants lament "not qualifying" as the primary reason for not being insured (which is ultimately about cost).

"[My partner and I are] both independent contractors, so we pay everything out of pocket. We don't qualify for help." ~Focus Group Participant, Uninsured

3. The changing discourse about the ACA has amplified existing barriers.

A key finding of this study is that, while recent events don't necessarily create a new barrier, they add confusion and thus exacerbate existing impediments to enrollment. Survey respondents and uninsured participants in focus groups (when they think about the changing situation) confirm this amplification effect.

"Will it still be available, and how much will it cost to have it?"
~Survey Respondent, Insured

"It confuses me more because I don't know what is going to happen, what they're going to do, so [I am] less willing [to enroll]."
~Focus Group Participant, Uninsured

- a. In both the quantitative and qualitative studies, there are indications of high awareness of the incoming leadership's intention to repeal the ACA, but a lack of a clarity over what will actually change, and how that will affect Covered California.⁹ Various participants wonder:**
- i. Whether rules for participation or eligibility criteria will change
 - ii. Whether it will be more difficult to qualify
 - iii. (For some) whether Covered California will be taken away, or just be modified
 - iv. What the distinctions are between the ACA itself and Covered California (in relation to funding, hierarchy, rules, etc.), since many see the ACA as more vulnerable than Covered California

"I'm concerned the ACA will be repealed without a sustainable replacement that will provide coverage to those of us with preexisting health conditions and those needing assistance with paying the premium." ~Survey Respondent, Insured

⁹ What concerns do you have?



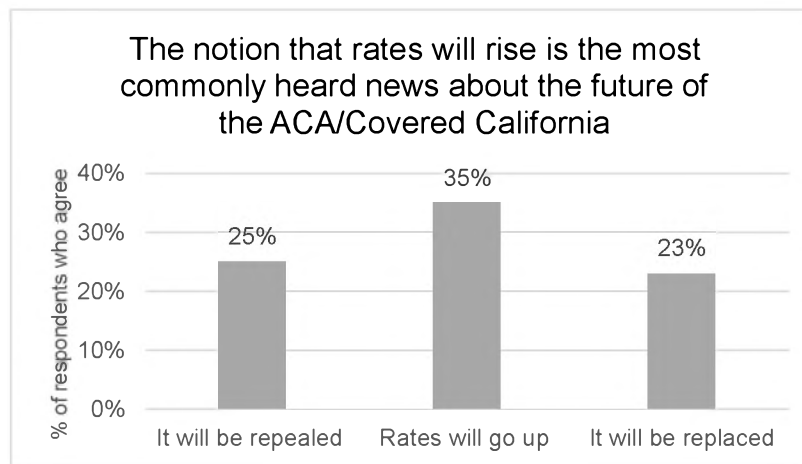
b. Foremost on people’s minds in both the quantitative and qualitative studies is the cost of insurance coverage, which it is generally assumed will be the first casualty of the new thinking, and now registers even higher as a concern.

i. Public discussion around recent events adds another layer of uncertainty and confusion. This is shaped by sources like hearsay conversations and exposure to media stories emphasizing unknowns about the future of health care.

“Even though on TV they may talk [a lot] about it, it’s the last thing you want to hear.” ~Focus Group Participant, Uninsured

“I’m a little concerned what kind of national health care we will get under the new president. I hope it’s affordable and the coverage is inclusive.”
~Survey Respondent, Insured

ii. The notion that rates will rise is the most commonly heard news about the future the ACA/Covered California (35%), beating out repeal (25%) and replacement (23%).¹⁰



c. In qualitative responses, the difficulty and complexity of enrolling (already a barrier) is now potentially more daunting, since some additional uncertainty now floats over coverage options.

d. In qualitative research, Spanish-Dominant focus group participants also mention immigration-related barriers to coverage when their own discussion raises the topic of changes in Washington (with respect to immigration enforcement policies) by participants.

“When you don’t have legal papers to be here, you don’t qualify.”
~Focus Group Participant, Uninsured

e. For those who have health insurance workarounds (e.g., reliance on Planned Parenthood instead of health insurance for women’s reproductive health care), there is similar anxiety about the “overlapping” impact of the political environment on institutions that supply these services, increasing worry about how they will get care.

¹⁰ Which of the following have you seen, heard, and/or read about the future of the Affordable Care Act/Covered California?



4. In qualitative research, future health care policy uncertainty comes on top of deeper problems with the insurance concept.

“Why should I be paying \$300 a month if I am healthy?”

~Focus Group Participant, Uninsured

“That’s the health insurance industry as a whole; it’s backwards in a lot of ways where you’re being penalized for being healthy ... you should be incentivized to be healthy instead of the other way around.”

~Focus Group Participant, Uninsured

- a. **Some, especially the healthy, young, and low-income, fail to see the appeal of paying premiums they cannot afford when they are not currently in need of medical care.**
- b. **For some, the cost-benefit analysis is a simple day-to-day reality check: those who know they don’t have the cash flow to pay premiums see the conversation as a non-starter.**
- c. **Uninsured Californians who have access to “viable alternatives” (e.g., emergency room, community clinics, special-interest free medical resources) have little incentive to tackle the cost and complication of coverage.**
 - i. Those **focus group** participants who mention these alternatives describe sourcing them for short-term health care needs, which speaks to the inability some have to rationalize paying for health insurance when they’re well and don’t “need” it.
- d. **Some generalized cynicism and skepticism are observed in uninsured focus groups, due to hearsay or personal prior disappointments with health insurance or Covered California. Some doubt that “full coverage” actually means comprehensive coverage.**

5. Uncertainty among uninsured focus group participants adds to existing concerns. For some, it enhances motivation to enroll now, for others it seems to cause a “wait and see” attitude.

Among uninsured Californians who already have concerns about the ACA/Covered California, confusion related to recent events provides added justification to delay enrolling.

“... because of everything we’ve heard, we’re waiting for next year [2017] to ... see the reaction, how the new president is going to start, what changes he may do, what he’s going to decide, basically about everything.”

~Focus Group Participant, Uninsured

“People aren’t knowledgeable [about] what exactly his [President-elect] powers are and how fast he can affect it, so [they aren’t sure] if it’s worth getting it now or waiting it out. I don’t want to miss out getting it, in case it’s cancelled.” ~Focus Group Participant, Uninsured

- a. **Qualitatively, among uninsured focus group participants, uncertainty adds scaffolding to existing concerns. This creates a “why bother?” (or, at the very least, a “wait and see”) attitude, since the future of health insurance is unknown (in its current form, at its current cost, or at all). This was especially true among Spanish-Dominants.**



- b. Conversely, with both survey respondents and focus group participants, a smaller “Fear of Missing Out” segment sees this uncertainty as an incentive to enroll sooner, i.e., before it becomes too late, not wanting to be left behind as systemic changes take away coverage options.**
 - i. 21% of survey respondents (and 31% of current Covered California members) say that, if true, the statement “Covered California is likely to go away immediately and not be replaced” would make them more likely to enroll or renew their coverage.¹¹
- c. Faced with an information vacuum, some are filling in their own narrative. Some focus group participants actually respond to the uncertainty around the ACA’s future by expressing hope that a new administration could:**
 - i. “Bring order” to health coverage
 - ii. Lower the cost of coverage
 - iii. Remove the requirement to have coverage (and the tax penalty)
 - iv. Simplify the process

6. Despite uncertainty, trust in the “California brand” seems to be even greater. This reinforces the strength of assets and opportunities that Covered California has to overcome existing barriers and concerns.

These perceptual challenges come with some silver linings: a willingness to believe that California will save the day, and openness to and trust in the idea that Covered California will be part of the solution.

“I’m glad we live in the ‘Republic of California’ ... California wants to take care of us.” ~Focus Group Participant, Uninsured

“Right now, I feel California is looking out for us, and we can’t trust what’s going on in D.C.” ~Focus Group Participant, Uninsured

- a. Covered California has a strong brand (independent of the ACA and the national conversation).**
 - i. The “California” label and positive consumer experiences with Covered California help the brand:
 - o When asked in an open-ended question why they are confident about the future of Covered California and the ACA, several “confident” survey respondents brought up their positive impressions of and trust in the Covered California brand (31%) and its quality of service (8%).¹²
 - o Comments from survey respondents like “Just the name ‘California’ in it” and “trust in the product” show that the California component of the brand increases confidence in the future of the program.

“It is a good program for the people who need it. Having health insurance is important. That is what needs to be stressed.”
~Survey Respondent, Insured

¹¹ Setting aside any other factors that may impact your decision to enroll in health insurance through Covered California, how would this information impact your likelihood to [enroll in/renew your] health insurance through Covered California? For the purposes of this question, please think about how you would respond to the information, assuming the statement was true. % saying they would be somewhat/much more likely to enroll/renew their coverage if “Covered California is likely to go away immediately and not be replaced.”

¹² What makes you confident?



- ii. In both the quantitative survey and qualitative focus groups, there is high awareness of Covered California and low awareness of the ACA.
 - o Across survey segments, people are more aware of Covered California than they are of the ACA.¹³
 - o 47% of survey respondents know “a fair amount” about Covered California, compared to only 35% who know “a fair amount” about the ACA.¹⁴
 - o Among Spanish-Dominants, the familiarity gap is even wider, with twice as many reporting “a fair amount” of knowledge about Covered California (31%) as reporting the same about the ACA (15%).¹⁵
- iii. In the face of a news barrage on pending changes, both focus group participants and survey respondents express trust that the State of California will prevail in protecting their interests.
 - o Several survey respondents specifically note their faith in California as the reason they are optimistic about Covered California’s future (8%).¹⁶

“I don't think California will let us down. We moved here for a government that takes care of its people.” ~Survey Respondent, Insured Through Covered California

Section II: Summary

While the cost of health insurance remains the top concern and barrier to enrollment, other factors play a role in exacerbating this:

- a. Concerns about the impact of recent conversations about changes to the ACA are neither top-of-mind nor existential, yet are real and complex.
- b. These concerns amplify the existing serious barriers to obtaining coverage by adding uncertainty and confusion, leading to inaction.

¹³ How familiar are you with...? The Affordable Care Act (ACA) / Covered California

¹⁴ See footnote 13.

¹⁵ See footnote 13.

¹⁶ See footnote 12



Consumer and Market Implications of Affordable Care Act Repeal without a Viable Replacement

Covered California is monitoring and reviewing the implications of both policies and the timing of policies that could impact the consumers who have and are benefiting from the Affordable Care Act in California (ACA). This document reviews the issues specific to the potential consumer and market impacts should a “repeal” occur absent viable changes to transition consumers, health plans and providers to new arrangements. The hope of Covered California is that any transition to Affordable Care Act “replacement” policies would not put at risk the individual markets (both subsidized and unsubsidized) and millions of patients/consumers (and the providers who serve them) enrolled in the individual market and in expanded Medicaid programs.

Without knowing the nature and structure of proposed changes in how tax credits might be administered or Medicaid funding structured, it is impossible to frame a “glide path” that would give health plans the certainty they need to continue in the individual market. Any proposal that would only assure funding continuity for two years (e.g., through 2018) would virtually guarantee the collapse of the individual market — eliminating the individual market in many states and in others states would lead to very large rate increases for the 2018 plan year to cover the underwriting uncertainty — but even longer “transition periods” would result in huge uncertainty and market instability.

What’s At Stake

There is an increasing understanding and mounting evidence that the stability of our health care sector is at great risk if changes in policies are not enacted prudently. These risks include:

- **Potential collapse of the individual market for health insurance.** Absent a transition being in place, health plans across the nation will very likely adopt one of two strategies: (1) they will exit the individual market, or (2) they will substantially raise premiums in the face of great uncertainty and a worsening risk mix.¹ With the collapse of the individual market, not only would 9.3 million Americans lose tax credit supported coverage, an additional 8.4 million who have been in the individual market with NO subsidy would lose coverage (these are small business owners, individuals who make too much for the current tax credit — but would be potentially without any insurance options).² In a recent analysis, the Congressional Budget Office (CBO) reported that partially repealing the ACA without a replacement would have an immediate effect on health plans and that in the first year after the repeal of marketplace subsidies took effect, about half of the nations population would be living in areas that would have *no insurer participation in the nongroup market.*³

Possible Risks of ACA Repeal without a Viable Replacement:

- Potential collapse of the individual market for health insurance.
- Partial repeal of the ACA would negatively affect coverage and premiums.
- Immediate and precipitous reductions in revenue for hospitals, integrated delivery systems, physicians, other providers and insurance agents.
- Substantial impact on jobs and the economy.

This paper was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

Consumer and Market Implications of Affordable Care Act Repeal without Replacement

- **Partial repeal of the ACA would negatively affect coverage and premiums.** The CBO also found that repeal without replacement would impact the uninsured rate in the individual market as well as those enrolled in Medicaid. In the first new plan year following the enactment of a partial repeal, the CBO estimates that 18 million people would become uninsured, with that number increasing to 32 million in 10 years.⁴ Premiums are projected to rise by 20 to 25 percent in the first plan year following implementation and by up to 50 percent following the elimination of the individual mandate, federal subsidies and Medicaid expansion.⁵ The CBO also found that in the first year after the repeal of marketplace subsidies took effect, about half of the nation's population would be living in areas that would have no insurer participation in the nongroup market.⁶
- **Immediate and precipitous reductions in revenue for hospitals, integrated delivery systems, physicians, other providers and insurance agents.** The reduction in revenue could result in dramatic workforce reduction and require other significant operating changes such as redirecting staff from patient service functions. One estimate is that there would be a \$114 billion reduction in federal/state spending in 2019, which would translate into an increase of approximately \$88 billion in uncompensated care.⁷ The near term impact of dramatic increases in uncompensated care are threefold: (1) a likely increase in employer-based health care costs as providers shift costs to employers; (2) reductions in employment by hospitals and other providers⁷; and (3) increased medical debt and personal bankruptcies as a consequence of providing care to the newly uninsured.
- **Substantial impact on jobs and the economy.** Instability in the health care sector is not just a coverage and care issue — it is a vital economic concern at the state and local level. Repeal without viable replacement is also an economic stability issue in California, with partial repeal of the ACA predicted to lead to California losing between 209,000 and 334,000 jobs.⁸

Working Toward A Realistic Timeframe

Policy proposals advancing a replacement for the ACA should take into account the significant transition from one health care financing mechanism to another. New policies will take time to be implemented and, in many cases, may require complementary state-level legislative action. To minimize disruption to both patients/consumers and health industry sectors, there need to be clearly developed policies and a workable implementation timeline. A three, four or five year “transition period” may be required, depending on policy specifics, to limit the adverse impact on consumers/patients, the health care sector and the entire economy.

Major Risks During a Transition of ACA Policies

Key elements of the existing market-structure, law and regulatory environment should be maintained during any transition period to ensure national and regional market stability. In particular, any changes in policies that are specifically incorporated in existing plan year contracting (for the 2017 plan year) would not only reflect bad faith on the part of the government, but would lead many insurers to immediately withdraw from individual markets – both subsidized and unsubsidized. For the elements below, changes could be made by Congress or by administrative action, but disruption of any of these policies would result in very high risk to patients/consumers and the health insurance market. These include:

- **Funding Changes for Cost Sharing Reduction (“CSR”) Subsidies Need Clear Timeframe and Recognition of Potentially Higher Federal Spending.** If direct federal funding of CSR’s were eliminated for all or part of 2017, many health plans would likely decide to immediately withdraw from the individual market or seek mid-year rate increases that would be substantial. While with early notice, health plans could build the cost of CSR into their premium pricing for the Silver products for 2018, the impact on enrollment, tier selection and on federal spending needs analysis. While health plans could build CSR into their premium pricing, recent analysis commissioned by Covered California found that such a change would result in approximately 29 percent higher cost to the federal government. A comprehensive report commissioned by Covered California on this issue can be found at: http://coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf
- **Defunding Reinsurance to Plans for 2016 Would Breach Contract and Commercial Expectations:** if the contracted reinsurance payments due for plan year 2016 were not funded, health plans would confront additional substantial losses for 2016 and would be far less likely to risk losses in 2017 and beyond in the face of uncertainty. Plans would likely consider withdrawing during 2017 or not continuing to offer coverage in 2018.
- **Non-enforcement of the Individual Mandate Without Putting a Parallel Tactic in Place would Have Immediate Negative Impacts on the Risk Pool:** the direct impact of eliminating the penalty while maintaining guaranteed issue — the provision the health plans may not consider pre-existing conditions during enrollment — and NOT instituting at the same time comparable policies to promote enrollment would lead to lower enrollment AND a worse risk mix. Some health plans would likely withdraw from the individual market immediately, leaving entire states or regions within states with no coverage. Any remaining health plans would implement substantial rate increases. If the penalty were eliminated/not enforced in 2017, there is the prospect that plans could seek to immediately withdraw from the individual market. For plans remaining in 2018, rating would be conservative and likely substantially higher than was experienced in 2017. Any elimination of the individual penalty would need to be implemented in concert with the implementation

Consumer and Market Implications of Affordable Care Act Repeal without Replacement

of alternate mechanisms to assure a balanced risk pool.

- **Assuring Viable Risk Stabilization Funding and Policies:** funding for higher risk in the individual market and policies to assure those enrolling are eligible and appropriate are critical to assuring a sustainable risk pool that maintains a functioning individual market. In the absence of a mechanism, such as continued reinsurance or a risk corridor program, some states could see additional insurers leave the individual market. States could experience significant rate increases on consumers/patients as remaining insurers readjust and adapt to the worsening risk mix. In addition to funding, there need to be clear policies that assure health plans that the new and continued enrollees reflect a balanced risk pool, this includes policies with regard to assuring robust marketing to promote enrollment in the individual market, Special Enrollment Periods, third-party payment and administration of the grace period. Risk stabilization policies will play a crucial role in some health plans' decision to participate in the individual market in 2018 and beyond, as well as their pricing if they were to participate.

About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.

¹ American Society of Actuaries, December 7, 2016. http://www.actuary.org/files/publications/HPC_letter_ACA_CSR_120716.pdf; and, Congressional Budget Office, January 2017. <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf>

² Urban Institute, December 2016. <http://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliatio.pdf>

³ Congressional Budget Office, January 2017.

⁴ Congressional Budget Office, January 2017.

⁵ Congressional Budget Office, January 2017.

⁶ Urban Institute, December 2016; and, Dobson/DaVanzo, 2016 <http://www.aha.org/content/16/impact-repeal-aca-report.pdf>

⁷ Dobson/Davanzo, 2016 <http://www.aha.org/content/16/impact-repeal-aca-report.pdf>

⁸ University of California (UCB Labor Center) "California's Projected Economic Losses Under ACA Repeal", December 20, 2016. <http://laborcenter.berkeley.edu/californias-projected-economic-losses-under-aca-repeal/>; and, The Commonwealth Fund "Repealing Federal Health Reform: Economic and Employment Consequences for States". January 25, 2017. <http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform>



Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

By Wesley Yin, Ph.D., and Richard Domurat, Ph.D. candidate

EXECUTIVE SUMMARY

This study modeled the effects of an increase in premiums that would result if the federal CSR subsidy were defunded and health plans had the opportunity to build the costs of such subsidies into their rates. Based on actuarial value calculations, we calculate the required premium adjustment to be a 16.6% increase in the gross premiums across all Silver plans. We then modeled how consumer choice of plans responds to the premium adjustment, and report the resulting changes in enrollment, metal tier market shares, gross and net premiums and Advanced Premium Tax Credit (APTC), in both the exchange and off-exchange markets.

We find that loading the value of the CSR onto the premiums of Silver plans results in a significant increase in federal funding for consumers' APTC. This results in the net premiums of Silver plans on the exchange remaining constant, and a decrease in the net premiums of Bronze, Gold and Platinum plans. In response, consumers substitute away from Silver to Bronze plans (and to a lesser extent, Gold and Platinum plans). At the same time, the lower net premiums in these tiers induce an increase in subsidized exchange coverage by 1.4% (about 20,000 covered lives). In the unsubsidized off-exchange market, the increase in Silver premiums induces a decline in coverage by less than 1% (about 6,000 covered lives). In aggregate, if this premium adjustment policy were to have been applied in 2016, there would have been an increase in the total market APTC by \$976 million/year, significantly greater than the approximately \$750 million in CSR subsidies now directly paid by the federal government.

Introduction

Consumers eligible for subsidies through state-based or the federal exchange currently have the ability to obtain two kinds of subsidies from the federal government. Most observers know about the Advanced Premium Tax Credits (APTC) that reduce net premiums for about 85% of enrollees on Exchanges nationally. In California, approximately 90% of enrollees receive APTC and these premium credits on average lower net premiums of their recipients by \$298 per month.

Summary of Findings:

- Eliminating direct federal funding for cost-sharing reductions for health plan enrollees would raise premiums by 16.6% in 2018 for Silver plan consumers.
- Modeling suggests consumers who benefit from subsidies would shift to non-Silver plans.
- Overall, the federal premium subsidy funding for enrollees would rise by an amount significantly above the current cost-sharing reduction funding.
- Enrollment in Covered California would rise slightly, while enrollment off-exchange would decrease slightly, increasing the federal cost by approximately 29% for the same benefit to consumers.

NOTE ON THE AUTHORS:

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This paper was commissioned by Covered California to assist with its ongoing planning and to inform policy-making in California and nationally.

In addition, low-income enrollees (those with incomes below 250% of the federal poverty level) qualify for additional subsidies that reduce their costs at the point of obtaining services. These cost-sharing reduction (CSR) subsidies are paid directly to insurers to cover reducing deductibles, coinsurance, copays and maximum out-of-pocket (MOOP) costs for Silver plan enrollees by increasing actuarial values to 73%, 87% or 94%. About 50% of Covered California enrollees choose these CSR Silver plan variants. The rationale behind the CSR subsidies is that the lower-income individuals will be deterred from seeking needed care if their cost-sharing is not adjusted to reflect their own finances. For example, in California for 2016 an individual with the “standard” cost-sharing for the Silver plan would be responsible to pay \$45 for a primary care visit, while a consumer with the 94% actuarial value CSR (representing about 18% of Covered California’s enrollees) would pay \$5. The difference in those amounts is what has been funded by the direct CSR subsidies to health plans to reduce the consumer’s cost at point of care.

A lawsuit initiated by U.S. House of Representative Republican members in 2014 sought to terminate direct CSR funding, alleging there has not been any direct authorization of these payments. If that were to happen, the Patient Protection and Affordable Care Act (ACA) would continue to require insurers to offer the Silver plan variants but there would no longer be any separate funding available.¹ As a consequence, some insurers may terminate their participation in the exchange markets while remaining insurers would need to “load” the Silver plan with an additional premium to require all Silver plan participants to cover the missing funding.² This load, which is likely to be between 15% and 20%, would increase APTC subsidies for those enrollees who qualify, and at the same time hold net premiums for those receiving subsidies for Silver plans constant, while lowering net premiums for Bronze, Gold and Platinum plans among APTC-qualifying consumers. For unsubsidized enrollees, this load would also raise premiums for Silver plans, both on-exchange and off-exchange.³

This study models the impact of loading the premiums of Silver plans in the exchange and the off-exchange market in California. To do this, we estimate a discrete choice model of plan choice using Covered California enrollment data, which permits estimation of own-plan price and cross-plan price elasticities. We use these estimates to simulate consumer plan choices given the premium adjustment. From the projected plan choices, we calculate enrollment, market share, APTC, gross and net premiums (for the total market, and per member, per month levels). We report results separately for both on- and off-exchange markets and for subsidized and unsubsidized individuals.

We also include a Results Appendix, which reports the projected enrollment and budgetary impact of an alternative premium adjustment policy, in which the CSR load is spread across all plans. Additional details about the model are discussed in the Model Appendix which can be found at:

http://coveredca.com/news/pdfs/Appendix-Consequences_of_Terminating_CSR.pdf

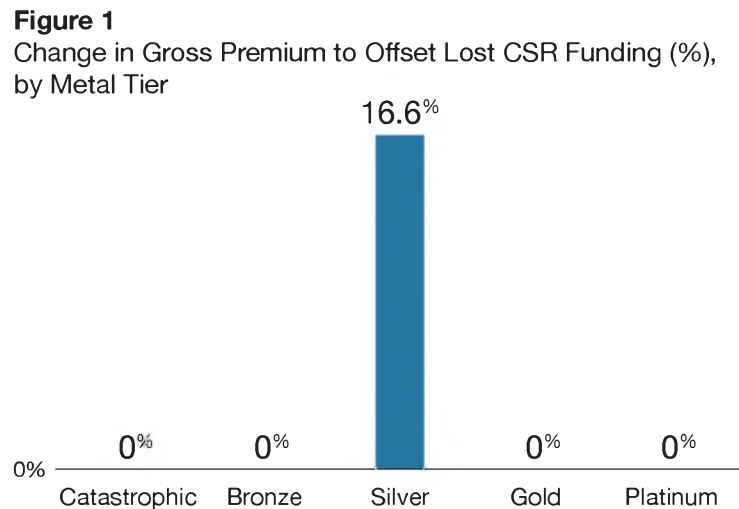
¹ This analysis looks only at the prospective impact on health plans and consumers if the direct CSR funding were eliminated and health plans had the opportunity to build the costs for such subsidies into premiums. For 2017, health plans developed their rates and pricing based on the assumption that there would be direct federal support for CSR. This analysis does not examine the potential impact on health plans or consumers if direct CSR funding were removed for 2017. If health plans in California were to operate through the full year on the same terms on which they offered coverage, they would face unplanned losses/expenses of approximately \$750 million.

² In a different interpretation of the ACA, insurers might load all tiers of plans (Bronze, Silver, Gold and Platinum). In a separate model, we assumed the load is spread across all Exchange and Off-Exchange individual plans. The projected enrollment and budgetary impacts of this scenario are reported in the Results Appendix of this report.

³ The requirement that insurers continue to offer the Silver plan variants on the Exchange, but without CSR funding, would apply to all state marketplaces. Hence, the effects of premium adjustments in the Exchange modeled in this report offer guidance on the potential effects of defunding the CSR in other states.

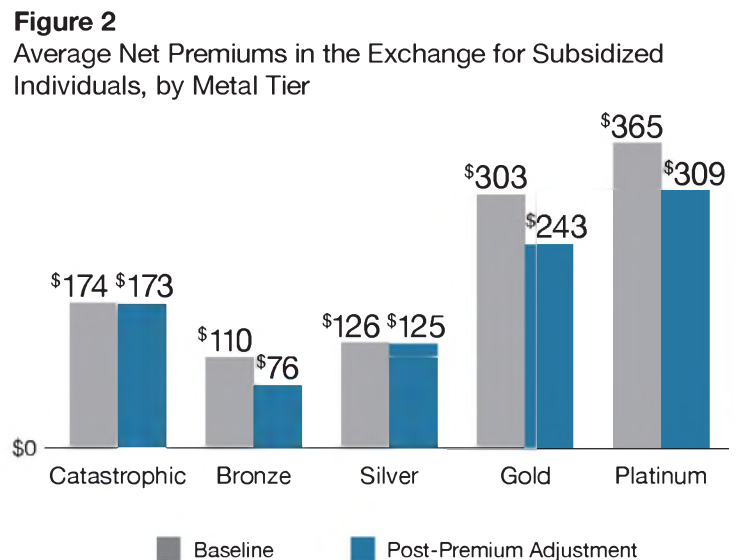
Main Findings

We modeled the plan choice of the approximately 1,368,000 consumers in the exchange, applying a 16.6% increase in the gross premium of Silver plans, while holding the gross premiums of all other plans unchanged. The 16.6% was determined as the increase in the premiums of Silver plans on the exchange required to offset the lost CSR funding. The change in gross premiums, by tier, required to offset the lost CSR subsidy is shown in Figure 1. The model accounted for changes in the premium credit, which is anchored to the premium of the second-lowest Silver plan in each rating region. Separately, we modeled the plan choice of the approximately 750,000 consumers in the off-exchange market, where we assumed premiums of Silver plans also increase 16.6%, given the requirement in California that health plans offer the same products on- and off-exchange at the same prices.



The impact of the 16.6% increase in Silver premiums in the exchange is summarized in Figure 2. We find that:

- The APTC for subsidized enrollees is calculated based on the price of the second-lowest Silver plan. Therefore, an increase in Silver premiums results in an approximately equal increase in the APTC. For subsidized enrollees, this leaves Silver net-of-subsidy premiums unchanged (henceforth “net subsidy”), but the higher levels of APTC — on average \$60 more per subsidy-eligible member per month — reduces net premiums across Bronze, Gold and Platinum plans (Figure 2).
- In response to the relative changes in net premiums across the metal tiers, the overall market share of Silver plans in the exchange drops from 63% to 57%. Enrollment primarily shifts to Bronze, whose market share rises to 31% from 28%, and to a lesser extent to Gold and Platinum, whose combined market share rises to 11% from 9% (see Figure 3).
- These effects vary by federal poverty level (FPL) group, with larger shifts from Silver among higher-income consumers. At the highest incomes — above 400% FPL — 21% of Silver plan enrollees (7% of enrollees in this income bracket) switch from Silver to Bronze (and to a lesser extent, Gold and Platinum).



- In addition to plan switching, the model accounts for entry and exit from the exchange, in response to changes in net premiums. As an upper bound, we estimate that 0.5% of enrollees in the unsubsidized >400% FPL income bracket will exit the market, all among Silver plan enrollees (or new enrollees who would have purchased Silver plans). This amounts to less than 0.1% of the entire on-exchange market.
- Due to the increased APTC, and the resulting decreases in net premiums for Bronze, Gold and Platinum plans, overall enrollment in the exchange is estimated to increase by 1.4% (approximately 20,000 covered lives). At low incomes, both the existing large subsidies, and the subsidy cap on Bronze plans, mute the impact of the increased APTC on new coverage. At higher subsidized income brackets, e.g. 250%–400% FPL, the increase in APTC induces a 3% increase in enrollment.
- Overall, we find that total market APTC increases by \$976 million/year, which is significantly larger than the approximately \$750 million in lost subsidies due to the defunding of the CSR (Figure 4). This additional federal expense of approximately \$226 million would reflect an increase of over 29% for the same benefit. Note that the \$976 million in additional APTC already factors in the \$195 million/year in APTC forfeited by Bronze plan enrollees whose subsidies are limited by having reached the minimum net premium.⁴

Figure 3
Metal Tier Market Share in the Exchange (%)

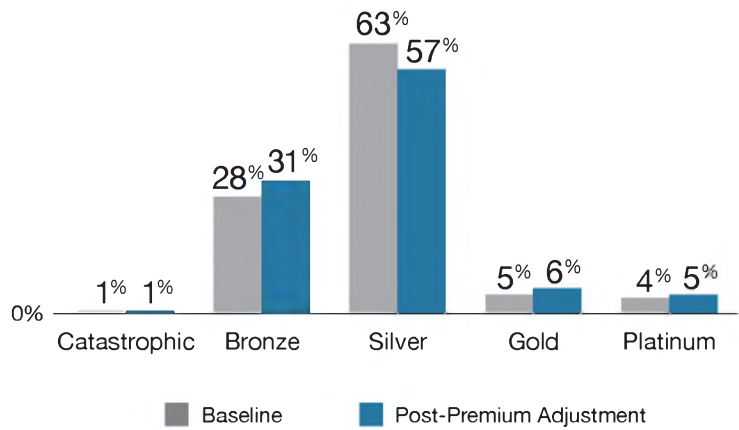
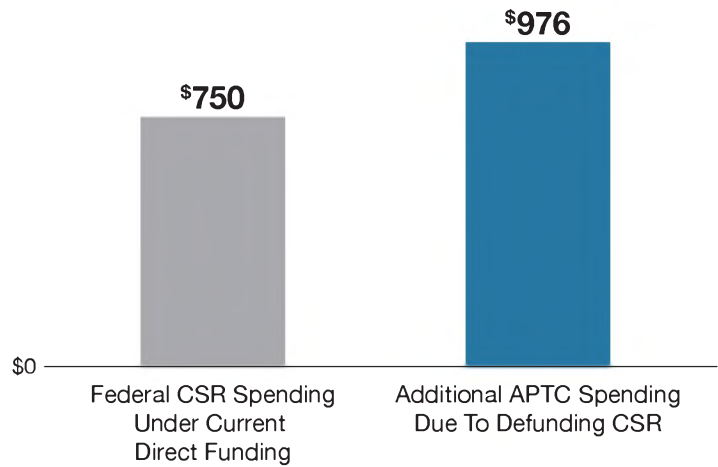


Figure 4
Comparing Current CSR Funding with New APTC Funding Levels Due to Loss of CSR (in millions of dollars)



⁴ The actual federal costs would be substantially higher than those presented in this modeling, which uses 2016 premiums. On average, premiums in California increased 13.2% from 2016 to 2017. If premiums increased an average 4% in 2018 and also reflected the 2017 increases, with the same number of consumers selecting the same plans in 2018, the potential APTC increase for 2018 would be $(\$976 \times 1.132 \times 1.04) = \1.149 billion/year, which is significantly larger than the approximately $(\$750 \times 1.132 \times 1.04) = \883 million/year in lost subsidies due to the defunding of the CSR. This would reflect approximately \$266 million/year in additional federal subsidy funding for 2018.

Effects of CSR Premium Adjustments for Unsubsidized Individuals

The estimated impacts in the off-exchange market and for individuals on-exchange who do not receive subsidies are reported in Figure 5.

- The Silver plan premium increases are not accompanied by increases in APTC (Figure 5), and on average Silver plan premiums rise \$65 per month.
- With no APTC to offset Silver premium increases, consumer response to the higher premiums will qualitatively resemble that of the unsubsidized exchange market. We find that 18.2% of Silver plan enrollees (4% of the off-exchange market) switch from Silver to Bronze (and to a lesser extent, Gold). (Figure 6).
- We estimate that less than 1% of enrollees will exit the off-exchange market. The impact on coverage is muted because most Silver plan enrollees affected by the premium increase will switch to Bronze plans, rather than exit the market. Only a smaller fraction of impacted Silver enrollees will respond by exiting the market altogether, primarily among enrollees with incomes below 400% of FPL.

For results and model appendix, go to: http://coveredca.com/news/pdfs/Appendix-Consequences_of_Terminating_CSR.pdf

Figure 5
Average Gross Premiums for Unsubsidized Individuals, by Metal Tier

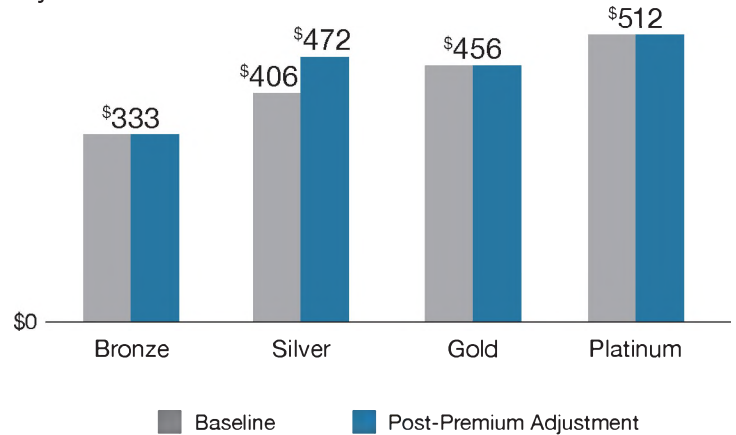
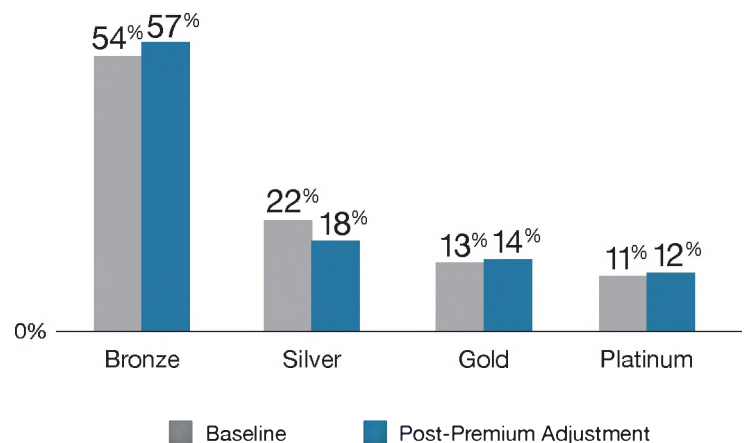


Figure 6
Metal Tier Market Share In the Off-Exchange Market



About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California’s consumers. It is overseen by a five-member board appointed by the governor and the legislature. For more information about Covered California, please visit www.CoveredCA.com.



Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

The following is an Appendix to “Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding,” a paper by UCLA researchers Wesley Yin, Ph.D., and Richard Domurat, Ph.D. candidate.

RESULTS APPENDIX

As a supplementary analysis, we modeled the market impact of loading the CSR premium adjustment onto all plans, not just Silver plans. We modeled the premium adjustment as an 11.3% increase in the gross premiums of all plans. We find that:

- In the subsidized exchange market (Appendix Table 1), the gross premiums for plans in all tiers rise; however, net premiums of Bronze plans decrease slightly. For Silver plans, net premiums remain stable; and for Gold and Platinum plans they increase slightly. For these plans, the increase in APTC provides an incomplete offset to the increase in gross premium.
- As a result, the combined share of Platinum and Gold plans decreases slightly from 8% to 7%, the share of Silver remains the same, while the share of Bronze plans increases slightly, from 28% to 29%. Overall, there is a substitution to lower generosity plans, but the movements are small.
- Above 400% FPL, we estimate as an upper bound that 1% of enrollees will leave the market. Among the <400 FPL group, the increase in the net premiums of Silver, Gold and Platinum plans, results in a decline in total Exchange enrollment by less than 0.5%.
- In the off-exchange market (Appendix Table 2), gross premiums rise for plans in all metal tiers, but no APTC exists to offset premium increases. Moreover, the proportional premium increases means that absolute premiums rise more for Gold and Platinum plans, and least for Bronze plans. Consequently, we anticipate the share of Gold and Platinum plans declining from 25% to 23%, the share of Silver to remain stable, and the share of Bronze increasing 1.5 percentage points.
- Because rates are rising for all plans, exit rates are the most notable in this scenario for the off-exchange market. As an upper bound, we estimate that 3% of the off-exchange market may exit.
- Total market APTC increases by \$687 million/year, which is less than the approximately \$750 million in actuarial value loss due to the defunding of the CSR subsidy. The \$687 million accounts for the \$24 million/year in APTC forfeited by Bronze plan enrollees who pay the minimum net premium.

In summary, loading the actuarial value of the CSR onto the premiums of all plans results in an increase in total market APTC by \$687 million/year, less than \$750 million lost subsidy from defunding the CSR. Designing the premium adjustment across all plans induces relatively little switching across the tiers, but leads to approximately 3% disenrollment from the off-exchange market.

MODEL APPENDIX

Discrete Choice Model

We use 2015-2016 enrollment data to estimate a discrete choice regression model. This has advantages over product-by-product regression analysis in that it allows for the estimation of own-product as well as cross-product price elasticities. This framework not only permits us to estimate how the increase in the price of one plan may lead to disenrollment in that plan, but also allows us to model precisely how consumers substitute to other available plans.

The model generates parameter estimates for how individuals value characteristics of each product, including price, plan type and carrier. In addition, our model also allows for the valuations of these product characteristics to vary by the characteristics of the enrollees themselves. For instance, lower-income consumers may perceive greater disutility from a higher price than a higher-income consumer. Similarly, a person with a higher risk score, or who is older, may place greater value on a PPO (vs an HMO) than a younger, healthier consumer.

With these parameter estimates, we simulate enrollment and plan choices given counterfactual policies. Specifically, we modeled the two scenarios described in the memo: 1) an 11.3% increase in the gross premiums of all plans, or 2) a 16.6% increase in the gross premiums of Silver plans only, assuming all other aspects of the 2016 plan year remain fixed. For example, we continue to hold fixed the composition of new (~500,000) and returning (~1,000,000) enrollees observed in 2016, an important assumption given markedly different price sensitivities across the two consumer groups.

Assumptions of the Off-Exchange Market

We do not have data on the Off-Exchange market. To model the Off-Exchange market, we simulated the market, based on summary statistics of that market provided to us by Covered California. Specifically, Covered California provided us with the market share across metal tiers, separately for the <400 FPL and >400 FPL segments of the market. Covered California also provided us with an estimate of the total Off-Exchange market size of 750,000.

With this information, we weighted individuals from the on-Exchange market to match the enrollment size and joint distribution of income and tier choice observed in the off-exchange market (based on data provided by Covered California, as described above). Under the plausible assumption that the elasticities estimated for observationally similar individuals in the on-exchange market reflect behavioral responses of consumers in the off-exchange market, then our simulated sample and discrete choice model allow for reasonable simulations of choice behavior in the off-exchange market in response to premium adjustments.

Extensive Margin Enrollment Elasticities

While the choice model estimates own- and cross-price elasticities, we draw on Tebaldi (2016) for extensive margin elasticities — that is, the effect of an increase on all plan prices on any coverage, not just disenrollment from any one plan. In particular, Tebaldi (2016) estimates this extensive margin semi-elasticity using Covered California Exchange data. Our analyses generated estimates consistent with those reported. We apply the semi-elasticity corresponding to the average market age of enrollees to the changes in premiums estimated by our model, separately for each income bracket reported in the results tables. For >400 FPL consumers, we use a semi-elasticity of -3.12 (a \$100 increase in the premiums of all plans results in a 3.125% decline market coverage. For consumers <400 FPL, who are more price sensitive, we assume a semi-elasticity of -10.0. Note that this is not directly comparable to typical own-price elasticities, given that semi-elasticities reflect the choice to leave the market entirely, not just switch out of a particular plan. (As a reference, the same study also estimated own-price elasticities in the Covered California, which range from -1.0 to -3.0, reflecting the high price sensitivity of consumers in this market.)

Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

Table 1. On-Exchange Market: Adjustment to Silver, Only

Panel 1. All 2016 Members

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Catastrophic	10,753	10,715	1%	1%	1,870,487	1,852,886	-	-	173.95	172.92
Bronze	378,814	434,226	28%	31%	41,498,985	33,207,516	85,749,688	111,404,806	109.55	76.48
Silver	866,668	796,612	63%	57%	109,565,374	99,289,330	265,389,658	304,756,055	126.42	124.64
Gold	61,731	80,908	5%	6%	18,687,343	19,658,271	10,027,674	19,540,498	302.72	242.97
Platinum	49,951	64,019	4%	5%	18,242,470	19,750,804	7,842,257	14,673,572	365.21	308.52
Overall	1,367,917	1,386,480	100%	100%	189,864,661	173,758,807	369,009,277	450,374,931		

0.014

Panel 2. <150 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Catastrophic	88	83	0%	0%	14,919	14,212	-	-	170.11	170.31
Bronze	20,275	21,909	9%	9%	251,444	55,762	5,946,420	6,570,794	12.40	2.55
Silver	206,225	202,182	90%	88%	11,663,366	11,664,045	73,361,384	85,636,472	56.56	57.69
Gold	1,813	3,413	1%	1%	204,997	222,566	588,747	1,375,824	113.07	65.20
Platinum	1,816	3,096	1%	1%	280,690	360,211	656,329	1,266,513	154.55	116.34
Overall	230,217	230,684	100%	100%	12,415,416	12,316,797	80,552,880	94,849,603		

0.002

Panel 3. 150-200 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Catastrophic	650	564	0%	0%	110,733	96,062	-	-	170.44	170.37
Bronze	86,506	97,791	19%	22%	2,599,782	980,730	24,728,647	29,395,509	30.05	10.03
Silver	347,197	329,372	77%	73%	31,159,194	29,649,198	120,462,925	139,310,709	89.74	90.02
Gold	7,423	12,737	2%	3%	1,219,127	1,355,058	2,220,555	4,924,593	164.23	106.38
Platinum	6,908	11,282	2%	2%	1,526,473	1,861,795	2,086,952	4,251,146	220.98	165.03
Overall	448,684	451,746	100%	100%	36,615,308	33,942,843	149,499,079	177,881,957		

0.007

Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

Panel 4. 200-250 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Catastrophic	1,123	891	0%	0%	197,907	155,684	-	-	176.26	174.80
Bronze	84,264	97,076	37%	41%	5,771,210	3,041,094	23,742,976	30,473,572	68.49	31.33
Silver	126,765	111,866	55%	48%	19,139,550	16,861,070	39,889,963	44,736,685	150.98	150.73
Gold	10,168	14,530	4%	6%	2,405,994	2,467,829	2,696,659	5,213,177	236.63	169.85
Platinum	7,724	10,851	3%	5%	2,406,822	2,643,323	1,990,684	3,783,797	311.61	243.60
Overall	230,044	235,214	100%	100%	29,921,483	25,169,001	68,320,283	84,207,230		

0.022

Panel 5. 250-400 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Catastrophic	3,551	3,380	1%	1%	611,830	573,636	-	-	172.28	169.74
Bronze	137,318	161,313	42%	48%	16,910,673	11,321,245	31,331,644	44,964,931	123.15	70.18
Silver	140,933	117,380	43%	35%	30,452,813	25,604,320	31,675,386	35,072,189	216.08	218.13
Gold	25,007	31,276	8%	9%	7,473,630	7,466,983	4,521,713	8,026,904	298.87	238.74
Platinum	18,990	22,998	6%	7%	6,909,878	7,095,680	3,108,293	5,372,116	363.86	308.54
Overall	325,800	336,347	100%	100%	62,358,823	52,061,863	70,637,036	93,436,140		

0.032

Panel 6. > 400 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Catastrophic	5,341	5,798	4%	4%	935,099	1,013,291	-	-	175.07	174.77
Bronze	50,450	56,137	38%	42%	15,965,877	17,808,685	-	-	316.47	317.24
Silver	45,548	35,812	34%	27%	17,150,451	15,510,696	-	-	376.54	433.11
Gold	17,320	18,951	13%	14%	7,383,596	8,145,835	-	-	426.30	429.83
Platinum	14,513	15,792	11%	12%	7,118,608	7,789,796	-	-	490.49	493.29
Overall	133,172	132,490	100%	100%	48,553,631	50,268,304	-	-		

(0.005)

Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

Table 2. Off-Exchange Market: Adjustment to Silver, Only

Panel 1. All 2016 Members

Metal-Tier	Enrollment		Market Shares		Gross Premiums		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Bronze	399,891	416,937	54%	57%	133,405,250	139,006,644	333.60	333.40
Silver	160,578	130,812	22%	18%	65,271,063	61,723,711	406.47	471.85
Gold	99,980	103,676	13%	14%	45,566,926	47,308,019	455.76	456.31
Platinum	82,077	84,836	11%	12%	42,017,669	43,463,668	511.93	512.32
Overall	742,527	736,261	100%	100%	286,260,908	291,502,042		

(0.008)

Panel 2. 250-400 FPL

Metal-Tier	Enrollment		Market Shares		Gross Premiums		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Bronze	189,819	198,474	53%	56%	66,706,596	69,704,309	351.42	351.20
Silver	83,964	67,075	23%	19%	36,354,774	33,816,262	432.98	504.15
Gold	50,725	52,651	14%	15%	24,677,646	25,643,666	486.50	487.05
Platinum	35,654	36,913	10%	10%	19,662,045	20,368,214	551.46	551.78
Overall	360,162	355,114	100%	100%	147,401,060	149,532,452		

(0.014)

Panel 3. >400 FPL

Metal-Tier	Enrollment		Market Shares		Gross Premiums		Avg PMPM Net Premiums	
	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver	Baseline	Sim Silver
Bronze	210,073	218,463	55%	57%	66,698,655	69,302,335	317.50	317.23
Silver	76,615	63,736	20%	17%	28,916,290	27,907,449	377.42	437.86
Gold	49,255	51,024	13%	13%	20,889,280	21,664,353	424.10	424.59
Platinum	46,422	47,923	12%	13%	22,355,624	23,095,454	481.57	481.93
Overall	382,365	381,147	100%	100%	138,859,848	141,969,590		

(0.003)

Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

Appendix Table 1. On-Exchange Market: Adjustment to All Tiers

Panel 1. All 2016 Members

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Catastrophic	10,753	10,477	1%	1%	1,870,487	2,015,508	-	-	173.95	192.37
Bronze	378,814	393,911	28%	29%	41,498,985	43,283,743	85,749,688	103,613,057	109.55	109.88
Silver	866,668	861,502	63%	63%	109,565,374	111,116,762	265,389,658	303,583,529	126.42	128.98
Gold	61,731	56,856	5%	4%	18,687,343	18,317,564	10,027,674	10,864,208	302.72	322.17
Platinum	49,951	44,215	4%	3%	18,242,470	17,247,589	7,842,257	8,186,345	365.21	390.09
Overall	1,367,917	1,366,961	100%	100%	189,864,661	191,981,166	369,009,277	426,247,138		

(0.001)

Panel 2. <150 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Catastrophic	88	71	0%	0%	14,919	13,405	-	-	170.11	188.59
Bronze	20,275	20,704	9%	9%	251,444	235,008	5,946,420	6,793,989	12.40	11.35
Silver	206,225	206,100	90%	90%	11,663,366	11,829,821	73,361,384	82,693,961	56.56	57.40
Gold	1,813	1,682	1%	1%	204,997	198,335	588,747	614,752	113.07	117.92
Platinum	1,816	1,642	1%	1%	280,690	263,109	656,329	677,086	154.55	160.24
Overall	230,217	230,199	100%	100%	12,415,416	12,539,678	80,552,880	90,779,788		

Panel 3. 150-200 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Catastrophic	650	522	0%	0%	110,733	98,523	-	-	170.44	188.68
Bronze	86,506	89,005	19%	20%	2,599,782	2,407,764	24,728,647	28,775,683	30.05	27.05
Silver	347,197	346,156	77%	77%	31,159,194	31,265,364	120,462,925	137,003,425	89.74	90.32
Gold	7,423	6,852	2%	2%	1,219,127	1,167,101	2,220,555	2,340,473	164.23	170.34
Platinum	6,908	6,078	2%	1%	1,526,473	1,397,922	2,086,952	2,120,391	220.98	230.00
Overall	448,684	448,612	100%	100%	36,615,308	36,336,674	149,499,079	170,239,972		

Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

Panel 4. 200-250 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Catastrophic	1,123	909	0%	0%	197,907	177,036	-	-	176.26	194.69
Bronze	84,264	87,268	37%	38%	5,771,210	5,487,293	23,742,976	28,407,240	68.49	62.88
Silver	126,765	125,676	55%	55%	19,139,550	19,048,194	39,889,963	46,123,835	150.98	151.57
Gold	10,168	9,275	4%	4%	2,405,994	2,269,197	2,696,659	2,876,792	236.63	244.65
Platinum	7,724	6,714	3%	3%	2,406,822	2,188,770	1,990,684	2,037,337	311.61	326.00
Overall	230,044	229,843	100%	100%	29,921,483	29,170,490	68,320,283	79,445,204		

Panel 5. 250-400 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Catastrophic	3,551	3,340	1%	1%	611,830	632,865	-	-	172.28	189.46
Bronze	137,318	144,551	42%	44%	16,910,673	16,733,030	31,331,644	39,636,145	123.15	115.76
Silver	140,933	139,022	43%	43%	30,452,813	30,355,687	31,675,386	37,762,308	216.08	218.35
Gold	25,007	22,932	8%	7%	7,473,630	7,098,350	4,521,713	5,032,191	298.87	309.54
Platinum	18,990	16,830	6%	5%	6,909,878	6,399,086	3,108,293	3,351,531	363.86	380.23
Overall	325,800	326,675	100%	100%	62,358,823	61,219,017	70,637,036	85,782,175		

Panel 6. > 400 FPL

Metal-Tier	Enrollment		Market Shares		Net Premiums		APTC		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Catastrophic	5,341	5,634	4%	4%	935,099	1,093,680	-	-	175.07	194.11
Bronze	50,450	52,384	38%	40%	15,965,877	18,420,648	-	-	316.47	351.65
Silver	45,548	44,548	34%	34%	17,150,451	18,617,697	-	-	376.54	417.92
Gold	17,320	16,115	13%	12%	7,383,596	7,584,581	-	-	426.30	470.65
Platinum	14,513	12,951	11%	10%	7,118,608	6,998,702	-	-	490.49	540.39
Overall	133,172	131,633	100%	100%	48,553,631	52,715,307	-	-		

(0.012)

Appendix: Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding

Appendix Table 2. Off-Exchange Market: Adjustment to All Tiers

Panel 1. All 2016 Members

Metal-Tier	Enrollment		Market Shares		Gross Premiums		Avg PMPM Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Bronze	399,891	398,398	54%	55%	133,405,250	147,430,207	333.60	370.06
Silver	160,578	154,217	22%	21%	65,271,063	69,524,574	406.47	450.82
Gold	99,980	93,820	13%	13%	45,566,926	47,339,593	455.76	504.58
Platinum	82,077	75,896	11%	11%	42,017,669	42,953,455	511.93	565.95
Overall	742,527	722,330	100%	100%	286,260,908	307,247,829		

(0.03)

Panel 2. 250-400 FPL

Metal-Tier	Enrollment		Market Shares		Gross Premiums		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Bronze	189,819	184,984	53%	54%	66,706,596	72,206,161	351.42	390.34
Silver	83,964	79,036	23%	23%	36,354,774	38,024,554	432.98	481.10
Gold	50,725	47,270	14%	14%	24,677,646	25,483,718	486.50	539.11
Platinum	35,654	32,844	10%	10%	19,662,045	20,053,505	551.46	610.56
Overall	360,162	344,134	100%	100%	147,401,060	155,767,938		

(0.04)

Panel 3. >400 FPL

Metal-Tier	Enrollment		Market Shares		Gross Premiums		Avg PMPM Net Premiums	
	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All	Baseline	Sim All
Bronze	210,073	213,414	55%	56%	66,698,655	75,224,046	317.50	352.48
Silver	76,615	75,181	20%	20%	28,916,290	31,500,020	377.42	418.99
Gold	49,255	46,550	13%	12%	20,889,280	21,855,874	424.10	469.52
Platinum	46,422	43,052	12%	11%	22,355,624	22,899,951	481.57	531.92
Overall	382,365	378,196	100%	100%	138,859,848	151,479,891		

(0.01)



Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose

The 2016 election of Donald Trump as president, combined with a Republican-controlled Congress, could result in a partial or complete repeal of the Affordable Care Act (ACA). Here is a reminder of what has been achieved under the ACA — and what California now stands to lose.

Nationally, the uninsured rate is at a historic low:

- ▶ 20 million Americans are covered as a result of the ACA.¹
- ▶ 90% of all Americans are now covered: The uninsured rate fell from 14.4% in 2013 to a historic low of 9.4% in 2015.²

Some of the ACA's biggest gains have been in California:

- ▶ Over 5 million Californians have insurance as a result of the ACA — roughly a quarter of all Americans covered under the law.
- ▶ 91% of Californians are now insured. The uninsured rate in California fell from 17.0% in 2013 to a historic low of 8.5% in 2015.³
- ▶ In California, the uninsured rate dropped across all racial/ethnic groups, with the greatest gains seen among Latinos. Between 2013 and 2015, the number of California Latinos who were uninsured fell by 1.5 million, and the uninsured rate in this population fell from 23% to 12%.⁴

The sources of coverage for the more than 5 million Californians insured under the ACA include:

- ▶ 1.4 million bought insurance on Covered California.⁵
- ▶ 3.7 million Californians enrolled in Medi-Cal under the ACA expansion — representing more than a quarter of the 13.6 million Californians now covered under Medi-Cal.⁶
- ▶ Hundreds of thousands of young adults under the age of 26 were able to stay on their parents' plan.

Over 1 million Californians receive financial assistance to afford coverage through Covered California:

- ▶ Of Covered California's 1.4 million consumers, 1.2 million receive federal subsidies to help them pay their monthly premiums.⁷
- ▶ The average federal premium subsidy per household is \$438/month.⁸

The California Health Care Foundation will continue to work to protect the coverage and access to care that millions of Californians have gained under the ACA. We remain committed to building a health care system that works for all Californians. Learn more at www.chcf.org.

Endnotes

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By Jon R. Gabel, Daniel R. Arnold, Brent D. Fulton, Sam T. Stromberg, Matthew Green, Heidi Whitmore, and Richard M. Scheffler

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Consumers Buy Lower-Cost Plans On Covered California, Suggesting Exposure To Premium Increases Is Less Than Commonly Reported

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ABSTRACT With the notable exception of California, states have not made enrollment data for their Affordable Care Act (ACA) Marketplace plans publicly available. Researchers thus have tracked premium trends by calculating changes in the average price for plans offered (a straight average across plans) rather than for plans purchased (a weighted average). Using publicly available enrollment data for Covered California, we found that the average purchased price for all plans was 11.6 percent less than the average offered price in 2014, 13.2 percent less in 2015, and 15.2 percent less in 2016. Premium growth measured by plans purchased was roughly 2 percentage points less than when measured by plans offered in 2014–15 and 2015–16. We observed shifts in consumer choices toward less costly plans, both between and within tiers, and we estimate that a \$100 increase in a plan’s net annual premium reduces its probability of selection. These findings suggest that the Marketplaces are helping consumers moderate premium cost growth.

Six years after its passage, the Affordable Care Act (ACA) remains a focal point of political controversy in the United States. The announced 22 percent increase in Marketplace premiums in October 2016 likely played a role in the election of Donald Trump as the forty-fifth president of the United States. In pledging to “repeal and replace” the ACA, President-elect Trump cited increases more than double the 22 percent figure in speeches and debates.

The 2016 presidential election illustrates how the political debate surrounding the ACA has been based largely on partisanship and ideology. In contrast, analysts, when debating the merits of the ACA, often turn to three metrics: the number of people enrolled on the individual Marketplaces; trends in the number of uninsured Americans; and trends in Marketplace premiums.

With regard to the first metric, an estimated 12.7 million people enrolled in Marketplace cov-

erage for 2016.^{1,2} With regard to the second, the Department of Health and Human Services (HHS) estimates that twenty million people have gained coverage as a result of the ACA, primarily through the use of subsidized Marketplace premiums and Medicaid expansion.³

The third metric, trends in Marketplace premiums, is the focus of this article. The spike in average premiums in 2017 of 22 percent nationwide and 14 percent in California contrasts with modest 2016 estimates reported by multiple organizations.^{4,5} For states using the federally funded Marketplace, HHS calculated the average premium increase at 7.5 percent.⁶ The Robert Wood Johnson Foundation reports from all states that premiums increased 11 percent during 2015–16.⁷ In previous work on the 2016 plan year, I and my colleagues at NORC at the University of Chicago estimated premium increases at 6 percent.⁸

However, these estimates have a major short-

coming. Because enrollment data in Marketplace plans are not publicly available, researchers have calculated premium changes for plans offered rather than plans purchased. The one exception is a recent study by the HHS Office of the Assistant Secretary for Planning and Evaluation of federally facilitated Marketplaces,⁹ which found that after shopping¹⁰ was taken into account, premiums increased 8 percent in 2015–16. The authors of that study note that 43 percent of consumers who returned to the Marketplace in a subsequent year switched plans.

The objective of our study was to determine differences in premiums for *offered* versus *purchased* plans. To better understand consumers' behavior, we examined the percentage of plan enrollment accounted for by the lowest- or second-lowest-cost plans in coverage tiers. Through multivariate analysis, we estimated, for new enrollees, the effect on probability of selection when a plan or carrier raises annual premiums by \$100.

The ACA sets the subsidy for Marketplace plans based on the cost of the second-lowest-cost silver plan in the consumer's locality. The consumer pays the full cost of the difference in the premium between the more expensive plan and the base silver plan. This incentive structure encourages consumers to choose lower-cost plans and helps them become price-sensitive.

The study context is Covered California, the California insurance Marketplace, with its nineteen rating regions and twelve insurers competing in the state. Based on the behavioral economics finding that too much choice overloads and immobilizes consumers, Covered California has implemented a number of policies intended to make comparisons of different plans easier for consumers.¹¹ Covered California requires standardized benefits and cost sharing for each tier, and it restricts the number of plans an insurer can offer on a metal tier in a rating region. California uses an active purchaser model, in which premiums are negotiated and competitive bidding is used to limit market entry.

The Covered California market structure grew out of legislation enacted by the state legislature, as well as administrative decisions by Covered California.

Study Data And Methods

DATA We obtained individual-level plan enrollment data from Covered California via a Public Records Act request. Our analytic data set contains over 3.6 million enrollees: 872,844 from 2014, 1,311,444 from 2015 and 1,445,908 from 2016. These totals represent all active enrollment as of April 1 for each of Covered California's

first three years. Additionally, we used plan premium data that are publicly available on the Covered California website. All premiums reported in this article correspond to the monthly premium faced by an unsubsidized forty-year-old, which we used as a standard measure of the full premium cost.

In our descriptive analysis, we use the universe of persons enrolled in Covered California, so with the use of a finite multiplier, standard errors equal 0.¹² Hence, all differences among categories are statistically significant.

In California, carriers can vary Marketplace plan premiums by age, geographic rating region, product type, and coverage tier. California instituted a standard benefit design for each coverage tier, meaning that carriers are restricted to offering one plan per tier, unless they offer multiple product types (for example, a health maintenance organization and a preferred provider organization). The detail of our enrollment data allowed us to match posted premiums to the plans enrollees selected. Plans are defined by carrier, tier, product type (health maintenance organization, preferred provider organization, or exclusive provider organization), and rating region. Eleven insurance carriers offered coverage through the California Marketplace in 2014, ten in 2015, and twelve in 2016. Carriers were required to offer plans across all five coverage tiers in the rating regions in which they participated. The names and actuarial values of the coverage tiers are as follows (percentage of medical expenses covered by the plan for an average individual): catastrophic (less than 60 percent), bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). Covered California has nineteen rating regions statewide, each made up of one or more counties. The lone exception is Los Angeles County, which was split by ZIP code into two rating regions. There were 429 plans offered in 2014, 428 in 2015, and 476 in 2016.

We report averages for both offered and purchased premiums. Offered premium averages are calculated by taking a simple average of premiums across available plans. Purchased premium averages weight premiums by enrollment. Hence, if the plans with lower premiums receive a higher share of enrollment—which is expected because enrollees are price-sensitive—average purchased premiums will be lower than average offered premiums.

MULTIVARIATE ANALYSIS To address the question of how much market share is lost when a carrier raises premiums, we conducted a conditional logit analysis. This logit model examined how changes in a plan's premium, deductible, out-of-pocket maximum, and brand affect the

plan's probability of being selected. The dependent variable is equal to 1 if a person chooses plan X and 0 if that person chooses another plan.

We restricted our analysis to 2016 plan choices made by 139,497 new single exchange enrollees ages 31–64 for the following reasons. First, this allowed us to exclusively analyze “active” plan choices (as opposed to automatic reenrollment). Studies have shown that enrollees tend to display inertia such that their choices after the initial enrollment decision do not reflect their underlying preferences.^{13,14} Examining enrollees older than age thirty removes catastrophic plans from the choice set of potential enrollees, as catastrophic plans are generally available only to people younger than thirty. We restricted the analysis to single enrollees so there would be one-to-one matching of age, income, and out-of-pocket payments for premiums.

We defined plans by carrier–metal tier combinations (for example, Kaiser–silver). Plan characteristics can vary by individual. Our data show us each enrollee's federal poverty level income bracket (for example, 150–200 percent of poverty) and the rating area in which he or she resides. Thus, we know the menu of the plans available to each enrollee. This is particularly important for the menu of silver plans. For example, an enrollee with income of 150–200 percent of poverty is eligible for the “Enhanced Silver 87” version of the silver plans.¹⁵ This means that all of the silver plans in this enrollee's choice set will have an annual deductible of \$550 and an annual out-of-pocket maximum of \$2,250, instead of the annual deductible of \$2,250 and annual out-of-pocket maximum of \$6,250 that come along with standard silver plans. For non-silver plans, these financial characteristics do not vary by the enrollee's income.

Premiums are age-adjusted and net of advanced premium tax credits. Knowing the income bracket of enrollees and the second-lowest-cost silver plan in the enrollee's rating area allows us to compute premiums net of advanced premium tax credits. Enrollees in each income bracket were assumed to receive the tax credit that a person in the middle of the bracket would receive (for example, individuals in the 150–200 percent of poverty bracket were assumed to receive the subsidy of an individual with income of 175 percent of poverty).

LIMITATIONS This analysis is limited to one state. California, unlike most states, requires standardized benefits and cost sharing, and it limits the number of plans an insurer can offer on a tier within a rating region. Twelve carriers compete statewide, although within most rating regions there are four to six. With greater transparency and more insurers in the marketplace, it

The average purchased price is less than the average offered price, which does not account for the fact that enrollment is higher in lower-price plans.

is possible that there is more shopping in California than in most other states. A study by Avalere found that only one-third of returning enrollees in states using a federally facilitated Marketplace purchased the same plan in 2016 that they did in 2015.¹⁶ Nonetheless, a similar analysis of such states is necessary to clarify whether the difference between the average purchased price and the average offered price would be as great in other states.

Study Results

In 2016, enrollment by metal tier in Covered California was 64 percent silver, 27 percent bronze, 5 percent gold, 4 percent platinum, and 1 percent catastrophic. Three carriers—Blue Shield, Anthem, and Kaiser Permanente—accounted for 78 percent of total enrollment, with Blue Shield the leader at 29 percent (online Appendix 1).¹⁷ Health Net (13 percent) and Molina (5 percent) were the only other insurers with enrollment above 2 percent.

For every metal tier for the years 2014–16, the average purchased prices weighted by enrollment in the purchased plans were lower than average offered prices (Exhibit 1). In 2014 the average purchased price for all plans was 11.6 percent less than the average offered price; in 2015 the difference was 13.2 percent less, and in 2016 it was 15.2 percent less. For all study years, the average purchased price for silver plans was at least 9 percent less than the average offered price.

In all study years and for all tiers, premium growth measured as average purchased price was less than the average offered price (Exhibit 1). For 2014–15, premium increases were 3.9 percent when measured as average offered price

EXHIBIT 1

Average premiums of Covered California plans offered and purchased, by tier and year

	All plans	Plan tier			
		Bronze	Silver	Gold	Platinum
2014					
Offered average premium	\$336	\$255	\$330	\$395	\$449
Purchased average premium	297	244	300	358	413
Percent lower (purchased relative to offered)	11.6%	4.3%	9.1%	9.4%	8.0%
2015					
Offered average premium	\$349	\$266	\$342	\$412	\$470
Purchased average premium	303	252	310	373	425
Percent lower (purchased relative to offered)	13.2%	5.3%	9.4%	9.5%	9.6%
2016					
Offered average premium	\$368	\$279	\$354	\$434	\$509
Purchased average premium	312	262	319	394	455
Percent lower (purchased relative to offered)	15.2%	6.1%	9.9%	9.2%	10.6%
CHANGE, 2014–15					
Offered premium	3.9%	4.3%	3.6%	4.3%	4.7%
Purchased premium	2.0	3.3	3.3	4.2	2.9
CHANGE, 2015–16					
Offered premium	5.4%	4.9%	3.5%	5.3%	8.3%
Purchased premium	3.0	4.0	2.9	5.6	7.1

SOURCE Authors' analysis of data provided by Covered California, <http://hbex.coveredca.com/data-research/> **NOTES** A total of 429, 428, and 476 plans were offered in 2014, 2015, and 2016, respectively. Unique carrier-metal tier-product type-rating area combinations define a plan. "All plans" includes catastrophic, bronze, silver, gold, and platinum plans. Premiums correspond to the monthly rate for an unsubsidized forty-year-old.

and 2.0 percent when measured as average purchased price. Corresponding figures for 2015–16 were 5.4 percent and 3.0 percent. With one exception (gold, 2015–16), premium growth by tier measured by average purchased price was less than premium growth using average offered price.

Readers will note in Exhibit 1 that the overall rate of increase of 2 percent for 2014–15 in “purchased” premiums is lower than the figure for any tier. This implies an enrollment shift to lower-cost bronze and silver plans in 2015. To verify this shift, we constructed a fixed market basket price index using constant 2015 enrollment weights for each tier for all years. With fixed weights, the 2014–15 growth of offered premiums was 4.1 percent rather than 3.9 percent; purchased premiums rose by 3.1 percent rather than 2.0 percent (Appendix 2).¹⁷ Using the same fixed weights, in 2015–16, “offered” premiums increased by 4.2 percent rather than 5.4 percent, and “purchased” premiums rose by 3.6 percent rather than 3.0 percent.

Looking at the Covered California rating regions, the average purchased price in 2015 and 2016 was lower than the average offered price for these corresponding years in all nineteen rating regions (Exhibit 2). The change in premiums from 2015 to 2016 was lower in all but two of

the nineteen rating regions when average purchased price was used instead of average offered price. The two exceptions were Central Valley and Los Angeles Rating Region 16.

One reason that purchased prices are lower than offered prices is that consumers buy the lowest- or second-lowest-price plan on the tier nearly 60 percent of the time (Exhibit 3). These shares were stable throughout the study period—57.1 percent in 2014, 59.2 percent in 2015, and 57.5 percent in 2016.

In 2016, 61.7 percent of new enrollees and 55.8 percent of continuing enrollees chose the lowest- or second-lowest-price plan (not shown). In 2014 and 2015, purchasers of platinum plans were the least likely to buy one of the two lowest-price plans on the tier.

For each tier and for each rating region, we ranked plans from the lowest to the highest premium. We then constructed state averages, weighted by enrollment. In general, the lower the premium rank of the plan, the larger the market share (Exhibit 4).¹⁸ For example, 33 percent of bronze plans had premiums in premium rank 1 (lowest). Bronze plans' market share fell continuously with rank, whereas other plan tiers in general showed a falling market share with some deviations. The second-lowest-price silver plan (32 percent) had a higher percentage of

EXHIBIT 2

Offered versus purchased plan premiums in Covered California, all plans, 2015 and 2016

Rating region	Average offered premium			Average purchased premium		
	2015	2016	Change	2015	2016	Change
1 - Northern counties	\$344	\$397	15.3%	\$304	\$334	8.9%
2 - North Bay counties	380	403	5.9	352	372	5.4
3 - Greater Sacramento	404	437	8.1	335	358	6.5
4 - San Francisco County	407	424	4.1	368	373	1.6
5 - Contra Costa County	381	400	4.8	344	358	3.9
6 - Alameda County	365	397	8.8	345	359	3.9
7 - Santa Clara County	380	408	7.4	337	357	5.7
8 - San Mateo County	423	452	7.0	382	400	4.5
9 - Central Coast	400	443	10.7	356	393	9.4
10 - Central Valley	339	372	9.7	291	315	7.8
11 - Central Valley	329	347	5.4	287	291	1.4
12 - Central Coast	344	376	9.3	323	333	3.0
13 - Eastern Region	395	391	-1.1	367	339	-8.4
14 - Central Valley	311	312	0.4	285	291	2.1
15 - Los Angeles (partial)	276	276	-0.3	255	252	-1.3
16 - Los Angeles (partial)	297	299	0.5	277	282	1.8
17 - Inland Empire	293	300	2.2	273	273	-0.1
18 - Orange County	317	326	2.9	296	298	0.5
19 - San Diego County	334	343	2.6	309	311	0.7
Statewide	349	368	5.4	303	312	2.7

SOURCE Authors' analysis of data provided by Covered California, <http://hbex.coveredca.com/data-research/>. NOTE Premiums correspond to the monthly rate for an unsubsidized forty-year-old.

enrollment than the lowest-price plan (28 percent), probably because the second-lowest-price silver plan is the benchmark plan on which the federal premium tax credit is based.

MULTIVARIATE RESULTS We present the estimates of our model as odds ratios in Appendix 3.¹⁷ (Appendix 4 presents the untransformed coefficient estimates.) The odds ratio associated with premiums implies that a \$100 increase in a plan's annual premium would reduce its odds of selection by 0.879 times what it had been previously.

Hence, if a plan had a probability of selection of 0.7 and it raised its annual premium by \$100, its probability of selection would fall to 0.67.¹⁹ A plan with 40 percent market share would see its probability of selection fall to 0.37. We note that the average net premium in California in 2016 is \$1,866 annually, so a \$100 annual increase represents a 5.4 percent increase. The implication is that small increases in premiums lead to significant declines in the probability of selection, and thus market share.

The odds ratios (Appendix 3)¹⁷ also show that increases in a plan deductibles or out-of-pocket maximums will lead to a reduction in market share. However, the implied reduction in market share from an increase in a plan's deductible or out-of-pocket maximum is less than the reduction in market share from an equal-size increase in premiums. This can be seen from the odds ratios of deductibles and out-of-pocket maximums being closer to 1 than the odds ratio for premiums.

The odds ratios for brand effects show that there is generally a preference for the state's larger, more well-known insurers. An insurer odds ratio above 1 implies that the insurer is preferred over Anthem (the reference insurer) when both are available. Anthem, Blue Shield,

EXHIBIT 3

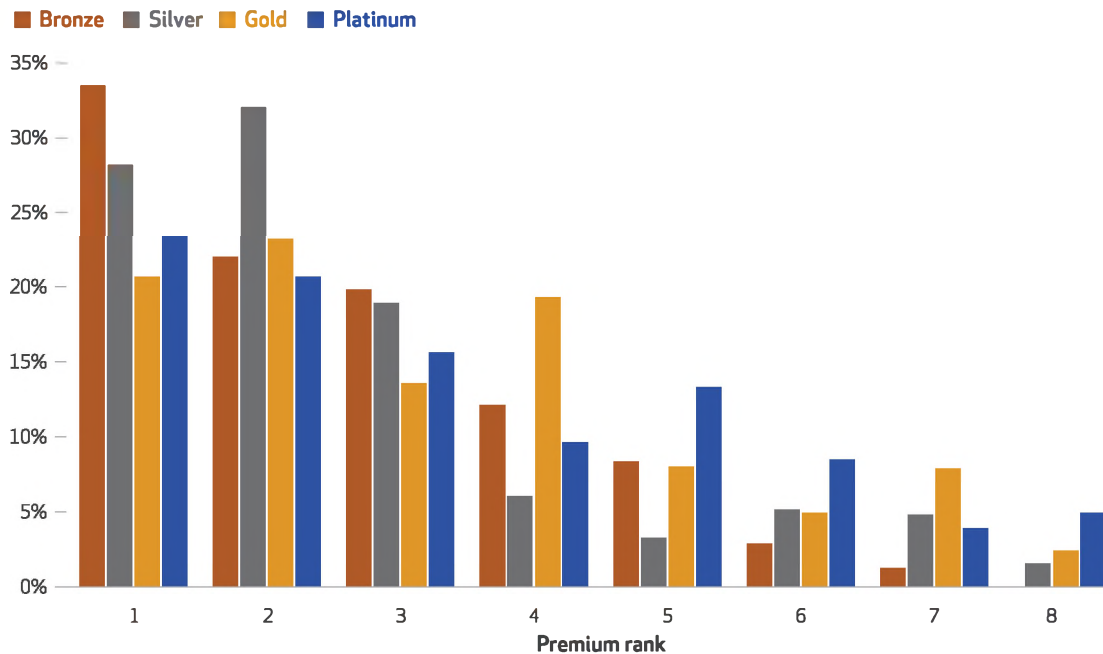
Percent of Covered California enrollees buying the lowest- or second-lowest-price plan on each plan tier, 2014-16

Tier	2014	2015	2016	Percentage-point change	
				2014-15	2015-16
Bronze	59.4%	66.0%	55.5%	6.6	-10.5
Silver	57.2	57.7	60.3	0.5	2.6
Gold	55.4	53.4	43.9	-2.0	-9.5
Platinum	46.3	50.2	44.1	3.9	-6.1
All plans	57.1	59.2	57.5	2.1	-1.7

SOURCE Authors' analysis of data provided by Covered California, <http://hbex.coveredca.com/data-research/>. NOTE "All plans" includes catastrophic, bronze, silver, gold, and platinum plans.

EXHIBIT 4

Market share of Covered California plans in four tiers, by lowest to highest premiums



SOURCE Authors' analysis of data provided by Covered California, <http://hbex.coveredca.com/data-research/> **NOTES** The number of plans available in a tier varies by rating area (from three to eight). Premium rank 1 has the lowest premium in the tier; premium rank 8, the highest.

Health Net, and Kaiser plans are offered in the majority of Covered California's rating areas. The other eight insurers are smaller, more locally focused plans. Sharp, an insurer that offers coverage to people in the San Diego rating area only, stands out from the group of smaller plans: Its odds ratio above 1 implies that it is preferred over Anthem.

Discussion

With remarkable consistency, for virtually every year and metal tier, as well as geographic area, the average purchased price—the average price that enrollees actually paid—is less than the average offered price, which does not account for the fact that enrollment is higher in lower-price plans. In 2016 the average purchased price was 15.2 percent lower than the average offered price. Premium increases were also consistently less when measured as purchased than as offered price. In 2016 the figures were 5.4 percent versus 3.0 percent.

This is not to say that premium changes for plans offered is not a useful statistic. It represents changes in prices that consumers face. When consumers switch to lower-price plans, they may have to switch providers because their previous provider was not in the network, there-

by impairing continuity of care. There may be different preferred brand drugs in the old and new plans that may force consumers to switch medications. Consumers may also endure the inconvenience of learning the ways of filing claims with a new insurer.

Much of the discrepancy between purchased and offered price is attributable to more enrollees buying lower-cost bronze and silver plans, and fewer gold and platinum plans. However, the shift to lower-cost plans is traceable in part to platinum plans having the largest offered premium increase in 2014–15 and 2015–16. Gold plans had the second-highest offered premium increase in 2016.

Some may wonder why so much attention is paid to 2 percentage points—roughly the difference in premium increase between offered and purchased plans. Two percentage points represents 50 percent of the increase in premiums during the study years. Premium growth of 2 or 3 percentage points exceeds the rate of overall inflation in recent years. Moreover, 2 percentage points compounded over ten years is the difference between a 48 percent increase and a 22 percent increase.

Our conditional logit analysis shows new Marketplace enrollees' sensitivity to differences in net premiums—after tax credits. We find that

a \$100 increase in net premiums—a 5.4 percent increase in 2016 premiums to enrollees—would reduce the probability of selection to a hypothetical plan with a 70 percent market share to 0.67.

Covered California demonstrates—straight out of Economics 101—that if consumers have easy-to-understand, transparent information without being overwhelmed by too many choices, they will buy lower-premium products available on their tier. In 2016, 62 percent of new enrollees purchased the lowest- or second-lowest plan on the tier, and 56 percent of returning customers did so.

The major question is, to paraphrase F. Scott Fitzgerald, “Is California different?” Is there greater plan substitution and price competition with standardized benefits and cost sharing and limits on the number of plans offered on a tier in California? Economic theory would say so, but without enrollment data from other states, we cannot confirm this. But it is also highly likely that states without standardized benefits and cost sharing are also experiencing a shift to lower-price plans.

Policy Implications

We note three policy implications from our findings. First, the average premium growth of purchased plans on the exchanges is lower than common reports of premium growth of offered plans, which suggests that the Marketplaces are helping consumers moderate cost growth. We suspect that when enrollment data become available for 2017, premium growth measured in plans purchased will be substantially less than the 14 percent figure in California for plans offered. Covered California has stated that “nearly 80 percent of consumers will pay less or see a rate bump of no more than 5 percent if they switch plans.”²⁰ Shopping can be particularly effective in California, where 93 percent of consumers can choose from three or more insurers and all consumers can select from at least two insurers.

Second, with consumers being so price-sensitive, market entry may be easier, while maintaining a loyal consumer base is more difficult. Third, if a structure similar to that in California were adopted for Medicare/Medicare Advantage plans and employer-based insurance, more intense price competition among insurers would result, and likely lower premium growth as well. ■

The authors thank the Commonwealth Fund for its financial support. The authors thank Sara Collins for her insights and suggestions throughout the project.

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House Committee on
Energy and Commerce
Majority Staff
energycommerce.house.gov

House Committee on Ways
and Means
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waysandmeans.house.gov

**ADDENDUM TO
JOINT CONGRESSIONAL
INVESTIGATIVE REPORT
INTO THE SOURCE OF
FUNDING FOR THE ACA'S
COST SHARING
REDUCTION PROGRAM**

DECEMBER 2016



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II. Executive Summary

In February 2015, the House Committee on Energy and Commerce and the House Committee on Ways and Means launched a joint investigation to understand the rationale behind the Administration's decision to fund the Cost Sharing Reduction (CSR) program through a permanent appropriation, found at 31 U.S.C. § 1324, instead of through the annual appropriations process. To date, the Administration has spent an estimated \$13 billion on CSR payments without a lawful congressional appropriation. Understanding the rationale—learning who made these decisions, when, and why—was and remains critical to Congress's appropriations and oversight authorities. Under the powers set forth in the Constitution, Congress has an obligation to understand the facts of the Obama Administration's decisions here and must ensure that any future administration spends taxpayer dollars prudently and in accordance with the law.

In July 2016, the Committee on Energy and Commerce and the Committee on Ways and Means held two hearings and issued a joint staff report detailing the committees' investigation into the source of funding for the cost sharing reduction program to date. At a hearing before the Subcommittee on Oversight of the Committee on Ways and Means, a senior Treasury official testified, "If Congress doesn't want the moneys appropriated, they could pass a law that specifically said, do not appropriate moneys from that account."¹

Spurred by this testimony that Congress should appropriate in the negative—a statement that directly contradicts the Constitution²—and the number of questions still unanswered, the committees continued the investigation. Since July, the committees continued to press the Administration to produce documents responsive to the multiple subpoenas issued over the course of the investigation, and the Administration finally caved and made documents available. Staff have reviewed thousands of pages of documents to date about the source of funding for the CSR program. This update to the July 2016 CSR report begins to answer the outstanding questions.

As detailed in the July 2016 CSR report, the Administration requested funding for the CSR program in the President's Fiscal Year 2014 budget. The committees have now learned that HHS also included a request for an advance appropriation to cover one month of payments for the CSR program in its FY 2013 budget submission to OMB. This new information—that HHS requested an annual appropriation for the CSR program not once, but twice, further indicates that HHS believed it required an annual appropriation to fund the program.

Numerous communications occurred between the Administration and the Senate Finance Committee between the issuance of the President's FY 2014 budget in April 2014 and the Senate Finance Committee's rejection of funding for the CSR program in July 2014. Ellen Murray,

¹ *Defying the Constitution: The Administration's Unlawful Funding of the Cost Sharing Reduction Program: Hearing Before the Subcomm. on Oversight, H. Comm. on Ways & Means, 114th Cong. 69-70 (2016) (unofficial transcript on file with Committee).*

² U.S. CONST. art. I, § 9, cl. 7 ("No money shall be drawn from the Treasury, but in Consequence of Appropriation made by law[.]").

HHS Assistant Secretary for Financial Resources, testified that she recalled one telephone conversation with Erik Fatemi, the Staff Director for the Senate Appropriations Committee, in which she informally withdrew the Administration's request for funding for the CSR program. However, email exchanges between Ms. Murray and Mr. Fatemi over just a one-week period from late June to early July 2013 demonstrate much back and forth over the CSR program, and also indicate multiple in-person or phone conversations between the two. Emails also indicate that the Administration continued to internally discuss the budget request for CSR funding months after it was included in the President's budget.

Just weeks after Ms. Murray informally withdrew the request for funding and the Senate Appropriations Committee subsequently denied the request for CSR program funding, senior officials at HHS, Treasury, OMB, and the White House discussed via email funding the CSR program from the permanent appropriation for tax credits and refunds—the ultimate source of funding for the program. Moreover, indicating the role that sequestration may have played in the funding decision, these officials discussed the permanent appropriation as a source of funds for the CSR program in the context of the potential impact of sequestration on the program.

More than four months later, in mid-December 2013, IRS officials who were ultimately responsible for making the CSR payments to issuers finally learned of the source of funding for the payments—31 U.S.C. § 1324. Senior IRS officials raised concerns not just to the IRS's legal department—as discussed in the July 2016 CSR report—but also to the Office of the General Counsel at Treasury and other senior Treasury officials. After learning of the decision on the source of funding, IRS officials worried about the potential impact of sequestration on their readiness to make the payments. They did not learn that the CSR program would not be subject to sequestration until a week before the first payments were to be made and months after HHS officials appear to have been aware of the decision. IRS officials rushed to draft and finalize a Memorandum of Understanding (MOU) with CMS governing the CSR payments. Emails about the MOU further document the IRS's concern over the source of funding decision. And, given their concerns over the legality of the source of funding, IRS officials insisted on having Secretary Lew's January 2014 Action Memorandum in hand before proceeding beyond organizational discussions with CMS.

The OMB memorandum on the source of funding for the CSR program was an integral part of the Administration's justification that the permanent appropriation for tax refunds and credits could be used to fund the program. OMB initially refused to produce this document to the committees—even pursuant to subpoena—but the committees received testimony describing the contents of the memorandum as discussed in the July 2016 CSR report. The committees have since reviewed the memorandum and found that it does not provide a cognizable legal basis for using the permanent appropriation to fund the CSR program.

While this update to the July 2016 CSR report answers many of the questions left outstanding, it does not answer all of them. Most notably, the committees have not determined why the Administration requested funding for the program in the FY 2014 budget, and why the Administration subsequently and surreptitiously withdrew that request. The committees plan to pursue this matter until these and other questions are answered.

III. Background

A. The Administration Surreptitiously Raided a Permanent Appropriation to Pay for the CSR Program

In January 2014, the Administration began making payments for the CSR program established by the Patient Protection and Affordable Care Act (ACA) without a lawful congressional appropriation, and has continued to do so ever since. Found under Section 1402 of the ACA, the CSR program requires health insurance companies that offer qualified health plans to reduce co-payments, deductibles, and other out-of-pocket expenses for eligible beneficiaries.³ Section 1412(c)(3) authorizes the federal government to make direct payments to insurance companies to offset estimated costs incurred by providing CSRs to eligible beneficiaries.⁴ While the ACA authorized the CSR program, it did not provide an appropriation or otherwise specify a source of funding for making CSR payments.⁵ Therefore, the Administration needed an appropriation from Congress to make these payments.

The Administration, however, has been making CSR payments to insurance companies through a permanent appropriation, found at 31 U.S.C. § 1324. To date, the Administration has made an estimated \$13 billion in CSR payments from the permanent appropriation.⁶ The appropriation's statutory language limits payments from the appropriation to only tax refunds and specific credit provisions within the Internal Revenue Code.⁷ Congress must amend this appropriation to include other programs. Congress did just that for one part of the ACA—the premium tax credit.⁸ Congress did not do so, however, for the CSR program.

After passage of the ACA, the Administration took steps indicating that it understood that it needed an annual appropriation to fund the CSR program. Most notably, on April 10, 2013, the Administration requested an annual appropriation for the program in its FY 2014 budget request to Congress.⁹ This budget requested nearly \$4 billion to make CSR payments.¹⁰ On July 11, 2013, the Senate Committee on Appropriations denied the President's request to fund the CSR program.¹¹

During the course of the investigation, however, the committees learned that HHS Assistant Secretary for Financial Resources Ellen Murray engaged in several key conversations about the source of funding for the CSR program between April 10 and July 11, including: (1) a

³ See 42 U.S.C. § 18071(b)(1).

⁴ 42 U.S.C. § 18082(c)(3).

⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1402, 124 Stat. 119 (2010).

⁶ Office of Mgmt. and Budget, Budget of the U.S. Government, Fiscal Year 2017, Appendix 1061 (Feb. 9, 2016); Office of Mgmt. and Budget, Budget of the U.S. Government, Fiscal Year 2016, Appendix 1048 (Feb. 2, 2015).

⁷ 31 U.S.C. § 1324.

⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (amending 31 U.S.C. § 1324 by adding “36B” to the list of tax credits available to be paid from the permanent appropriation).

⁹ Office of Mgmt. & Budget, Budget of the U.S. Government Fiscal Year 2014, Appendix 448 (Apr. 10, 2013).

¹⁰ *Id.*

¹¹ S. Comm. on Appropriations, *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2014*, 113th Cong. (S. Rept. 113-71).

telephone conversation with someone in the Executive Office of the President, the name of whom the Administration refuses to disclose; (2) a conversation with HHS General Counsel William Schultz; and (3) a telephone conversation with the then-Staff Director of the Senate Appropriations Committee.¹² Ms. Murray told the committees that she informally withdrew the Administration’s request for funding for the CSR program during her conversation with the former Staff Director of the Senate Appropriations Committee.¹³ Ms. Murray testified, “I told [Erik Fatemi] that there was already any appropriation for the program, and we did not need the bill to include one.”¹⁴

Around the same time that the Administration informally withdrew its CSR funding request, the Office of Management and Budget (OMB) began to develop a memorandum justifying another source of funding for the CSR program. The memorandum provided OMB’s final legal analysis and justification for making CSR payments using the premium tax credit account—the account funded through the 31 U.S.C. § 1324 permanent appropriation.¹⁵ OMB shared this memorandum with top Administration officials at Treasury and HHS.¹⁶ In addition, then-OMB General Counsel Geovette Washington briefed then-Attorney General Eric Holder on the issue, who approved the legal analysis in the memorandum.¹⁷

Toward the end of 2013, several high-level IRS officials learned that the CSR payments would be made from the permanent appropriation for tax credits and refunds, and they began raising concerns about this source of funding.¹⁸ After the IRS raised these concerns to OMB, OMB permitted the IRS officials to review its memorandum at the Old Executive Office Building on January 13, 2014.¹⁹ OMB officials instructed the IRS officials not to take notes and did not permit them to take a copy of the memorandum with them. The OMB memorandum did not alleviate all of the IRS officials’ concerns that the Administration’s course of action violated appropriations law.²⁰

A few days later, senior IRS officials met with IRS Commissioner John Koskinen. The IRS officials who attended the OMB meeting were given an opportunity to raise their concerns directly to the Commissioner. Although Commissioner Koskinen listened to those concerns, the Administration had already decided to move forward with its plan to make the CSR payments through the premium tax credit account.²¹ By the time of this meeting, Secretary Lew had already signed an Action Memorandum that authorized the IRS to administer the CSR payments through the § 1324 appropriation in the same way it administered the Advance Premium Tax

¹² STAFF OF H. COMM. ON ENERGY & COMM. AND H. COMM. ON WAYS & MEANS, 114TH CONG., JOINT CONGRESSIONAL INVESTIGATIVE REPORT INTO THE SOURCE OF FUNDING FOR THE ACA’S COST SHARING REDUCTION PROGRAM 45-51 (July 2016) [hereinafter JULY 2016 CSR REPORT].

¹³ *Id.* at 45-48.

¹⁴ H. Comm. on Energy & Comm., Transcribed Interview of Ellen Murray, at 37 (Mar. 4, 2016) [hereinafter Murray Tr.]

¹⁵ JULY 2016 CSR REPORT, *supra* note 12, at 55-57.

¹⁶ *Id.* at 57-58.

¹⁷ *Id.* at 59-60.

¹⁸ *Id.* at 62-67.

¹⁹ *Id.* at 67-74.

²⁰ *Id.* at 74-76.

²¹ *Id.* at 82-84.

Credit (APTC) payments.²² This Action Memorandum, coupled with the OMB memorandum, paved the way for the Administration to begin making CSR payments from the permanent appropriation for tax refunds and credits.

B. The Administration Relentlessly Obstructed This Investigation, Refusing to Provide Documents and Testimony

As detailed in the July 2016 report, the committees faced a level of obstruction by the Administration previously unprecedented at both the Committee on Energy and Commerce and the Committee on Ways and Means. The committees first requested documents from Treasury and HHS about the source of funding for the CSR program on February 3, 2015. Between February 2015 and January 2016, the departments did not produce a single document. The committees also requested that OMB provide a copy of the legal memorandum justifying the source of funding for the CSR program on April 25, 2016, after learning of the memorandum through interviews. OMB refused to produce the document. Both committees ultimately issued subpoenas for documents to the Department of the Treasury, the Department of Health and Human Services, and the Office of Management and Budget.²³

The Administration refused to comply with document subpoenas issued by the United States Congress.²⁴ The Department of the Treasury refused to confirm to the Committee on Ways and Means whether it ever delivered deposition subpoenas to witnesses.²⁵ During transcribed interviews, the Department of the Treasury limited its employees' and former employees' testimony to Congress by issuing testimony authorizations to witnesses based on over-broad *Touhy* regulations inconsistent with federal law.²⁶ The Department of Health and Human Services and the Office of Management and Budget also severely restricted the scope of testimony provided by current and former employees.²⁷ Administration lawyers further instructed witnesses not to answer purely factual questions—including questions seeking the names of individuals involved in decisions about the source of funding for the CSR program, or confirmation of the occurrence of meetings about the CSR program.²⁸ Finally, lawyers for the Administration pressured at least one witness into following the restrictions set forth in his testimony authorization issued by the IRS after the witness questioned the Administration's ability to limit his testimony.²⁹

When asked to justify the testimonial restrictions imposed on witnesses appearing before the committees, Administration lawyers explained that the Executive branch has “confidentiality interests” and “heightened sensitivities” that allow it to withhold this information from Congress. When asked to explain the basis of those “interests” and “sensitivities,” Administration lawyers

²² *Id.* at 76-82.

²³ *Id.* at 90-98.

²⁴ *Id.* at 99-109.

²⁵ *Id.* at 109-112.

²⁶ *Id.* at 113-121.

²⁷ *Id.* at 122-125.

²⁸ *Id.* at 125-145.

²⁹ *Id.* at 145-154.

refused to do so.³⁰ The position of the Administration—that it could unilaterally block from disclosure to Congress the answer to any question that sought internal or interagency information, or implicated an undefined “confidentiality interest,” or simply sought a fact it did not want Congress to know—effectively would exempt the entire Executive branch from Congressional oversight.

The Administration also argued that the ongoing *House v. Burwell*³¹ litigation effectively preempted any oversight by the committees of the CSR program. The litigation and this investigation, however, have always been distinct from each other. The lawsuit involved no factual discovery. The parties stipulated to the facts. The question before the court was purely a question of law. The committees’ separate and independent oversight inquiry focused on the underlying facts surrounding the Administration’s decision to fund the CSR program through the permanent appropriation instead of through the annual appropriations process. Understanding the rationale—learning who made these decisions, when, and why—was and remains critical to Congress’s appropriations and oversight authorities. Under the powers set forth in the Constitution, Congress has an obligation to understand the facts of the Administration’s decisions here. The committees have an oversight interest in the laws and regulations passed by Congress, and must ensure that the Administration spends taxpayer dollars prudently and in accordance with the law. Nevertheless, the Administration attempted to use the lawsuit to excuse it from cooperating with the committees’ oversight efforts.

C. Since July 2016, the Committees Have Continued Their Investigation, Obtaining Significantly More Information About Decisions Related to the Source of Funding for the CSR Program

While the July 2016 staff report answered many questions about the Administration’s decision to fund the CSR program through the permanent appropriation for tax credits and refunds, many more questions remained outstanding.

The committees first sought answers to these questions through two hearings. On July 7, 2016, the Subcommittee on Oversight of the Committee on Ways and Means held a hearing entitled, “Defying the Constitution: The Administration’s Unlawful Funding of the Cost Sharing Reduction Program.”³² Witnesses from each department involved in the committees’ investigation testified, including the Treasury Department’s Assistant Secretary for Tax Policy Mark Mazur. The witnesses were questioned about the facts surrounding the Administration’s

³⁰ *Id.* at 134-137.

³¹ The *House v. Burwell* litigation is currently before the U.S. Court of Appeals for the District of Columbia Circuit. On November 21, 2016, the U.S. House of Representatives filed a motion requesting to hold the briefing for the appeal in abeyance to allow the incoming administration of the President-elect to discuss potential options for resolution of the matter. Appellee’s motion to hold briefing in abeyance or, in the alternative, to extend the briefing schedule, *U.S. House of Reps. v. Burwell*, No. 16-5202 (D.C. Cir. Nov. 21, 2016). On December 5, 2016, the court ordered that the case be held in abeyance pending further order of the court, and directed the parties to file motions to govern further proceedings by February 21, 2017. Per Curiam Order, *U.S. House of Reps. v. Burwell*, No. 16-5202 (D.C. Cir. Dec. 5, 2016).

³² *Defying the Constitution: The Administration’s Unlawful Funding of the Cost Sharing Reduction Program: Hearing Before the Subcomm. on Oversight, H. Comm. on Ways & Means, 114th Cong.* (2016).

decision to fund the CSR program through the permanent appropriation for tax refunds and credits and the Administration's obstructive tactics in response to the committees' investigation.

At the hearing, Mr. Mazur testified that if Congress did not want the Executive branch to make CSR payments through the permanent appropriation, it could pass a law making that clear. Mr. Mazur testified:

Mr. Mazur. Congresswoman Black, I mean, I think you can look at this in a somewhat different way. **If Congress doesn't want the moneys appropriated, they could pass a law that specifically said, do not appropriate the moneys from that account.**

Mrs. Black. That is not my understanding, sir. And you are an expert in this area. So what you are saying is, if it is left without direction, that it can just be made a mandatory? Is that what you are telling me?

Mr. Mazur. I am saying that the Affordable Care Act -- and I think the legal piece that we referred to goes to this. The Affordable Care Act directs the executive branch to make these cost-sharing reduction payments. And these payments are of a piece with the same payments that are made to the insurance companies under the premium tax credit. And that is the justification for using the same account.

Mrs. Black. So the justification comes because the administration then decides that that is the way they want to do it, even though it is not stipulated in the law.

Mr. Mazur. **And, frankly, if you would like to make the law clearer, you could pass an appropriation law that said, do not make them.**³³

When given the opportunity to correct this answer in response to the Committee's Questions for the Record, the Department of the Treasury doubled down on Mr. Mazur's assessment, stating, "Congress has never sought to prevent the Executive Branch's use of the permanent appropriation or to otherwise prohibit the use of federal funds to make the cost-sharing reduction payments mandated by the ACA."³⁴ Mr. Mazur's claim—that Congress should appropriate in the negative—is not a principle of appropriations law. In fact, it is in direct contradiction to the Constitution, which requires that the Executive only spend monies appropriated by Congress.³⁵

³³ *Id.* at 69-70 (2016) (emphasis added) (unofficial transcript on file with Committee).

³⁴ *Id.* (Questions for the Record responses on file with Committee).

³⁵ U.S. CONST. art. I, § 9, cl. 7 ("No money shall be drawn from the Treasury, but in Consequence of Appropriation made by law[.]").

The Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce held a hearing on July 8, 2016 entitled “The ACA’s Cost Sharing Reduction Program: Ramifications of the Administration’s Decision on the Source of Funding for the CSR Program.”³⁶ Witnesses at this hearing discussed the ramifications of the Administration’s decision on the source of funding on appropriations law, health care law, and congressional prerogatives. One witness specifically discussed Mr. Mazur’s testimony before the Ways and Means Committee. Tom Miller of the American Enterprise Institute testified:

Mr. Murphy. Is that how appropriations laws are supposed to work that Congress has to pass a law specifying how the executive branch cannot spend a specific account or appropriations? You may have heard me reference the idea that which is not permitted is allowed.

Mr. Miller. Your question implies the answer, Chairman Murphy. **That's exactly the opposite as to what happens. It's trying to say we can spend whatever we want until you stop us as opposed to it is the role of Congress under the Constitution to first authorize and then appropriate the funding.** Failing to say you can't spend is not the same thing as saying it was originally approved for spending.³⁷

The committees also continued to seek documents and information from the Administration about the source of funding for the CSR program after issuing the July 2016 staff report. Given the Administration’s refusal to produce documents in response to subpoenas issued by both committees, the Committee on Ways and Means issued deposition subpoenas to a number of relevant officials involved in decisions about the source of funding for the CSR program. After much negotiation, Ways and Means offered a substantial accommodation to the various departments whereby the departments produced documents, largely *in camera*, for review by staff of both committees so as to obviate the need to speak with Administration officials.

Since July, staff of the committees have reviewed thousands of pages of documents responsive to the subpoenas, including the OMB legal memorandum. This addendum provides an update to the July 2016 CSR report based on the significant additional information the committees have learned.

³⁶ *The ACA’s Cost Sharing Reduction Program: Ramifications of the Administration’s Decision on the Source of Funding for the CSR Program: Hearing Before the Subcomm. on Oversight, H. Comm. on Energy & Commerce, 114th Cong. (2016).*

³⁷ *Id.* at 44 (emphasis added) (unofficial transcript on file with Committee).

IV. Documents Reviewed by the Committees Confirm the Findings in the Committees' Report and Answer Questions Raised by the Report*

A. As Early as Summer 2010, the Administration Discussed the CSR Program and Understood It Was Not a Tax Credit, and Was Separate from Tax Programs

Through their transcribed interviews, the committees learned that the Administration began to have discussions about the source of funding for the CSR program soon after the passage of the ACA in 2010. According to IRS Associate Chief Counsel Linda Horowitz, top IRS officials discussed the source of funding both internally and with OMB.³⁸ The committees have more recently learned that IRS officials also questioned the involvement of the IRS in the CSR program in communications with HHS officials in 2010.

On March 23, 2010, President Obama signed the ACA into law.³⁹ Less than three months later, on June 23, 2010, Chiquita Brooks-LaSure of the HHS Office of Coverage Policy emailed IRS Deputy Division Counsel⁴⁰ Catherine Livingston and others, asking them to review a document before it was sent to the White House for comment.⁴¹ Ms. Livingston replied, questioning the IRS' involvement in the cost-sharing subsidy. She wrote, "It is a straight subsidy, not a tax benefit, so we are not clear on the connection."⁴² Brooks-LaSure responded, "its [sic] more that it would be one regulation and we think of the tax credit/cost sharing policies as linked, but we can delete if you prefer."⁴³

In 2010, the Obama Administration understood that the cost sharing reduction was a subsidy—not a tax benefit. This understanding has not been challenged by any documents or testimony the committees have received. The question remains, however, how the Administration decided that a subsidy that was neither a tax credit nor a tax refund could be funded from the permanent appropriation for tax credits and tax refunds.

* Many of the documents cited by the committees herein were reviewed by staff *in camera* as an accommodation to the Department of the Treasury, the Department of Health and Human Services, and the Office of Management and Budget. Documents in the possession of the committees are indicated as such throughout. Otherwise, all quotes and explanations of the documents are from staff notes, and have been cross-referenced among the notes of multiple staffers across the committees.

³⁸ JULY 2016 CSR REPORT, *supra* note 12, at 21–22.

³⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

⁴⁰ In October 2010, Ms. Livingston became the IRS Health Care Counsel.

⁴¹ Email from Chiquita Brooks-LaSure, Dir. of Coverage Policy, U.S. Dep't of Health & Human Servs., to Catherine Livingston, Deputy Division Counsel, I.R.S., et al. (June 23, 2010) [01202016.WM.UST-001952].

⁴² Email from Catherine Livingston, Deputy Division Counsel, I.R.S., to Chiquita Brooks-LaSure, Dir. of Coverage Policy, U.S. Dep't of Health & Human Servs., et al. (June 23, 2010) [01202016.WM.UST-001952].

⁴³ Email from Chiquita Brooks-LaSure, Dir. of Coverage Policy, U.S. Dep't of Health & Human Servs., to Catherine Livingston, Deputy Division Counsel, I.R.S., et al. (June 23, 2010) [01202016.WM.UST-001952].

B. HHS Included a Request for Funding for the CSR Program in its FY 2013 Annual Appropriations Request to OMB

While the committees have been aware of the Administration's request for an annual appropriation for the CSR program since the FY 2014 budget was first made public, the committees recently learned that HHS also included a request for an advance appropriation for the CSR program in its FY 2013 budget submission to OMB. This provides even more evidence that the Administration knew that it needed an annual appropriation for the CSR program.

As described in the July 2016 CSR Report, in a typical HHS budget process, HHS begins to meet with operating divisions the summer before the President's final budget request is submitted to Congress.⁴⁴ The summer meetings include ones with the Secretary's Budget Council, which includes the Deputy Secretary, the Office of the Secretary, the Office of the Assistant Secretary for Financial Resources, and other senior officials. The meetings culminate with HHS Secretary making "tough choices between different requests to come up with [the] final proposal to OMB."⁴⁵ HHS typically submits its initial budget request to OMB around Labor Day.⁴⁶

In the summer of 2011, HHS was preparing its FY 2013 budget request. On July 27, 2011, HHS Assistant Secretary for Financial Resources Ellen Murray met with HHS Secretary Kathleen Sebelius to review the recommendations from the Secretary's Budget Council for FY 2013 mandatory spending.⁴⁷ Ms. Murray prepared a memorandum for Secretary Sebelius in advance of the briefing and included with the memorandum a document entitled "Significant FY 2013 Mandatory Legislative Proposals with no Budget Impact." This document discussed submitting a request in the FY 2013 budget to fund the cost sharing reduction program.⁴⁸

Appropriation for Cost Sharing Reductions: Submits language in the FY 2013 budget for an advance appropriation to fund the entitlement to reduced cost-sharing for certain individuals enrolled in qualified health plans through the Exchange.

On August 18, 2011, Ms. Murray emailed the members of the Secretary's Budget Council requesting final review of the CMS and ACF mandatory proposals for the Secretary's request to OMB.⁴⁹ Ms. Murray made clear that the final decision on any ACA-related proposals would rest with OMB. She wrote:⁵⁰

⁴⁴ JULY 2016 CSR REPORT, *supra* note 12, at 30-32.

⁴⁵ Murray Tr., *supra* note 14, at 17.

⁴⁶ JULY 2016 CSR REPORT, *supra* note 12, at 32-33.

⁴⁷ Memorandum from Ellen Murray, Assistant Sec'y for Fin. Res., U.S. Dep't of Health & Human Servs., to Hon. Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs., HHS FY 2013 Budget Briefing—Part II (July 27, 2011) (on file with Committee).

⁴⁸ *Id.*

⁴⁹ Email from Ellen Murray, Assistant Sec'y for Fin. Res., U.S. Dep't of Health & Human Servs., to Norris Cochran, Deputy Assistant Sec'y for Budget, U.S. Dep't of Health & Human Servs., et al. (Aug. 18, 2011) (on file with Committee).

⁵⁰ *Id.*

Treatment of ACA-Related Proposals

This strawman package assumes that all ACA-related proposals approved through the legislative team and SBC clearance process will advance to OMB given that the HHS position is that these represent sound policy and good government. The determination on whether to actually include any ACA-related proposals in the Budget will be left to OMB.

HHS submitted its FY 2013 budget submission to OMB by September 12, 2011.⁵¹ The budget submission included a request for an advance appropriation of \$400 million to make CSR payments to issuers of qualified health plans for the first quarter of FY 2014.⁵² The explanation accompanying the request stated that the amount requested was estimated to cover one month of payments to be made in December 2013 for January 2014 coverage, and would avoid the need for an anomaly request in the event of a continuing resolution in FY 2014.⁵³

The final FY 2013 budget, released on February 13, 2012, did not include a request for an advance appropriation for the CSR program. OMB presumably made the decision not to include this request, given Ms. Murray's comment to the Secretary's Budget Council that the final decision on inclusion of ACA-related proposals rested with OMB. HHS' inclusion of this request in its budget submission to OMB is notable, however, because the inclusion of a request for an annual appropriation for the CSR program by HHS not once, but twice—in FY 2013 and FY 2014—further indicates that HHS believed it required a congressional appropriation to fund the program.

C. Extensive Communications Occurred Between HHS and the Senate Appropriations Committee on the FY 2014 Funding Request for the CSR Program

The committees' July 2016 CSR report describes how the Administration initially requested an annual appropriation of nearly \$4 billion for the CSR program in the President's FY 2014 budget request submitted to Congress on April 10, 2013.⁵⁴ On July 11, 2013, however, the Senate Committee on Appropriations issued a report denying the request.⁵⁵

The committees' investigation revealed that, between April 10, 2013 and July 11, 2013, the Administration informally withdrew its appropriation request for an annual appropriation for the CSR program through an undocumented phone call. In her transcribed interview, HHS Assistant Secretary for Financial Resources Ellen Murray testified that she called Senate Appropriations Committee Staff Director Erik Fatemi to tell him that "HHS would not need an appropriation" for the CSR program.⁵⁶

⁵¹ Email from HHS Legis. Affairs Staff to H. Comm. on Energy & Comm. Maj. Staff (Oct. 7, 2016) (on file with Committee).

⁵² U.S. Dep't of Health & Human Servs., *Performance Budget Submission to OMB* (Sept. 12, 2011).

⁵³ *Id.*

⁵⁴ JULY 2016 CSR REPORT, *supra* note 12, at 40–41.

⁵⁵ *Id.* at 45.

⁵⁶ Murray Tr., *supra* note 14, at 36; *see also* JULY 2016 CSR REPORT, *supra* note 12, at 45–46.

Ms. Murray testified that she recalled only one conversation with Mr. Fatemi between April and July 2013. She stated, “[t]he only conversation I specifically remember is calling Erik Fatemi and letting him know that we did not need an appropriation for the Cost Sharing Reduction Program.”⁵⁷ Ms. Murray recalled very few details about the conversation. She testified:

Q. Did you provide an explanation to Mr. Fatemi about why an appropriation was not necessary?

HHS Counsel. Thank you.

Witness. Yes, we did. Yes, I did.

Q. What explanation did you provide to him?

A. I told him that there was already an appropriation for the program, and we did not need the bill to include one.

Q. Did you explain to him why there was already an appropriation for the program?

A. I don’t recall.

Q. Do you recall if he asked you why there was already an appropriation for the program?

A. I don’t recall, but I don’t believe he did.⁵⁸

Ms. Murray was later asked whether she recalled any other details about that conversation. She testified, “I do not.”⁵⁹ Ms. Murray further testified that she did not recall sending or receiving any emails about the decision to withdraw the funding request for the CSR program.⁶⁰

The committees have since learned that Ms. Murray and Mr. Fatemi had many more interactions about the budget request between April and July 2013 than Ms. Murray recalled during her interview. In fact, email exchanges between Ms. Murray and Mr. Fatemi over just a one-week period demonstrate much back and forth over the CSR program, and also indicate multiple in-person or phone interactions between the two.

On June 24, 2013, Mr. Fatemi asked Ms. Murray whether she had any update on “Reduced cost sharing.”⁶¹ His email further indicated that he had seen Ms. Murray the previous week.⁶² The next day, Ms. Murray responded, “No update – legal beagles are back at work.”⁶³

⁵⁷ Murray Tr., *supra* note 14, at 38.

⁵⁸ *Id.* at 37.

⁵⁹ *Id.* at 38.

⁶⁰ *Id.* at 100.

From: Murray, Ellen (HHS/ASFR)
Sent: Tuesday, June 25, 2013 12:28 PM
To: 'Fatemi, Erik (Appropriations)'
Subject: RE: Reduced cost sharing

No update - legal beagles are back at work.

-----Original Message-----

From: Fatemi, Erik (Appropriations) [REDACTED]
Sent: Monday, June 24, 2013 6:26 PM
To: Murray, Ellen (HHS/ASFR)
Cc: Hallett, Adrienne (Appropriations)
Subject: Reduced cost sharing

Hi, Ellen. Any update on this?
Great to see you last week.

Later that same day, Ms. Murray emailed HHS Deputy Secretary Bill Corr and General Counsel William Schultz about the CSR language. She wrote, “Senate Approps asked this morning if we have to have CSR language. Should I direct them to OMB?”⁶⁴ Given that Mr. Fatemi’s email was sent the day prior, on June 24, this email indicates that a conversation between Ms. Murray and the Senate Appropriations Committee—presumably Mr. Fatemi—likely occurred on June 25. Given that the email exchange continues into July, this conversation was probably not the one where Ms. Murray withdrew the funding request.

On June 26, Mr. Fatemi emailed Ms. Murray, “We’re starting to cut it close on this. We have to get the bill scored by CBO soon.” Mr. Fatemi also indicated that he would be leaving shortly for an event that evening.⁶⁵ Ms. Murray replied, “See you there - I’ll try to leave at the same time.”⁶⁶ This email implies another interaction between Ms. Murray and Mr. Fatemi on June 26.

⁶¹ Email from Erik Fatemi, Staff Dir., S. Comm. on Appropriations, to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (June 24, 2013) (on file with Committee).

⁶² *Id.*

⁶³ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to Erik Fatemi, Staff Dir., S. Comm. on Appropriations (June 25, 2013) (on file with Committee).

⁶⁴ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to Bill Corr, Deputy Sec’y, U.S. Dep’t of Health & Human Servs., & William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Servs. (June 25, 2013).

⁶⁵ Email from Erik Fatemi, Staff Dir., S. Comm. on Appropriations, to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (June 26, 2013) (on file with Committee).

⁶⁶ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to Erik Fatemi, Staff Dir., S. Comm. on Appropriations, (June 26, 2013) (on file with Committee).

From: Murray, Ellen (HHS/ASFR)
Sent: Wednesday, June 26, 2013 4:32 PM
To: 'Fatemi, Erik (Appropriations)'
Subject: RE: Reduced cost sharing

See you there - I'll try to leave at the same time.

-----Original Message-----
From: Fatemi, Erik (Appropriations) [REDACTED]
Sent: Wednesday, June 26, 2013 4:27 PM
To: Murray, Ellen (HHS/ASFR)
Subject: RE: Reduced cost sharing

We're starting to cut it close on this. We have to get the bill scored by CBO soon. Meanwhile, I will probably leave here around 6:15 for the CAMR event....

On June 28, Erik Fatemi asked again about the CSR program. He wrote, “Any word? I have to show bill text to the minority on Monday. We can still make some changes past Monday, of course, but this is not an issue I want to be waffling back and forth on in front of the Republicans.”⁶⁷ Ms. Murray responded, “Not yet—I know this is unfair.”⁶⁸

From: Murray, Ellen (HHS/ASFR)
Sent: Friday, June 28, 2013 12:18 PM
To: 'Fatemi, Erik (Appropriations)'
Subject: RE: Reduced cost sharing

Not yet - I know this is unfair.

-----Original Message-----
From: Fatemi, Erik (Appropriations) [REDACTED]
Sent: Friday, June 28, 2013 11:25 AM
To: Murray, Ellen (HHS/ASFR)
Subject: RE: Reduced cost sharing

Any word? I have to show bill text to the minority on Monday. We can still make some changes past Monday, of course, but this is not an issue I want to be waffling back and forth on in front of the Republicans.

On July 1, Mr. Fatemi emailed Ms. Murray again, writing, “Pestering again. When do you think we’ll know?”⁶⁹

⁶⁷ Email from Erik Fatemi, Staff Dir., S. Comm. on Appropriations, to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (June 28, 2013) (on file with Committee).

⁶⁸ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to Erik Fatemi, Staff Dir., S. Comm. on Appropriations, (June 28, 2013) (on file with Committee).

⁶⁹ Email from Erik Fatemi, Staff Dir., S. Comm. on Appropriations, to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (July 1, 2013) (on file with Committee).

From: Fatemi, Erik (Appropriations) [REDACTED]
Sent: Monday, July 01, 2013 12:52 PM
To: Murray, Ellen (HHS/ASFR)
Subject: RE: Reduced cost sharing

Pestering again. When do you think we'll know?

Two days later, on July 3, Mr. Fatemi emailed Ms. Murray that “We’re pulling the language tonight. Just thought I’d give you one last chance!”⁷⁰ Ms. Murray forwarded this email to Mr. Corr and Mr. Schultz.⁷¹

From: Murray, Ellen (HHS/ASFR)
Sent: Wednesday, July 03, 2013 3:21 PM
To: Schultz, William B (HHS/OGC); Corr, Bill (HHS/IOS)
Subject: FW: Reduced cost sharing

From Approps

-----Original Message-----
From: Fatemi, Erik (Appropriations) [REDACTED]
Sent: Wednesday, July 03, 2013 3:13 PM
To: Murray, Ellen (HHS/ASFR)
Subject: RE: Reduced cost sharing

We're pulling the language tonight. Just thought I'd give you one last chance!

Deputy Secretary Corr responded that he would call Ms. Murray shortly.⁷²

On July 5, Ms. Murray emailed HHS Deputy Assistant Secretary for Budget Norris Cochran regarding “Senate Table,” noting, “CSR is still on there.”⁷³ Ms. Murray asked, “Are they going to take it all out?”⁷⁴ Mr. Cochran responded, “Don’t know. I can talk to Erik [Fatemi], but would assume they plan to keep it in.”⁷⁵

⁷⁰ Email from Erik Fatemi, Staff Dir., S. Comm. on Appropriations, to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (July 3, 2013) (on file with Committee).

⁷¹ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to Bill Corr, Deputy Secretary, U.S. Dep’t of Health & Human Servs., & William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Servs. (July 3, 2013) (on file with Committee).

⁷² Email from Bill Corr, Deputy Secretary, U.S. Dep’t of Health & Human Servs., to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. and William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Servs. (July 3, 2013) [HHSCSR0000070].

⁷³ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to Norris Cochran, Deputy Assistant Sec’y for Budget, U.S. Dep’t of Health & Human Servs. (July 5, 2013) [HHSCSR0000019].

⁷⁴ *Id.*

⁷⁵ Email from Norris Cochran, Deputy Assistant Sec’y for Budget, U.S. Dep’t of Health & Human Servs., to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (July 5, 2013) [HHSCSR0000019].

In her testimony before the committees, Ms. Murray could only recall one phone conversation with Mr. Fatemi. But based on these emails, there was in fact a substantial amount of back-and-forth about the CSR program between Ms. Murray and Mr. Fatemi in the weeks before the Senate rejected the Administration's request for funding for the CSR program. The emails also indicate that in-person interactions and at least one conversation occurred between the two. Notably, these emails do not appear to include reference to the one conversation Ms. Murray recalled having with Mr. Fatemi—the one where she informally withdrew the Administration's budget request for the CSR program. These emails also show that the Administration continued to internally discuss the budget request for CSR funding months after it was publicly included in the President's budget. These emails do not explain, however, how or why the Administration withdrew its budget request for CSR program.

D. Administration Officials Discussed Funding the CSR Program through the Permanent Appropriation for Tax Refunds and Credits as Early as July 2013

The committees have not yet identified who first identified the permanent appropriation for tax refunds and credits as a potential source of funding for the CSR program, or when this identification took place. The committees recently learned, however, that HHS, Treasury, and OMB officials discussed the idea to fund the CSR program from the permanent appropriation as early as July 31, 2013—only weeks after HHS informally withdrew its request for an annual appropriation for the program. Moreover, these officials discussed the permanent appropriation as a source of funds for the CSR program in the context of the potential impact of sequestration⁷⁶ on the program. These interagency conversations came after internal deliberations at HHS regarding the source of funding for CSR payments.

HHS officials appear to have discussed the appropriation for CSR payments in a meeting on June 18, 2013—the week before Ms. Murray's emails with Mr. Fatemi began. HHS Deputy General Counsel Ken Choe sent a meeting request to HHS General Counsel William Schultz and other HHS counsels. According to Mr. Choe's meeting request, the meeting was about the "appropriation for CSR payments" and would take place in "Bill's office."⁷⁷ Three days later, on June 21, 2013, Mr. Schultz requested copies of Section 1402 and 1412 of the ACA.⁷⁸

On July 2, 2013—in the midst of her email conversations with Senate Appropriations Staff Director Erik Fatemi—HHS Assistant Secretary for Financial Resources Ellen Murray sent HHS General Counsel William Schultz a copy of the Memorandum of Understanding between the IRS and CMS governing the Advanced Premium Tax Credit (APTC) payments. Ms. Murray

⁷⁶ The Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, required nearly across-the-board budget cuts for most annually appropriated programs. Known as "sequestration," the cuts would reduce federal spending by more than \$1 trillion over ten years. Most permanent appropriations—including the permanent appropriation for tax credits and refunds—were not subject to sequestration.

⁷⁷ Meeting between William Schultz, Gen. Counsel, U.S. Dep't of Health & Human Serv., Ken Choe, Deputy Gen. Counsel, U.S. Dep't of Health & Human Servs., et al. (June 18, 2013) [HHSCSR00000063].

⁷⁸ Email from William Schultz, Gen. Counsel, U.S. Dep't of Health & Human Servs., to Law Library (June 21, 2013) [HHSCSR00000042].

wrote, “Could do the same for CSR or modify this MOU.”⁷⁹ Mr. Schultz replied, “Makes sense” and asked if he needed to do anything at that time.⁸⁰ Ms. Murray responded, “No, just a FYI.”⁸¹ Mr. Schultz later wrote to Ms. Murray that the MOU was “very interesting and helpful to read.”⁸² Modifying the APTC MOU, which identified 31 U.S.C. § 1324 as the source of funding for the APTC payments, to include the CSR program would presumably link the CSR payments to the same appropriation. Accordingly, this email chain is the earliest reviewed by the committee to date potentially linking the CSR payments to the permanent appropriation for tax refunds and credits.

On July 31, 2013, HHS Deputy General Counsel Ken Choe emailed OMB General Counsel Geovette Washington, OMB counsel Sam Berger and White House Special Assistant and Senior Counsel to the President Jeremy Maltby about 31 U.S.C. § 1324—the permanent appropriation for tax refunds and credits. He asked whether this “pot of money appropriated for tax credits” was subject to sequestration, noting that his inquiry was “time-sensitive.”⁸³ Mr. Choe subsequently added Treasury General Counsel Christopher Meade and HHS General Counsel William Schultz to the chain, ensuring that key officials at HHS, Treasury, OMB, and the White House were involved in the conversation.

Including OMB’s “budget folks” in his response, Sam Berger replied that the premium tax credits are exempt from sequestration because they are refundable tax credits to individuals.⁸⁴ He continued to explain that while CSRs are not explicitly exempt, “there is a question” as to whether they would be exempt from sequestration “were we to determine they were paid from 31 USC 1324.”⁸⁵ He acknowledged that the issue of funding the CSR payments from the permanent appropriation wouldn’t be resolved “by tomorrow,”⁸⁶ indicating that discussions about utilizing the permanent appropriation as the source of funding were already underway.

HHS Deputy General Counsel Choe then asked if those included on the email chain would be comfortable if the CMS Administrator testified that the question of how sequestration affects cost sharing reductions is under consideration by OMB.⁸⁷ Mr. Berger replied with a

⁷⁹ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Serv. (July 2, 2013) [HHSCSR00000021].

⁸⁰ Email from William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Serv., to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (July 2, 2013) [HHSCSR00000033].

⁸¹ Email from Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs., to William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Serv. (July 2, 2013) [HHSCSR00000033].

⁸² Email from William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Serv., to Ellen Murray, Assistant Sec’y for Fin. Res., U.S. Dep’t of Health & Human Servs. (July 2, 2013) [HHSCSR00000021].

⁸³ Email from Ken Choe, Deputy Gen. Counsel, U.S. Dep’t of Health & Human Servs., to Geovette Washington, Gen. Counsel, Office of Mgmt. & Budget, Sam Berger, Office of Mgmt. & Budget, & Jeremy Maltby, White House Special Assistant and Senior Counsel to the President (July 31, 2013) [01202016.WM.UST.002801].

⁸⁴ Email from Sam Berger, Office of Mgmt. & Budget, to Ken Choe, Deputy Gen. Counsel, U.S. Dep’t of Health & Human Servs., Geovette Washington, Gen. Counsel, Office of Mgmt. & Budget, Jeremy Maltby, White House Special Assistant and Senior Counsel to the President, William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Servs., Christopher Meade, Gen. Counsel, U.S. Dep’t of the Treasury, *et al.* (July 31, 2013) [01202016.WM.UST.002801–02].

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Email from Ken Choe, Deputy Gen. Counsel, U.S. Dep’t of Health & Human Servs., to Geovette Washington, Gen. Counsel, Office of Mgmt. & Budget, Sam Berger, Office of Mgmt. & Budget, & Jeremy Maltby, White House

proposed response from OMB: “We believe that sequestration is not necessary, should not occur, and is highly destructive to core government functions. Congress can and should act to undo the sequester. As we move into FY 2014, HHS and OMB will continue to examine how sequestration affects cost sharing reductions.”⁸⁸

This email chain is the earliest reviewed by the committees to date explicitly linking the source of funding for the CSR program to 13 U.S.C. § 1324—the permanent appropriation ultimately used by the Administration to fund the program. Furthermore, these are the earliest emails reviewed by the committees linking the potential impact of sequestration on the CSR program to the source of funding for the program, indicating that alleviating the stress of a sequestration cut on the CSR program was a concern for HHS, Treasury, OMB, and White House officials.

The very next day, on August 1, 2013, CMS Administrator Marilyn Tavenner testified before the Committee on Energy and Commerce about the potential impact of sequestration on the CSR program—the very issue discussed amongst HHS, Treasury, OMB, and White House officials the day before. She testified:

Mr. Pitts. Ms. Tavenner, on April the 10th, 2013, the Office of Management and Budget released its sequestration preview report for fiscal year 2014. In this report, OMB confirmed the cost-sharing subsidy program in the ACA is subject to sequester to 7.2 percent reduction, a reduction of \$4 billion. Has CMS communicated to officials operating an exchange, both Federal and State, how this sequester will be applied?

Ms. Tavenner. We have not. We are still working with OMB.

Mr. Pitts. Will the navigators and other assistance personnel be expected to properly explain to enrollees the new cost-sharing levels under sequester?

Ms. Tavenner. That is currently under review with OMB, so I would have to get back to you on that.

Mr. Pitts. Well, doesn't this mean applicants may not be aware of their financial liability when signing up for an exchange plan?

Ms. Tavenner. Congressman Pitts, I will have to work with OMB and get back with you on that.⁸⁹

Special Assistant and Senior Counsel to the President, William Schultz, Gen. Counsel, U.S. Dep't of Health & Human Servs., Christopher Meade, Gen. Counsel, U.S. Dep't of the Treasury, *et al.* (July 31, 2013) [01202016.WM.UST.002801-02].

⁸⁸ *Id.*

⁸⁹ *PPACA Pulse Check: Hearing Before the H. Comm. on Energy & Comm.*, 113th Cong. 104-105 (2013).

Ms. Tavenner's response indicates that she received instruction to refer questions about the impact of sequestration on the CSR program to OMB. She did not acknowledge or indicate to the Committee—and thereby Congress and the American people—that the CSR program may not be subject to sequestration. The committees have not learned whether Ms. Tavenner knew of the conversations taking place between HHS, Treasury, OMB, and the White House about the source of funding for the CSR program in July 2013, though it seems unlikely that Ms. Tavenner would have been involved in decisions about the source of funding at this point in time.

E. The Administration Scrambled to Make CSR Payments by January 2014

The first cost sharing reduction payments were scheduled to be paid in January 2014. Yet, the IRS did not learn that source of funding for these payments would come from the IRS-administered permanent appropriation for tax refunds and credits until December 12, 2013. As the July 2016 CSR Report highlights, IRS officials raised concerns about the source of funding, and that those concerns fell on deaf ears because the Administration's decision on the source of funding was all but final by that time.⁹⁰

Documents reviewed since July 2016, however, provide a much richer understanding of what happened at the IRS between December 2013 and January 2014. Senior IRS officials raised concerns not just to the IRS's legal department—as discussed in the July 2016 CSR report—but also to the Office of the General Counsel at Treasury and other senior Treasury officials. After learning of the decision on the source of funding, IRS officials worried about the potential impact of sequestration on their readiness to make the payments. They did not learn that the CSR program would not be subject to sequestration until January 14, 2013—just over a week before the first payments were to be made and months after HHS officials knew of the decision. IRS officials rushed to draft and finalize a Memorandum of Understanding with CMS governing the CSR payments in a two-week time span. Emails regarding the MOU further document the IRS's concern over the source of funding decision. And, given their concerns over the legality of the source of funding, IRS officials insisted on having Secretary Lew's January 15, 2014, Action Memorandum authorizing the payments in hand before proceeding beyond organizational discussions with CMS. All of this occurred before the first payments went out on January 22, 2014. Despite their concerns, the IRS had to get on board and make the payments happen.

1. IRS Officials Raised Concerns About the Legality of the Source of Funding for the CSR Program Immediately After Learning of the Decision

The IRS officials who would be charged with administering the CSR payments were among the last to learn that the permanent appropriation for tax refunds and credits would fund the payments. As IRS Chief Risk Officer David Fisher testified, upon learning of the decision, senior IRS officials immediately began raising significant concerns about audit trail issues,

⁹⁰ JULY 2016 CSR REPORT, *supra* note 12, at 62–67.

sequestration, and whether the account could be used to make the CSR payments. The committees have now learned that senior IRS officials raised these concerns not just to the IRS's legal department, as Mr. Fisher described, but also to the Treasury General Counsel's office and other Treasury officials.

On December 11, 2013, HHS Senior Analyst Heather Tompkins emailed HHS Deputy General Counsel Ken Choe to let him know about an "ongoing workgroup between CMS, IRS, and our ASFR Finance colleagues on APTCs."⁹¹ Ms. Tompkins explained that the IRS participants in that workgroup were the individuals to contact regarding cost-sharing reductions, and specifically highlighted the IRS' Chief Financial Officer's office.⁹² Mr. Choe forwarded that email to Treasury Deputy General Counsel Roberto Gonzalez.⁹³

The following day, the IRS CFO's office learned for the first time about the Administration's plan to fund the CSR program using the § 1324 permanent appropriation. On December 12, 2013, IRS accountant Anne Field emailed several IRS officials including IRS Deputy Chief Financial Officer Gregory Kane and IRS Deputy Associate Chief Financial Officer Howard Marcus. Ms. Field explained that, per discussions with Sean Creighton at CMS, the legal counsels of OMB, Treasury, and HHS had determined that the appropriate source of funds for the CSR payments are the funds appropriated for the Advance Premium Tax Credits.⁹⁴ She commented, "[t]his is the first we've heard of this."⁹⁵

Mr. Marcus replied, asking the group, "can we also make sure that legal agrees that this can be done."⁹⁶ Mr. Kane responded that he was trying to discuss the issue with Sarah Hall Ingram, Director of the Affordable Care Act office within the IRS, because he was concerned that the IRS CFO's office had not been involved in the decision.⁹⁷

Mr. Kane then forwarded Ms. Field's December 12 email to Sarah Hall Ingram, Director of the IRS's Affordable Care Act Office, and Thomas Reeder, Health Care Counsel in the IRS Office of the Chief Counsel, copying Robin Canady, IRS Chief Financial Officer. Mr. Kane asked, "Are either of you aware of this and do we know who at IRS has been involved in the discussion?"⁹⁸ Mr. Kane further stated that three weeks would not be sufficient time to address the accounting issues, noting that GAO already had concerns about treating APTC as a refund on

⁹¹ Email from Heather Tompkins, Senior Analyst, U.S. Dep't of Health & Human Servs., to Ken Choe, Deputy Gen. Counsel, U.S. Dep't of Health & Human Servs., *et al.* (Dec. 11, 2013) [HHSCSR 000000229].

⁹² *Id.*

⁹³ Email from Ken Choe, Deputy Gen. Counsel, U.S. Dep't of Health & Human Servs., to Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep't of the Treasury (Dec. 11, 2013) [HHSCSR 000000229].

⁹⁴ Email from Anne Field, I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., *et al.* (Dec. 12, 2013) [0102016.WM.UST-000124].

⁹⁵ *Id.*

⁹⁶ Email from Howard Marcus, Deputy Associate Chief Fin. Officer, I.R.S., to Anne Field, I.R.S., *et al.* (Dec. 12, 2013) [0102016.WM.UST-000128].

⁹⁷ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Howard Marcus, Deputy Associate Chief Fin. Officer, I.R.S., *et al.* (Dec. 12, 2013) [0102016.WM.UST-000130].

⁹⁸ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Sarah Hall Ingram, Dir., Affordable Care Act Office, I.R.S., *et al.* (Dec. 12, 2013) [0102016.WM.UST-00132].

the IRS's statements and that the GAO might have trouble distinguishing the CSR payments from APTC payments when the IRS sent its books to the GAO.⁹⁹

Ms. Ingram replied, "News to me—we don't administer the cost sharing thing—either up front or on any tax return."¹⁰⁰ She further noted that the IRS would not be getting cost sharing data from the marketplaces and "there is no entry on the tax return about cost sharing."¹⁰¹ Mr. Kane replied that he was concerned about the audit support and other issues that could arise, "esp since we were not planning for it." He said he was considering notifying the IRS's Office of General Legal Services (GLS), specifically Linda Horowitz, Deputy Chief Counsel for GLS, and Kirsten Witter, Chief of the Ethics and General Government Branch within GLS.¹⁰²

Ms. Ingram then told him, "Run, do not walk, to [General Legal Services] and get them to sort out who has been talking with whom at Treasury."¹⁰³ She said she did not know why Treasury's legal counsel would be discussing this issue without the ACA team and that she had not heard anything from the "Treasury ACA nerds in [the Office of Tax Policy]."¹⁰⁴ Mr. Reeder then replied, "This is disconcerting."¹⁰⁵

Mr. Kane forwarded his emails with Ms. Ingram to Ms. Witter and Ms. Horowitz asking for their perspectives.¹⁰⁶ Ms. Horowitz replied only to Mr. Kane that she had not heard of the issue and would talk to Ms. Witter in the morning.¹⁰⁷ Mr. Kane replied, "I find this very interesting these discussions have been going on impacting our account and no one thought to invite IRS."¹⁰⁸

The next day, on December 13, Mr. Kane forwarded the email chain to senior Treasury CFO and budget officials including Department Budget Director Robert Mahaffie and Treasury Deputy Chief Financial Officer Dorrice Roth. Mr. Kane asked whether they were aware of the decision on the source of funding for the CSR program, and stated that IRS counsel—who had not been contacted and "disagree this is legal"—would be reaching out to Treasury.¹⁰⁹ Mr. Kane

⁹⁹ *Id.*

¹⁰⁰ Email from Sarah Hall Ingram, Dir., Affordable Care Act Office, I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., et. al (Dec. 12, 2013) [0102016.WM.UST-000136].

¹⁰¹ *Id.*

¹⁰² Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Sarah Hall Ingram, Dir., Affordable Care Act Office, I.R.S. (Dec. 12, 2013) [0102016.WM.UST-00136].

¹⁰³ Email from Sarah Hall Ingram, Dir., Affordable Care Act Office, I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., et al. (Dec. 12, 2013) [0102016.WM.UST-000138].

¹⁰⁴ *Id.*

¹⁰⁵ Email from Tom Reeder, Counsel, I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., et al. (Dec. 12, 2013) [0102016.WM.UST-000190].

¹⁰⁶ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Linda Horowitz, Deputy Chief Counsel, Gen. Legal Servs., I.R.S. & Kirsten Witter, Chief, Ethics & Gen. Gov't Branch, Gen. Legal Servs., I.R.S. (Dec. 12, 2013) [0102016.WM.UST-000138].

¹⁰⁷ Email from Linda Horowitz, Deputy Chief Counsel, Gen. Legal Servs., I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., (Dec. 12, 2013) [0102016.WM.UST-000143].

¹⁰⁸ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Linda Horowitz, Deputy Chief Counsel, Gen. Legal Servs., I.R.S., (Dec. 12, 2013) [0102016.WM.UST-000143].

¹⁰⁹ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Robert Mahaffie, Dir. for Dep'tl Budget, U.S. Dep't of the Treasury, et al. (Dec. 13, 2013) [0102016.WM.UST-000190].

stated, “It is our belief there is an account at HHS and so something has to be driving this.”¹¹⁰ He also asked if Treasury Assistant Secretary for Management Nani Coloretti was aware and how he should proceed.”¹¹¹

Shortly thereafter, Dorrice Roth forwarded Mr. Kane’s email to Ms. Coloretti and Assistant General Counsel Rochelle Granat and asked if they were aware of the issue. Ms. Granat then forwarded Ms. Roth’s email to Treasury General Counsel Christopher Meade and Deputy General Counsel Roberto Gonzalez asking them to read it, noting she had not responded to Ms. Roth.¹¹² Mr. Gonzalez responded, “There are a number of inaccuracies in the below and there appears to be some confusion.”¹¹³ Mr. Gonzalez later confirmed that he had spoken with Ms. Coloretti.¹¹⁴

Less than a week later, officials from OMB stepped in, potentially to smooth over the situation. On December 21, 2013, Tom Reilly, Deputy Associate Director for Health at OMB, emailed Gregory Kane and Margaret Sherry, IRS Deputy Commissioner for Operations Support. He wrote that his boss, Julian Harris, Associate Director for Health at OMB, spoke with Christian Weideman, Chief of Staff to Secretary Lew, about the “relatively recent decision” on an ACA program—presumably the CSR program.¹¹⁵ IRS officials then began to prepare for a phone conversation with OMB, which was scheduled to take place at 9:00 a.m. on Monday, December 23.

As the emails indicate, several high-level IRS officials were concerned about the source of funding for the CSR program. The news was “disconcerting” to these officials. So much so, that one of them instructed her colleagues to “run, do not walk” to IRS’ General Legal Services. Although Treasury and OMB learned about their concerns, there was little time to assuage them, because the CSR payments were shortly due.

2. The Administration Rushed to Write a Memorandum of Understanding Governing the CSR Account

Although the first CSR payments were to be paid at the end of January 2014, the agencies did not have necessary agreements in place about the process of making those payments at the

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Email from Rochelle Granat, Assistant Gen. Counsel, U.S. Dep’t of the Treasury, to Christopher Meade, Gen. Counsel, U.S. Dep’t of the Treasury, & Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep’t of the Treasury (Dec. 13, 2013) [0102016.WM.UST-001608].

¹¹³ Email from Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep’t of the Treasury, to Rochelle Granat, Assistant Gen. Counsel, U.S. Dep’t of the Treasury, & Christopher Meade, Gen. Counsel, U.S. Dep’t of the Treasury (Dec. 13, 2013) [0102016.WM.UST-001777].

¹¹⁴ Email from Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep’t of the Treasury, to Rochelle Granat, Assistant Gen. Counsel, U.S. Dep’t of the Treasury, & Christopher Meade, Gen. Counsel, U.S. Dep’t of the Treasury (Dec. 13, 2013) [0102016.WM.UST-001786].

¹¹⁵ Email from Tom Reilly, Deputy Assistant Dir., Health, Office of Mgmt. & Budget, to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., & Margaret Sherry, Deputy Comm’r for Operations Support, I.R.S. (Dec. 21, 2013) [0102016.WM.UST-000413].

start of the year.¹¹⁶ Documents confirm that the agencies scrambled to write a Memorandum of Understanding (MOU) while awaiting analysis on the legal basis for using the § 1324 permanent appropriation to fund the CSR payments. Emails recommending the creation of a separate MOU for the CSR payments instead of amending the APTC MOU further document the IRS's concern over the source of funding decision. The IRS ultimately reviewed OMB's memorandum on the source of funds on January 13—four days before the IRS and CMS signed the MOU.

As discussed above, HHS Assistant Secretary for Financial Resources Ellen Murray and HHS General Counsel William Schultz discussed the potential modification of the MOU governing the APTC payments to also include CSR payments on July 2, 2013. Six months later, in early January 2014, IRS officials discussed the same issue. On January 3, 2014, Kristen Witter emailed Gregory Kane and Linda Horowitz that she had been asked again about the status of the MOU between the IRS and CMS on the CSR payments. Noting that she was “still waiting for the legal analysis from Justice,” Ms. Witter wrote, “I recall that we were going to use the [APTC] MOU as a starting point.”¹¹⁷ Referencing “pressure to get this moving quickly and finalized,” Ms. Horowitz told Ms. Witter and Mr. Kane that they should move forward with revisions and then add any legal changes.¹¹⁸ She added that she was “still hoping for something in writing from OMB/OLC or Treasury that sets forth an analysis of the legal basis for using the refund appropriation as the source of funding for these payments.”¹¹⁹

The IRS continued to wait for a legal analysis of the source of funding for the CSR program. On January 6, 2014, IRS Deputy Associate Chief Financial Officer Howard Marcus emailed Mr. Kane and others in the CFO's office asking if they would receive anything from counsel on this decision.¹²⁰ Mr. Kane responded, “eventually,” and noted that it would most likely come from IRS Chief Counsel Bill Wilkins or OMB.¹²¹ In the meantime, IRS employees continued to work on a draft MOU.

On January 9, Mr. Kane sent the original APTC MOU and a draft MOU for the CSR payments to IRS Chief Financial Officer Robin Canady. He wrote, “Counsel is concerned about marrying these two sections together in the previous MOU for the following reasons.”¹²² The reasons included [paraphrased]:

¹¹⁶ JULY 2016 CSR REPORT, *supra* note 12, at 85–86.

¹¹⁷ Email from Kirsten Witter, Chief, Ethics & Gen. Gov't Branch, Gen. Legal Servs., I.R.S. to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., & Linda Horowitz, Deputy Chief Counsel, Gen. Legal Servs., I.R.S. (Jan. 3, 2014) [0102016.WM.UST-000434].

¹¹⁸ Email from Linda Horowitz, Deputy Chief Counsel, Gen. Legal Servs., I.R.S., to Kirsten Witter, Chief, Ethics & Gen. Gov't Branch, Gen. Legal Servs., I.R.S. & Gregory Kane, Deputy Chief Fin. Officer, I.R.S. (Jan. 3, 2014) [0102016.WM.UST-000434].

¹¹⁹ *Id.*

¹²⁰ Email from Howard Marcus, Deputy Associate Chief Fin. Officer, I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., et al. (Jan. 6, 2014) [0102016.WM.UST-000448].

¹²¹ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Howard Marcus, Deputy Associate Chief Fin. Officer, I.R.S., et al. (Jan. 6, 2014) [0102016.WM.UST-000448].

¹²² Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Robin Canady, Chief Fin. Officer, I.R.S. (Jan. 9, 2014) [0102016.WM.UST-000869].

- The existing MOU references that the source of funding for the PTC, including APTC, is 31 U.S.C. 1324, a permanent indefinite appropriation to the Secretary of the Treasury for the payment of refunds and refundable credits administered by the IRS.
- ACA law specifically called out this was the funding source while the ACA law does not address CSR payments being paid from this fund.
- It is our understanding there will be no written opinion provided to IRS or CMS so without knowing how this is tied together they are concerned having everything prefaced with this opening section.¹²³

Mr. Kane explained in a separate email to Mr. Canady and Margaret Sherry that IRS counsel recommended addressing CSRs in a separate MOU from the PTCs because, in part, the “ACA law does not address CSR payments being paid from this fund and we may not have an actual written opinion on the legal analysis for using this funding source.”¹²⁴

Ultimately, IRS and CMS entered into a separate MOU governing the CSR payments. The parties quickly drafted the CSR MOU, exchanging drafts until January 17—the same day the MOU was signed. One of the last issues to be resolved was whether to specifically cite 31 U.S.C. § 1324 as the source of funding. On January 15, HHS added back into the MOU language citing § 1324.¹²⁵ The IRS does not appear to have challenged this edit. On January 16, Gregory Kane emailed Charles Messing and Kirsten Witter that he left the decision to IRS and Treasury counsel, “if they are fine with it.”¹²⁶

The final MOU read, in part “The source of funding for CSR is 31 U.S.C. § 1324, a permanent, indefinite appropriation to the Secretary of the Treasury. IRS manages and administers this appropriation on behalf of the Secretary of the Treasury. Per OMB, guidance, CSR are not subject to sequestration.”¹²⁷

3. IRS Officials Learned the CSR Program Would Not Be Subject to Sequestration Days Before the First Payments Were Made

While IRS officials busily drafted the MOU governing CSR payments, IRS and Treasury officials also sought clarification about the impact of sequestration on the payments. These officials believed sequestration played a vital role in the administration of the CSR payments, specifically, that the IRS would not be ready to make CSR payments at the end of January if the

¹²³ *Id.*

¹²⁴ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Margaret Sherry, Deputy Comm’r, Operations Support, I.R.S. & Robin Canady, Chief Fin. Officer, I.R.S. (Jan. 9, 2014) [0102016.WM.UST-001804-05].

¹²⁵ Email from Charles Messing I.R.S., to Kirsten Witter, Chief, Ethics & Gen. Gov’t Branch, Gen. Legal Servs., I.R.S. & Gregory Kane, Deputy Chief Fin. Officer, I.R.S. (Jan. 15, 2014) (indicating that HHS added back in language citing 31 U.S.C. § 1324 as the source of funding for the CSR payments) [0120216.WM.UST-001186].

¹²⁶ Email from Gregory Kane, Deputy Chief Fin. Officer, I.R.S., to Charles Messing, I.R.S. & Kirsten Witter, Chief, Ethics & Gen. Gov’t Branch, Gen. Legal Servs., I.R.S. (Jan. 16, 2014) [0120216.WM.UST-002480].

¹²⁷ Memorandum of Understanding between the I.R.S. and the Ctrs. for Medicare & Medicaid Servs., MOU14-127 (Jan. 17, 2014) (on file with Committee).

payments would be subject to the sequester. They did not learn that the CSR payments would not be subject to sequestration until January 14, 2014—days before the first payments were due to be made and months after HHS officials appear to have been aware of the decision.

On January 9, 2014, Treasury Budget Director Robert Mahaffie emailed IRS Deputy Chief Financial Officer Gregory Kane, copying Treasury Budget Analyst Lily Kwok. Mr. Mahaffie wrote that Ms. Kwok was checking OMB's sequestration report to determine whether the cost sharing account was listed as subject to sequestration.¹²⁸ Ms. Kwok responded, "Yes, it's subject to sequestration (7.2%)."¹²⁹

IRS officials worried that a decision that the CSR payments were subject to sequestration could delay their processing of the payments. On January 13, Howard Marcus wrote to Gregory Kane and others in the CFO's office, "Of course if sequestration is in play for CRS [sic] we are not ready for the end of January."¹³⁰

The next day, word began to spread that the CSR payments would not be subject to sequestration. On January 14, Lily Kwok emailed Robert Mahaffie and others that the CSR program was no longer subject to sequestration. She wrote, "You can take this off your radar."¹³¹ Mr. Mahaffie also told Mr. Kane via email that OMB will be sending "a note stating the CSR is not subject to sequestration."¹³²

That note came on January 16, one day before the IRS and CMS signed the Memorandum of Understanding governing CSR payments. OMB Deputy Associate Director for Health Tom Reilly emailed Robert Mahaffie that "OMB has determined that the advance payments authorized under section 1412 of the ACA, including both the premium tax credit and cost-sharing reduction portions, are exempt from sequestration."¹³³

The same day, Mr. Reilly sent a similar email to HHS Deputy Assistant Secretary for Budget Norris Cochran and other HHS officials.¹³⁴ Emails reviewed by the committees,

¹²⁸ Email from Robert Mahaffie, Dir. for Dep'tl Budget, U.S. Dep't of the Treasury, to Gregory Kane, Deputy Chief Fin. Officer, I.R.S. & Lily Kwok, Budget Analyst, U.S. Dep't of the Treasury (Jan. 9, 2014) [0120216.WM.UST-002234].

¹²⁹ Email from Lily Kwok, Budget Analyst, U.S. Dep't of the Treasury, to Robert Mahaffie, Dir. for Dep'tl Budget, U.S. Dep't of the Treasury & Gregory Kane, Deputy Chief Fin. Officer, I.R.S. (Jan. 9, 2014) [0102016.WM.UST-002234-35].

¹³⁰ Email from Howard Marcus, Deputy Associate Chief Fin. Officer, I.R.S., to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., et al. (Jan. 13, 2014) [0120216.WM.UST-001000].

¹³¹ Email from Lily Kwok, Budget Analyst, U.S. Dep't of the Treasury, to Robert Mahaffie, Dir. for Dep'tl Budget, U.S. Dep't of the Treasury, et al. (Jan. 14, 2014) [0102016.WM.UST-002339].

¹³² Email from Robert Mahaffie, Dir. for Dep'tl Budget, U.S. Dep't of the Treasury, to Gregory Kane, Deputy Chief Fin. Officer, I.R.S., and Lily Kwok, Budget Analyst, U.S. Dep't of the Treasury (Jan. 14, 2014) [01202016.WM.UST-002316].

¹³³ Email from Tom Reilly, Deputy Assistant Dir., Health, U.S. Office of Mgmt. & Budget, to Robert Mahaffie, Dir. for Dep'tl Budget, U.S. Dep't of the Treasury, et al. (Jan. 16, 2014) [01202016.WM.UST-002315].

¹³⁴ Email from Tom Reilly, Deputy Assistant Dir., Health, U.S. Office of Mgmt. & Budget, to Norris Cochran, Deputy Assistant Sec'y for Budget, U.S. Dep't of Health & Human Servs., et al. (Jan. 16, 2014) [HHSCSR00000023].

however, indicate that HHS officials learned that the CSR payments would not be subject to sequestration long before IRS and Treasury officials did.

For example, on September 4, 2013, Chief of Staff to the CMS Administrator Aryana Khalid emailed HHS General Counsel William Schultz expressing her confusion on how cost sharing reductions would affect the contracts qualified health plans offering insurance on the health insurance exchange would sign with CMS.¹³⁵ She wrote, “If we will eventually say sequester doesn’t affect CSR we aren’t sure why that affects the contract.”¹³⁶ Notably, Ms. Khalid sent this email just weeks after OMB counsel Sam Berger wrote to Mr. Schultz’ deputy, Ken Choe, that, while CSR payments were not explicitly exempt from sequestration, the issue of whether CSR payments funded from 31 U.S.C. § 1324 would be exempt was under consideration.

Similarly, on December 6, 2013, HHS press official Jennifer Friedman emailed Lisa Thimjon, HHS Director of Special Projects for the Office of the Assistant Secretary for Legislation, asking how to respond to a question from Reuters on how sequestration would be applied to the cost sharing reduction program payments. The prepared answer was “cost-sharing reductions are funded through the same Treasury account as the PTCs for Marketplace enrollees. This account is exempt from sequestration, therefore, there will be no sequestration impact on cost-sharing reductions.”¹³⁷ Ms. Friedman further wrote that if pressed by the reporter, to respond that “[w]hen the OMB preview report for sequestration was released in April of this year, we incorrectly identified cost-sharing reductions as a program subject to sequestration, but have since determined it is funded through a source that is exempt.”¹³⁸ Ms. Thimjon replied, “This is all that’s out there currently—ASFR is currently working with OMB on getting this resolved.”¹³⁹ This email indicates not only that HHS press officials knew that the CSR payments would not be subject to sequestration over a month before relevant IRS officials knew, but also that HHS press officials were authorized to reveal this decision to a reporter.

It is clear from documents reviewed to date that the IRS placed great importance on knowing whether CSR payments would be subject to sequestration. It is also clear that relevant IRS officials did not informally learn of the decision that the CSR payments would not be subject to sequestration until January 14, 2016—two days before OMB officially notified IRS and HHS of the sequestration decision. HHS officials—including press officials—apparently knew of this decision far earlier. As with the source of funding decision, the IRS was among the last to know.

¹³⁵ Email from Aryana Khalid, Chief of Staff to Adm’r, Centers for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., to William Schultz, Gen. Counsel, U.S. Dep’t of Health & Human Servs. (Sept. 4, 2016) [HHSCSR0000039].

¹³⁶ *Id.*

¹³⁷ Email from Jennifer Friedman, U.S. Dep’t of Health & Human Servs., to Lisa Thimjon, Office of the Assistant Sec’y for Legis., U.S. Dep’t of Health & Human Servs. (Dec. 6, 2013) [01202016.WM.UST-002216].

¹³⁸ *Id.*

¹³⁹ Email from Lisa Thimjon, Office of the Assistant Sec’y for Legis., U.S. Dep’t of Health & Human Servs., to Jennifer Friedman, U.S. Dep’t of Health & Human Servs. (Dec. 6, 2013) [01202016.WM.UST-002216].

4. The Action Memorandum Signed by Secretary Lew Was Vital to Moving Forward

As detailed in the committees' July 2016 CSR Report, Treasury did not typically use an Action Memorandum to approve the funding sources for programs. The Chief of the IRS's Ethics and General Government Law Branch told the committees that, in her experience, action memoranda were generally used "to permit the acceptance of gifts to the agency."¹⁴⁰ With respect to the source of funding for the CSR program, however, Secretary Lew signed an Action Memorandum authorizing the IRS not to accept a gift, but "to use the section 1324(b) appropriation as the source for [CSR] payments."¹⁴¹ IRS Chief Counsel Bill Wilkins told the committees that he understood the Action Memorandum to be a "decision document that authorized and commanded action."¹⁴² The committees have since learned that the IRS considered the Action Memorandum to be essential to moving forward and making CSR payments from the permanent appropriation. Given the importance of this final, decision-making document, it is inexcusable that the Department of the Treasury still refuses to produce an unredacted version of this document to the committees.

On January 10, 2014, Chief of Staff to Secretary Lew Christian Weideman emailed IRS Senior Adviser to the Chief of Staff David Vandivier and other senior Treasury officials to set up a meeting the following week to discuss the IRS' operational readiness to begin making APTC and CSR payments at the end of the month. According to Mr. Weideman, the meeting would include Secretary Lew, Commissioner Koskinen, and staff from Treasury and IRS.¹⁴³ Mr. Vandivier then emailed IRS General Counsel Bill Wilkins about the meeting.¹⁴⁴ Adding Treasury Deputy General Counsel Roberto Gonzalez to his reply, Mr. Wilkins wrote, "Please understand that operations are contingent on our getting the decision memorandum with the Secretary's approval."¹⁴⁵ Mr. Wilkins explained that he copied Treasury Deputy General Counsel Roberto Gonzalez "to re-emphasize our earlier discussion."¹⁴⁶ He concluded that the IRS could discuss operational issues while waiting for the memo, "but it would feel better if we had the decision memorandum in hand."¹⁴⁷ Mr. Gonzalez confirmed that the memo was on track for Tuesday.¹⁴⁸

¹⁴⁰ H. Comm. on Ways & Means, Transcribed Interview of Kristin Witter, at 23-25 (Apr. 8, 2016).

¹⁴¹ Action Memorandum from Mark Mazur, Ass't Sec'y for Tax Policy, U.S. Dep't of the Treasury, to Hon. Jacob Lew, Sec'y, U.S. Dep't of the Treasury, *Cost-Sharing Payments Under the Affordable Care Act* (Jan. 15, 2014) (on file with Committee).

¹⁴² H. Comm. on Ways & Means, Transcribed Interview of William Wilkins at 37 (Mar. 17, 2016); JULY 2016 CSR REPORT, *supra* note 12, at 81-82.

¹⁴³ Email from Christian Weideman, Chief of Staff, U.S. Dep't of the Treasury, to David Vandivier, Senior Advisor to the Chief of Staff, I.R.S., et al. (Jan. 10, 2014) [0102016.WM.UST-001574].

¹⁴⁴ Email from David Vandivier, Senior Advisor to the Chief of Staff, I.R.S., to William Wilkins, Gen. Counsel, I.R.S. (Jan. 10, 2014) [0102016.WM.UST-001871].

¹⁴⁵ Email from William Wilkins, Gen. Counsel, I.R.S., to David Vandivier, Senior Advisor to the Chief of Staff, I.R.S., and Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep't of the Treasury (Jan. 10, 2014) [0102016.WM.UST-001871].

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ Email from Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep't of the Treasury, to William Wilkins, Gen. Counsel, I.R.S., et al. (Jan. 10, 2014) [0102016.WM.UST-001871].

Five days later, on January 15, 2013, a Treasury employee sent the signed Action Memorandum to Treasury General Counsel Christopher Meade and Deputy General Counsel Roberto Gonzalez.¹⁴⁹ With the Action Memorandum in hand, the IRS could begin making CSR payments from the permanent appropriation for tax refunds and credits the following week.

Since releasing its July 2016 CSR Report, the committees have learned a great deal about the work done at the IRS in December 2013 and January 2014 to prepare to make CSR payments from the permanent appropriation for tax refunds and credits. IRS officials were blindsided by the decision about the source of funding and raised substantial concerns about the legality of the decision to the IRS General Counsel's Office, Treasury General Counsel's office, and other senior Treasury officials. These concerns may have prompted the unusual Action Memorandum approved by Secretary Lew.

F. OMB's Memorandum Does Not Provide a Cognizable Legal Basis for Using the Permanent Appropriation as the Source of Funding for the CSR Program

OMB's memorandum on the source of funding for the CSR program was an integral part of the Administration's justification that the permanent appropriation for tax refunds and credits could be used to fund the program. The committees first learned about this memorandum through witness testimony describing the contents of the memorandum. At the time the committees released the July 2016 CSR report, OMB had still refused to produce the document—even subject to subpoena. Since publishing its report, the committees have reviewed the memorandum and found that it does not provide a cognizable legal basis for using the permanent appropriation to fund the CSR program.

The memorandum, dated December 19, 2013 and entitled “Funding for Advance CSR payments,” was from John Simpkins, Steve Aitken, and Sam Berger to the “General Counsel.”¹⁵⁰ The purpose of the memorandum was to analyze the source of funding for ACA subsidies, specifically whether advance CSR payments can be funded from the permanent appropriation at 31 U.S.C. § 1324. The drafters state at the outset that they “believe” funding payments from the permanent appropriation is permissible, and ultimately conclude that it is “permissible” for the Administration to make advance CSR payments from the 31 U.S.C. § 1324 appropriation based on the “purpose, text, and structure” of the Affordable Care Act.¹⁵¹ The drafters also indicated in the first footnote that the memorandum did not address if an appropriation had been provided for payments made under section 1402, the provision authorizing the CSR program.¹⁵²

The memorandum argues that sections 1412(c)(2), which provides for advance payment of the premium tax credit, and 1412(c)(3), which provides for advance payment of cost sharing

¹⁴⁹ Email from [U.S. Dep't of the Treasury employee] to Christopher Meade, Gen. Counsel, U.S. Dep't of the Treasury, & Roberto Gonzalez, Deputy Gen. Counsel, U.S. Dep't of the Treasury (Jan. 15, 2014) [0102016.WM.UST-001643].

¹⁵⁰ Memorandum from John Simpkins, Steve Aitkin, and Sam Berger, Office of Mgmt. & Budget, to General Counsel, Office of Mgmt. & Budget (Dec. 19, 2013).

¹⁵¹ *Id.*

¹⁵² *Id.*

reductions, should be read together as a unified whole instead of as separate provisions, and as appropriated from the same mandatory funding source. In the opinion of the drafters, this is consistent with the provision's "stated purpose."¹⁵³ The drafters argue that insurers would charge higher premiums without a permanent appropriation. This, in turn, would lead to increases in the subsidies to cover premiums, and so the permanent appropriation would be used to cover the costs eventually. According to the drafters, this could not be Congress's intended outcome.¹⁵⁴ The drafters further argue that Congress could have established separate advance payments for PTCs and CSRs, with payments made by the Secretary of the Treasury and the HHS Secretary, respectively, but instead created one unified advance payment program with payments for both parts of the payment made by the Treasury Secretary.¹⁵⁵

The memorandum includes a long discussion of selected legislative history, citing versions of prior health care bills that were not enacted and floor statements by Senators and Members of Congress not specifically related to CSR payments. In the drafters' view, however, these statements suggested that Congress viewed the two subsidies as intertwined.¹⁵⁶

The memorandum only briefly addresses the fact that section 1412 is not listed in the appropriation at 31 U.S.C. § 1324, and does not at all address the fact that section 1402—which authorizes the CSR program—is not included in the permanent appropriation. Instead, in concluding that the permanent appropriation can be used for advance payment of CSRs, the drafters argue that section 1324 has been interpreted to provide funding for payments made pursuant to provisions not listed and that, in this instance, the drafters point to section 36B, which was specifically enumerated and operates through section 1412.¹⁵⁷ The drafters do not mention that section 36B was created by the ACA to allow for payment of premium tax credits through the permanent appropriation for tax credits and refunds, and that there is no language in the ACA tying the CSR program to the permanent appropriation at 31 U.S.C. § 1324 appropriation.

The justification for funding the CSR program from the permanent appropriation is based almost entirely on the fact that section 1412 authorizes advance payments of both CSRs and premium tax credits. But this analysis is tenuous at best, and does not even address that the clear text of the ACA provided an authorization and an appropriation for premium tax credits, but only an authorization for CSR payments. The Administration went to great lengths to keep this memorandum from the committees, only providing it for *in camera* review after much effort. Perhaps the shaky analysis provides a reason why.

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

V. Conclusion

The Obama Administration has been unconstitutionally funding the cost sharing reduction program—an Affordable Care Act program—through a permanent appropriation intended only for tax refunds and credits. As detailed in the committees’ July 2016 report, the Administration knew that the ACA did not fund the CSR program. It even requested an annual appropriation for the CSR program from Congress. The Administration, however, surreptitiously withdrew that request and developed a *post hoc* justification to pay for the CSR program through the 31 U.S.C. § 1324 permanent appropriation. The Administration still has refused to explain why it withdrew that request.

Nevertheless, the committees’ persistence pulled back the curtain further to learn more about how the Administration came to unconstitutionally fund the CSR program. Documents reviewed since July 2016 reaffirmed that Administration officials understood that CSRs were not tax credits, and therefore needed an annual appropriation. And just before the Administration withdrew its request for an annual appropriation, HHS and the Senate Appropriations Committee had—not just one—but several conversations about the Administration’s funding request for the CSR program. As the Administration scrambled to make the CSR payments on time, senior IRS officials learned about the source of funding for the CSR program and immediately raised concerns about the legality of the funding source. As they quickly pulled together a memorandum of understanding needed to administer the payments, they were provided an unusual Action Memorandum signed by Secretary Lew explicitly authorizing the permanent appropriation as the source of funding and shown OMB’s memorandum justifying the Administration’s actions. This memorandum, however, does not provide a cognizable legal basis for using the permanent appropriation to fund the CSR program.

Questions, however, still remain—especially why Administration withdrew its request for an annual appropriation. The committees plan to continue to press until this and other outstanding questions are answered.

Almost 12 Million Americans Stand to Gain Financial Help Buying Health Coverage This Year, But May Not Know It

December 5, 2016 | By: *Kathryn Martin*, Acting Assistant Secretary for Planning and Evaluation at HHS

Summary: Research shows that about half of the remaining uninsured don't know that premium tax credits are available to keep coverage affordable.

Nobody likes to leave money on the table. But what if you don't know you are doing it? That is what is happening to millions of Americans who are likely eligible for financial help when buying health insurance. That includes millions of people already buying coverage, who don't know that they could get a better deal by shopping on HealthCare.gov. And it includes millions of uninsured Americans. Research shows that about half of the remaining uninsured don't know that premium tax credits are available to keep coverage affordable.¹

Already, about 8.8 million Americans who buy health insurance through HealthCare.gov receive premium tax credits to help keep their coverage affordable. Across the country, many more are eligible for help, including:

- **Current HealthCare.gov consumers:** Almost 300,000 HealthCare.gov consumers who didn't get premium tax credits last year could be eligible for premium tax credits in 2017, *even if their income remains the same*, because financial assistance moves along with rates. That's more than one in five currently unsubsidized HealthCare.gov consumers.
- **Off-Marketplace individual consumers:** About 2.5 million Americans who currently pay full price for individual coverage off-Marketplace could be eligible for premium tax credits if they purchase a 2017 plan through HealthCare.gov instead.
- **The remaining uninsured:** About 9 million uninsured Americans – 84 percent of the Marketplace-eligible uninsured – earn incomes indicating they, too, could be eligible for financial assistance.

The state-by-state tables below show the number of consumers who could benefit in 2017 from the financial assistance Marketplace premium tax credits provide. If these consumers were to take advantage of the help offered on HealthCare.gov, they could find affordable, quality coverage options.

Affordable by design. The Marketplace's premium tax credits are designed to keep pace with premium increases. This means that for many consumers already receiving premium tax credits, the value of that financial assistance will increase this year to keep pace with the cost of coverage in their area. It also means that more individuals may qualify for premium tax credits as premiums rise. For people eligible for financial assistance, the ACA specifies the share of income the consumer is expected to contribute toward health coverage. The premium tax credits make up the difference between that amount and the actual cost of a consumer's benchmark (second-lowest-cost silver) plan.

For example:

- In 2017, a 27-year old making \$25,000 per year will pay \$142 per month to purchase the benchmark plan, almost exactly the same as in 2016, when the same consumer would have paid \$143 monthly – even though benchmark premiums have increased. That's because the 27-year old will, on average, get a \$160 premium tax credit – 62 percent higher than in 2016.
- A family of four with an income of just over \$85,000 per year is expected to pay \$686 per month for the benchmark plan. If premiums are less than or equal to \$687, the family does not receive a premium tax credit. But, if premiums for the benchmark plan rise from \$686 to \$786, the family becomes eligible for a premium tax credit of \$100 per month. The premium tax credit absorbs the full cost of the premium increase for the benchmark plan.

Check out your options. The 2017 Open Enrollment period is here and the Marketplace is open for business now through January 31, 2017. HHS is encouraging anyone who might need coverage next year to visit HealthCare.gov and check out their options. Millions of Americans could be surprised to find out they're eligible for financial assistance this year, giving them affordable, quality options to choose from. Visit HealthCare.gov to browse and shop for quality, affordable

health plans. If you sign up by December 15, 2016, your coverage can start as early as January 1, 2017. More than 70 percent of current consumers will find plans for less than \$75 per month, and the vast majority can save by coming back to actively shop instead of waiting to be re-enrolled in their current plan.

Table 1. Availability of Financial Assistance among Current Health Insurance Marketplace Consumers in HealthCare.gov States

	Percent of Consumers Receiving Premium Tax Credits in 2016*	Percent of Consumers Potentially Eligible for Premium Tax Credits in 2017	Number of Unsubsidized Consumers in 2016	Number of Consumers Potentially Newly Eligible for Premium Tax Credits in 2017**	Percent of Unsubsidized Consumers in 2016 Who Are Potentially Newly Eligible for Premium Tax Credits in 2017
Total	85%	89%	1,297,900	286,100	22%
AK	86%	90%	2,800	600	21%
AL	89%	93%	16,700	5,300	31%
AR	87%	90%	8,500	1,900	22%
AZ	74%	83%	45,700	13,200	29%
DE	82%	86%	4,700	1,200	26%
FL	91%	94%	138,700	34,800	25%



GA	86%	92%	59,700	14,300	2
HI	81%	86%	2,600	600	2
IA	85%	89%	7,300	2,000	2
IL	75%	81%	89,300	22,000	2
IN	81%	84%	33,800	4,800	2
KS	82%	86%	16,800	4,200	2
LA	89%	93%	19,300	4,400	2
ME	87%	90%	9,700	2,400	2
MI	83%	87%	50,800	10,000	2
MO	87%	90%	31,100	7,100	2
MS	90%	94%	8,500	3,000	3
MT	83%	87%	8,900	2,300	2
NC	89%	93%	52,700	13,100	2
ND	85%	91%	2,400	600	2
NE	88%	92%	8,500	2,200	2



NH	66%	70%	17,000	1,600	-
NJ	80%	84%	54,300	8,700	-
NM	68%	76%	16,500	3,700	2
NV	87%	90%	10,300	2,000	2
OH	80%	85%	41,600	7,600	-
OK	84%	88%	21,200	5,600	2
OR	71%	78%	39,500	8,200	2
PA	76%	82%	94,700	20,800	2
SC	89%	92%	22,200	4,800	2
SD	88%	93%	2,500	800	3
TN	85%	89%	35,000	8,900	2
TX	84%	88%	193,300	38,600	2
UT	86%	90%	23,000	6,000	2
VA	82%	86%	65,700	11,400	-
WI	84%	87%	34,800	6,000	-



WV	85%	89%	4,900	1,200	2
WY	90%	92%	2,100	300	1

* U.S. Department of Health and Human Services, "Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," ASPE Issue Brief, ASPE, March 11, 2016, available at:

<https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf> - PDF.

** This column shows the total number of returning consumers estimated to be newly eligible for premium tax credits. The net increase in the number eligible for tax credits is slightly less, about 284,200.

Note: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis. This analysis holds *all* enrollee characteristics unchanged and calculates 2017 premiums and tax credits based on the same age, family composition, and household income as in 2016. This analysis includes only enrollees who could be linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users. Consumers enrolled in catastrophic plans, which are not available to all consumers, were not considered in these calculations. For additional details, see "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace" (available at: <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace>).

To return to the page content, select the respective footnote number.

¹ The Commonwealth Fund. "Most Adults with Marketplace or Medicaid Coverage Continue to Be Satisfied with Their Health Insurance, But Many Remain Uninsured." Available at: <http://acatracking.commonwealthfund.org/>.



THE ECONOMIC RECORD OF THE
OBAMA ADMINISTRATION:
REFORMING THE HEALTH CARE SYSTEM

December 2016



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Introduction

The health care system has profound effects on Americans' lives. Access to high-quality health care contributes to good health, which helps Americans meet obligations to their families, succeed in the workplace and the classroom, and enjoy an overall high quality of life. At the same time, health care is a major expense for families and governments alike, so the health care system's ability to deliver needed care at a reasonable cost is an important determinant of Americans' overall standard of living.

When President Obama took office, he confronted a health care system that was falling short both in ensuring broad access to high-quality care and in providing care at a reasonable cost. These shortcomings were the result of large gaps in our health insurance system and a health care delivery system that too often provided inefficient, low-quality care. Through the Affordable Care Act (ACA) and other legislation enacted under this Administration, as well as accompanying administrative actions, the United States has made considerable progress in addressing these two major problems.

Turning first to the health insurance system, more than one-in-seven Americans—44 million people—lacked health insurance coverage in 2008, the year before the Obama Administration began. Many uninsured individuals were simply unable to afford coverage, while many others were locked out or priced out of the individual health insurance market because they had pre-existing health conditions. Their lack of insurance coverage kept them from being able to obtain the care they needed, and left them vulnerable to financial catastrophe if they became seriously ill. Meanwhile, even many Americans with health insurance faced similar risks due to significant gaps in their coverage.

In his first month in office, President Obama took an initial step toward ensuring that all Americans had access to affordable, high-quality health insurance coverage by signing legislation improving the Children's Health Insurance Program (CHIP). Slightly more than a year later, the President signed the ACA, which reformed the individual health insurance market to ensure that all Americans could find affordable, high-quality coverage, provided generous financial support to states that wished to expand their Medicaid programs to cover more of their low-income residents, and allowed young adults to remain on a parent's plan until age 26. Together, these actions led to a historic expansion in the number of people with health insurance. Because of the coverage provisions of the ACA, an estimated 20 million additional adults now have health insurance. In addition, thanks in large part to the ACA and the improvements to CHIP that the President signed into law, the uninsured rate among children has fallen by almost half since the President took office, providing health insurance to more than 3 million additional children. Following these gains, the uninsured rate stands below 9 percent for the first time ever.

A growing body of evidence demonstrates that broader insurance coverage is generating major benefits for the newly insured and the health care system as a whole. Access to medical care has improved substantially; the share of people reporting that they have recently forgone medical

care because they could not afford it has fallen by more than a third since the ACA became law. Expanded coverage has also reduced the burden of medical debt and generated corresponding reductions in the amount of uncompensated care. Nationwide, uncompensated care has fallen by more than a quarter as a share of hospital operating costs from 2013 to 2015, corresponding to a reduction of \$10.4 billion. Early evidence also suggests that expanded coverage is driving improvements in health that are consistent with those observed in prior research; if experience under the ACA matches what was observed under Massachusetts health reform, an estimated 24,000 deaths are already being avoided annually. Looking beyond the health care sector, the ACA has also sharply reduced income inequality, and it has achieved this broad range of benefits without the adverse near-term effects on the labor market that the ACA's critics predicted, while also helping to lay the foundation for a stronger labor market over the long term.

The ACA also introduced reforms to improve financial security and access to care for those who were already insured. These reforms are generating important benefits. Because of the law, private insurance plans are generally required to limit enrollees' annual out-of-pocket spending. Due to the spread of out-of-pocket limits since 2010, an estimated 22 million additional people enrolled in employer-sponsored plans are protected against catastrophic costs in 2016. Similarly, because of the ACA's provision phasing out the Medicare Part D coverage gap, more than 11 million Medicare beneficiaries have received cumulative savings on prescription drugs averaging more than \$2,100 a person as of the middle of 2016.

Turning next to the health care delivery system, the United States devoted roughly a sixth of its gross domestic product (GDP) to health care when President Obama took office, a far larger share than peer nations. Yet health outcomes in the United States were, at best, no better. At the same time, health care spending and health outcomes varied widely across regions of the United States, with no evidence that higher-spending areas achieved better outcomes. This and other evidence showed that there were major opportunities to reform the health care delivery system in ways that could reduce the burden that health care spending placed on the U.S. economy, while improving health outcomes.

The ACA and related legislation have implemented comprehensive reforms to make the health care delivery system more efficient and improve the quality of care. The ACA achieved significant near-term savings by better aligning payments to medical providers and private insurers in Medicare with the costs of providing services. The law also set in motion a long-term effort to develop and deploy alternative payment models (APMs) that reward providers who deliver efficient, high-quality care, unlike existing fee-for-service payment systems, which base payment chiefly on the quantity of services delivered. Using the tools provided by the ACA, the Administration has made considerable progress in deploying APMs, including accountable care, bundled payment, and medical home models. As of early 2016, more than 30 percent of traditional Medicare payments were estimated to be associated with APMs, up from virtually none in 2010. The tools provided by the ACA, which were enhanced by the bipartisan physician payment reform legislation enacted in 2015, will drive further progress in the years ahead.

Changes in Medicare’s payment systems appear to be catalyzing similar changes by private payers. Indeed, at the beginning of 2016, 17 million—or roughly one in ten—private insurance enrollees are estimated to have been covered under payment arrangements similar to the accountable care contracts being deployed in Medicare, up from virtually none as recently as 2011. Similarly, one large survey found that around a quarter of provider payments made by private insurers were associated with APMs in 2015. The Administration has also taken several steps to accelerate the diffusion of APMs in the private sector by directly engaging private payers in payment reform efforts in Medicare and Medicaid, facilitating information sharing across payers, and fostering the development of common standards. The ACA’s excise tax on high-cost employer-sponsored coverage, scheduled to take effect in 2020, will provide an additional impetus for private sector plans to engage in payment reform efforts over the coming years.

The six years since the ACA became law have seen very encouraging trends in both health care costs and health care quality. Prices of health care goods and services have grown at a slower rate under the ACA than during any period of the same length since these data began in 1959. Recent years have also seen exceptionally slow growth in per enrollee spending in both public programs and private insurance. In parallel, there have been promising indications that quality of care is improving. The rate at which patients are harmed while seeking hospital care has fallen by 21 percent since 2010, which is estimated to have led to approximately 125,000 avoided deaths cumulatively through 2015. Medicare beneficiaries’ risk of returning to the hospital soon after discharge has also declined substantially, corresponding to an estimated 565,000 avoided readmissions from April 2010 through May 2015.

A considerable body of research has aimed to understand the causes of these encouraging trends. The Great Recession does not appear to have been an important driver of the slow growth in health care costs in recent years. The recession had little effect on Medicare spending, and, while the Great Recession did dampen private sector spending growth in the years during and immediately after the downturn, its ability to explain slow growth over the last few years is limited. Similarly, neither demographic changes nor changes in cost sharing appear to explain much of the slow growth in health care costs under the ACA.

It therefore appears that recent years’ favorable trends in health care costs and quality primarily reflect structural changes in the health care delivery system. While multiple factors are likely playing a role, payment reforms introduced in the ACA have made substantial, quantifiable contributions to slowing the growth of health care costs in both Medicare and private insurance. Congressional Budget Office (CBO) estimates imply that the ACA has reduced the growth rate of per beneficiary Medicare spending by 1.3 percentage points a year from 2010 through 2016. “Spillover” effects of the ACA’s Medicare reforms on the prices that private insurers pay for care have likely subtracted between 0.6 and 0.9 percentage point a year from the growth rate of per enrollee private insurance spending over the same period. Moreover, there is reason to believe that the ACA has had systemic effects on trends in health care costs and quality that go beyond what can be directly quantified.

Recent positive developments in the health care delivery system are generating major benefits to families and the economy. The average premium for people who hold employer-based family coverage was nearly \$3,600 lower in 2016 than if premium growth since the ACA became law had matched the preceding decade, savings families will receive directly in the form of lower premium costs and indirectly in the form of higher wages. Far from offsetting the slowdown in premium growth, growth in out-of-pocket costs has slowed as well, and accounting for out-of-pocket costs increases these savings to \$4,400 in 2016.

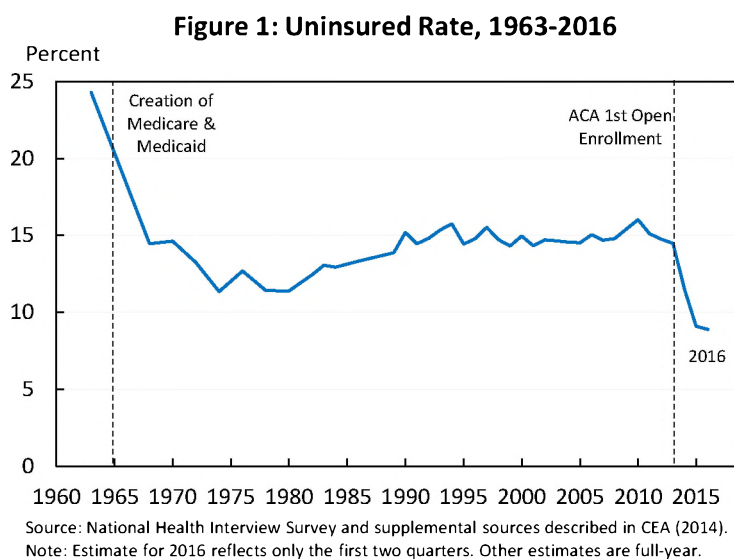
People who get coverage outside the workplace have also realized important savings on premiums and cost sharing. The typical Medicare beneficiary enrolled in traditional Medicare will incur around \$700 less in premiums and cost sharing in 2016 than if Medicare spending trends had matched what was projected in 2009. This figure does not include reductions in cost sharing on prescription drugs due to the combination of the ACA's provision closing the Medicare Part D coverage gap and slower-than-expected growth in prescription drug spending, so it actually understates the total savings to Medicare beneficiaries.

Because State and Federal governments finance a substantial share of health care spending, slower growth in health care costs has also greatly improved the fiscal outlook. Due in large part to the ACA's provisions slowing the growth of health care costs, CBO projects that the law will reduce deficits by increasing amounts in the years ahead, rising to an average of 1 percent of GDP over the decade starting in 2026. Over the next two decades as a whole, the law is projected to reduce deficits by more than \$3 trillion. In addition, since just after the ACA became law, CBO has reduced its projections of Medicare spending under current policies by an additional \$125 billion in 2020 or around 0.6 percent of GDP in that year, further improving the fiscal outlook. The combination of the ACA and broader trends in the health care sector have also added 11 years to the life of the Medicare Trust Fund relative to 2009 projections.

The remainder of this report provides additional detail on the challenges the United States health care system faced when the President took office, the actions this Administration has taken to meet those challenges, and the progress that has been achieved to date. The first section of this report focuses on progress in expanding and improving health insurance coverage, and the second focuses on improvements in the health care delivery system. The final section concludes.

I. Expanding and Improving Health Insurance Coverage

Prior to the Obama Administration, the United States last made substantial progress in expanding health insurance coverage in the years after Medicare and Medicaid were created in 1965, as illustrated in Figure 1.¹ Over the decade that followed, the United States uninsured rate fell by more than half, from 24 percent in 1963 to 11 percent in 1974, driven by the ramp-up of Medicare and Medicaid, legislative improvements that expanded those programs to people with serious disabilities, and the continued spread of employer-based health insurance. But progress stalled by the mid-1970s, and the uninsured rate rose steadily through the 1980s before stabilizing in the 1990s. In 2008, the year before President Obama took office, 44 million people—nearly 15 percent of the U.S. population—lacked health insurance.



This section of the report reviews the progress that has been made under this Administration in expanding and improving health insurance coverage. The section begins by describing the features of the pre-ACA health insurance landscape that caused so many Americans to go without coverage. It then discusses the actions taken under this Administration to increase health insurance coverage and presents evidence that those actions have been highly effective. It closes by surveying early evidence demonstrating that expanded coverage is improving access to care, health, and financial security for the newly insured, reducing the burden of uncompensated care for the health care system, and reducing income inequality, all without the adverse effects on labor markets that the law’s critics predicted.

¹ This discussion draws upon the historical health insurance series described in CEA (2014). The series is based primarily on analysis of data from the National Health Interview Survey. The methods described by Cohen et al. (2009) and Cohen (2012) were used to construct a consistent series over time. For 1980 and earlier, the NHIS was supplemented with information from other survey and administrative data sources.

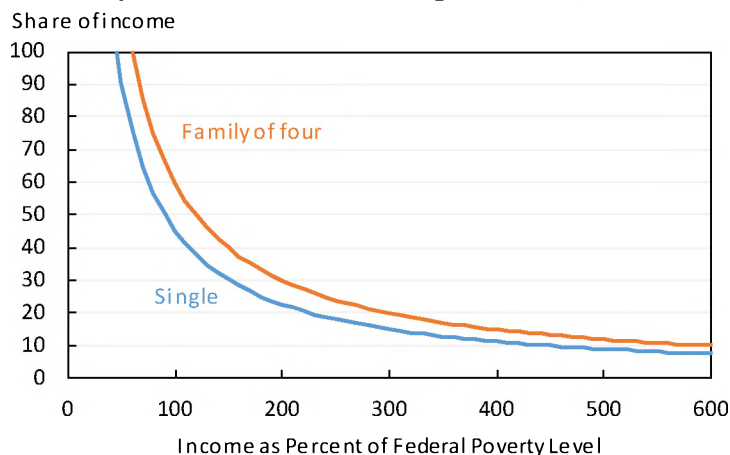
Barriers to Obtaining Health Insurance Coverage Before the Obama Administration

Prior to the reforms introduced during this Administration, uninsured Americans faced a pair of often -insurmountable barriers to obtaining coverage. The first was the high cost of health insurance, which made coverage unaffordable for many. The second was the dysfunction of the pre-ACA individual health insurance market, which caused many people to be locked out or priced out of the market due to pre-existing health conditions and kept many others from finding high-quality coverage. The role of each of these factors is discussed in greater detail below.

Cost Barriers to Obtaining Health Insurance Coverage

Health insurance has long been one of the most costly products that most families purchase. In 2008, the average premium for a policy offered in the employer market was \$4,700 for single coverage and \$12,700 for family coverage (KFF/HRET 2016). These amounts would have been a major expense for most families, but they represented a particularly heavy burden for low- and moderate-income families already struggling to meet other basic needs. As illustrated in Figure 2, for a family of four with an income below 200 percent of the Federal Poverty Level, the average premium for an employer-sponsored family policy would have consumed 30 percent or more of family income. For a family below the poverty line, it would have consumed 60 percent or more of family income, an essentially insurmountable barrier.²

Figure 2: Share of Income Required to Purchase Employer-Sponsored Plan with Average Premium, 2008



Source: KFF/HRET Employer Health Benefits Survey; CEA calculations.

Public policy played an important role in helping families meet these affordability challenges, but the adequacy of these efforts varied widely by age. For people age 65 and older, Medicare had succeeded in achieving nearly universal coverage at all income levels, as illustrated in Panel C of

² Families bore these burdens whether they purchased coverage directly or, as was typically the case, obtained it through an employer. While employers typically pay around three-quarters of the total premium, both economic theory and empirical evidence indicate that employees ultimately bear the cost of that subsidy in the form of lower wages and salaries (for example, Summers 1989; Baicker and Chandra 2006).

Figure 3. But individuals under age 65 were served by a patchwork of programs and incentives that left significant gaps.

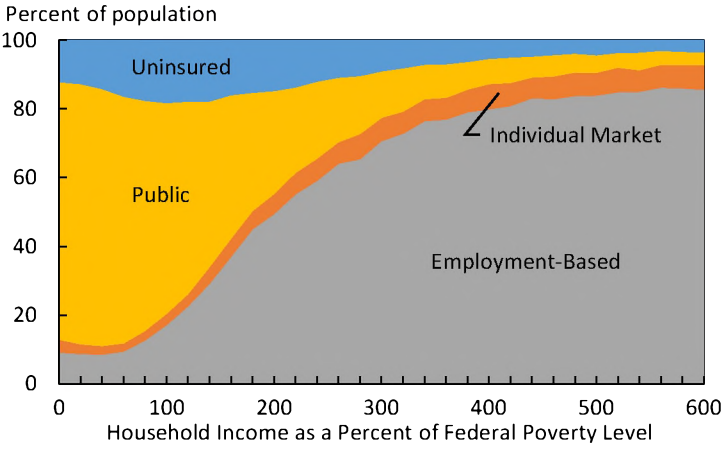
For people with access to coverage through an employer, the tax code provided a large implicit subsidy for purchasing coverage. Unlike cash compensation, the compensation employers provide in the form of health insurance is excluded from payroll and income taxation. The Federal marginal tax rate on labor income averages around 35 percent, so for each dollar of compensation a family received in the form of health insurance instead of wages, the family saved 35 cents in Federal taxes, reducing the effective cost of that dollar of health insurance coverage to just 65 cents.³ This favorable tax treatment played a central role in making coverage affordable for many middle- and upper-middle class families.⁴

However, the tax benefit for employer-sponsored coverage was inadequate to make coverage affordable for many low- and moderate-income families. As depicted in Panels A and B of Figure 3, the likelihood of having private insurance from any source fell sharply with income. Bipartisan efforts during the 1980s and 1990s had made significant progress in filling these gaps for low- and moderate-income children by broadening eligibility for Medicaid and creating the Children's Health Insurance Program (CHIP). But these efforts left significant gaps even for children. They left even larger gaps for adults. Prior to the ACA, most state Medicaid programs did not cover adults without children, no matter how low their incomes, and the median state only covered working parents with incomes below 61 percent of the Federal Poverty Level (Heberlein, Brooks, and Alker 2013). As a result, low- and moderate-income non-elderly adults were by far the age and income group most likely to lack health insurance, as illustrated in Panel B of Figure 3.

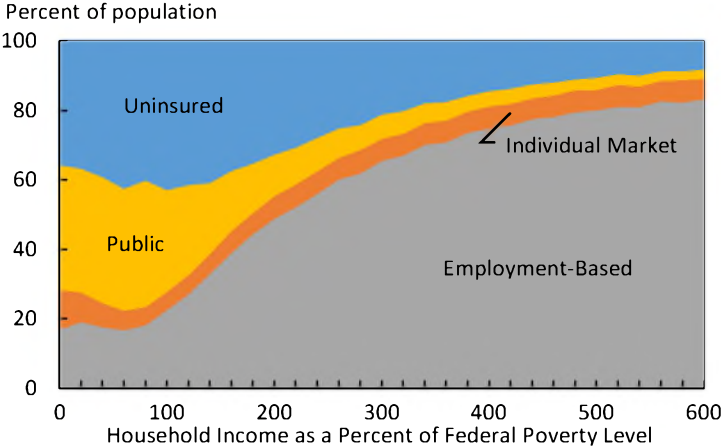
³ The Federal marginal tax rate reported here was estimated using data from Urban-Brookings Tax Policy Center Tables T13-0253 and T14-0091. States also generally exclude employer-provided health insurance coverage from taxation, so the value of the tax subsidy is somewhat larger than reported here.

⁴ While this favorable tax treatment played an important role in making coverage affordable for many families, its unlimited nature also encouraged some employers to offer inefficient and overly generous plans. The ACA introduced a tax reform that maintains this tax benefit, but mitigates the inefficiencies created by its unlimited nature; this reform is discussed in the second half of the chapter.

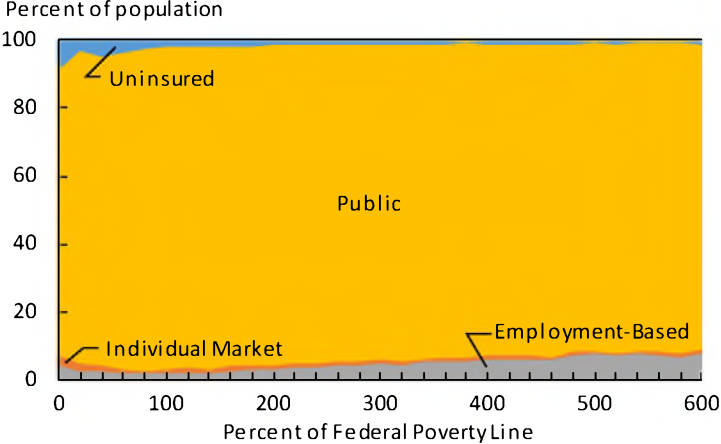
Figure 3: Health Insurance Coverage Status by Household Income, 2008
Panel A: Children Under Age 19



Panel B: Adults Ages 19 to 64



Panel C: Adults Ages 65 and Up

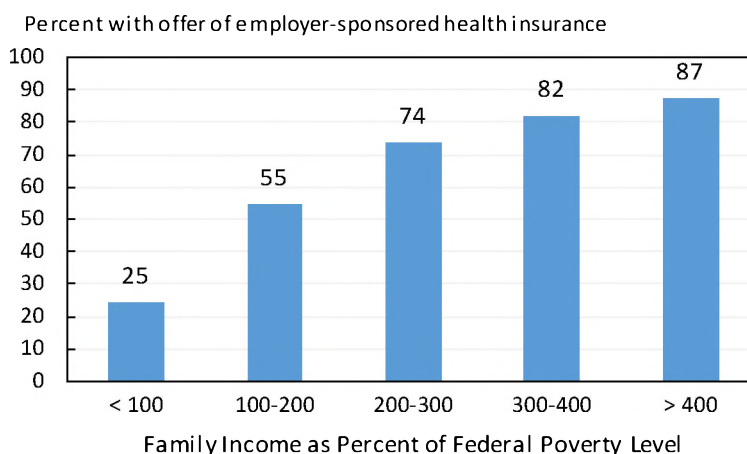


Source: American Community Survey; CEA calculations.
 Note: Employment-based coverage is defined as coverage from a current or former employer, including military and VA coverage. Public coverage is defined as Medicare, Medicaid, and other government coverage for people with low-incomes or a disability. Individuals reporting multiple sources of coverage were assigned to a single insurance type using the following hierarchy: Medicare; military health coverage; VA health coverage; Medicaid and other government coverage for people with low-incomes or disabilities; coverage through a current or former employer; and coverage purchased directly from an insurance company. This hierarchy was applied prior to categorizing individuals into the coverage groups described above.

Failures of the Individual Health Insurance Market

In addition to the affordability challenges described above, many uninsured Americans faced an additional barrier: the dysfunction of the individual health insurance market. While most non-elderly individuals had access to coverage through an employer, it was far from universal, even at relatively high income levels, as depicted in Figure 4. Retirees, many students, the self-employed, people working part-time due to family or other obligations, and the unemployed were all particularly likely to lack access to coverage through the workplace, as were individuals who happened to work at smaller firms or in industries where insurance coverage was not commonly offered. These individuals, if they did not qualify for public programs, had no choice but to turn to the individual market.

Figure 4: Share of Non-Elderly Individuals With an Offer of Employer-Sponsored Health Insurance in the Family, 2008



Source: National Health Interview Survey; CEA calculations.

The fundamental flaw of the pre-ACA individual health insurance market was that, unlike the employer market, the individual market lacked a mechanism for forming broad pools that included both relatively healthy and relatively sick individuals. The employer market forms broad pools by taking advantage of the fact that people are matched to employers based on a wide variety of factors, many of which are only loosely related to health status. In addition, employers typically cover around three-quarters of the premium, ensuring participation by a broad cross-section of their workforces, including both healthier and sicker workers (KFF/HRET 2016). Insurers offering coverage through employers can therefore be confident that their products will attract a balanced pool of healthier and sicker enrollees. As a result, their economic incentives generally drive them to design products that maximize the well-being of the pool as a whole.

By contrast, insurers in the individual market had to contend with the possibility of “adverse selection,” the tendency of people with greater health care needs—and thus higher costs to insurers—to prefer more generous insurance coverage. Insurers’ concerns that they would attract an adversely selected pool drove them to engage in a wide range of practices aimed at discouraging enrollment by sicker individuals. These practices kept the individual market from performing the core functions of a health insurance market: sharing risk between the healthy

and the sick; providing robust financial protection against unexpected health shocks; and facilitating access to needed health care.

Most destructively, insurers typically offered coverage on worse terms or not at all to people with pre-existing health conditions, a group estimated to include between 50 million and 129 million non-elderly Americans, depending on the definitions used (ASPE 2011). Before issuing a policy, insurers generally required applicants to submit information about their health history. Individuals with a pre-existing condition might then be charged a higher premium, offered a policy that excluded care related to the condition, or denied coverage entirely. While estimates of the frequency of these practices vary, they were clearly quite common. An industry survey found that 34 percent of individual applicants were charged higher-than-standard rates based on demographic characteristics or medical history (AHIP 2009). Similarly, a report by the Government Accountability Office (2011) estimated that, as of early 2010, the denial rate among individual market applications was 19 percent, and the most common reason for denial was health status. A 2009 survey found that, among adults who had individual market coverage or shopped for it in the previous three years, 36 percent were denied coverage, charged more, or had exclusions placed on their policy due to pre-existing conditions (Doty et al. 2009).

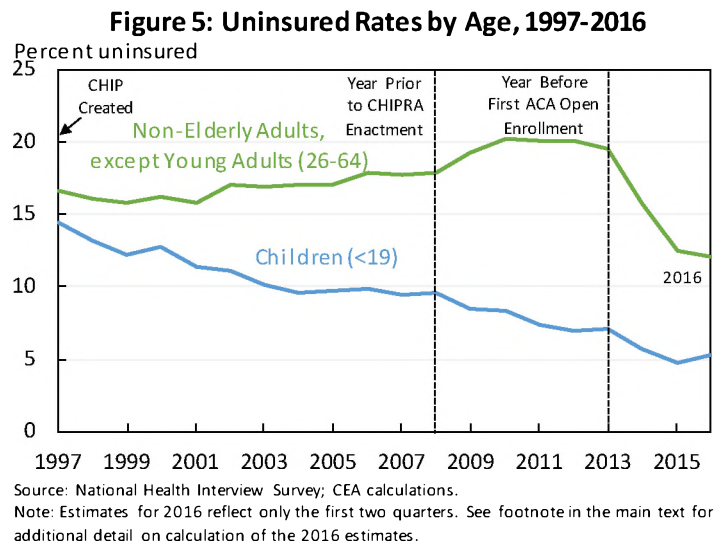
Insurers' desire to discourage enrollment by individuals with significant health care needs also led them to limit coverage in ways that undermined enrollees' access to care and financial security. For example, plans offered on the individual market frequently excluded or charged a high premium for services like maternity care, prescription drugs, and mental health care (Whitmore et al. 2011). One study estimated that, in 2011, 62 percent of individual market enrollees lacked coverage for maternity services, 34 percent lacked coverage for substance abuse services, 18 percent lacked coverage for mental health services, and 9 percent lacked prescription drug coverage (ASPE 2011). Individual market policies also frequently imposed very high cost-sharing requirements or placed annual, lifetime, or other limits on the amount they would cover. Half of individual market enrollees were estimated to be in policies that covered less than 60 percent of their total medical spending (Gabel et al. 2012). Similarly, an estimated 89 percent of people purchasing individual coverage had a lifetime limit on their benefits (Musco and Sommers 2012).

Reforms to Expand and Improve Health Insurance Coverage

The Obama Administration has implemented a series of reforms designed to overcome the barriers described above and ensure that all Americans can access high-quality, affordable health insurance coverage. This work began in February 2009 with the enactment of legislation improving CHIP and continued with the enactment and implementation of the ACA, which made broader reforms to the health insurance system in the United States. These reforms, as well as the evidence that they have dramatically expanded access to health insurance coverage, are described in detail below.

Strengthening the Children’s Health Insurance Program

The Children’s Health Insurance Program (CHIP) was created in 1997 and provides financial support beyond what is available through the existing Medicaid program to states wishing to cover additional low- and moderate-income children. Research has found that CHIP was highly effective in increasing insurance coverage among children and implies that CHIP was likely the main reason that the uninsured rate among children declined almost without interruption from the late 1990s through the mid-2000s, as illustrated in Figure 5 (Howell and Kenney 2012).⁵ Progress stalled after the mid-2000s, however, and 9.5 percent of children still lacked health insurance coverage in 2008.



In February 2009, just weeks after taking office, President Obama signed the Children’s Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA aimed to further reduce the uninsured rate among children by making a range of improvements to CHIP. Notably, the law: provided new options for states that wanted to simplify enrollment, improve outreach, or expand eligibility; created financial incentives for states to adopt best practices; and extended the program’s funding.

In the years after CHIPRA’s enactment, the children’s uninsured rate resumed its rapid decline. From 2008 through 2013, the uninsured rate among children declined by around a quarter, equivalent to 1.9 million children gaining coverage. The timing of these gains, combined with the fact that uninsured rates actually rose during this period for adults—likely due to the Great Recession and its aftermath—suggests that policy changes introduced by CHIPRA played an

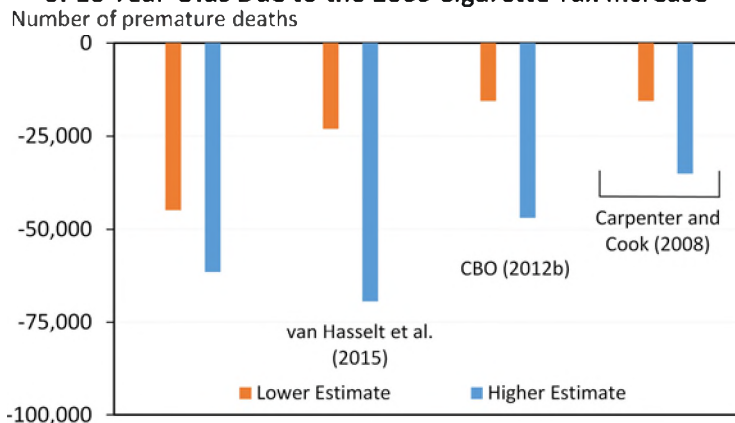
⁵ Estimates of the uninsured rate for 0-18 year olds have not yet been reported for 2016, so the uninsured rate for 0-18 year olds reported in Figure 5 was calculated by extrapolating the 2015 estimate using the percentage point change for 0-17 year olds, which has been reported. Similarly, estimates of the uninsured rate for 26-64 year olds were extrapolated using the percentage point change for the larger group consisting of 18 year olds and 26-64 year olds.

important role in reducing the uninsured rate among children.⁶ Consistent with this time-series evidence, research examining specific changes in state CHIP and Medicaid programs enabled by CHIPRA has concluded these changes were effective in expanding coverage for children (Blavin, Kenney, and Huntress 2014; Goldstein et al. 2014).

Box A: Public Health Benefits of CHIPRA

In addition to extending and improving CHIP, CHIPRA also raised the Federal cigarette tax from \$0.39 per pack to approximately \$1.01 per pack. By increasing cigarette prices, cigarette taxes substantially reduce smoking rates and generate large improvements in public health. Research examining the impact of Federal cigarette tax increases on the number of teen or young-adult smokers imply that the 2009 Federal cigarette tax increase will reduce youth smoking by between 3 and 15 percentage points (van Hasselt et al. 2015; Huang and Chaloupka 2012; CBO 2012b; Carpenter and Cook 2008). Assuming that roughly a third of youth smokers die prematurely due to smoking (U.S. Surgeon General 2014), these estimates suggest that the 2009 cigarette tax increase plausibly reduced the number of premature deaths due to smoking in each cohort by between 15,000 and 70,000, as illustrated in Figure A.

Figure A: Estimated Reduction in Premature Deaths in a Cohort of 18 Year-Olds Due to the 2009 Cigarette Tax Increase



Note: Lower estimate for van Hasselt et al. (2015) based on results for 18-25 year-olds, higher based on results for 12-17 year-olds.
 Source: Huang and Chaloupka (2012), van Hasselt et al. (2015), CBO (2012b), Carpenter and Cook (2008), CEA calculations.

⁶ Figure 5 uses adults ages 26-64 (rather than all non-elderly adults) as a comparison group in order to exclude any effects of the Affordable Care Act's dependent coverage expansion, which took effect in late 2010. That coverage expansion is discussed in greater detail below.

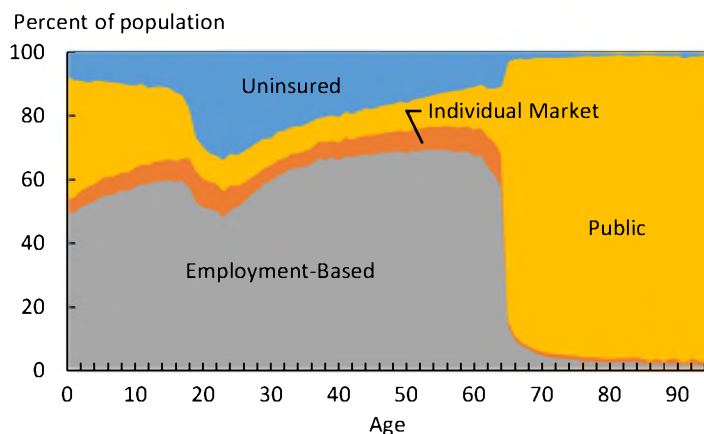
Legislative actions subsequent to CHIPRA have ensured that CHIP can continue to be a source of affordable coverage for low- and moderate-income children. The ACA extended funding for CHIP through fiscal year 2015 and increased the share of CHIP costs paid by the Federal Government, making the program even more financially attractive for states. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) extended funding for CHIP, as well as many of the policy improvements introduced in CHIPRA and the ACA, through fiscal year 2017.

Expanding Access to Coverage for Young Adults

In 2008, 44 million Americans lacked health insurance. Individuals with pre-existing conditions were often locked out of health insurance, unable to obtain insurance at any price. For many others, health insurance was available but unaffordable. Workers often faced strong financial incentives to remain in low-quality jobs or jobs they were poorly matched for because they needed the health insurance those jobs provided, even when a better job was available or they saw an opportunity to go back to school or to start a business. In short, flaws in the U.S. health care system drove too many decisions they should not have and imposed unnecessary suffering on those without access to health insurance.

The ACA’s comprehensive reforms to ensure access to health insurance coverage are described below, but the law also included a targeted provision to reduce the particularly high uninsured rate among young adults, which is illustrated in Figure 6. Young adults’ uninsured rates exceeded those for older adults for a number of reasons. Because many young adults are still in school, and those who have already joined the labor force are less likely to be offered health insurance through work, they were much less likely to have employer coverage. They also were much less likely to have Medicaid coverage than children, reflecting the stricter eligibility rules that apply to adults.

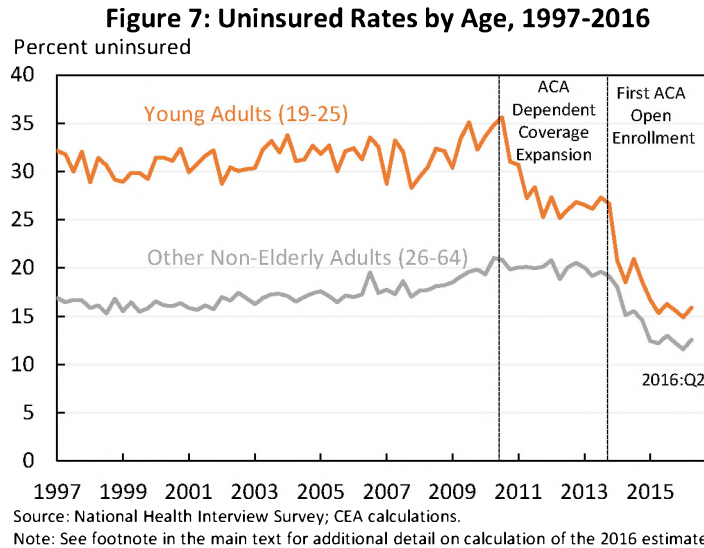
Figure 6: Health Insurance Coverage Status in 2008, by Age



Source: American Community Survey; CEA calculations.

Note: Individuals were categorized into coverage groupings using the procedure described in the note to Figure 3.

To address the unique challenges faced by young adults, the ACA required private insurance plans to allow young adults to remain on a parent’s policy until age 26. Immediately after this policy took effect during September 2010, the uninsured rate among young adults ages 19-25 started declining rapidly, as shown in Figure 7.⁷ The uninsured rate fell from 34.1 percent in the four quarters ended in September 2010 to 26.7 percent in the four quarters of 2013, just before the ACA’s broader coverage provisions took effect. The timing of this decline, combined with the fact that the uninsured rate for older non-elderly adults was essentially flat during this period is strong evidence that the decline was caused by the ACA provision.



On the basis of these data, the U.S. Department of Health and Human Services (HHS) estimates that 2.3 million young adults gained coverage because of this provision (ASPE 2015). The broader academic literature has also concluded that the provision generated substantial gains in young adult coverage, though estimates vary across studies, with some estimates higher than ASPE’s and others lower (Cantor et al. 2012; Antwi, Moriya, and Simon 2013; Porterfield and Huang 2016).

Comprehensive Coverage Expansions

Starting in 2014, the ACA implemented broad-based coverage expansions designed to ensure that all Americans could access affordable, high-quality health insurance coverage. These expansions consisted of two main pieces: an expansion of eligibility for Medicaid coverage and comprehensive reforms to the individual health insurance market. Each of these reforms is described in greater detail below.

⁷ The estimates of the uninsured rate for 26-64 year olds reported in Figure 7 were derived using the same approach described in footnote 5.

To provide affordable coverage options for the lowest-income Americans, the ACA provided states with generous financial assistance to expand Medicaid coverage to all non-elderly people with incomes below 138 percent of the Federal Poverty Level (FPL), around \$16,200 for an individual and \$33,500 for a family of four in 2016.⁸ As specified in the ACA, the Federal Government has funded 100 percent of the cost for newly eligible individuals to date, and this share gradually phases down to 90 percent in 2020 and subsequent years. This generous matching rate makes expanding Medicaid a very attractive proposition for states, particularly since research has generally concluded that states that expand Medicaid realize significant offsetting savings elsewhere in their budgets, including in existing portions of their Medicaid programs, in programs that defray the costs of uncompensated care, and in programs that provide mental health services (Buettgens, Dorn, and Carroll 2011; Dorn, McGrath, and Holahan 2014). To date, 31 states and the District of Columbia have expanded Medicaid under the ACA.

For Americans with incomes too high to qualify for Medicaid, the ACA implemented an interlocking set of reforms in the individual health insurance market. The first component of these reforms was a new set of consumer protections that guaranteed access to high-quality health insurance coverage. Most importantly, to ensure that both healthy and sick individuals could access coverage, the law required insurers to offer coverage on common terms to all enrollees, regardless of whether they had pre-existing health conditions, with premiums allowed to vary based solely on age, geography, and tobacco use. In order to ensure that the coverage available on the reformed market offered real access to medical care and financial protection, the law required all plans to cover a set of essential health benefits and provide a basic level of protection against out-of-pocket costs. As a complement to these reforms, the law created a risk adjustment program that compensates insurers that attract a sicker-than-average group of enrollees, thereby ensuring that insurers have incentives to design plans that meet the needs of all types of consumers, both healthy and sick. Finally, to foster competition, the law created the Health Insurance Marketplaces (Marketplaces), web-based markets that help consumers comparison shop to find a plan that matches their particular preferences and needs.

The second component of these reforms was designed to ensure that coverage on the reformed individual market was affordable. To overcome the affordability challenges that kept many low- and middle-income Americans from obtaining coverage before the ACA, the law created a premium tax credit for people with incomes between 100 percent and 400 percent of the FPL who purchase coverage through the Marketplaces.⁹ The premium tax credit ensures that all consumers have affordable coverage options by limiting the amount enrollees must contribute to a “benchmark” plan to a specified percentage of their income; if the premium for the benchmark plan exceeds that amount, the tax credit makes up the difference. For individuals

⁸ The base income eligibility threshold is 133 percent of the FPL. However, Medicaid program rules provide for an additional “income disregard” of 5 percent of income, which brings the effective eligibility threshold to 138 percent of the FPL. The dollar amounts reported in the text reflect the 2015 version of the FPL because those are the amounts used to determine eligibility for coverage during 2016.

⁹ In states that have expanded Medicaid, people with incomes between 100 and 138 percent of the FPL receive coverage through Medicaid. In non-expansion states, these people are generally eligible for subsidized coverage through the Marketplace.

with incomes below 250 percent of the FPL, the law also provides cost-sharing reductions that reduce enrollees' out-of-pocket costs. As an additional measure to keep premiums affordable, the law implemented an individual responsibility provision that requires people who can afford coverage to make a payment if they elect to go without it. This requirement encourages healthy individuals to enroll in coverage, which protects the individual market's ability to pool risk between the healthy and the sick, thereby helping keep premiums affordable; indeed, the Congressional Budget Office has estimated that individual market premiums would be around 20 percent higher in the absence of this provision (CBO 2015b). The provision also discourages individuals from shifting their health care costs to others in the form of uncompensated care.

The U.S. uninsured rate has declined dramatically since these reforms took effect at the beginning of 2014, falling from 14.5 percent in 2013 to 8.9 percent in the first half of 2016, as illustrated in Figure 1. The decline in the uninsured rate seen over this period is, by far, the largest decline since the years following the creation of Medicare and Medicaid in 1965. Consistent with the nearly unprecedented magnitude of this decline, research aimed at isolating the effect of the ACA from other trends in the health care system or the economy has concluded that the overwhelming majority of these gains are directly attributable to the ACA's reforms (Courtemanche et al. 2016; Blumberg, Garrett, and Holahan 2016). Using a methodology that controls for unrelated economic and demographic changes, HHS estimates that 17.7 million non-elderly adults have gained coverage since the end of 2013 because of the ACA's comprehensive reforms (Uberoi, Finegold, and Gee 2016). Combining these gains since 2013 with the gains for young adults because of the ACA's provision allowing young adults to remain on a parent's plan until age 26, an estimated 20 million adults have gained coverage because of the ACA.

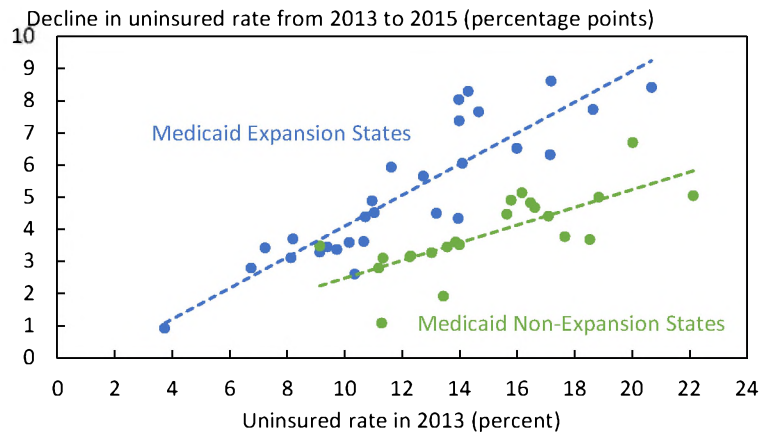
The ACA's main coverage provisions have also driven further coverage gains among children, which are not captured in the data from the Gallup-Healthways Well-Being Index used by Uberoi, Finegold, and Gee (2016). As illustrated in Figure 5 above, the uninsured rate among children has seen another sharp decline as the ACA's major coverage expansions have taken effect, equivalent to an additional 1.2 million children gaining coverage.¹⁰ Combining the gains that began in 2014 with the gains in children's coverage from 2008 through 2013 that were discussed above, an additional 3.1 million children have coverage in 2016 because of the decline in the uninsured rate among children since 2008.

Both the law's Medicaid expansion and its reforms to the individual health insurance market are contributing to this major expansion in health insurance coverage. To illustrate this, Figure 8 reports the decline in the uninsured rate from 2013 to 2015 by state in relation to that state's uninsured rate in 2013. While every state in the country has seen a decline in its uninsured rate since 2013, states that have taken advantage of the law's Medicaid expansion have seen

¹⁰ The 1.2 million figure cited here reflects coverage gains for individuals ages 0 to 17 from 2013 through the first half of 2016, as reported in the National Health Interview Survey. The data reported in Figure 5 include individuals ages 0 to 18 because 18-year-olds are considered children for Medicaid and CHIP eligibility purposes, making this the most appropriate age range to examine when discussing CHIPRA. By contrast, 18-year-olds are already included in the estimate reported by Uberoi, Finegold, and Gee (2016) regarding the effects of the ACA, so including 18-year-olds in this estimate would double-count post-2013 gains for 18-year-olds.

markedly larger declines, with the largest declines in those states that both took up Medicaid and had high uninsured rates before the ACA’s reforms took effect. However, even those states that have not taken up Medicaid expansion have made considerable progress in reducing the uninsured rate, indicating that the law’s reforms to the individual health insurance market are also working to expand insurance coverage.

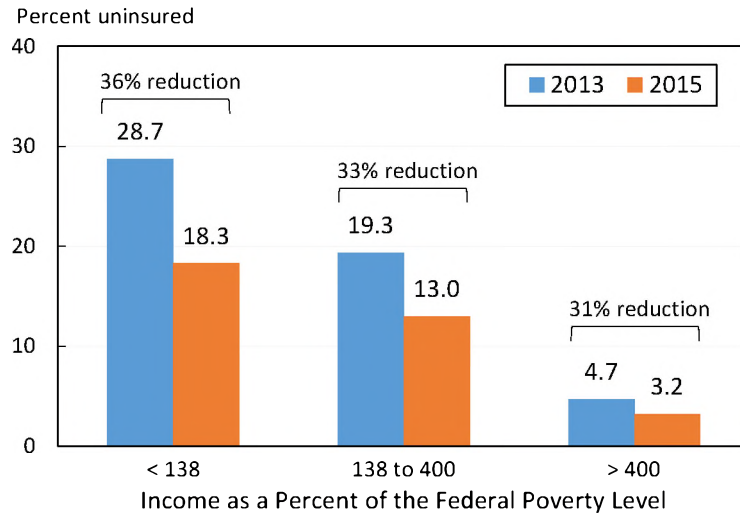
Figure 8: Decline in Uninsured Rate from 2013 to 2015 vs. Level of Uninsured Rate in 2013, by State



Source: American Community Survey; CEA calculations.
 Note: States are classified by Medicaid expansion status as of July 1, 2015.

The pattern of coverage gains by income provides additional evidence that the law’s reforms to the individual health insurance market are contributing to coverage gains, alongside Medicaid expansion. In particular, Figure 9 shows that the uninsured rate has declined markedly among individuals with incomes above the Medicaid eligibility threshold of 138 percent of the FPL, and these declines are similar in proportional terms to those for individuals with incomes below 138 percent of the FPL. Notably, declines have been seen both for people with incomes between 138 percent and 400 percent of the FPL, who are generally eligible for financial assistance to purchase Marketplace coverage, and people above 400 percent of the FPL, who are not eligible for financial assistance. The substantial coverage gains among the higher-income group, individuals who are not eligible for financial assistance through the Marketplaces, indicates that the combination of the ACA’s consumer protections guaranteeing access to coverage and its individual responsibility requirement are also proving effective in increasing health insurance coverage.

Figure 9: Non-Elderly Uninsured Rate by Income



Source: National Health Interview Survey; CEA calculations.

Box B: Dynamics in the Individual Health Insurance Market

After two years of moderate premium growth for plans offered through the Health Insurance Marketplace, premiums are increasing at a faster pace for 2017, though experience will vary widely across states (ASPE 2016b). This box discusses the factors that are driving changes in Marketplace premiums in 2017, as well as their implications for the future of the individual market. Contrary to some recent claims, a range of evidence demonstrates that this year's premium changes are part of the ordinary process of adjustment in a new market, not a harbinger of future market instability.

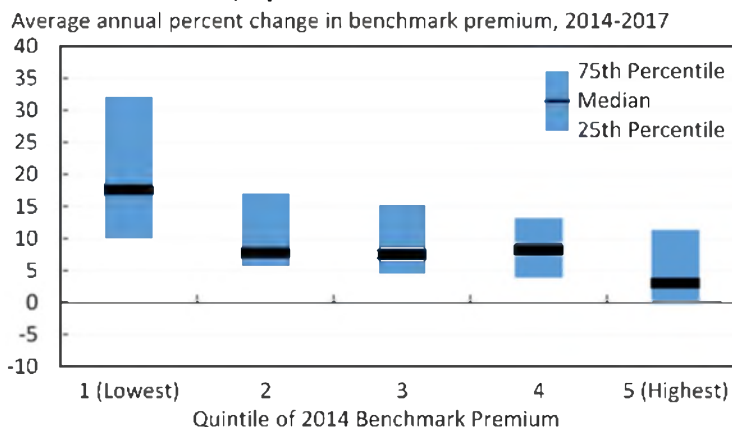
Factors Driving 2017 Premium Changes. Insurers faced significant challenges in setting premiums in the years immediately following implementation of the ACA's reforms to the individual market. The ACA brought many new people into the individual market, including people with pre-existing health conditions who had previously been locked out of the market and people who could newly afford coverage because of the law's financial assistance. These major changes made predicting average medical costs in the reformed market difficult. This in turn created a significant risk that insurers would underestimate or overestimate the level of premiums required to finance those claims. In addition, some insurers may have intentionally underpriced when setting premiums in an attempt to attract the many new consumers who have entered the individual health insurance market during its first few years, accepting losses in the short run in exchange for higher market shares in the long run.

(continued)

It is now clear that, on average, insurers underpriced in the early years of the new market. Insurers are estimated to have incurred losses of around 5 percent of premium revenue on ACA-compliant health insurance policies in 2014, the market's first year (McKinsey 2016). To achieve sustainable pricing in subsequent years, insurers needed to make up for these initial losses while also accommodating two additional factors. The first was the ordinary upward trend in medical costs, which averaged around 4 percent a year, though, as discussed below, this has likely been partially offset by ongoing improvements in the ACA-compliant risk pool relative to 2014. The second was the scheduled phasedown of the ACA's transitional reinsurance program, which defrayed a portion of insurers' claims spending on high-cost enrollees in 2014 through 2016. The decline in payments from this program added around 7 percent to premium growth in each of 2015, 2016, and 2017. The net effect of these various factors is that returning premiums to a sustainable level by 2017 likely required premium increases averaging a bit more than 10 percent per year in 2015, 2016, and 2017. But the premium for the second-lowest silver (or "benchmark") plan increased by just 2 percent in 2015 and 7 percent in 2016 in the states using the HealthCare.gov enrollment platform, necessitating much more significant adjustments in 2017.

The pattern of premium changes across areas strongly supports the view that Marketplace premium changes are being driven in substantial part by insurers' efforts to bring premiums in line with costs after having initially underpriced. Figure B.1 illustrates how the annual percentage increase in the premium for the benchmark plan from 2014 to 2017 varies based on the level of the benchmark premium in 2014. In the four-fifths of the country with higher benchmark premiums in 2014, the median person has seen average annual increases in the benchmark of below 10 percent, less than what would have been needed to cover normal increases in medical costs and the gradual phasedown of the ACA's transitional reinsurance program. By contrast, the fifth of the country that had the lowest premiums in 2014 has seen much larger increases since then. This pattern is what would have been expected if insurers in some areas significantly underpriced in 2014 and have been working to bring premiums back in line with costs since then, while insurers in other areas priced appropriately or overpriced.

Figure B.1: Average Annual Change in Benchmark Premium from 2014 to 2017, by Quintile of 2014 Benchmark Premium



Source: HHS; American Community Survey; CEA calculations.
 Note: Premiums analyzed at the county level. Quintiles defined to have equal non-elderly populations. Data limited to states using HealthCare.gov in all years.

(continued)

It is also important to note that, even after the increases seen for 2017, Marketplace premiums remain roughly in line with CBO's initial projections (ASPE 2016b). The average benchmark premium for 2014 was about 15 percent *below* what the Congressional Budget Office had projected during the debate over the ACA (CBO 2014), and analysts have estimated that premiums remained between 12 percent and 20 percent below CBO's initial projections in 2016, depending on the methodology used (Levitt, Cox, and Claxton 2016; Adler and Ginsburg 2016). The 2017 increases are therefore taking Marketplace premiums back to their originally expected trajectory, consistent with the view that these increases are a one-time correction, not an indication of underlying problems in the individual market.

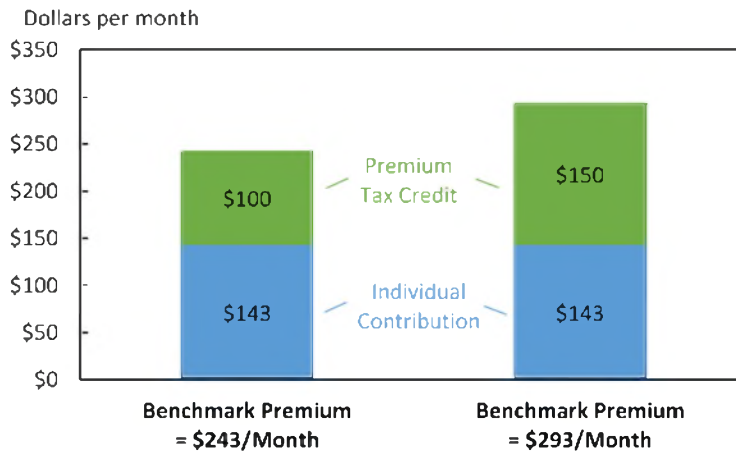
Implications of 2017 Premium Changes for the Future of the Individual Market. By bringing insurers' premium revenue back in line with their claims costs, the premium increases being implemented for 2017 help create the conditions for a more stable market in the years ahead. However, some analysts and commentators have taken a more negative view. They argue that premium increases will drive large reductions in individual market enrollment, particularly among healthy individuals. This decline in enrollment among the healthy, they argue, will increase average medical costs in the individual market, triggering further premium increases and enrollment reductions. Some observers have even speculated this feedback loop between higher premiums and falling enrollment will become so intense that it will cause a "death spiral," a scenario in which enrollment in the individual market ultimately falls nearly to zero. Some of these observers have further suggested that the premium increases seen for 2017 are evidence that this type of vicious cycle has already begun.

In fact, there is no evidence that a death spiral is underway. The defining feature of a death spiral is declining enrollment, particularly among the healthy, resulting in a deteriorating risk pool. In fact, the exact opposite is occurring. Marketplace enrollment has grown every year since the Marketplace opened in 2014, and enrollment in the individual market as a whole was estimated to be around 18 million in early 2016, up from around 11 million in 2013 (ASPE 2016a). Furthermore, it appears that the average individual market enrollee is actually getting *healthier* over time. Using data on medical spending in the individual market submitted by insurers as part of the ACA's transitional reinsurance program, the Centers for Medicare and Medicaid Services (CMS) estimate that nominal per member per month medical spending fell slightly from 2014 to 2015, and an outside analysis of a private claims database supports a similar conclusion (CMS 2016a; Avalere Health 2016). Due to the underlying upward trend in medical costs, per member per month spending would have been expected to increase if the average health status of individual market enrollees had held steady, so these data suggest that the average health status improved from 2014 to 2015.

Looking to the future, the design of the ACA's premium tax credit ensures that a death spiral can never occur in this market. The tax credit is designed so that an individual's contribution to the benchmark plan is capped at a specified percentage of income; the tax credit pays the remainder of the premium. Figure B.2 provides a concrete example of how this works for a single person making \$25,000 per year. This individual's required contribution to the benchmark plan is \$143 a month in 2017. If the premium for the benchmark plan in the individual's area were \$243 a month, the tax credit would then pay the remaining \$100 per month, as illustrated in the left column of the Figure. If the premium for the benchmark plan were \$50 a month higher, as in the right column of the Figure, the individual's contribution would remain at \$143 a month, and the tax credit would increase to \$150 a month. Thus, the individual is fully protected from the higher benchmark premium. Importantly, even individuals who qualify for only modest premium tax credits benefit from this protection since their required contribution, though larger, also does not depend upon the actual level of premiums.

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Figure B.2: Premium for the Benchmark Plan for an Individual Making \$25,000 Per Year, 2017



Source: CEA calculations.

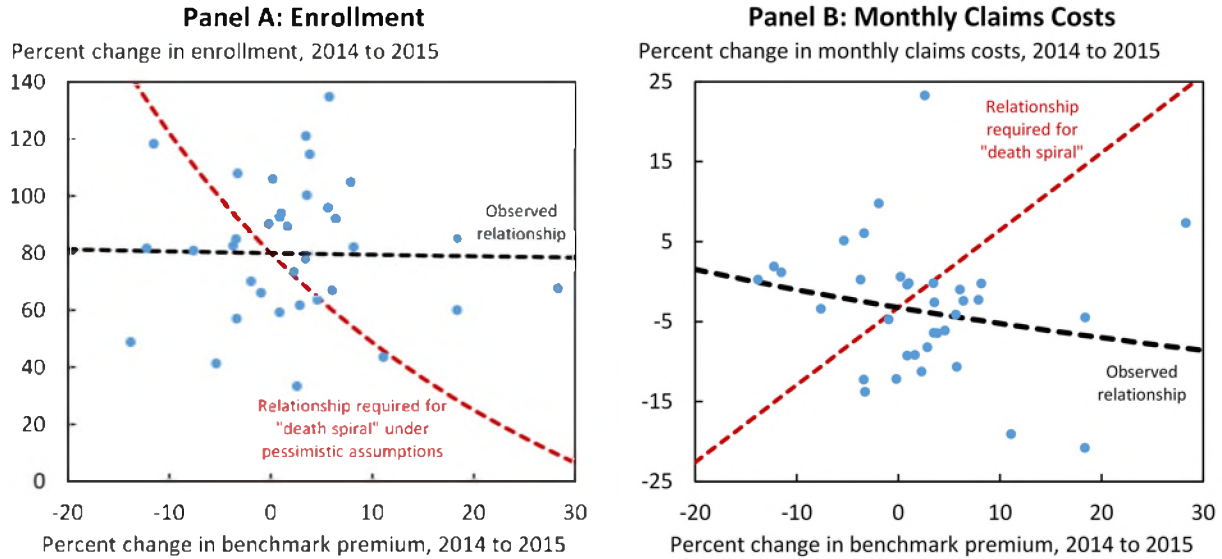
Around 85 percent of individuals who get coverage through the Marketplace receive the premium tax credit, and about two-thirds of people in the individual market as a whole are eligible for tax credits (ASPE 2016a). The premium tax credit therefore ensures that the overwhelming majority of Marketplace enrollees and the sizeable majority of individuals in the individual market overall are protected against premium increases and have no reason to leave the market when premiums rise. That, in turn, stabilizes the overall individual market risk pool and helps keep premiums affordable for people who are not eligible for tax credits. The result is that any negative effects of higher premiums on enrollment and the risk pool will be greatly attenuated, arresting the feedback loop of falling enrollment and higher premiums that would cause the market to unravel.

Consumers' actual behavior under the ACA to date provides no support for the view that premium increases will trigger significant market unraveling. Panel A of Figure B.3 examines the relationship between changes in the average benchmark premium in each state from 2014 to 2015 and the corresponding changes in enrollment in the state's ACA-compliant individual market (including both on- and off-Marketplace enrollment). For there to be any risk of a death spiral, premium changes would need to have very large negative effects on enrollment, akin to the scenario illustrated by the red dashed line. In fact, there was essentially no difference in enrollment growth across areas experiencing larger and smaller increases in the benchmark premium from 2014 to 2015, as illustrated by the black dashed line.

Similarly, Panel B of Figure B.3 examines the relationship between the change in the benchmark premium in each state from 2014 to 2015 and the change in average claims costs in the ACA-compliant market in that state. For there to be any risk of a death spiral, increases in premiums would have to result in substantial increases in claims costs (as a result of healthy individuals leaving the market), akin to the relationship between premium and cost changes illustrated by the red dashed line. In fact, consistent with the evidence from Panel A that premium increases did not meaningfully affect enrollment, there is no evidence that premium increases adversely affected the risk pool. If anything, larger premium increases appeared to be associated with slightly *slower* year-over-year growth in monthly claims costs, as illustrated by the black dashed line.

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Figure B.3: Change in Benchmark Premium vs. Change in Individual Market Enrollment and Claims Costs, by State, 2014 to 2015



Source: CMS; HHS; Census Bureau; CEA calculations.

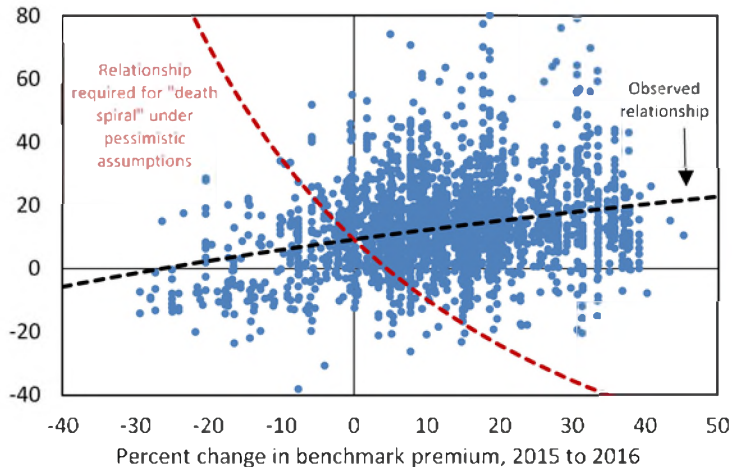
Note: Sample is limited to States that used HealthCare.gov in all years due to availability of data on benchmark premiums. Changes in benchmark premiums are calculated on a population-weighted basis. Enrollment and monthly claims spending for the ACA-compliant market are measured using data submitted to CMS for the risk adjustment and reinsurance programs. Enrollment is measured as the number of member months of enrollment during the year. Monthly claims spending is measured as aggregate claims in the State's individual market divided by the aggregate number of member months of enrollment. Observed relationships use a simple log-log fit. The "relationship required for 'death spiral'" lines use the same intercept coefficient estimated for the "observed relationship" lines, but different slope coefficients. In Panel A, the "relationship required for 'death spiral'" line reflects a slope coefficient of -2; for a demand elasticity of -2 to allow a death spiral, individuals who leave the market in response to higher premiums would need to have claims costs half as large as individuals who remain enrolled, a relatively extreme assumption. In Panel B, the "relationship required for 'death spiral'" line depicts a slope coefficient of 1, which is sufficient to ensure that additional revenue from higher premiums is fully offset by higher claims costs.

Complete data on how enrollment and claims in the ACA-compliant individual market changed from 2015 to 2016 are not yet available. However, the county-level relationship between changes in benchmark premiums and changes in the number of people selecting Marketplace plans, depicted in Figure B.4, reinforces the conclusion that the individual market is at no risk of unraveling. As above, for the individual market to be at risk of a death spiral, counties experiencing larger increases in the benchmark premium would have to see much smaller growth in plan selections, akin to the scenario illustrated by the red dashed line. To the contrary, counties that saw larger increases in the benchmark premium from 2015 to 2016 actually seem to have seen slightly *larger* increases in Marketplace plan selections over that period. Notably, while average premium increases were lower in 2016 than 2017, some counties saw rate increases of 30 percent or more in 2016, and even these counties show no clear evidence of slower enrollment growth.

(continued)

Figure B.4: Change in Benchmark Premium versus Change in Marketplace Plan Selections, by County, 2015 to 2016

Percent change in Marketplace plan selections, 2015 to 2016



Source: CMS; HHS; Census Bureau; CEA calculations.

Note: Observed relationship reflects a simple log-log fit. The “relationship required for ‘death spiral’” lines uses the same intercept coefficient estimated for the “observed relationship” line, but a slope coefficient of -2. For a demand elasticity of -2 to allow a death spiral, individuals who leave the market in response to higher premiums would need to have claims costs half as large as individuals who remain enrolled, a relatively extreme assumption.

Improvements in Existing Health Insurance Coverage

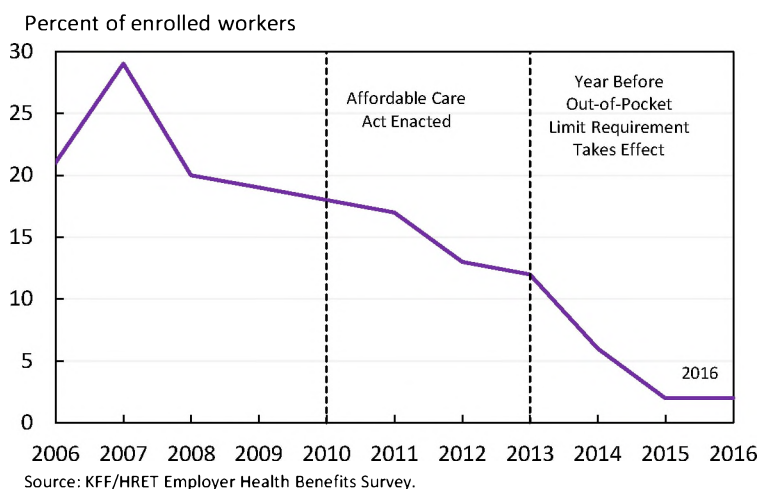
In addition to implementing reforms that have greatly increased the number of people with health insurance coverage, the ACA has also implemented reforms that are improving insurance coverage for people who were already insured, including people covered through an employer or through Medicare. Because of these reforms, tens of millions more Americans are now better protected against catastrophic out-of-pocket costs in the event of serious illness and have greater access to needed medical care.

One such set of reforms is ensuring that all private insurance plans provide real protection against catastrophic costs. When the ACA became law in 2010, 18 percent of workers enrolled in single coverage through an employer were exposed to potentially unlimited out-of-pocket spending, as illustrated in Figure 10 (KFF/HRET 2016). To address this problem, the ACA required that all non-grandfathered private insurance plans place a limit on enrollees’ annual out-of-pocket spending starting in 2014.¹¹ The share of enrollees lacking an out-of-pocket limit fell modestly in the years immediately after the ACA became law (likely in part because some firms elected to make

¹¹ The ACA specified that certain insurance policies in place prior to the law’s enactment would be “grandfathered” and thus not subject to some of the insurance reforms implemented under the law. The number of grandfathered policies has fallen steadily over time (KFF/HRET 2016).

changes in advance of 2014) then fell sharply as the ACA requirement took effect. In 2016, just 2 percent of enrollees in single coverage lacked an out-of-pocket limit. If the share of enrollees in employer coverage who lack an out-of-pocket limit had remained at its 2010 level, at least 22 million additional people enrolled in employer coverage would lack this protection today.¹² The ACA also prohibits private insurance plans from imposing lifetime limits on the amount of care they will cover and, with the exception of a dwindling number of grandfathered policies in the individual market, imposing annual limits on benefits.

Figure 10: Share of Workers in Employer-Based Single Coverage Without an Out-of-Pocket Limit



The ACA also strengthened protections against high out-of-pocket costs in Medicare Part D, the portion of Medicare that provides prescription drug coverage. The original Medicare Part D benefit design included a gap in coverage, commonly referred to as the “donut hole.” Because of the coverage gap, Medicare beneficiaries spending more than about \$2,700 on prescriptions in 2009 were required to pay the next roughly \$3,500 entirely out of pocket. The ACA is phasing out the coverage gap and will close it entirely by 2020. In 2015, the most recent full year for which data are available, 5.2 million Medicare beneficiaries with high drug costs saved \$5.4 billion, an average of more than \$1,000 per affected beneficiary (CMS 2016d). Cumulatively through July 2016, more than 11 million beneficiaries have saved \$23.5 billion, an average savings of more than \$2,100 per beneficiary (CMS 2016b).

Another set of ACA reforms sought to encourage greater use of preventive services. Research prior to the ACA had documented that many preventive services—such as blood pressure screenings, mammograms, and colonoscopies—were seriously underutilized, despite strong

¹² Trends for those enrolled in family coverage are similar to those reported for single coverage in Figure 10. In 2010, 17 percent of family coverage enrollees lacked an out-of-pocket limit, and the decline in this percentage almost exactly paralleled the decline for single coverage through 2014; estimates for family coverage have not been reported for years after 2014. To be conservative, the 22 million estimate presented in the text assumes that the overall share of enrollees lacking an out-of-pocket limit declined from 17 percent in 2010 to 2 percent in 2016. It assumes that 150 million people were enrolled in employer coverage in 2016, consistent with KFF/HRET (2016).

evidence of their effectiveness (McGlynn et al. 2003; Commonwealth Fund 2008). To encourage greater utilization, the ACA required that private insurance plans and Medicare cover preventive services that are recommended by the United States Preventive Services Task Force without cost sharing. While the research literature examining the effects of this provision is still limited, one recent study examined plans that implemented this provision at different times and concluded that eliminating cost sharing had the expected effect of increasing use of the service studied, in this case contraception (Carlin, Fertig, and Dowd 2016).

Economic Consequences of Broader Health Insurance Coverage

The historic expansion in insurance coverage described in the last section is still very new, so research to evaluate its consequences is just beginning. Early evidence shows, however, that recent coverage gains are already generating major benefits similar to those documented in prior research on the effects of health insurance coverage. This evidence demonstrates that the law has already succeeded in improving access to care, health, and financial security for the newly insured and in reducing the burden of uncompensated care for the health care system as a whole. Looking beyond the health care sector, the law is helping to reduce income inequality, and it is achieving this broad range of benefits without the negative near-term effects on the labor market that many of the law's critics had predicted, while laying the foundation for a stronger labor market over the long term. This subsection of the report reviews this evidence base, with a particular focus on the effects of the major coverage provisions of the Affordable Care Act that took effect at the start of 2014.

Improved Access to Care

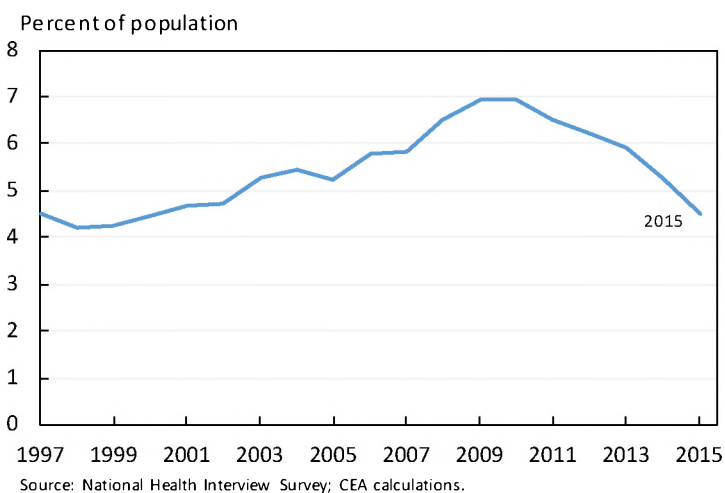
One objective of expanding insurance coverage is to ensure that individuals can access needed health care.¹³ Research examining prior coverage expansions leaves little doubt that expanding insurance coverage is an effective tool for increasing access to care. For example, the Oregon Health Insurance Experiment, a randomized-controlled trial of expanding Medicaid coverage to low-income adults, found that Medicaid increased receipt of health care services, including preventive services, prescription medications, and physician visits (Baicker et al. 2013). Studies

¹³ While many non-economists consider it a self-evidently good thing when expanded insurance coverage increases use of health care, a long-standing strand of economic research emphasizes the possibility that health insurance will drive overconsumption of health care by insulating enrollees from the cost of services, a phenomenon referred to as “moral hazard” (Pauly 1968). For several reasons, however, moral hazard is not the appropriate analytic lens for considering increases in the use of health care that arise from a coverage expansion. First, health insurance can increase the use of health care services by increasing the resources that individuals have available to them when seriously ill, thereby allowing them to access very expensive, but cost-effective treatments (Nyman 1999); these types of increases in use of care do not represent overconsumption. Second, in light of evidence that many effective services are persistently underused, increases in the use of care that result from reducing the cost of accessing care may, in some cases, reflect a reduction in underconsumption rather than a shift toward overconsumption (Baicker, Mullainathan, and Schwartzstein 2015). Third, the standard moral hazard analysis defines care as excessive if the individual would prefer to receive a cash payment equal to the cost of the care in lieu of that care. Because low- and moderate-income families face serious constraints on their budgets, they will often prefer a cash payment even to highly effective health care services, so care that is judged excessive by the moral hazard definition may still be quite valuable when judged using a broader social perspective.

in many other contexts, including the RAND Health Insurance Experiment (Newhouse et al. 1993), studies of past Medicaid expansions targeting adults (Sommers, Baicker, and Epstein 2012) and children (Howell and Kenney 2012), studies of the effect of gaining Medicare eligibility at age 65 (McWilliams et al. 2007; Card, Dobkin, and Maestas 2009), and studies of Massachusetts health reform (Van der Wees, Zaslavsky, and Ayanian 2013; Sommers, Long, and Baicker 2014), have similarly concluded that having health insurance or having more generous health insurance enhances individuals’ ability to obtain care.

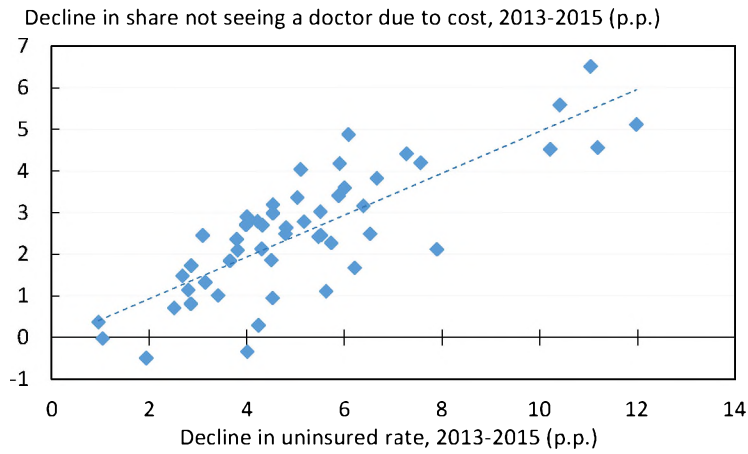
A range of evidence demonstrates that recent coverage expansions are having similar effects on individuals’ ability to access care. One important measure of individuals’ ability to access care is the share of people reporting that they failed to obtain needed medical care due to cost during the last 12 months. As illustrated in Figure 11, this share rose by more than 50 percent during the decade preceding the ACA’s passage, with particularly sharp increases coinciding with the onset of the Great Recession. By contrast, since 2010, the overall share of individuals reporting these types of affordability problems has declined by more than a third, returning to levels last seen 15 years ago.

Figure 11: Share of Population Not Receiving Needed Medical Care Due to Cost in the Last 12 Months



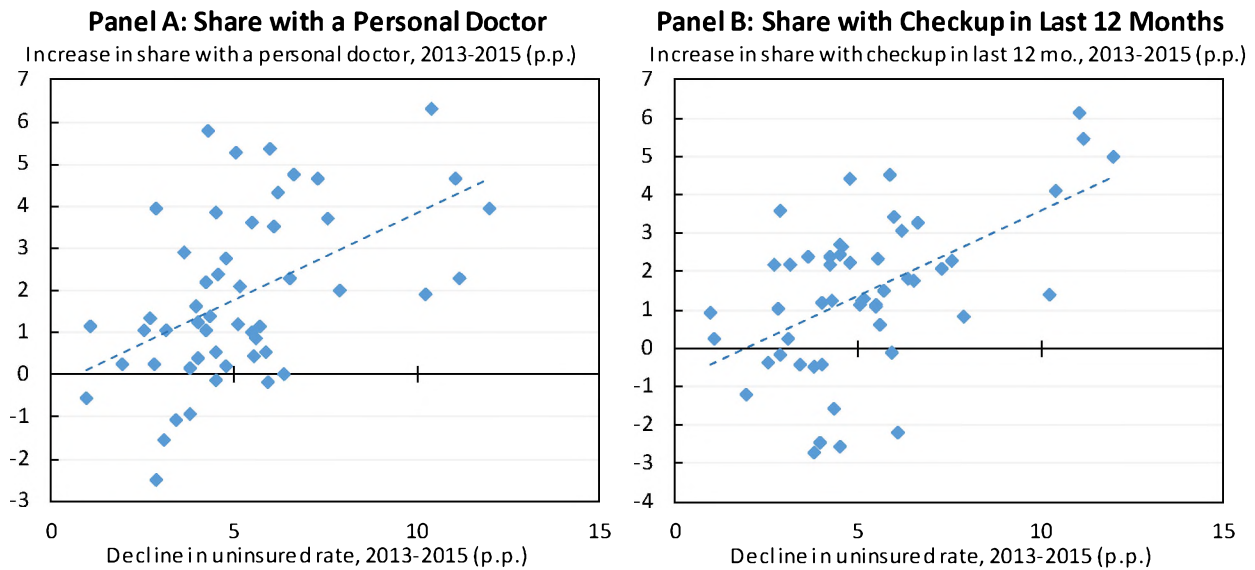
The recovery from the Great Recession has likely played some role in reducing cost barriers to accessing care, as increased employment and rising wages have reduced financial stress on families. However, the fact that this measure is now so far below its pre-recession trend, combined with the particularly sharp declines seen after 2013, strongly suggests that recent coverage expansions are playing an important role. Consistent with that interpretation, Figure 12 looks across states and demonstrates that states experiencing larger reductions in their uninsured rates from 2013 to 2015 experienced larger reductions in the share of individuals reporting difficulty accessing care due to cost. State-level data show that larger coverage gains are also strongly associated with increases in the share of individuals with a personal doctor and the share of individuals with a checkup in the last 12 months, as shown in Figure 13.

Figure 12: Decline in Share Not Seeing a Doctor Due to Cost vs. Decline in Uninsured Rate, by State, 2013-2015



Source: Behavioral Risk Factor Surveillance System; CEA calculations.
 Note: Sample limited to non-elderly adults.

Figure 13: Increases in Measures of Access to Care vs. Decline in Uninsured Rate, by State, 2013-2015



Source: Behavioral Risk Factor Surveillance System; CEA calculations.
 Note: Sample limited to non-elderly adults. Percentage points denoted p.p.

Researchers using other survey data sources have documented similar sharp improvements in access to care as the ACA's coverage provisions have taken effect. For example, examining data through March 2015, Shartzter, Long, and Anderson (2016) report that the share of non-elderly adults with a usual source of care and the share who received a routine checkup in the last 12 months has risen alongside insurance coverage, while the share reporting problems accessing care or forgoing care due to cost has fallen. Examining a similar time period, Sommers et al. (2015) report reductions in the share of non-elderly adults reporting that they lack easy access to medicine, lack a personal physician, or are unable to afford care. As with the trends reported in Figure 12 and Figure 13, the pattern of the access gains reported in these studies is consistent with their having been caused by the ACA's coverage expansion. Both studies cited above, as well

as Simon, Soni, and Cawley (2016) and Wherry and Miller (2016), document that gains in access to care have been largest in states that expanded their Medicaid programs. Similarly, Shartzter, Long, and Anderson (2016) find that low- and moderate-income adults, who saw the largest coverage gains, also saw the largest improvements in access to care.

Better Health Outcomes

The ultimate goal of expanding access to health care services is improving health. Research examining prior coverage expansions that targeted populations similar to those targeted under the ACA provides a basis for confidence that expanded insurance coverage will translate into better health. The Oregon Health Insurance Experiment documented significant improvements in self-reported health status and mental health due to expanded Medicaid coverage (Finkelstein et al. 2012; Baicker et al. 2013). Studies of Massachusetts health reform concluded that the coverage expansion drove improvements in self-reported physical and mental health, as well as reductions in mortality (Van der Wees, Zaslavsky, and Ayanian 2013; Sommers, Long, and Baicker 2014), and a study of state Medicaid expansions targeting low-income adults during the early 2000s reached similar conclusions (Sommers, Baicker, and Epstein 2012). Studies of prior expansions of Medicaid and CHIP coverage targeting low- and moderate-income children have documented that health benefits of expanded coverage can be long-lasting, with adults who had access to coverage in childhood experiencing lower risk of death and hospitalization many years later (Wherry et al., 2015; Brown, Kowalski, and Lurie 2015; Wherry and Meyer 2016).

Early evidence on the effects of the ACA appears quite consistent with evidence from earlier coverage expansions. Barbaresco, Courtemanche, and Qi (2015) report improvements in self-reported health status among young adults following implementation of the ACA's provision allowing young adults to remain on a parent's plan. Looking at the main ACA coverage provisions that took effect in 2014, Sommers et al. (2015) find that the share of non-elderly adults reporting that they are in fair or poor health has fallen as coverage has expanded, as has the percentage of days that respondents report having their activities limited by health problems. Research has also found evidence that gains in self-reported health status have been larger in states that have expanded their Medicaid programs (Sommers et al. 2016; Simon, Soni, and Cawley 2016).

While direct estimates of the law's effects on physical health outcomes are not yet available, largely because these data become available with longer lags, these effects are likely to be quite important. Consider, for example, one particularly important health outcome: mortality. As discussed in detail in CEA (2015), there is considerable evidence that prior coverage expansions targeting populations similar to those targeted in the ACA generated substantial reductions in mortality rates. The most relevant existing estimate of the effect of insurance coverage on mortality comes from work by Sommers, Long, and Baicker (2014) on Massachusetts health reform. By comparing experiences in Massachusetts to those in neighboring states, they estimate that one death was avoided annually for every 830 people who gained health insurance. In conjunction with the estimate cited earlier in this report that 20 million adult have gained coverage because of the ACA as of early 2016, this estimate implies that around 24,000 deaths are being avoided annually because of the ACA.

Box C: Interpreting Results from the Oregon Health Insurance Experiment

The Oregon Health Insurance Experiment (OHIE) is an important recent contribution to the literature on the effects of health insurance coverage (Finkelstein et al. 2012; Baicker et al. 2013). The OHIE arose from the state of Oregon's decision in early 2008 to reopen enrollment under a pre-ACA Medicaid expansion that targeted low-income adults. Because the State could not accommodate all applicants, it allocated the opportunity to enroll in Medicaid by lottery. This decision by the State created a unique research opportunity because the only systematic difference between lottery winners and lottery losers was whether they could access Medicaid coverage. As a result, the OHIE researchers were able to estimate the effect of Medicaid coverage on a range of outcomes by comparing lottery winners to lottery losers and have confidence that those estimates represented the causal effect of Medicaid.

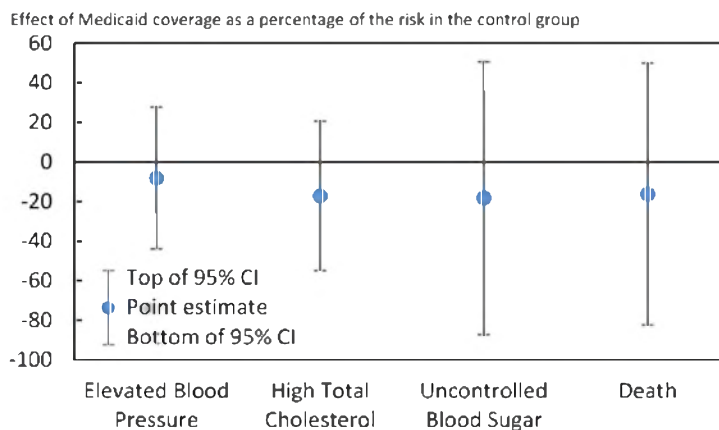
As discussed in the main text, the OHIE found that Medicaid coverage generated substantial benefits for those who enrolled, including greater access to health care services, improved financial security, better mental health, and better self-reported health status. The OHIE did not, however, find statistically significant evidence that Medicaid improved several objective measures of physical health, including the risk of high blood pressure, high cholesterol, uncontrolled blood sugar, and death.

The OHIE's failure to find statistically significant evidence that Medicaid improves physical health has sometimes been interpreted as evidence that Medicaid has no clinically significant effect on physical health (for example, Roy 2013; Cannon 2014). But this conclusion is incorrect. The OHIE's sample size was limited, so its estimates of how Medicaid affected physical health were quite imprecise. As a result, while the OHIE did not find statistically significant evidence of improvements in physical health, the study also could not rule out the possibility that Medicaid caused very large improvements in physical health. For this reason, the correct interpretation of the OHIE results is that they provide little insight into how Medicaid affects the objective measures of physical health examined in the OHIE, whether positively or negatively (Frakt 2013a; Frakt 2013b; Mulligan 2013; Richardson, Carroll, and Frakt 2013).

(continued)

To make this point concrete, Figure C plots the OHIE estimates of the effect of Medicaid on four adverse health outcomes, death, and one outcome from each of the three physical health domains examined in Baicker et al. (2013), as well as the associated 95 percent confidence intervals. For scale, both the point estimates and confidence intervals are shown as a percentage of the risk of each outcome in the control group; the estimates reported in Figure C can therefore be interpreted as the proportional reduction in the risk of each outcome attributable to Medicaid coverage.

Figure C: Estimated Proportional Reduction in the Risk of Adverse Health Outcomes Due to Medicaid



Source: Finkelstein et al. (2012); Baicker et al. (2013); CEA calculations.
 Note: Uncontrolled blood sugar refers to glycated hemoglobin greater than 6.5 percent.

For none of these four health outcomes can the OHIE rule out a proportional reduction in risk of more than two-fifths. For three of the outcomes, the OHIE evidence cannot rule out a risk reduction of more than a half, and for uncontrolled blood sugar and death, the OHIE evidence cannot rule out nearly complete elimination of the outcomes. Effects of this size would be clinically important and quite valuable to individuals, indicating that the OHIE simply cannot resolve the question of whether Medicaid has important effects on physical health.

Furthermore, Figure C demonstrates that the OHIE point estimates suggest that Medicaid reduced the risk of these adverse health outcomes by between 8 and 18 percent in proportional terms, depending upon the outcome. These estimates are broadly consistent with the improvements that Medicaid coverage would have been expected to achieve in light of the prior literature on the efficacy of treatment for these conditions (Frakt 2013a; Frakt 2013b; Mulligan 2013; Richardson, Carroll, and Frakt 2013). Thus, while the OHIE estimates provide little direct evidence on the effects of Medicaid on physical health of any kind, they certainly do not suggest that Medicaid generates markedly smaller improvements in physical health than would have been expected based on the pre-OHIE evidence base.

Fortunately, the OHIE is not the only source of evidence on how health insurance affects health outcomes. Many prior studies have used “quasi-experiments” stemming from prior coverage expansions or quirks in program design to study how health insurance affects physical health outcomes. Quasi-experimental studies are more vulnerable to systematic biases than studies using randomized research designs, but they can often draw on much larger samples and, thus, deliver much more precise estimates. As discussed in the main text, well-designed studies of this type have concluded that health insurance improves physical health in a number of ways, including by reducing the risk of death.

Greater Financial Security

Another function of health insurance is to protect against the medical costs associated with serious illness. As discussed above, one benefit of that protection is that it allows sick individuals to obtain needed medical care. An additional important benefit, however, is that it helps ensure that families do not experience financial hardship due to illness, ranging from having to cut back spending on other needs, to taking on debt, to failing to pay other bills and thereby impairing their ability to get a loan in the future.¹⁴

Research examining prior coverage expansions convincingly established that expanding health insurance coverage substantially improves financial security. The Oregon Health Insurance Experiment found that having Medicaid coverage virtually eliminated the risk of facing catastrophic out-of-pocket medical costs (defined as medical costs in excess of 30 percent of income) and sharply reduced the share of individuals reporting trouble paying bills due to medical expenses (Baicker et al. 2013). Mazumder and Miller (2016) examine the effects of Massachusetts health reform and document reductions in the amount of debt past due, the amount of debt in third-party collection, and the risk of bankruptcy, as well as improvements in credit scores. Similarly, Gross and Notowidigdo (2011) document substantial reductions in bankruptcy risk due to Medicaid expansions during the 1990s and early 2000s, and Finkelstein and McKnight (2008) demonstrate that the introduction of Medicare led to large reductions in exposure to high out-of-pocket medical costs among individuals over the age of 65.

Recent research indicates that the ACA's major coverage provisions are having similar beneficial effects on financial security. Research using survey data show that the share of families reporting problems paying medical bills has fallen substantially since 2013, with particularly large reductions for low- and moderate-income adults (Shartzler, Long, and Anderson 2016). Studies using data from consumer credit reports to compare states that have and have not expanded Medicaid found similar improvements in financial security, including reductions in the amount of debt sent to a collection agency and improvements in credit scores (Dussault, Pinkovskiy, and Zafar 2016; Hu et al. 2016). The magnitude of these improvements is substantial; Hu et al. (2016) estimate that state Medicaid expansions reduce the amount of debt sent to collection by between \$600 and \$1,000 per person gaining coverage under expansion.

Lower Uncompensated Care Costs

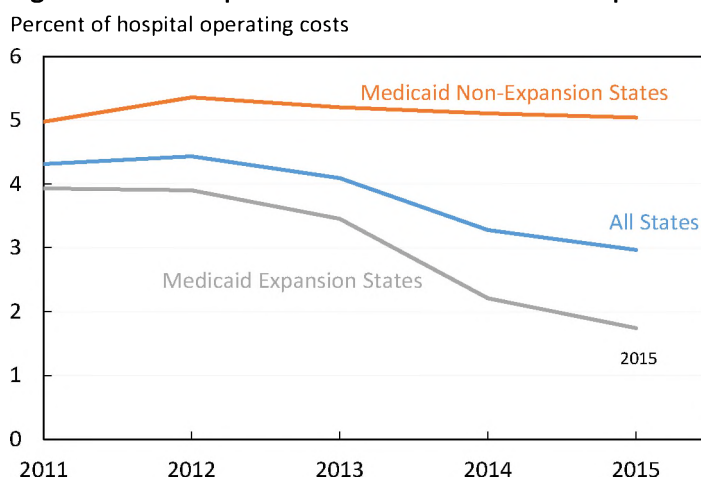
While the most salient benefits of expanded insurance coverage accrue to the newly insured, expanding insurance coverage also has implications for other participants in the health care system. Uninsured individuals still receive some medical care, and when they do so, they are often unable to pay for that care; Coughlin et al. (2014) estimated that health care providers delivered roughly \$1,000 in uncompensated care per uninsured person in 2013, costs that must

¹⁴ Medical costs are not the only financial consequence of serious illness. Dobkin et al. (2016) document that non-elderly individuals experience large earnings losses after serious health shocks, with the result that even insured individuals are at risk of financial hardship under these circumstances. A progressive tax code and the safety net, which have been strengthened by the ACA's reforms to help low- and moderate-income families afford health insurance coverage, play an important role in cushioning households against these types of shocks.

then be borne either by the health care provider itself or by some other entity. Correspondingly, recent research has emphasized that one important consequence of expanding insurance coverage is to reduce the amount of uncompensated care that health care providers deliver (Garthwaite, Gross, and Notowidigdo 2015; Finkelstein, Hendren, and Luttmer 2015).

Recent trends provide strong evidence that the expansion in insurance coverage driven by the Affordable Care Act is, as expected, driving substantial reductions in uncompensated care. Figure 14 uses data from hospitals' cost reports to the Centers for Medicare and Medicaid Services to examine trends in uncompensated care. Nationwide, these data show that uncompensated care fell by more than a quarter as a share of hospital expenses from 2013 to 2015. Had uncompensated care as a share of hospital expenses remained at its 2013 level, hospitals would have delivered an additional \$10.4 billion of uncompensated care in 2015. The reductions in uncompensated care since 2013 have been concentrated in Medicaid expansion states, likely both because expansion states have seen larger coverage gains and because the low-income uninsured individuals targeted by Medicaid expansion were particularly likely to receive uncompensated care. In Medicaid expansion states, uncompensated care as a share of hospital operating costs has fallen by around half since 2013.

Figure 14: Uncompensated Care as a Share of Hospital Costs



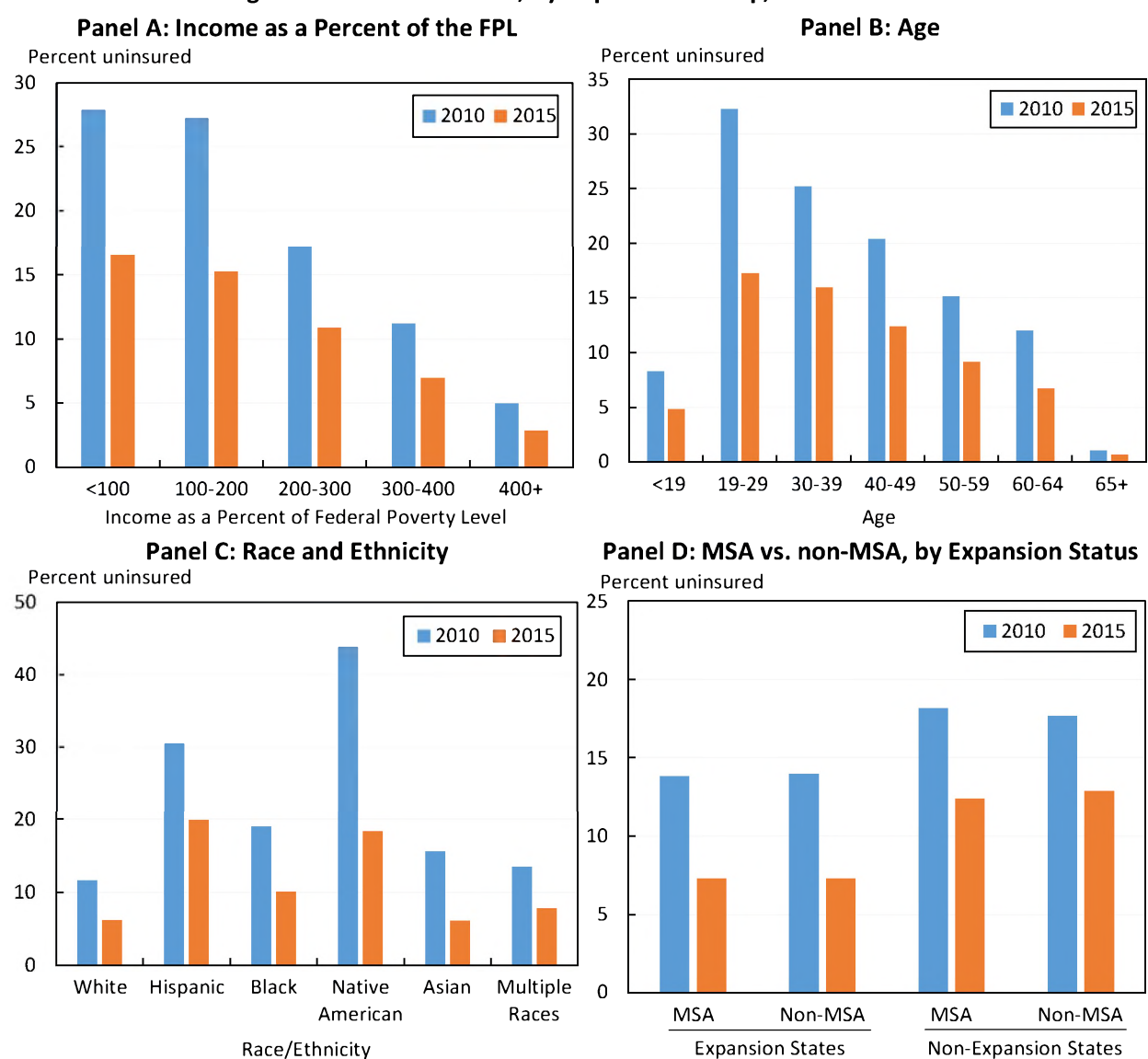
Source: Centers for Medicare and Medicaid Services, Hospital Cost Reports; CEA calculations.
 Note: State Medicaid expansion status is as of July 1, 2015. Data for 2015 are incomplete.

More detailed research using these hospital cost report data has provided additional evidence that the Affordable Care Act's coverage provisions, particularly Medicaid expansion, have driven substantial reductions in uncompensated care. Dranove, Garthwaite, and Ody (2016) and Blavin (2016) document similar aggregate trends in uncompensated care, including larger declines in uncompensated care in expansion states than non-expansion states. Dranove, Garthwaite, and Ody (2016) also look at hospital-level trends in uncompensated care, finding that reductions in uncompensated care are larger for hospitals located in areas that had larger numbers of individuals likely to become eligible for Medicaid under Medicaid expansion.

Reduced Economic Disparities

The ACA's coverage expansions have also substantially reduced economic inequality, as discussed in greater detail in CEA (2016). Most directly, the law has sharply narrowed differences in uninsured rates across population groups. As illustrated in Figure 15 below, the coverage gains from 2010 through 2015 have been broadly shared, with the uninsured rate falling across all income, age, and race and ethnicity groups. Gains have also been seen in both urban areas, defined here as counties included in a metropolitan statistical area (MSA), and rural areas, defined as counties outside an MSA. However, the population groups that had the highest risk of being uninsured in 2010 have seen the largest gains; in particular, gains have been larger for younger adults than for older adults, larger for lower-income individuals than higher-income individuals, and larger for racial and ethnic minorities than for Whites.

Figure 15: Uninsured Rate, by Population Group, 2010 and 2015

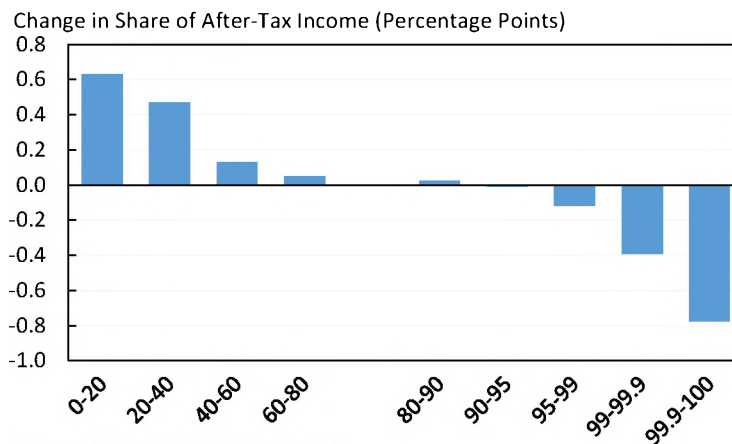


Source: National Health Interview Survey; American Community Survey; CEA calculations.

Note: Panels A through C display estimates from the National Health Interview Survey. Panel D displays estimates from the American Community Survey, which provides more detailed geographic breakdowns. Medicaid expansion status is as of July 1, 2015.

The ACA has also helped to reduce income inequality. As discussed in detail above, the ACA achieved its coverage expansion in part by providing financial assistance to low- and moderate-income individuals who obtain coverage through Medicaid and the Marketplaces. That financial assistance has greatly boosted income for these households. Those coverage expansions were, in turn, financed in part through tax increases on higher-income Americans. These and other ACA coverage provisions, together with other tax policies enacted during the Obama Administration, are making the income distribution in the United States considerably more equal, as illustrated in Figure 16. Because of these policies, the share of after-tax income received by the bottom fifth of income distribution will rise by 0.6 percentage point (18 percent), while the share of income received by the top 1 percent will fall by 1.2 percentage points (7 percent).

Figure 16: Change in Share of After-Tax Income by Income Percentile: Changes in Tax Policy Since 2009 and ACA Coverage Provisions, 2017



Source: U.S. Treasury, Office of Tax Analysis.

Continued Labor Market Recovery

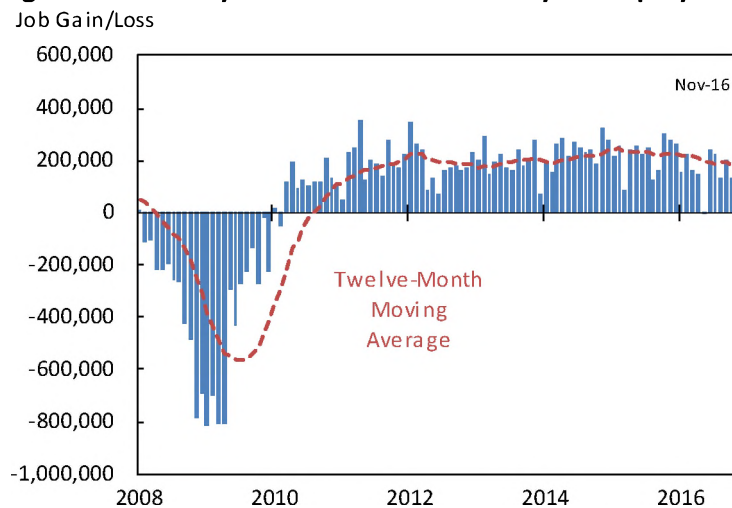
Many critics of the Affordable Care Act argued that its coverage expansions would seriously harm the labor market. While critics of the law were not always explicit about how these harms would arise, some analysts argued that the law’s provisions providing low- and moderate-income people with affordable coverage options would reduce individuals’ incentive to work, leading some people to leave the labor force or reduce their work hours (such as Mulligan 2014a; Mulligan 2014b). These analysts also argued that the ACA’s requirement that large employers offer health insurance coverage to their full-time employees or pay a penalty would cause some employers to shift workers from full-time status to part-time status.

Other analysts noted that the law’s coverage expansions had the potential to drive important positive changes in individuals’ labor supply decisions. Economists have long argued that the lack of good coverage options for those who do not get coverage through the workplace can lead to “job lock,” in which workers remain in a job that offers insurance coverage, despite the fact that their time and talents could be better employed elsewhere (for example, Madrian 1994). The pre-ACA research literature provided some empirical support for this view. Some research has

suggested broader insurance coverage increases worker mobility and facilitates appropriate risk-taking in the labor market (for example, Farooq and Kugler 2016). Providing better coverage options outside the workplace may also facilitate entrepreneurship (Fairlie, Kapur, and Gates 2011; DeCicca 2010); enable workers to invest in additional years of education (Dillender 2014); or give workers additional flexibility in structuring their work lives, such as by retiring when it makes sense for them or reducing their work hours in order to have more time to care for a family member (for example, Heim and Lin 2016).

Fully understanding how the ACA’s coverage expansions have affected the labor market will require additional research, but it is already quite clear that predictions of large reductions in total employment and large increases in part-time employment have not come to pass. Implementation of the ACA has occurred alongside the steady recovery of the labor market from the Great Recession, as illustrated in Figure 17. The private sector started adding jobs in March 2010, the month the ACA became law, and businesses have added a cumulative 15.6 million jobs since that time. Private-sector employment has actually increased somewhat more quickly since the ACA’s main coverage provisions took effect at the beginning of 2014 (around 209,000 jobs per month) than over the rest of the employment expansion (around 181,000 jobs per month).

Figure 17: Monthly Gain in Private-Sector Payroll Employment

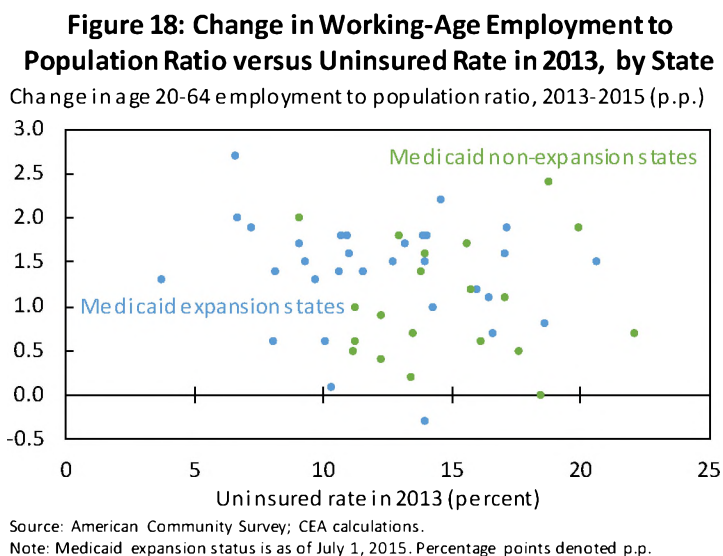


Source: Bureau of Labor Statistics, Current Employment Statistics; CEA calculations.

This time series evidence, particularly the fact that private-sector job growth has actually been slightly faster after the ACA’s main coverage provisions took effect than before they took effect, is sufficient to demonstrate that the ACA has not had the extreme negative effects on employment that many critics predicted. However, more rigorous evidence on the ACA’s effects on labor markets can be obtained by comparing labor market performance between states where the ACA’s coverage provisions were likely to have had larger or smaller impacts. One crude indicator of the scope of the effects of the ACA’s coverage provisions is simply a state’s uninsured rate in 2013; consistent with this, it is a strong predictor of the magnitude of a state’s coverage gains since 2013, as demonstrated in Figure 8. Comparing states with higher and lower uninsured rates in 2013 can therefore provide insight into the effect of the ACA’s coverage provisions on

the labor market. Another useful indicator is whether the state has expanded Medicaid, which provides insight into the labor market effects of Medicaid expansion in particular.

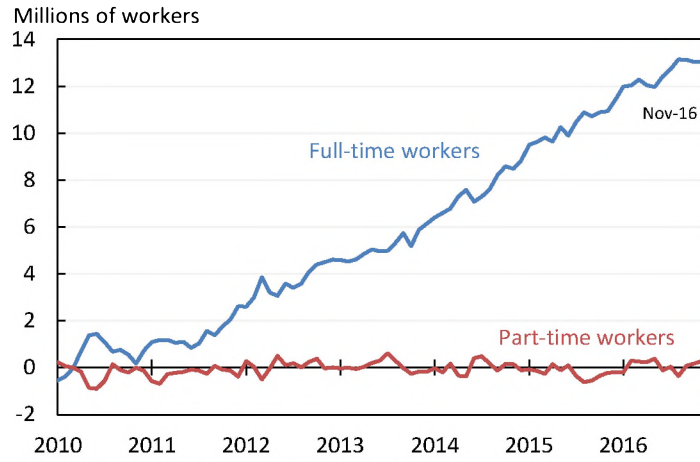
Figure 18 plots each state’s uninsured rate in 2013 against the change from 2013 to 2015 in the share of working-age individuals who are currently employed.¹⁵ Contrary to what would have been expected if the ACA’s coverage provisions had reduced employment, there is essentially no correlation between a state’s uninsured rate in 2013 and its employment gains from 2013 to 2015. Similarly, states that expanded their Medicaid programs actually saw slightly larger employment gains than those that did not expand Medicaid (an increase in the working-age employment-population of 1.5 percentage points in expansion states versus 1.3 percentage points in non-expansion states). Several recent studies using related approaches have similarly found no evidence that the ACA’s coverage provision have reduced employment (Pinkovskiy 2015; Kaestner, Gangopadhyaya, and Fleming 2015; Leung and Mas 2016; Gooptu et al. 2016).



There is also no evidence that the ACA has driven the large-scale shift to part-time work predicted by critics of the law. As with overall employment, time series evidence is sufficient to dismiss the strong claims made by many of the ACA’s critics. As illustrated in Figure 19, since the ACA became law in March 2010, the number of workers employed full time has increased by 13.0 million, while the number of workers employed part-time has been essentially flat. This was true during the years leading up to the implementation of the ACA’s major coverage provisions in 2014, and it continued to be true thereafter, contrary to claims that the ACA would usher in a major shift to part-time work.

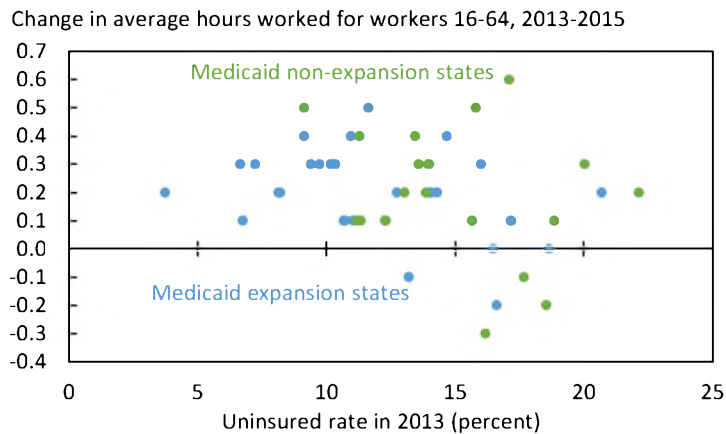
¹⁵ An alternative, simpler approach would be to compare labor market outcomes across states seeing larger and smaller declines in their uninsured rates. Comparisons of this type also support the conclusion that the ACA has not negatively affected the labor market. However, this approach has the disadvantage that improvements in labor market outcomes, whatever their cause, are likely to drive reductions in the uninsured rate since many people who gain jobs gain coverage at work. This could generate a spurious positive relationship between coverage gains and employment gains. The approach taken in Figure 18 and Figure 20 avoids this problem.

Figure 19: Change in Number of Full-Time and Part-Time Workers Since March 2010



More rigorous cross-state comparisons also provide little evidence that implementation of the ACA’s coverage provisions has meaningfully reduced workers’ hours. Figure 20 plots each state’s uninsured rate in 2013 against the change in average weekly hours among workers ages 16 to 64. Contrary to what would have been expected if the ACA’s coverage provisions had caused many workers to shift to part-time work or caused firms to curtail hours, there is essentially no correlation between a state’s uninsured rate in 2013 and the change in average hours worked from 2013 to 2015. Similarly, average hours worked has increased by about 0.2 hours per week in both Medicaid expansion and non-expansion states, inconsistent with the view that Medicaid expansion has put substantial downward pressure on worker hours. Outside estimates using a range of methodologies similarly conclude that there is little evidence that the law has driven a major shift toward part-time work, though some studies have found evidence of small effects (Even and Macpherson 2015; Mathur, Slavov, and Strain 2016; Moriya, Selden, and Simon 2016; Dillender, Heinrich, and Houseman 2016).

Figure 20: Change in Average Weekly Hours versus Uninsured Rate in 2013, by State

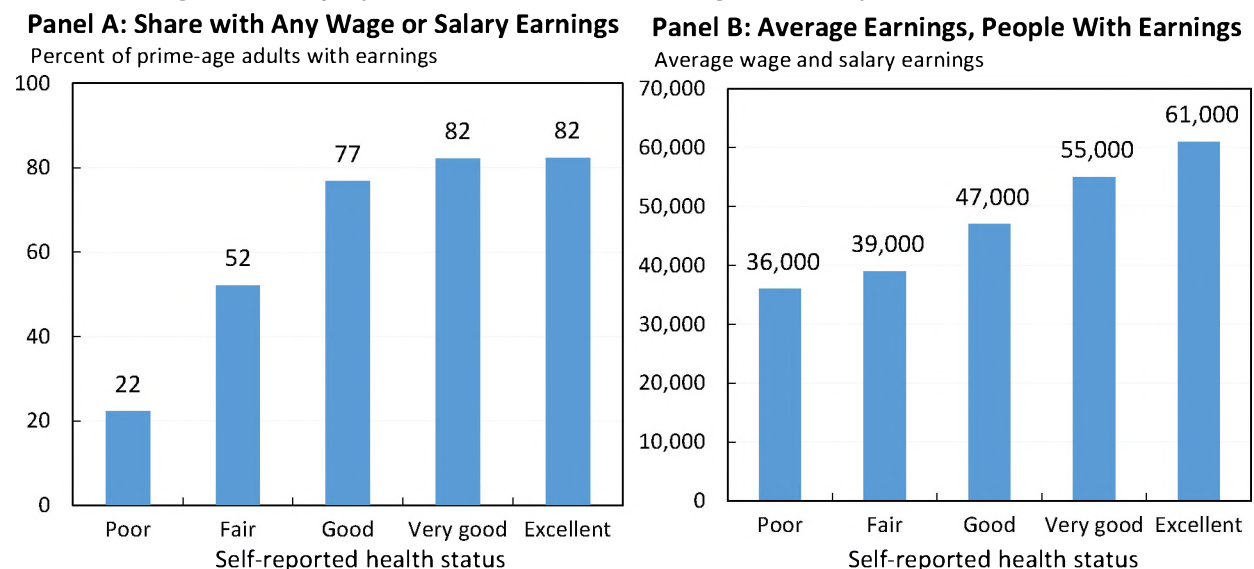


Long-Term Labor Market Benefits

The discussion above—like many discussions of the labor market effects of the ACA’s coverage expansions—focuses on how the ACA might directly affect the incentives of workers and firms in the short run. However, there are also mechanisms through which the ACA’s coverage provisions could have longer-run positive effects on labor market outcomes.

Most directly, by making workers healthier, the ACA may boost their employment and earnings prospects. Indeed, as discussed above, evidence from prior coverage expansions, together with early evidence on the effects of the ACA, demonstrates that insurance coverage improves both mental and physical health. Furthermore, a variety of evidence indicates that better health improves both individuals’ ability to work and their productivity on the job, which in turn leads to higher employment rates and higher earnings. Indeed, looking across individuals, healthier people have far higher employment rates and earnings, as depicted in Figure 21. Moreover, research has documented that adverse health shocks cause sharp reductions in employment and earnings, strongly implying that at least some of this cross-sectional relationship between health status and labor market outcomes reflects the effect of health status on labor market outcomes, rather than the effect of labor market outcomes on health status (Fadlon and Nielsen 2015; Dobkin et al. 2016).

Figure 21: Employment Outcomes for Prime Age Adults, by Health Status, 2015



Source: Current Population Survey; CEA calculations.

There is particularly compelling evidence that coverage gains for children improve educational attainment and earnings. Identifying such effects is challenging because they are likely to appear only gradually over time. However, a pair of recent studies has examined earlier expansions in insurance coverage for children through Medicaid and CHIP, using the fact that different states expanded coverage at different times and to different extents. Because some of these coverage expansions are now decades old, the authors have been able to study their effects on long-term labor market outcomes.

These studies find important long-term labor market benefits from expanded insurance coverage. Cohodes et al. (2015) find that having Medicaid or CHIP coverage in childhood increases the likelihood of completing high school and college. Brown, Kowalski, and Lurie (2015) find that female children with greater access to Medicaid or CHIP coverage in childhood have higher educational attainment and higher earnings in early adulthood. They also find evidence that both boys and girls with greater access to Medicaid or CHIP in childhood pay more in income and payroll taxes in their young adult years, potentially offsetting a substantial fraction of the cost of providing coverage to children. These results provide direct evidence that the increases in children's insurance coverage that have occurred under this Administration will generate important long-term labor market benefits and suggest that expanded coverage for adults could generate similar benefits.

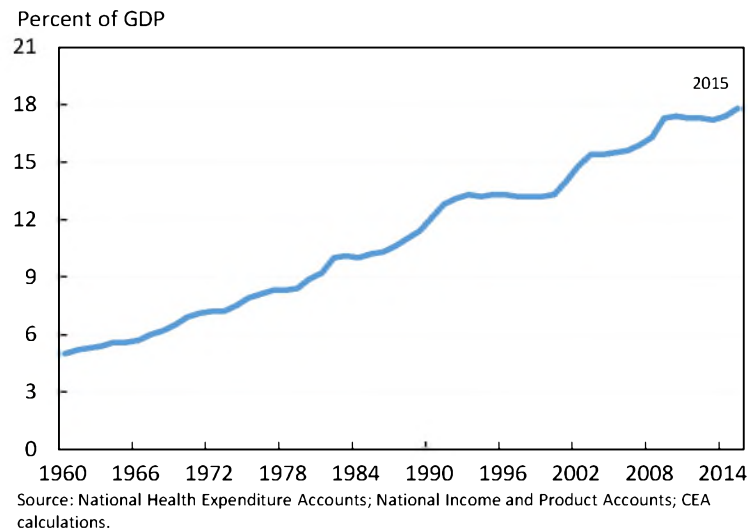
The ACA has also strengthened the U.S. system of automatic stabilizers, programs that automatically expand during hard times and contract during good ones, which will help to reduce the severity of future recessions. The ACA's coverage expansions help ensure that families facing job or income losses during a recession retain access to affordable health insurance options. Retaining access to affordable health insurance options safeguards families' ability to access health care and cushions their budgets, enabling these families to better smooth their consumption of health care and other necessities.

While these direct improvements in families' economic security in the face of recession are valuable on their own, they also have important macroeconomic benefits. By boosting consumption at the household level during recessions, the ACA will increase aggregate demand for goods and services at times when it would otherwise be impaired, increasing overall economic output and helping to mitigate the severity of the recession itself. Moreover, recent discussions of macroeconomic policy have suggested that changes in the U.S. economy have increased the likelihood that monetary policy will be constrained by the inability to cut nominal interest rates below the zero bound in future recessions, increasing the importance of a strong system of automatic stabilizers (Furman 2016).

II. Reforming the Health Care Delivery System

The United States has historically devoted a large fraction of its economic resources to delivering health care. In 2009, the year President Obama took office, the United States spent 17.3 percent of GDP—\$2.5 trillion—on health care. That fraction had risen rapidly over time, having increased from 13.2 percent a decade earlier and just 5.0 percent in 1960, as illustrated in Figure 22. Much of that spending on health care created substantial value. Indeed, economic research has emphasized that much of the long-term rise in health care spending results from the steady advance of medical technology and that the resulting improvements in length and quality of life have historically been more than sufficient to justify the increase in spending (Newhouse 1992; Cutler 2004). Nevertheless, evidence also demonstrated that the U.S. health care delivery system suffered from serious inefficiencies that drove up spending and undermined patients’ health. In light of the magnitude of the resources devoted to the health care system and the great value of better health, this evidence suggested that reform could bring large gains.

Figure 22: Health Care Spending as a Share of GDP, 1960-2015

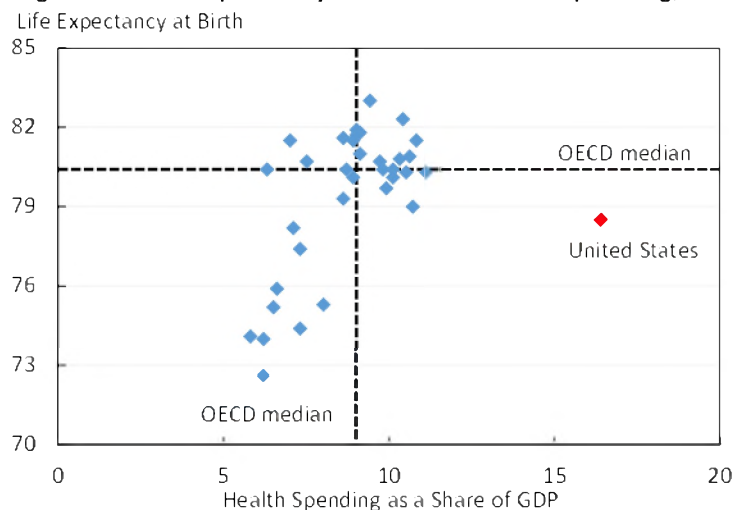


This section of the report reviews the progress that has been made under this Administration in reforming the health care delivery system. The section begins by summarizing the evidence that the health care delivery system has historically fallen short of its potential, and then describes the reforms implemented under this Administration to address these shortcomings. Next, the section documents the slow growth in health care costs and improvements in health care quality that have occurred as these reforms have taken effect, and presents evidence that the reforms have, in fact, played an important role in driving the positive trends of recent years. The section closes by discussing the benefits that an improved health care delivery system will have for the United States economy in the years to come.

Health Care Costs and Quality Before the Affordable Care Act

A range of evidence indicates that the U.S. health care delivery system has historically fallen short of its potential. One commonly cited piece of evidence was how health care spending and outcomes in the United States compared with those of its peer countries. The United States has historically been an extreme outlier in the share of GDP it devotes to health care, as illustrated in Figure 23. In 2009, the share of GDP that the United States devoted to health care was more than 80 percent higher than that of the median member of the Organisation for Economic Co-operation and Development (OECD) and nearly 50 percent higher than that of the next highest OECD member. Due in part to challenges in obtaining comparable data for the United States and other OECD countries, the reasons that spending was so much higher in the United States are not fully understood. However, research has generally concluded that the United States paid higher prices for health care services—potentially reflecting the greater market power held by providers and insurers in the United States’ system—and made greater use of costly, but not necessarily effective, medical technologies and treatments (Anderson et al. 2003; Garber and Skinner 2008).¹⁶

Figure 23: Life Expectancy at Birth vs. Health Spending, 2009



Source: OECD; CEA Calculations.

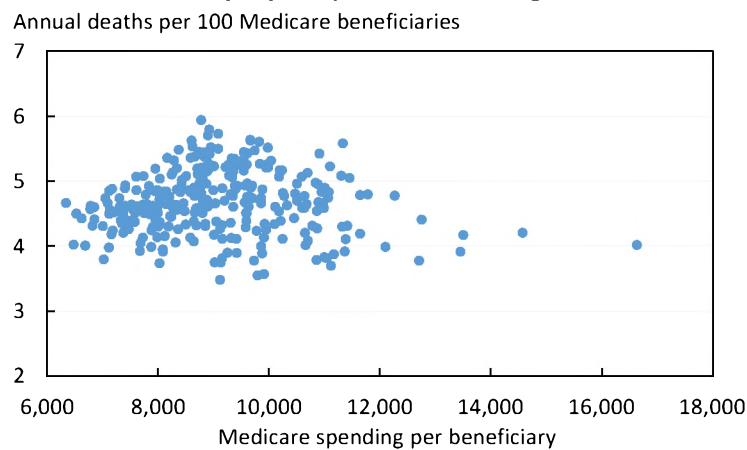
The United States’ much-higher spending could have been justified if the additional spending translated into better health care outcomes. In fact, life expectancy was almost two years shorter in the United States than in the median OECD country, and cross-country comparisons of various measures of the quality of care, such as the risk of hospital-acquired infections, found that the outcomes achieved in the United States were, at best, unremarkable (Drösler, Romano, and Wei 2009). In principle, this pattern could arise if factors outside the health care delivery system, such as the United States’ high obesity rate and uniquely large share of people without health insurance, masked the large returns generated by the United States’ higher health care spending. While these factors may have played some role in explaining the United States’ poor

¹⁶ These two drivers of higher health care spending in the United States may, to some degree, be related if providers’ ability to charge higher prices facilitates investment in costly medical technologies.

performance, the sheer magnitude of the difference in spending between the United States and its OECD peers made it unlikely that this was a full explanation (Garber and Skinner 2008).

Patterns of health care spending and quality performance within the United States provided additional evidence that the United States health care delivery system suffered from serious inefficiencies. Research documented that the amount Medicare spent per enrollee varied widely in the United States, largely reflecting substantial differences in the quantity of care provided in different parts of the country (Fisher et al. 2003a). Other research has documented a similarly large variation in spending among people covered through private insurance, with those in private insurance also seeing wide variation in the *prices* paid for care in different markets in addition to the quantity of care provided (Chernew et al. 2010; Philipson et al. 2010; Cooper et al. 2015). As with cross-county comparisons, however, there was little evidence that higher-spending areas achieved better health outcomes, suggesting that the additional spending in high-spending areas was unnecessary (Fisher et al. 2003b). Moreover, this research found that there was wide variation in health outcomes among areas with similar levels of spending, suggesting that there might be major opportunities to improve patient outcomes, even while holding spending fixed. Figure 24 illustrates these empirical patterns using data on spending and outcomes among Medicare beneficiaries from the Dartmouth Atlas of Health Care.

Figure 24: Mortality Rate vs, Medicare Spending per Beneficiary, by Hospital Referral Region, 2009



Source: Dartmouth Atlas of Health Care.
Note: Spending and mortality adjusted for age, sex, and race.

One important advantage of comparing cost and quality among different areas within the United States, as opposed to across countries, is that much richer data are available. This greater data availability makes it easier for researchers to have confidence that confounding factors were not masking a positive relationship between spending and health outcomes. For example, one possible explanation for the patterns in Figure 24 is that people in some areas of the country were in worse health, which led those areas to spend more on health care, but masked any benefits of that additional spending for health care outcomes. However, the research cited above found that these patterns held after controlling for individual-level characteristics, casting doubt on whether this could explain the observed patterns. More recent research has examined people

who move from one part of the country to another and similarly concluded that much of the variation in spending across areas reflects differences in how care is delivered in different areas, not differences in the characteristics or preferences of people in different places (Finkelstein, Gentzkow, and Williams 2016).

Aggregate data on patterns of care in the United States also suggested that the delivery system was falling short of what a well-functioning delivery system could be expected to achieve, driving up costs and leading to worse outcomes for patients. Research examining individual patient encounters with the health care system found that patients commonly failed to receive care that was recommended under clinical guidelines, while also commonly receiving care that was not recommended (McGlynn et al. 2003). Studies similarly found evidence that care was often poorly coordinated, with patients commonly receiving duplicate tests and different medical providers responsible for a patient's care often failing to communicate when a patient transitioned from one care setting to another (Commonwealth Fund 2008). Research also found that patients were often injured in avoidable ways when seeking medical care, suffering harms ranging from medication errors, to pressure sores, to infections (Institute of Medicine 1999). Others noted that patients were often readmitted to the hospital soon after discharge, despite evidence that these readmissions might be avoidable with better planning for post-discharge or other changes in medical practice (MedPAC 2007; Commonwealth Fund 2008).

Reforms to the Health Care Delivery System Under the Obama Administration

In light of the compelling evidence that the health care delivery system has historically fallen short of its potential, this Administration has implemented a comprehensive set of reforms, largely using tools provided by the ACA, to make the health care delivery system more efficient and improve the quality of care. These reforms fall in three main categories: better aligning payments to medical providers and insurers in public programs with actual costs; improving the structure of Medicare's provider payment systems to ensure that those systems reward providers who deliver efficient, high-quality care, rather than simply a high quantity of care; and engaging private insurers in a similar process of payment reform. Each of these reforms, as well as its underlying economic logic, is discussed in detail below.

Aligning Public Program Payment Rates with Actual Costs

One way of reducing spending on health care is to ensure that the amounts Medicare and other public programs pay for health care services match the actual cost of delivering those services. Setting Medicare payment rates at an appropriate level has at least two major benefits. Most directly, reductions in Medicare payment rates reduce costs for the Federal Government, which pays for the majority of care Medicare beneficiaries receive, as well as for beneficiaries themselves, who pay the remaining costs through premiums and cost sharing.¹⁷

¹⁷ Many Medicare beneficiaries have supplemental coverage that pays for some or all of their cost sharing. In some cases, they purchase this coverage individually and in other cases they receive it from a former employer or a state Medicaid program. In these cases, cost-sharing is ultimately financed by the entity paying for the supplemental

Recent research implies that reductions in Medicare payment rates can also generate savings for individuals enrolled in private insurance plans by enabling private insurers to secure better rates from medical providers.¹⁸ Clemens and Gottlieb (forthcoming) study a past reform in Medicare payments to physicians that had different effects in different parts of the country. They find that when Medicare reduces its payment rate by one dollar, private insurers reduce their payment rates for the same services by \$1.12, on average. White (2013) and White and Wu (2014) undertake a similar analysis focused on Medicare payment to hospitals using variation in how earlier Medicare payment reforms affected different hospitals. White (2013) finds that when Medicare reduces its payment rates by one dollar, private payers reduce their payment rates by \$0.77. White and Wu (2014) find that for each dollar Medicare saves in response to such a reform, other payers realize savings of \$0.55. These results run contrary to earlier conventional wisdom that Medicare payment reductions generate offsetting “cost shifts” to private payers that drive up the costs of private insurance.

The ACA made a range of changes designed to bring payment rates in public programs more closely in line with the actual cost of delivering services. Two of these were particularly important due to their large size. First, the ACA modified Medicare’s formula for updating payment rates to certain medical providers to reflect an expectation that providers will improve their productivity to a similar extent as the rest of the economy over the long run. Previously, Medicare had updated payment rates for these providers based solely on changes in the costs of the inputs they use to deliver care, without accounting for improvements in productivity, an approach that caused payment rates to rise more quickly than the providers’ actual cost of delivering health care services.

Second, the law addressed long-standing deficiencies in the system used to pay Medicare Advantage plans that led to those plans being paid far more to cover Medicare patients than it would have cost to cover the same patient in traditional Medicare (MedPAC 2009). To do so, the ACA phased in changes to the “benchmarks” used to determine payments to Medicare Advantage plans. These provisions have taken effect without adverse effects on the premiums or availability of Medicare Advantage plans, consistent with the view that pre-ACA payment rates were excessive. Access to Medicare Advantage plans remains essentially universal among Medicare beneficiaries, and the share of Medicare beneficiaries enrolled in a Medicare Advantage plan has risen from 24 percent in 2010 to a projected 32 percent in 2017, while average premiums are estimated to have fallen by 13 percent from 2010 through 2017 (CMS 2016b).

coverage. Similarly, some Medicare beneficiaries also have all or part of their premiums paid by another entity, typically a state Medicaid program or a former employer.

¹⁸ The mechanism by which Medicare payment rates affect private payment rates remains unclear. Clemens and Gottlieb (forthcoming) suggest that reducing Medicare’s payment rate may strengthen private payers’ negotiating position, perhaps because it becomes less attractive for a provider to walk away from the negotiation or because Medicare’s rates serve as a benchmark for judging whether contract terms are reasonable.

Reforming the Structure of Medicare's Payment Systems

A second approach to increasing the value produced by the health care delivery system is to improve the *structure* of the payment systems that public health care programs and private insurers use to pay medical providers. Historically, the U.S. health care system has been dominated by “fee-for-service” payment systems in which medical providers are paid separately for each individual service they deliver, like an office visit, a diagnostic test, or a hospital stay.

Fee-for-service payment undermines the efficiency and quality of patient care in three important ways. First, fee-for-service payment encourages providers to deliver more services than necessary since each additional service translates into additional revenue. Second, fee-for-service payment encourages providers to deliver the wrong mix of services. In a system with payment rates for thousands of different services, payment rates for some services will inevitably end up being set too high relative to the underlying cost of some services and too low for others, biasing care toward those services that happen to be particularly profitable, whether or not those services create the most value for patients. Third, fee-for-service payment fails to reward providers who improve health outcomes because payment is completely independent of the outcomes they achieve for their patients.¹⁹

The perverse short-run incentives created by fee-for-service payment may also distort the long-run trajectory of medical technology. Because of the shortcomings catalogued above, fee-for-service payment tends to encourage widespread use of resource-intensive new technologies, even if they generate modest health benefits, while often failing to ensure equally widespread use of less resource-intensive new technologies that generate large health benefits. When deciding what new technologies to develop, potential innovators and investors are likely to favor technologies that they expect to have a larger market, causing them to focus more on the former type of technology than the latter. Over time, this bias may lead to larger increases in health care spending and smaller improvements in health outcomes than would occur under a payment system that rewards efficient, high-quality care.

Largely using tools provided by the ACA, the Administration has implemented two types of reforms in the Medicare program designed to address the shortcomings of fee-for-service payment. The first was targeted improvements to existing fee-for-service payment systems to encourage more efficient, higher-quality care, which have the important advantage that they can be implemented quickly at scale. The second was setting in motion a longer-term shift away from fee-for-service payment and toward alternative payment models (APMs) that pay providers based on overall cost and quality of the care they deliver, rather than the numbers and types of services they provide. In addition, to facilitate continuous learning and progress along both of these tracks, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) to develop and test innovative new payment models. Importantly, the Secretary of Health and Human Services has the authority to expand a payment model tested through CMMI nationwide

¹⁹ While health care professionals have other reasons to deliver high-quality care, including their concern for their patients' well-being and their desire to attract and retain patients, the evidence summarized earlier demonstrates that this was not always sufficient to ensure that all patients received high-quality care.

if the model is determined to reduce spending without harming quality of care or to improve quality of care without increasing spending.

Targeted Reforms to Fee-For-Service Payment Systems

This Administration has implemented a range of targeted improvements to existing fee-for-service payment systems. One such improvement is greater use of “value-based” payment systems, which adjust providers’ fee-for-service payment amounts upward or downward according to how they perform on measures of the quality or efficiency of care. For hospitals, the ACA introduced value-based payment incentives aimed at encouraging hospitals to reduce their hospital readmission rates and their hospital-acquired infection rates. The ACA also introduced broader value-based payment programs for physicians and hospitals that reward providers that perform well across a broad array of quality and efficiency measures. More recently, CMMI began testing a value-based payment system for home health care services, and the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) introduced a new value-based payment system for physician services that will consolidate existing value-based payment programs for physicians into a single program starting in 2017.

Another type of improvement is beginning to pay providers to deliver high-value services for which payment was not previously available. For example, through CMMI, the Administration tested the Medicare Diabetes Prevention Program (MDPP), which provides coaching aimed at helping participants transition to a healthier lifestyle and lose weight. The evaluation of this initiative demonstrated that MDPP both reduced spending and improved quality of care for Medicare beneficiaries, and the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) has certified that expanding the initiative would not increase Medicare spending (RTI 2016; Spitalnic 2016; HHS 2016a). On this basis, CMS is now taking steps to begin paying providers to deliver MDPP services to eligible Medicare beneficiaries nationwide starting in 2018. The Administration has also used various pre-ACA authorities to begin covering other high-value services under Medicare in recent years, such as care management services for individuals with chronic diseases and care planning services for patients with cognitive impairments like Alzheimer’s disease or dementia.

Development and Deployment of Alternative Payment Models

Most important for the long term, the Administration has also made substantial progress in deploying APMs that reorient payment to be based upon the overall cost and quality of the care providers deliver. The Administration has tested and deployed a range of different types of APMs in Medicare. Two particularly important types of APMs are bundled payment models and accountable care organization (ACO) payment models, each of which is discussed in greater detail below.

Under bundled payment models, sometimes called episode payment models, Medicare makes a single payment for all care involved in a clinical episode, rather than paying for each of those

services separately.²⁰ Bundled payment models use a range of different approaches to define clinical episodes, but they generally start when a specified triggering event occurs and then continue for a follow-up period. For example, in a bundled payment model CMMI is currently testing for hip and knee replacement, the episode begins when the patient is admitted to the hospital for surgery and continues through 90 days after discharge. The bundled payment covers all the health care services the patient receives during that time, including the initial hospital admission, the surgeon's services, post-discharge home health services, and any other services associated with the patient's recovery, including those triggered by complications.

Making a single payment for this broad array of services associated with an episode allows providers to deliver the most appropriate combination of services to patients, without regard to how those individual services are compensated, creating opportunities to improve the efficiency and quality of care. Many bundled payment models further encourage quality improvement by providing a higher payment per episode to providers who perform well on specified measures of care quality. Medicare captures a portion of the savings generated by more efficient care by setting the bundled payment amount at a discount relative to the costs historically associated with each type of clinical episode.

CMMI is testing several different types of bundled payment models. Through the Bundled Payments for Care Improvement initiative, CMMI is testing bundled payments for 48 different clinical episodes, and this model has attracted nearly 1,500 participating provider organizations across the country as of the middle of 2016. Similarly, CMMI is testing bundled payment for the full scope of care provided to beneficiaries receiving chemotherapy through the Oncology Care Model, which has enrolled 194 oncology practices from markets across the country. CMMI has also begun tests of bundled payment models that include all providers in randomly selected metropolitan areas. Specifically, CMMI began this type of test of a bundled payment model for hip and knee replacement in 67 metropolitan statistical areas across the country in early 2016 and recently proposed a similar approach to testing bundled payment for additional orthopedic procedures and certain types of cardiac care.

Testing models on a geographic basis, as these new bundled payment models do, has two important advantages relative to other approaches. First, randomly selecting metropolitan areas to participate in the model ensures that participants will not differ systematically from non-participants, allowing the test to deliver particularly compelling evidence on how the model affects the efficiency and quality of care. Second, participation by all providers in the randomly-selected geographic areas allows the test to provide evidence on how the model would perform if it were expanded program-wide; evidence from tests that allow each individual provider to opt in or out of the model are much more challenging to generalize in this fashion. In light of these

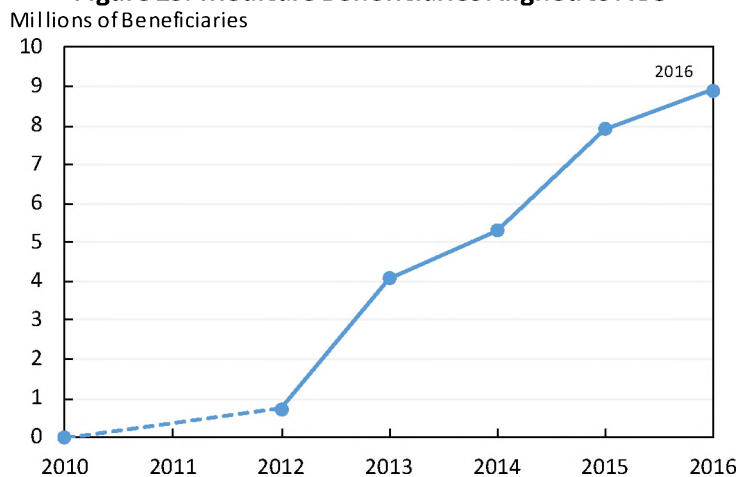
²⁰ Some bundled payment models literally make a single payment for the episode and rely on the providers involved in the patient's care to split that payment among themselves. However, most bundled payment models being tested by CMMI instead pay for care on a fee-for-service basis during the episode, and then "reconcile" these payments after the fact. If fee-for-service spending falls below the episode price, CMS makes a payment to the provider equal to the savings, while if the fee-for-service spending exceeds the episode price, the provider makes a corresponding payment to CMS. Either approach to bundled payment creates similar incentives.

advantages, CBO recently noted that CMMI’s ability to conduct geographically based tests is an important reason that CBO projects CMMI to generate substantial savings for the Medicare program (Hadley 2016).

A second major category of APM deployed under this Administration are ACO models, which go a step further than episode payment models and orient payment around the entirety of the care a patient receives during the year, rather than just the care delivered during a particular episode of care. Under an ACO model, a group of providers join together and agree to be held accountable for the overall cost and quality of the care their patients receive during a year. ACOs that reduce average per beneficiary spending below a “benchmark” level share a portion of the savings, giving providers a strong incentive to deliver care more efficiently. (Certain ACO models are “two-sided,” meaning that providers also agree to repay a portion of any spending in excess of the benchmark.) ACOs that perform well on a suite of measures of the quality of the care they deliver are eligible for larger financial rewards, giving them a strong incentive to deliver high-quality care and a corresponding disincentive to limit access to necessary care.

ACOs are now widespread in the Medicare program. As of January 2016, 8.9 million traditional Medicare beneficiaries—nearly a quarter of the total—were receiving care through more than 470 ACOs, as illustrated in Figure 25. The substantial majority of these beneficiaries are aligned with ACOs operating under the Medicare Shared Savings Program, the permanent ACO program created under the ACA. A smaller number are participating in ACO models being tested by CMMI that aim to improve upon existing ACO models in a range of ways. These CMMI ACO models include: the Next Generation ACO; the Comprehensive ESRD Care Model, which aims to improve outcomes for patients with a particular high cost, high risk condition; and the ACO Investment Model, which supports the participation of small practices or practices in rural areas. Notably, an earlier CMMI ACO model—the Pioneer ACO model—became the first model to meet the criteria for expansion under the Secretary’s expansion authority (L&M Policy Research 2015; Spitalnic 2015; HHS 2015). Features of the Pioneer ACO model have now been incorporated into the Medicare Shared Savings Program on a permanent basis.

Figure 25: Medicare Beneficiaries Aligned to ACO

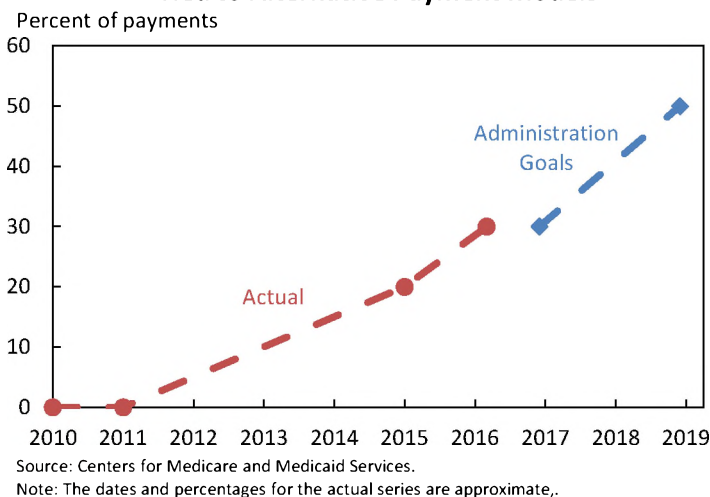


Source: Centers for Medicare and Medicaid Services.
Note: Beneficiary counts are for January of the year shown.

Through CMMI, the Administration has also tested a range of other innovative payment approaches in addition to bundled payments and ACOs. For example, CMMI is testing medical home models that provide additional resources to primary care practices that agree to engage in a set of specified activities, including care management and care coordination activities, and to be held financially accountable for the cost and quality of the care their patients receive. CMMI began its first major test of medical homes through the Comprehensive Primary Care Initiative, which began operating in October 2012; currently, there are 442 participating practices in seven states. In early 2016, CMMI announced an improved medical home initiative, known as the Comprehensive Primary Care Plus model, which will begin operating in 16 states in January 2017. In collaboration with the states of Maryland and Vermont, CMMI is also testing statewide all-payer initiatives aimed at making comprehensive changes in how providers in those states deliver care.

In light of the potential of APMs to improve the performance of the health care delivery system, the Administration set the goal of having 30 percent of traditional Medicare payments flowing through APMs by the end of 2016, up from essentially none before the ACA. As illustrated in Figure 26, CMS estimates that this goal was reached ahead of schedule in early 2016. The Administration has set the goal of having at least 50 percent of traditional Medicare payments flowing through APMs by the end of 2018.

Figure 26: Percentage of Traditional Medicare Payments Tied to Alternative Payment Models



Provisions included in the bipartisan MACRA will help accelerate the Administration’s efforts to deploy APMs in Medicare. Under the law, physicians who provide a sufficiently large fraction of their care through “advanced” APMs will receive a bonus payment equal to 5 percent of their annual Medicare revenue. Advanced APMs are a category that includes most of CMS’ most ambitious APMs, including the two-sided ACO models operating through the Medicare Shared Savings Program and CMMI, several of CMMI’s bundled payment models, and the new Comprehensive Primary Care Plus medical home model. Additionally, CMS has committed to

developing new models that qualify as advanced APMs as well to revising some existing models to meet the advanced APM criteria.

Engaging the Private Sector in Payment Reform

Reforming payment systems in Medicare is an important step, as Medicare accounts for around a quarter of all health care spending in the United States. However, more than half of Americans receive coverage through private insurers, which have also historically relied upon fee-for-service payment systems. Ensuring that all Americans receive efficient, high-quality care therefore requires improving private insurers' provider payment systems as well. In light of the substantial shortcomings of fee-for-service payment systems, it may seem puzzling that private insurers had not already done so. But insurers faced two major barriers: a serious collective action problem and poor incentives created by the tax treatment of employer-sponsored health insurance coverage.

A collective action problem exists because developing and deploying new payment models is a costly endeavor, requiring significant investments by both payers and providers, but, as described below, many of the benefits of investments made by any individual actor accrue to its competitors. As a result, each individual payer's return to investing in new payment methods is far below the overall return to the health care sector, leading private payers to substantially underinvest in new payment approaches.

The benefits of one payer's investment in alternative approaches to provider payment spill over to other payers in two important ways. First, once new approaches to payment have been developed and providers have been induced to make the investments needed to deploy them, other payers can adopt those same payment structures at lower cost, but still realize the resulting benefits for the efficiency and quality of care. Largely for this reason, private payers have often elected to base their payment systems on Medicare's payment systems, at least in part (Ginsburg 2010). Private payers typically set payment rates for physicians by starting with the Medicare physician fee schedule rates and increasing them by a specified percentage. Consistent with this, recent research has documented that when Medicare changes the relative amount it pays for different types of physician services, private payers follow suit, at least on average (Clemens and Gottlieb forthcoming). For hospital services, there is far more diversity in the methods used, though Medicare's payment systems are a common starting point (Ginsburg 2010).

A second reason spillovers occur is that medical providers often apply a common "practice style" across all of their patients, so changes made in response to payment changes implemented by one payer often affect patients covered by other payers as well. For example, research examining the diffusion of managed care in the 1990s found that increases in the prevalence of managed care in an area led to changes in treatment patterns for patients in non-managed policies as well (Glied and Zivin 2002). Research has found similar effects for the Alternative Quality Contract (AQC), an ACO-like contract that Blue Cross Blue Shield of Massachusetts has been experimenting with since 2009. McWilliams, Landon, and Chernew (2013) report that patients who were treated

by AQC-participating providers, but who were not covered by Blue Cross Blue Shield of Massachusetts, also benefited from lower costs and improved quality along some dimensions.

The Administration has taken several steps to overcome this collective action problem. The Administration's aggressive efforts to improve Medicare's payment systems, described in detail in the previous section, are one particularly important step. As discussed above, private payers often pattern their payment systems after Medicare's payment systems, so transforming payment in Medicare can facilitate improvements in private payment systems. The resulting trends in private payment approaches have been encouraging. For example, recent years have seen rapid growth in private ACO contracts alongside the growth in Medicare ACO contracts, and about 17 million—or roughly one in ten—private insurance enrollees were covered under ACO contracts at the beginning of 2016, up from virtually none as recently as 2011 (Muhlestein and McClellan 2016). Looking across all types of APMs, a recent survey of private insurers estimated that approximately one in four claims dollars paid by private insurers flowed through an APM during calendar year 2015 (HCPLAN 2016).

The Administration has also taken a range of steps to directly overcome the collective action problem described above by facilitating collaboration across payers in developing innovative payment models. The Administration created the Health Care Payment Learning and Action Network in 2015, a forum in which providers and payers can share best practices on how to design and deploy new payment methods. Similarly, in partnership with the members of the Core Quality Measure Collaborative, a group that includes representatives of payers, providers, and consumers, CMS released agreed-upon quality measures for six major medical specialties as well as for ACO and medical home models in early 2016. CMMI has also directly included private payers in many of its model tests. For example, the medical home interventions being tested through the Comprehensive Primary Care initiatives is being implemented in parallel by CMS and other payers in each of the test markets, and the all-payer models now being tested in Maryland and Vermont involve multiple payers by definition.

These steps to facilitate collaboration across payers may have benefits in addition to resolving a collective action problem. Notably, these efforts have the potential to reduce the administrative costs to providers of participating in APMs. Reducing administrative costs is valuable in their own right, but may also facilitate more rapid diffusion of these models. Aligning incentives across payers may also make APMs more effective by ensuring that providers do not face conflicting incentives from different payers.

In addition to the collective action problem discussed above, the tax treatment of employer-sponsored health insurance coverage has been a second important barrier to the adoption of better payment methods in the private sector. In particular, employees pay income and payroll taxes on compensation provided in the form of wages and salaries, but not on compensation provided in the form of health care benefits. As discussed earlier in this report, this treatment means that the Federal Government provides an implicit subsidy of around 35 cents on the dollar to compensation provided in the form of health benefits that it does not provide to other forms of compensation.

As also discussed earlier in this report, this subsidy plays a useful role in helping make coverage affordable for many families, but it also distorts employers' incentives. Because the Federal Government subsidizes each additional dollar of health benefits, employers have a strong incentive to provide excessively costly and inefficient health plans. This in turn undermines the business case for payers to make the plans they offer employers more efficient, including by adopting new approaches to provider payment developed in the public sector and making their own investments in better benefit designs and better approaches to provider payment.

The ACA addressed this problem by including an excise tax on high-cost employer-sponsored coverage. The tax, currently scheduled to take effect in 2020, will levy a 40-percent tax on employer plan costs in excess of about \$29,000 for family coverage and about \$10,700 for single coverage. Plans with higher costs due to factors such as the age-sex mix of their enrollment or the industry in which their enrollees work are eligible for higher thresholds. The tax applies only to the portion of plan costs in excess of the threshold; for example, a family plan with a cost of \$29,100 in 2020 would pay just \$40 in tax. For these very high-cost plans, this structure counteracts the perverse incentives to offer overly generous coverage that existed under pre-ACA law, while preserving strong incentives for employers to offer appropriate coverage. The U.S. Department of the Treasury estimates that 7 percent of enrollment in employer-sponsored coverage and around 1 percent of plan costs will be affected when the tax takes effect in 2020.

The most direct effects of the tax will be on enrollees in the high-cost plans affected by the tax. As their employers take steps to make their plans more efficient, workers at these firms will see lower premiums and correspondingly higher wages, which Congressional Budget Office and Joint Committee on Taxation estimates imply will be around \$43 billion in 2026 alone.²¹ However, the benefits of this reform are likely to be felt throughout the health care system, not just by enrollees in highly inefficient plans. Just as improvements in Medicare's payment systems generate spillover benefits for the rest of the health care system, payment innovations adopted by inefficient plans are likely to generate benefits for enrollees in many different types of coverage. Similarly, the excise tax on high-cost coverage will encourage plans and employers to engage in more aggressive price negotiation with medical providers. By weakening the bargaining position of providers relative to plans, the excise tax will help plans not directly affected by the tax secure lower prices for their enrollees (Baker, Bundorf, and Kessler 2015).

²¹ This estimate was derived from an August 2016 estimate by the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) that repealing the excise tax would increase the deficit by \$20 billion in 2026 (CBO 2016a). CBO/JCT assume that roughly three-quarters of the fiscal effects of the tax arises from the increase in payroll and income tax revenue as workers' wages rise (CBO 2015a). Calculations based on tables published by the Urban-Brookings Tax Policy Center imply that the average marginal tax rate on labor income for individuals with employer coverage is around 35 percent (see Urban-Brookings Tax Policy Center Tables T13-0253 and T14-0091). Combining these estimates implies an increase in wage and salary income of \$43 billion ($=[\$21 \text{ billion} * 0.75]/0.35$).

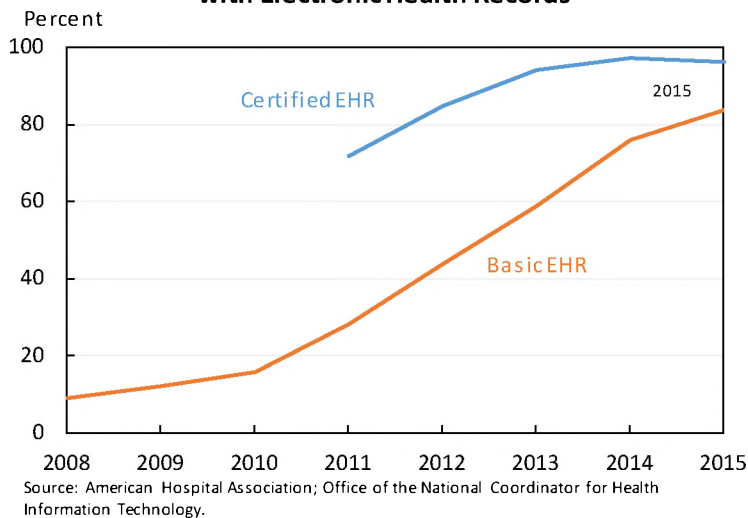
Additional Steps to Reform the Health Care Delivery System

This Administration has also taken a range of other steps to reform the health care delivery system that complement the provider payment reforms discussed in the rest of this section. One such effort aimed to accelerate the deployment of health information technology (IT). Studies of health IT adoption have found positive impacts on the quality and efficiency of patient care (Buntin et al. 2011; Shekelle et al. 2015). For example, numerous studies provide evidence that computerized physician order entry systems, which can alert doctors to possible medication allergies or dosing errors, prevent adverse drug events (Jones et al. 2014; Shamliyan et al. 2008).

To spur greater use of health IT, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 created financial incentives for Medicare and Medicaid providers to adopt and make “meaningful use” of electronic health records (EHR). More recently, MACRA updated the HITECH incentives for physicians to use health IT and integrated them into Medicare’s core physician payment system. Providers participating in the value-based payment system for physicians established under MACRA will be scored, in part, on their use of EHRs to improve the quality of patient care. MACRA also incorporates the use of certified EHRs (EHRs that meet certain criteria for capturing and sharing patient data) into the determination of whether a payment model qualifies as an advanced APM and thereby qualifies participating physicians for the bonus payments described in the last section.

Recent years have seen substantial progress in deploying EHRs. As illustrated in Figure 27, 84 percent of non-Federal acute care hospitals had adopted a basic EHR (an EHR that can perform a certain set of core functions) as of 2015, up from just 16 percent in 2010. An even greater share of hospitals possessed at least a certified EHR system. EHR use has also become common among office-based physicians. In 2015, 78 percent of office-based physicians had an EHR and more than a third had used their EHR system to transmit patient health information to external providers (Jamoom and Yang 2016). Focusing on hospitals, Dranove et al. (2015) found evidence that the HITECH payment incentives had accelerated EHR adoption.

Figure 27: Percent of Non-Federal Acute Care Hospitals with Electronic Health Records



This Administration has also taken steps to improve the availability of information on how cost and quality performance vary across medical providers to help consumers, employers, and others make better-informed choices about where to obtain care. For example, the Qualified Entity program, which was created by the ACA and expanded by MACRA, allows organizations that agree to abide by rigorous privacy and security requirements to use Medicare claims data to create public reports comparing the performance of different medical providers. CMS has also improved and expanded the websites it operates to deliver information on provider performance directly to consumers; these websites now include information on performance by hospitals, nursing homes, physicians, dialysis facilities, home health providers, and Medicare Advantage and Part D prescription drug plans. Additionally, CMS has begun releasing versions of Medicare’s claims databases that have been stripped of beneficiary-identifying information as public use files. The availability of public use files can help researchers better understand patterns of care in the Medicare program in order to evaluate the effectiveness of ongoing delivery system reform efforts and develop new approaches to delivery system reform.

The ACA also created a streamlined process for implementing needed changes to Medicare’s payment systems in the future. In detail, it established an Independent Payment Advisory Board (IPAB) of 15 voting members appointed by the President and confirmed by the Senate. If growth in Medicare spending per beneficiary is projected to exceed a target growth rate over a five-year period, IPAB is charged with recommending improvements in how Medicare pays providers to reduce Medicare spending growth; IPAB is not permitted to recommend changes to Medicare’s benefit design, including premiums, deductibles, and coinsurance. The Secretary of Health and Human Services then implements IPAB’s recommendations unless legislation that overrides the recommendations is enacted. Over the long run, the target growth rate for IPAB is the growth rate of per capita GDP plus 1 percentage point. However, a more stringent target was set for years through 2017: the average of projected growth in the overall Consumer Price Index (CPI) and the CPI for medical care. Because of the exceptionally slow growth in Medicare spending

since the ACA became law, which is discussed in greater detail in the next section, IPAB has not yet been called upon to make recommendations despite this stringent target.

Recent Trends in Health Care Costs and Quality

As the reforms described in the last section have taken effect, the United States has seen exceptionally slow growth in health care costs, as well as promising improvements in the quality of care patients receive. This progress has been seen in every part of the health care system, including both public insurance programs like Medicare and Medicaid and private coverage. While the factors driving these encouraging trends are not fully understood, there is clear evidence that the reforms introduced in the ACA, together with other actions taken by this Administration, are playing an important role. This section of the report provides a detailed description of recent trends in health care costs and quality, as well as what is known about the causes of these trends.

Recent Trends in Health Care Costs

Economists commonly focus on three distinct measures of health care costs: unit prices; per enrollee spending; and aggregate spending. Unit prices are the amounts paid for a single unit of a health care good or service, such as a physician visit, a hospital admission, or a dose of medicine. Lower unit prices, holding quality fixed, are unambiguously good for consumers because they allow consumers to purchase the same medical care for less money, leaving more money to purchase other valued goods and services.

Per enrollee spending refers to the average health care spending per person enrolled in insurance coverage and is determined by both the unit prices of health care and the average quantity of services used by enrollees. Per enrollee spending is what ultimately determines what consumers pay in the form of premiums and cost sharing. Slower growth in per enrollee spending that reflects slower growth in health care prices is unambiguously good for consumers, for the reasons described above. Slower growth in per enrollee spending that reflects slower growth in utilization of services will often benefit consumers as well, provided that slow growth is achieved without worsening the quality of care.

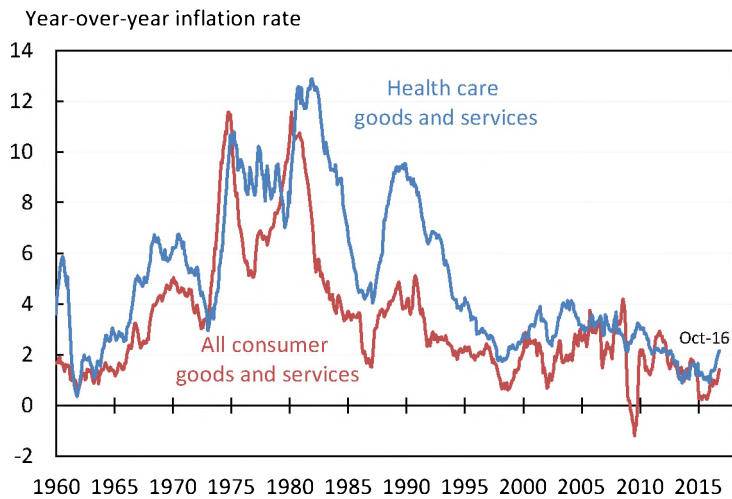
Aggregate spending refers to the total amount the country spends on health care and is influenced by both spending per individual enrolled in coverage and the number of individuals enrolled in coverage. Faster growth in aggregate spending can be a negative development if it reflects faster growth in per enrollee spending that is not justified by concomitant improvements in quality. However, it can also be a positive development if, for example, it reflects improvements in access to care due to expanded health insurance coverage. Aggregate spending is not directly relevant to consumers.

Recent trends in each of these measures are examined below.

Health Care Prices

The period since the ACA became law has seen exceptionally slow growth in health care prices, as depicted in Figure 28. From March 2010 through October 2016, prices of health care goods and services have risen at an annual rate of 1.7 percent, far below the 3.2-percent annual rate seen over the preceding decade and even farther below the 5.4-percent annual rate over the preceding 50 years.²² In fact, the rate of health care price inflation since the ACA became law has been slower than over any prior period of comparable length since these data began in 1959.

Figure 28: Health Care Price Inflation vs. Overall Inflation

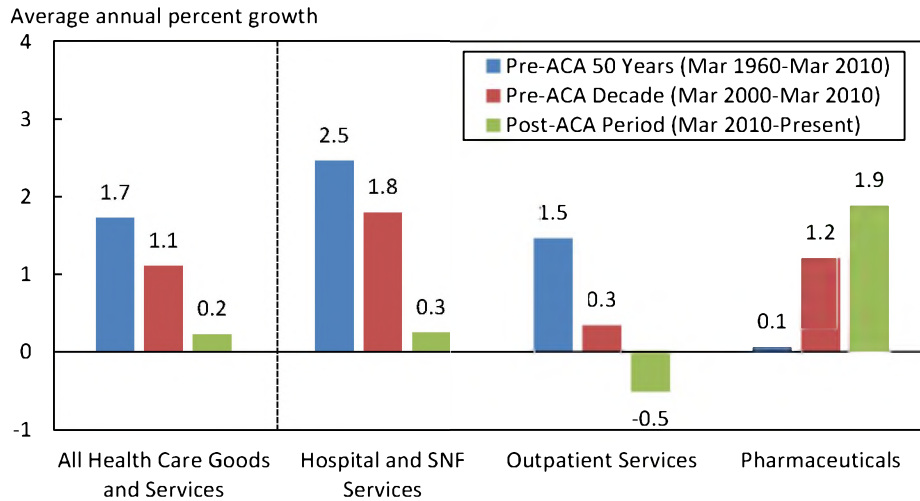


Source: National Income and Product Accounts; CEA calculations.

The slow growth in health care prices in recent years is not merely a reflection of slow inflation throughout the economy. Rather, the rate of increase in health care prices has been unusually low *relative* to the rate of increase in prices overall. Indeed, as depicted in Figure 29, the rate of increase in health care prices has exceeded the rate of overall inflation by just 0.2 percentage point since the ACA became law, whereas the rate of increase in health care prices exceeded overall inflation by 1 percentage point or more in both the recent and longer-term past.

²² The price index for health care goods and services reported here was derived from Personal Consumption (PCE) Expenditures data produced by the Bureau of Economic Analysis. Price indices for the outpatient services, hospital and nursing home services, pharmaceutical products, other medical products, therapeutic appliances and equipment, and net health insurance categories were combined to construct a Fisher index for the aggregate. The Bureau of Labor Statistics also reports data on health care prices as part of the Consumer Price Index (CPI). This chapter relies on the PCE price indices because they endeavor to measure trends in health care prices throughout the economy, whereas the CPI encompasses a more limited set of transactions. Both series, however, show broadly similar trends in health care prices.

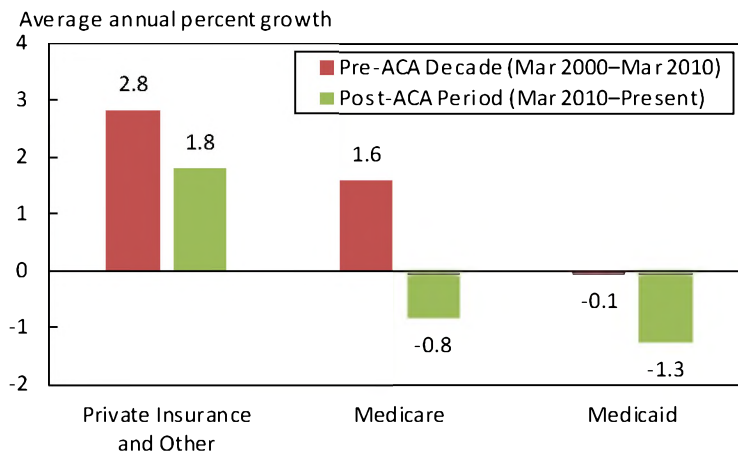
Figure 29: Trends in Real Health Care Prices, by Service



Source: National Income and Product Accounts; CEA calculations.

Health care prices have grown slowly in both of the two largest categories of health care spending: hospital and skilled nursing facility (SNF) services and outpatient services. Real prices for outpatient services have actually *fallen* during the post-ACA period, while real prices for hospital and SNF services have barely risen. The one important exception to this pattern is pharmaceutical prices, which have grown somewhat faster post-ACA than they have historically. For most categories of services, data limitations make it challenging to separately examine the prices paid by private insurance, Medicare, and Medicaid. One important exception, however, is services provided by general medical and surgical hospitals, which deliver the overwhelming majority of hospital services and account for around a third of total health care spending. As depicted in Figure 30, growth in prices paid to these hospitals has been sharply lower during the post-ACA period for all three payer categories, with a particularly large slowdown for services provided to Medicare beneficiaries.

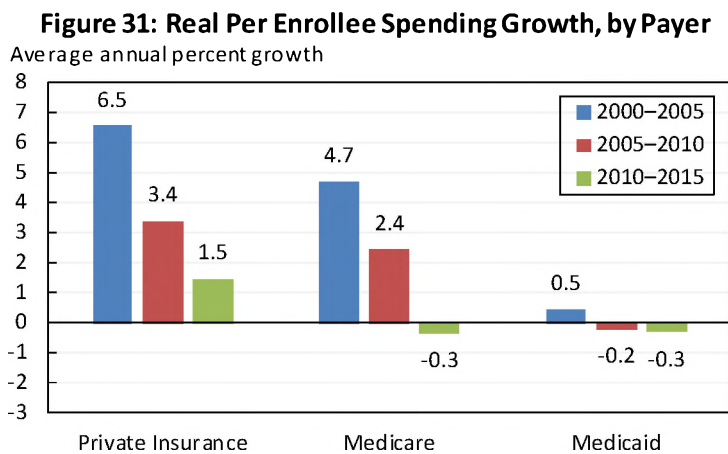
Figure 30: Trends in Real Prices for General Medical and Surgical Hospitals, by Payer



Source: Producer Price Indices; CEA calculations.

Per Enrollee Health Care Spending

The period since the ACA became law has also seen exceptionally slow growth in overall per enrollee health care spending, as illustrated in Figure 31.²³ Real per enrollee spending in private insurance has risen at an average rate of just 1.5 percent per year during the post-ACA period, well below the pace recorded over either the five-year period that immediately preceded the ACA or the five-year period before that. Medicare spending has followed a similar pattern, with real Medicare spending per enrollee actually falling at an average annual rate of 0.3 percent per year during the post-ACA period. (Per enrollee spending growth in Medicaid has also fallen during the post-ACA period, but these trends are harder to interpret due to significant changes in the types of individuals enrolled in Medicaid during both the pre-ACA and post-ACA periods.)



Source: National Health Expenditure Accounts; National Income and Product Accounts; CEA calculations.

Note: Medicare growth rate for 2005–2010 was calculated using the growth rate of non-drug Medicare spending in place of the growth rate of total Medicare spending for 2006 to exclude effects of the creation of Medicare Part D. Inflation adjustments use the GDP price index.

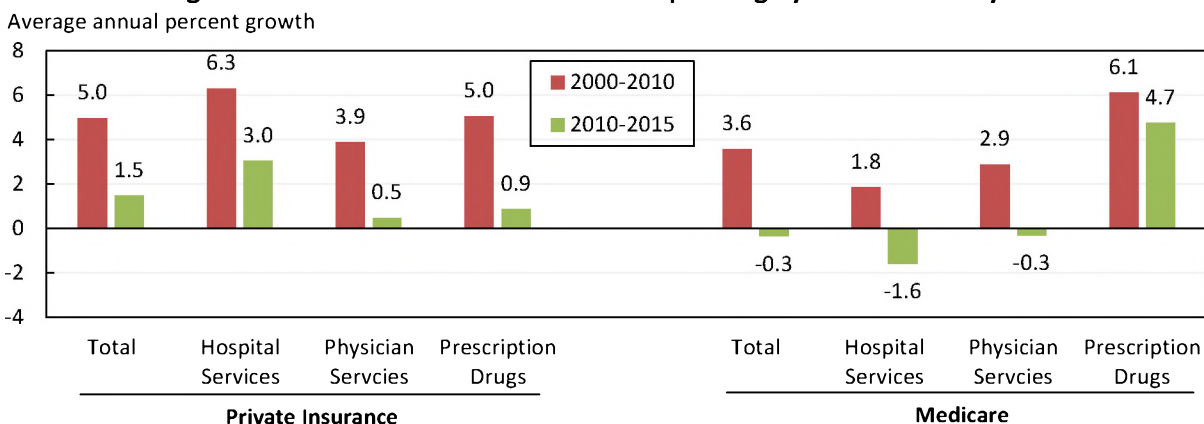
Per enrollee spending growth has slowed markedly across all major service categories, including hospital services, physician services, and prescription drugs, as illustrated in Figure 32. Notably, where comparable data are available, the decline in real per enrollee spending growth exceeds the decline in the growth of real health care prices described previously, indicating that much of the decline in per enrollee spending growth reflects slower growth in the utilization of health care services. For example, the average growth rate of real per enrollee private insurance spending on hospital services has been 3.3 percentage points lower in the post-ACA period than over the pre-ACA decade, whereas the growth rate of the prices private insurers pay for hospital care has declined by only 0.8 percentage point over the same period.²⁴ Similarly, real per enrollee Medicare spending on hospital services has fallen by 3.4 percentage points from the pre-ACA

²³ The spending amounts attributed to each insurance type in the National Health Expenditure Accounts reflect only the payments made by the insurer. They do not include amounts borne by enrollees such as deductibles, coinsurance, or copayments. Including these amounts would not change the main conclusions reached here.

²⁴ This estimate of the slowdown in growth of real hospital prices differs modestly from what is reported in Figure 28. This is because, to align with the estimates reported in Figure 31, this calculation reflects the 2010–2015 period rather than the March 2010–March 2016 time period and uses the GDP price index, rather than the PCE price index, to adjust for inflation.

decade to the post-ACA period, while the growth rate of the real prices Medicare pays for hospital services has declined by only 2.5 percentage points.

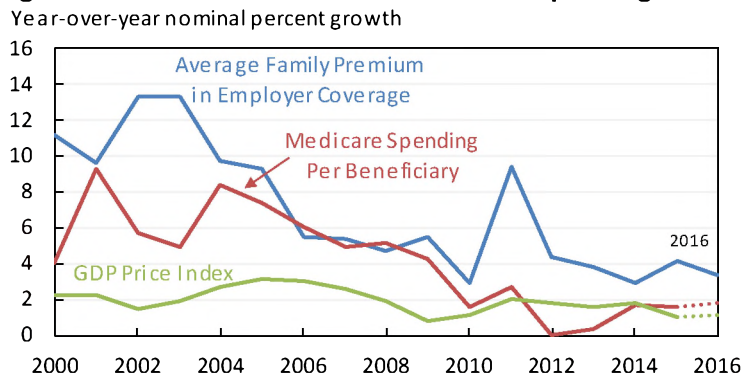
Figure 32: Real Per Enrollee Health Care Spending by Service and Payer



Source: National Health Expenditure Accounts; National Income and Product Accounts; CEA calculations.
 Note: To exclude effects of the creation of Medicare Part D, the average growth rate of Medicare spending for 2000-2010 was calculated using the growth rate of non-drug Medicare spending in place of the growth rate of total Medicare spending for 2006. Similarly, the average growth for Medicare prescription drug spending reflects 2006-2010 rather than 2000-2010.

Figures 31 and 32 extend only through 2015 because they rely upon data from the National Health Expenditure Accounts, which only report annual data. However, timely indicators of per enrollee health care spending indicate that spending growth has remained low into 2016, as illustrated in Figure 33. CEA analysis of data on Medicare spending published by the U.S. Department of the Treasury indicates that growth in Medicare spending per beneficiary for the first 10 months of 2016 was roughly in line with 2015 and well below longer-term historical experience. Similarly, data from the annual Employer Health Benefits Survey conducted by the Kaiser Family Foundation and Health Research and Educational Trust's (KFF/HRET) indicate that growth in employer premiums remained near its post-2010 lows in 2016.

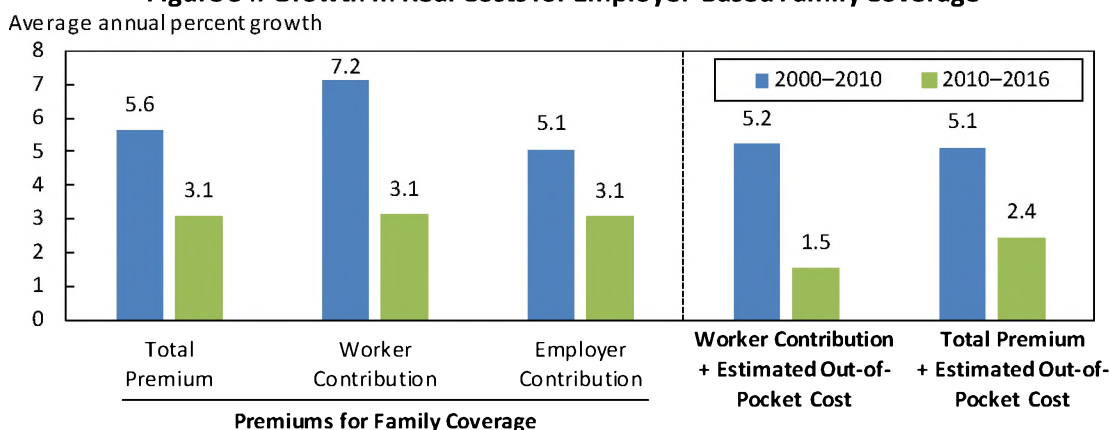
Figure 33: Nominal Per Enrollee Health Care Spending Growth



Source: KFF/HRET Employer Health Benefits Survey; National Health Expenditure Accounts; Monthly & Daily Treasury Statements; National Income and Product Accounts; CEA calculations.
 Note: Medicare estimates through 2015 are from the National Health Expenditure Accounts; the Medicare growth rate for 2006 reflects only non-drug spending to exclude effects of the creation of Medicare Part D. The Medicare estimate for 2016 reflects CEA analysis of Treasury data and covers the first ten months of the year. GDP price index for 2016 is a CBO projection.

Trends in employer coverage merit particularly detailed attention since well more than half of non-elderly Americans get coverage through an employer. As illustrated in Figure 34, slow growth in underlying medical costs has translated into slow growth in the premiums of employer plans, with real premium growth dropping from an average annual rate of 5.6 percent in the pre-ACA period to an average annual rate of 3.1 percent since the ACA became law. Notably, growth in the portion of the premium paid directly by the worker has fallen by more than growth in the total premium. While economists generally believe that the total premium is the more relevant measure of the overall premium burden because workers ultimately pay for the employer’s contribution to premiums indirectly through lower wages, workers’ direct contributions may be particularly salient to individuals.

Figure 34: Growth in Real Costs for Employer-Based Family Coverage



Source: KFF/HRET Employer health Benefits Survey; Medical Expenditure Panel Survey, Household Component; CEA calculations.
 Note: Out-of-pocket costs were estimated by first using the Medical Expenditure Panel Survey to estimate the out-of-pocket share in employer coverage for 2000-2014 and then applying that amount to the premium for each year to infer out-of-pocket spending. The out-of-pocket share for 2015 and 2016 was assumed to match 2014. Inflation adjustments use the GDP price index. GDP price index for 2016 is a CBO projection.

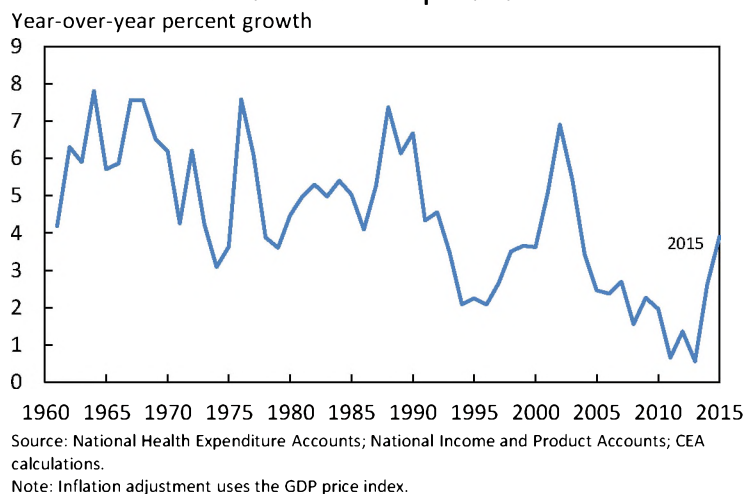
In principle, trends in premiums could be a misleading indicator of the overall trend in the health costs for individuals with employer coverage if the share of spending that enrollees bear in the form of out-of-pocket costs like coinsurance, copayments, and deductibles is changing over time. As discussed in greater detail in the next subsection of this report, there is no evidence that out-of-pocket spending obligations have risen more quickly during the post-ACA period than the preceding years. Indeed, the rightmost columns of Figure 34 combine the KFF/HRET data on premiums with data on the out-of-pocket share in employer coverage from the Medical Expenditure Panel Survey’s Household Component. If anything, accounting for out-of-pocket costs makes the decline in cost growth for individuals enrolled in employer coverage look slightly larger. While the extent to which incorporating data on out-of-pocket costs magnifies the slowdown in cost growth in employer coverage is somewhat sensitive to which data source is used to measure out-of-pocket costs, the core finding appears relatively robust.

Aggregate Health Care Spending

Driven by the very slow growth in per enrollee health care spending documented above, the years immediately after 2010 saw exceptionally slow growth in aggregate national health

expenditures, with 2011, 2012, and 2013 seeing the slowest growth rates in real per capita national health expenditures on record, as shown in Figure 35. Growth in aggregate national health expenditures increased in 2014 and 2015, driven in large part by the historic expansion in health insurance coverage that began in 2014.

Figure 35: Growth in Real Per Capita National Health Expenditures



Indeed, Holahan and McMorro (2015) estimate that the expansion in insurance coverage added between 1.4 percentage points and 2.1 percentage points to the growth of national health expenditures in 2014. This implies that, absent the expansion in coverage, 2014 would have been another year of historically slow growth in aggregate health care spending, falling somewhere between the slowest and third-slowest year on record. The coverage gains that occurred during 2015 were almost as large as those occurring during 2014, and some of the upward pressure on spending growth from coverage gains during 2014 may have appeared during 2015, so expanding coverage likely placed a similar degree of upward pressure on aggregate spending growth in 2015. Without this upward pressure, real per capita spending growth would have been around 2 percent in 2015, also near the bottom of historical experience.

Furthermore, as noted earlier, faster growth in aggregate health care spending due to expanding coverage is not a cause for concern. Faster aggregate spending growth is the expected consequence of the major improvements in access to care that have occurred as coverage has expanded and does not indicate that costs are rising more quickly for individuals who are already covered. Moreover, faster growth in aggregate spending due to expanding coverage will be temporary, continuing only until insurance coverage stabilizes at its new higher level. Consistent with that expectation, more timely data on health care spending from the Bureau of Economic Analysis suggest that aggregate health care spending growth has begun to moderate in recent months as the pace of coverage gains has slowed.

Understanding the Recent Slow Growth in Health Care Costs

An important question is what has caused the very slow growth in health care costs under the ACA. Broader economic and demographic trends do not provide a satisfactory explanation for recent trends. The Great Recession cannot explain the slow growth in Medicare spending, nor can it explain why spending growth in the private sector remains so low years after the end of the recession. Similarly, demographic changes can explain only a small portion of the slowdown in per enrollee health care spending and actually make the slowdown in aggregate health care spending growth look slightly larger.

This evidence implies that recent trends in health care spending primarily reflect developments internal to the health care sector. Changes in the cost sharing obligations borne by individuals do not appear to explain recent trends, suggesting that the main factor has been changes in the health care delivery system. Within the delivery system, there are likely a number of factors playing a role, but the ACA's changes to provider payment have made a large, readily quantifiable contribution, and there is reason to believe that the ACA's effects on recent trends may go beyond what can be easily quantified today.

Each of these factors is discussed in greater detail below.

The Great Recession and Its Aftermath

Some analysts have pointed to the economic disruptions caused by the Great Recession as a possible explanation for the slow growth in health care costs under the ACA. However, this explanation does not fit the available data. Most fundamentally, the Great Recession does not appear to be able to explain any meaningful portion of the slow growth in Medicare spending in recent years. In addition, while it appears that the Great Recession did dampen private sector spending growth in the years during and immediately after the downturn, it is doubtful that the recession and its aftermath can explain why spending growth has remained low all the way through the present, more than seven years after the recession's end.

The fact that health care spending growth has grown slowly in Medicare, not just private insurance, is the clearest evidence that recent health care spending trends reflect much more than just the Great Recession and its aftermath. Medicare beneficiaries are generally not employed and only around a fifth live in families that get more than half of their income from earnings, so they are relatively insulated from developments in the labor market. Likewise, only around a quarter of Medicare beneficiaries have asset income in excess of \$1,000 annually, suggesting that the typical beneficiary is relatively insulated from financial market developments as well.²⁵

Empirical evidence strongly supports the view that the Great Recession had little effect on trends in Medicare spending. Historically, weaker macroeconomic performance has not been associated with lower growth in Medicare spending per beneficiary, either at the national level or when

²⁵ These estimates reflect CEA analysis of the Current Population Survey Annual Social and Economic Supplement data covering 2015.

comparing across states experiencing stronger and weaker macroeconomic performance at a given point in time (Levine and Buntin 2013; Chandra, Holmes, and Skinner 2013; Sheiner 2014). Similarly, Dranove, Garthwaite, and Ody (2015) directly compare Medicare spending growth in areas of the country that experienced larger and smaller reductions in employment during the Great Recession. They conclude that the recession had only small effects on Medicare spending growth.

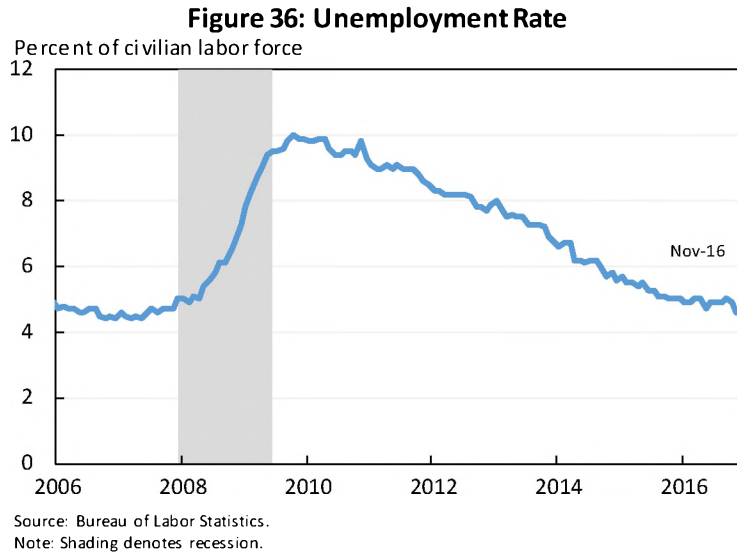
It is more plausible that the Great Recession could have affected health care spending among people under age 65. Non-elderly Americans generally depend on the labor market for their livelihoods, and those who have health insurance overwhelmingly receive coverage through an employer, as illustrated in Figure 3. As a result, there are many mechanisms through which the Great Recession could have affected the health care spending of people under age 65.

Most directly, an economic downturn could cause some individuals to become uninsured. For example, reduced employment could reduce access to employer coverage, and increased financial stress could cause families to conclude that premiums are unaffordable. Alternatively, financial pressure could cause employers to stop offering coverage or charge higher premiums. The uninsured rate among non-elderly adults did indeed increase sharply during and immediately after the Great Recession, as depicted in Figure 5. Because the uninsured are much less likely to access health care, as discussed earlier in this report, this development likely exerted downward pressure on aggregate health care spending growth during this period. However, the uninsured rate for non-elderly individuals peaked by 2010, so increases in the number of uninsured cannot explain why health care spending growth has remained low since that time. Furthermore, reductions in the number of people with coverage through an employer cannot explain why per enrollee health care spending, not just aggregate health care spending, has grown so slowly.

There are, however, mechanisms by which an economic downturn might affect spending by individuals who remain insured. Financial stress could cause individuals to de-prioritize spending on health care or cause employers to modify the coverage they offer in ways that reduce health care spending, such as by increasing cost sharing. Whatever the mechanism, there is empirical evidence that the Great Recession reduced the growth of per enrollee health care spending in employer coverage in its immediate aftermath. Ryu et al. (2013) find that the recession increased cost sharing in employer coverage and estimate that those increases subtracted around 1 percentage point per year from the growth of per enrollee health care spending in employer coverage in both 2010 and 2011, with smaller reductions in earlier years. Similarly, Dranove, Garthwaite, and Ody (2014) compare growth in per enrollee spending in employer coverage in metropolitan statistical areas that experienced larger and smaller reductions in employment during the Great Recession. They conclude that the Great Recession subtracted an average of 1.8 percentage points per year from growth in per enrollee spending in employer coverage in 2010 and 2011.

While this evidence demonstrates that the Great Recession exerted downward pressure on growth in private insurance spending in the years around 2010, it is doubtful that it can explain why per enrollee spending growth in private coverage has remained low through the present, as

was illustrated in Figure 33. Research comparing health care spending growth in states experiencing weaker and stronger economic performance at a given point in time has generally concluded that, to the extent economic downturns affect health care spending growth at all, those effects fade almost completely within a few years (Chandra, Holmes, and Skinner 2013; Sheiner 2014). Because the labor market reached its trough by early 2010 and has recovered steadily since then, as illustrated in Figure 36, this evidence would suggest that the recession can play only a limited role in explaining why private health care spending growth has been so slow during the post-ACA period, particularly over the last few years.



One potential shortcoming of using cross-state comparisons to estimate the relationship between macroeconomic conditions and private health insurance spending is that these types of analyses cannot capture effects of economic downturns that operate at the national level, rather than state or local level. It is possible that these types of national effects might persist for a longer period of time. In an effort to capture these national effects, some researchers have examined the correlation between economic growth and growth in private health insurance spending at the national level over time.

Taken at face value, results from these “time series” analyses suggest that economic growth has large effects on private health insurance spending that emerge with a four- or five-year lag (Chandra, Holmes, and Skinner 2013; Sheiner 2014). However, analyses of this type have important methodological weaknesses. Unlike analyses that compare outcomes across different geographic areas at the same point in time, time series analyses cannot control for unobserved factors that might cause health care spending to change over time. As a result, these approaches are at much greater risk of mistaking changes in private health insurance spending growth that *coincided with* an economic downturn for change in private health insurance spending growth that were *caused by* an economic downturn.

Moreover, it is unclear whether the results from these analyses are economically plausible. In particular, the most plausible way an economic downturn could generate long-lasting effects on health care spending growth is by changing the development and diffusion of medical technology. However, as noted by Sheiner (2014), four to five years may be too soon for a downturn to have meaningful effects on the path of medical technology, given the long duration of the research and development process. Furthermore, if economic downturns change the path of medical technology in the medium term, that should affect spending growth in Medicare in addition to private insurance. However, there is little evidence that economic downturns affect spending growth in Medicare at any time horizon.

Demographic Changes

Demographic changes are another factor outside the health care system that could affect health care spending trends. As illustrated in Figure 37, the United States population is currently aging. Because age is an important determinant of health care spending, differences in how the age distribution is changing at different points in time can cause differences in health care spending growth over time.

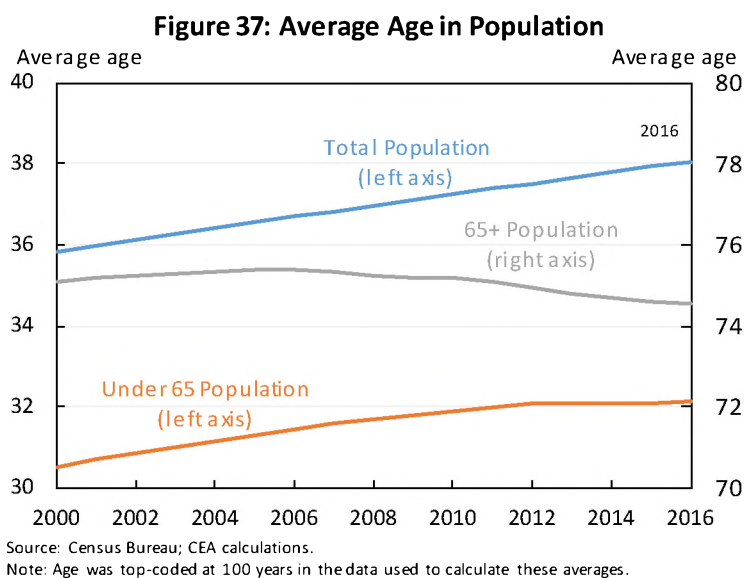
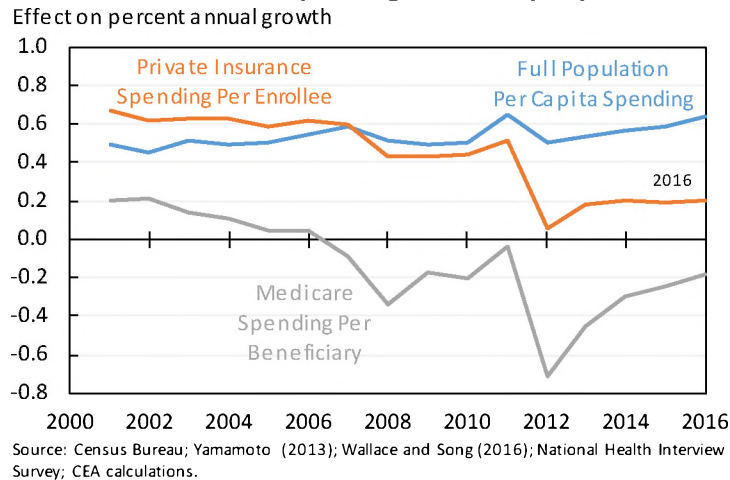


Figure 38 reports estimates of how health care spending would have changed in recent years based solely on changes in the age and sex distribution, holding fixed both spending and coverage patterns.²⁶ Consistent with the steady increase in the average age of the full population depicted

²⁶ The first step in producing these estimates was to allocate the population across private coverage, public coverage, and uninsurance in each year, holding the age-specific propensity to be enrolled in each type of coverage fixed, but allowing population demographics to change over time. Age-specific enrollment propensities for private insurance, public coverage, and uninsurance were set at the 2000-2015 average for each age, as estimated using the National Health Interview Survey for those years. Data on the population by age and sex in each year were obtained from various Census Bureau population estimates and projections.

in Figure 37, demographic changes have consistently added to aggregate health care spending growth in recent years. Over the decade preceding the ACA, these demographic factors added an average of 0.5 percentage point per year to growth of per capita health care spending in the full population. Those effects have been slightly larger in the years following passage of the ACA, averaging around 0.6 percentage point per year from 2010 through 2016. Thus, at the level of the population as a whole, demographic changes cannot explain why growth has slowed.

Figure 38: Effects of Changes in the Age Distribution on Health Care Spending Growth, by Payer



On the other hand, demographic changes can explain a small portion of the slowdown in the growth of per enrollee spending in private insurance and Medicare. As illustrated in Figure 37, the aging of the baby boomers drove a steady increase in the average age of the under 65 population during the decade that preceded the ACA, which essentially stopped when the first cohort of baby boomers reached age 65 in 2012. At that time, demographic factors abruptly began placing less upward pressure on per enrollee spending growth in private insurance, as illustrated in Figure 38. Whereas demographic changes added an average of 0.6 percentage point per year to private spending growth from 2000 through 2010, they have added an average of just 0.2 percentage point per year since 2010. Thus, demographics can explain a non-zero, but small portion of the decline in private health insurance spending growth.

The second step was to obtain data on spending by age and coverage type. Yamamoto (2013) reports data on relative spending by single year of age for commercial coverage and traditional Medicare coverage. Because Yamamoto (2013) reports relative spending by age within commercial and traditional Medicare coverage, additional information is required to put the commercial and traditional Medicare spending curves on the same absolute scale. To do so, CEA relied upon an estimate from Wallace and Song (2016) that spending falls by 34 percent, on average, for individuals converting from commercial coverage to traditional Medicare at age 65. The commercial age curve was used for all individuals with private coverage, while the traditional Medicare age curve was used for all Medicare enrollees. For individuals under age 65 with public coverage, spending was assumed to reflect the commercial age curve scaled down by 20 percent. For individuals under age 65 who were uninsured, spending was assumed to reflect the commercial age curve scaled down by 50 percent. The results are not particularly sensitive to the approach used for these groups.

Demographic changes have had a related effect in Medicare. As the early cohorts of baby boomers have turned 65, the average age among individuals 65 and older has declined, placing significant downward pressure on growth in Medicare spending per beneficiary. As reported in Figure 38, after having had little net effect on per beneficiary Medicare spending growth over the decade preceding the ACA, demographic changes have subtracted around 0.3 percentage point per year during the post-ACA period. As with the effects reported above, this effect is not trivial but still relatively small in relation to the overall slowdown in the growth of Medicare spending.

Changes in Enrollee Cost Sharing

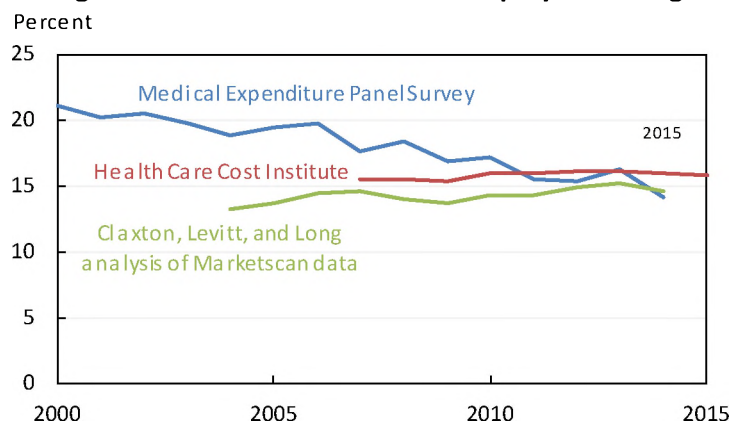
Changes in cost sharing obligations, such as coinsurance, copayments, and deductibles, are another possible explanation for the slower growth in health care spending since the ACA became law. It is well-established that higher cost sharing causes individuals to use less care (for example, Newhouse et al. 1993), so if cost sharing obligations had grown more rapidly during the post-ACA period than during the pre-ACA period, this could account for slower growth in health spending after the ACA's passage. In fact, there is no evidence that this has occurred.

Focusing first on individuals who get coverage through an employer, Figure 39 plots out-of-pocket spending as a share of total spending in employer coverage over time derived from three different data sets: the Household Component of the Medical Expenditure Panel Survey (MEPS) and two different databases of health insurance claims.²⁷ The MEPS estimates suggest that the out-of-pocket share has been declining steadily since at least 2000 with, if anything, a faster pace of decline after 2010 than before 2010. The estimates from the two claims databases suggest that the out-of-pocket share has been relatively flat, with small increases in the out-of-pocket share in the years before 2010 and little net change after 2010. Thus, there is no evidence that cost sharing obligations have grown more quickly after 2010 and, therefore, no evidence that faster growth in cost sharing can explain slower growth in health care spending over this period. If anything, these data suggest that cost sharing trends may have worked slightly *against* the slowdown in health care spending growth observed in recent years.²⁸

²⁷ Each of these data series has strengths and weaknesses. The MEPS is nationally representative, whereas the claims databases are not. On the other hand, the claims databases offer larger sample sizes. They also offer more accurate information on each individual transaction since they contain the actual transaction records.

²⁸ This conclusion is even stronger if consumers' decisions on whether to access care depend on the *dollar amounts* they pay when they access care rather than the *share of total spending* they pay. The absolute dollar amount of cost sharing has grown more slowly in the post-ACA period than the pre-ACA period due to the combination of sharply lower overall spending growth and the relatively steady trend in the out-of-pocket share.

Figure 39: Out-of-Pocket Share in Employer Coverage

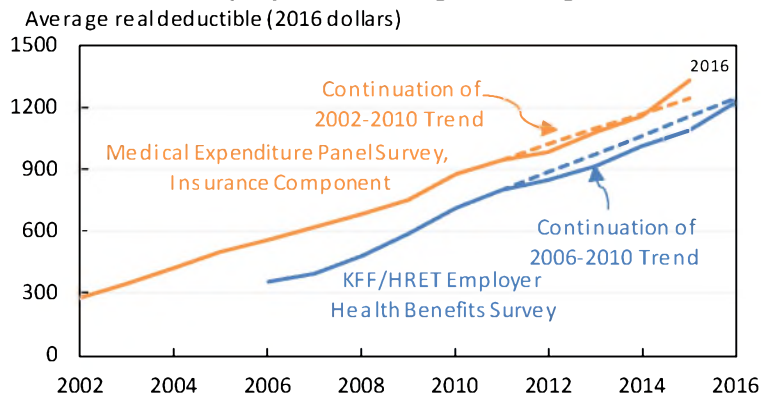


Source: Medical Expenditure Panel Survey, Household Component; Health Care Cost Institute and Herrera et al. (2013); Claxton, Levitt, and Long (2016); CEA calculations.
Note: Different vintages of the HCII series were combined by starting with the most recent series and extrapolating backwards based on percentage point changes.

The overall out-of-pocket share, reported in Figure 39, is the best metric for evaluating trends in cost sharing in employer coverage because it captures all types of cost sharing, including copayments, coinsurance, and deductibles. Focusing on individual categories of cost sharing can provide a misleading picture of the overall trend in out-of-pocket costs since different components can grow at different rates. Notably, enrollees' copayments and coinsurance obligations have grown quite slowly in recent years, while deductible spending has grown much more quickly (Claxton, Levitt, and Long 2016). This is likely in part because deductibles have simply supplanted these other types of cost sharing and in part because of the ACA's reforms requiring insurance plans to cover preventive services without cost sharing and to limit enrollees annual out-of-pocket spending, which were discussed earlier in this report.

Despite the limitations of doing so, public discussions have sometimes focused narrowly on trends in deductibles to the exclusion of other out-of-pocket costs. Even looking solely at deductibles, however, provides little support for the view that recent years' slow growth in health care spending can be explained in part by faster growth in cost sharing. Average deductibles in employer coverage have indeed risen steadily in recent years, as illustrated in Figure 40. However, the pace of this increase since 2010 has been similar to the increase prior to 2010, meaning it can do little to explain why growth in overall health spending has been slower during the post-ACA period than it was prior to the ACA.

Figure 40: Average Real Deductible in Employer-Based Single Coverage



Source: Medical Expenditure Panel Survey, Insurance Component; KFF/HRET Employer Health Benefits Survey; National Income and Product Accounts; CEA calculations.
 Note: Inflation adjustments use the GDP price index, including a CBO projection for 2016.

There is also little evidence that changes in cost sharing are an important explanation for the slow cost growth in types of coverage other than employer coverage. The largest change in Medicare’s benefit design in recent years was the creation of Medicare Part D in 2006. Creation of Medicare Part D did drive temporarily faster growth in drug spending by Medicare beneficiaries; however, the estimates of trends in per beneficiary Medicare spending that were presented in Figures 31 through 33 already adjusted for the large increase in drug spending associated with the creation of Medicare Part D. With respect to Medicaid and CHIP, systematic data on cost sharing obligations are not available, but both programs have historically included negligible beneficiary cost sharing, and there is no reason to believe that this has changed in recent years. Thus, it is doubtful that changes in cost sharing play a meaningful role in explaining slower spending growth in those programs in recent years.

Non-ACA Trends in the Health Care Delivery System

The inability of factors affecting the demand for medical care—including economic and demographic trends, as well as changes in cost sharing—to explain the slow growth in health care spending under the ACA suggests that changes in the health care delivery system have played the predominant role in recent years’ slow health care spending growth. The next section discusses the important role that the ACA’s changes in medical provider payment have played in slowing health care spending growth, but the fact that health care spending had started slowing prior to the ACA’s passage, as documented in Figure 31, suggests that the ACA is not the only reason that health care spending growth has been slower during the post-ACA period than in the past. A pair of such factors is discussed below.

The slower growth under the ACA relative to the preceding decade may, in part, reflect the removal of factors that put upward pressure on spending growth during years preceding the ACA, particularly during the early 2000s. The late 1990s and early 2000s saw a number of states pass laws that restricted the ability of private insurers to use a range of so-called “managed care” strategies, strategies that appear to have contributed to slower health care spending growth

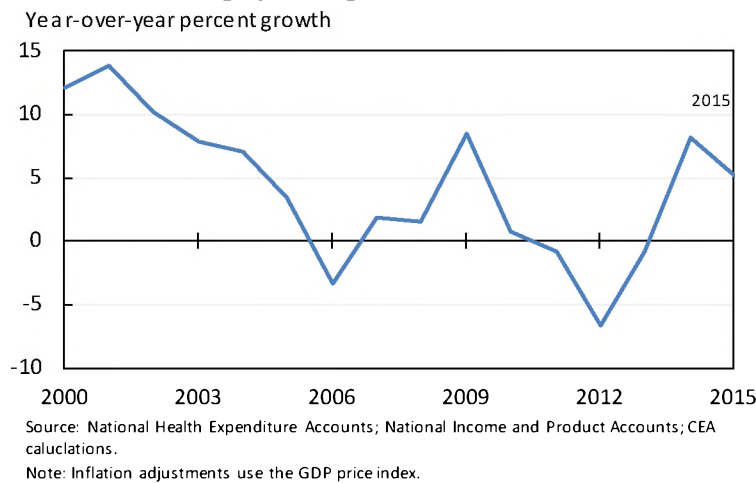
during the 1990s (Cutler, McClellan, and Newhouse 2000; Glied 2000). Recent economic research examining these state laws has concluded that they put substantial, but temporary upward pressure on health care spending in the years after they took effect (Pinkovskiy 2014). This may partially explain why health care spending growth under the ACA has been so much slower than the first half of the 2000s, though it cannot explain why spending growth has been slower under the ACA than during the second half of the 2000s.

Another possible explanation for why health care spending has grown more slowly in recent years is that the pace at which new medical technologies are being introduced has slowed. As noted earlier in this section, economists generally believe that the development of resource-intensive new medical technologies has been the main driver of the rapid growth in health care spending over the long term (Newhouse 1992; Cutler 2004). If these types of technologies are arriving at a slower pace than in the past, then that could explain why health care spending has grown at a slower pace.

The trajectory of medical technology likely can account for much of the recent swings in prescription drug spending growth. As illustrated in Figure 41, per enrollee prescription drug spending in private insurance grew very slowly in the years both immediately before and after passage of the ACA after having grown quite rapidly in the early 2000s.²⁹ Slow growth during this period appears to have resulted from a slew of patent expirations for blockbuster drugs that allowed less expensive generic versions of these drugs to enter the market, combined with a dearth of new drug introductions (Aitken, Berndt, and Cutler 2009; IMS 2013). This period of slow growth ended as a wave of costly new medications entered the market starting in 2014 (IMS 2016). Figure 41 and more-timely data from the Bureau of Economic Analysis suggest that prescription drug spending growth has begun to slow again as the effect of these new drug introductions on prescription drug spending has waned.

²⁹ Figure 41 focuses on private insurance because Medicare generally did not cover prescription drugs before 2006 and because, as noted previously, trends in per enrollee Medicaid spending are more difficult to interpret due to changes in the composition of program enrollment.

Figure 41: Real Per-Enrollee Prescription Drug Spending in Private Insurance



However, prescription drugs account for only a sixth of overall health care spending (ASPE 2016c),³⁰ and it is far from clear that changes in the trajectory of medical technology can account for the reductions in growth of other categories of health care spending that was documented in Figure 32. Chandra, Holmes, and Skinner (2013) document slower growth in utilization of certain surgical procedures in the years prior to the ACA and highlight similar evidence from Lee and Levy (2012) for certain imaging services, which they argue implies that a slower pace of technological change began restraining health care spending growth in the years prior to the ACA’s passage. But this evidence primarily reflects changes in how existing medical technologies were being used, not the pace at which new technologies are being introduced, so it is unclear that these data should be taken to reflect a change in the trajectory of medical technology, as opposed to some other change in medical practice that may have a wide variety of potential causes.

ACA Reforms to Provider Payment

As discussed above, the ACA is not the only factor that explains why health care spending has grown so much more slowly in the years since the ACA became law than in the preceding years. However, there is also clear evidence that payment reforms introduced in the ACA, plus the “spillover” effects of those reforms on the private sector, have exerted substantial, quantifiable downward pressure on health care spending growth since 2010. Furthermore, there is reason to believe that the ACA’s efforts to change the structure of provider payment have had additional effects that go beyond what can be readily quantified.

³⁰ The estimate that prescription drugs account for one-sixth of total health care spending cited here incorporates both prescription drugs sold directly to consumers and prescription drugs purchased and administered by a physician or other medical provider. The other data presented in this chapter only incorporate spending on prescription drugs sold to consumers because non-retail spending on prescription drugs is not included in the prescription drug category of the National Health Expenditure Accounts.

The most direct effect of the ACA on health care spending growth has been from the ACA's provisions to better align the rates Medicare pays to medical providers and private insurers with the actual cost of services; these provisions were described in detail earlier in this report. CBO estimates imply that these provisions have reduced the annual growth rate of Medicare spending by 1.3 percentage points from 2010 through 2016, generating a cumulative spending reduction of close to 8 percent in 2016.³¹ These provisions of the ACA, therefore, can account for around a third of the reduction in per beneficiary Medicare spending growth relative to the pre-ACA decade that was reported in Figure 32. Notably, more than half of this reduction in spending growth—or around 0.8 percentage point per year—comes from ACA provisions that reduce annual updates to various categories of medical providers to reflect productivity growth. These provisions will continue to reduce the growth rate of Medicare spending to a similar extent in the years to come.

In addition, recent research has concluded that reductions in Medicare's payment rates lead to corresponding reductions in the payment rates that private insurers are able to secure from medical providers, as discussed earlier in this report. If the magnitude of these spillover savings matches the prior literature, then the ACA's provisions reducing annual payment updates have reduced growth of private insurance spending by between 0.6 and 0.9 percentage point per year from 2010 through 2016, generating a cumulative reduction in private insurance spending of between 3 and 5 percent in 2016.³² These spillover effects on private insurance can account for half or more of the reduction in the growth of the prices private insurers pay for hospital care that was reported in Figure 30; they can explain between an eighth and a fifth of the reduction in the growth of private insurance spending per enrollee relative to the pre-ACA decade that was reported in Figure 32. Moreover, because the underlying Medicare provisions permanently reduce the growth of Medicare payment rates, these spillover effects on growth in private insurance spending would be expected to continue indefinitely as well.

While assessing the aggregate effects of the ACA's provisions to deploy alternative payment models is more challenging, early evidence is encouraging. Research examining the first three years of the Medicare Shared Savings Program, Medicare's largest ACO program, has estimated

³¹ These calculations account for the ACA's reductions to annual updates in traditional fee-for-service payment rates, reductions in Medicare Advantage benchmarks, and reductions in Medicare Disproportionate Share Hospital payments, but not other Medicare provisions included in the ACA. The magnitude of the savings from these provisions were estimated using CBO's original score of the ACA (CBO 2010c); the percentage reductions reflect CBO's March 2009 baseline projections for Medicare, which were the baseline projections used in scoring the ACA (CBO 2009). These calculations use CBO's original score of the ACA rather than its subsequent estimates of ACA repeal because those subsequent scores assume that Medicare's payment rules would not return to exactly what they would have been without the ACA if the ACA were repealed (CBO 2012a; CBO 2015a). For comparability with the other estimates included in this chapter, the CBO estimates were converted to a calendar year basis by assuming that the applicable amounts for a calendar year were three-quarters of the amount for the corresponding fiscal year and one-quarter of the amount for the subsequent fiscal year.

³² The lower bound of this range reflects the White (2013) estimate that each dollar reduction in Medicare payment rates reduces private payment rates by \$0.77, while the upper bound reflects the Clemens and Gottlieb (forthcoming) estimate that each dollar reduction in Medicare's payment rate reduces private payment rates by \$1.12.

that ACOs have reduced annual spending for aligned beneficiaries by 0 to 3 percent, with early evidence suggesting that ACOs start at the bottom of that range and move toward the top as they gain experience (McWilliams et al. 2016; McWilliams 2016). Research examining the first two years of CMMI's smaller Pioneer ACO model found savings of a broadly similar magnitude (Nyweide et al. 2015; McWilliams et al. 2015), while evidence from the first two years of CMMI's Bundled Payments for Care Improvement initiative, CMMI's largest bundled payment program, found savings of around 4 percent of episode spending among participating hospitals relative to non-participating hospitals (Dummit et al. 2016).

These results are encouraging, but they also suggest that APMs have generated only modest direct savings to the Medicare program to date. Importantly, the estimates reported above reflect the gross reduction in Medicare spending under the APMs, before accounting for performance payments made to providers. These performance payments have offset much of the gross savings reported above, at least in the Medicare Shared Savings Program (McWilliams 2016). In addition, while APMs have spread rapidly in the Medicare program since 2010, they still account for a minority of Medicare payments, so the savings estimates reported above apply to only a portion of program spending.

While the direct savings to the Medicare program may be relatively modest so far, these initiatives may be generating more substantial savings in the rest of the health care system. As discussed earlier in this report, research has suggested that providers use a common "practice style" with all of their patients, causing payment interventions implemented by one payer to generate savings for other payers whose enrollees see the same providers. If that evidence applies in this case, then Medicare's APM initiatives are already generating meaningful savings for private payers. Notably, unlike the savings that APM participants generate for Medicare, spillover savings are not offset by performance payments to providers. For this reason, it is conceivable that Medicare's APM initiatives have generated larger net savings for private payers than for the Medicare program itself so far.

In addition, as noted earlier in this report, private payers appear to have been making efforts to deploy APMs in parallel with Medicare, and it is unlikely that these efforts would have occurred in the absence of efforts to deploy these models in Medicare. While there is little systematic evidence on how successful these private sector efforts have been at reducing costs, these savings could be substantial. Furthermore, as also noted earlier in this report, one long-term benefit of transitioning to APMs is fostering the development of technologies and treatment approaches that generate the most value for patients, rather than the technologies and treatment approaches that are most profitable under fee-for-service payment. While changes of this type are likely to take years or even decades to reach their full effect, if even small shifts in this direction have already occurred, it would have large implications for total health care spending because these types of shifts would affect all providers, not just those participating in APMs.

Finally, whatever has happened so far, there are several reasons to believe that the savings generated by Medicare's APM initiatives will grow over time. First, as noted above, ACOs in the

Medicare Shared Savings Program appear to achieve greater gross savings as they gain experience; similarly, research examining an earlier private ACO-like contract found that savings grew steadily as providers gained experience with the contract (Song et al. 2014). Second, the Administration has been making continual improvements in its APMs, such as by improving the methodologies used to align beneficiaries to ACOs and to set ACOs' spending benchmarks. These improvements will strengthen ACOs' ability to achieve savings and their incentives to do so. Third, program rules for many APMs are structured so that the performance payments earned for any given level of gross savings will shrink over time, generating larger net savings to Medicare even if gross savings remain constant. Fourth, as discussed previously, a larger share of Medicare dollars is expected to flow through APMs in the coming years.

Recent Trends in Health Care Quality

The reforms implemented under this Administration were designed to improve the quality of care, not just reduce health care costs. Reducing costs in ways that worsen the quality of care will often reduce the total value generated by the health care sector. By contrast, reducing costs while maintaining or improving the quality of care, which the evidence presented at the beginning of this section of this report suggested is often possible, has the potential to greatly increase the total value generated by the health care sector.

In practice, studying trends in health care quality is inherently more challenging than studying trends in health care costs. The essential information about health care costs can be captured in a few key pieces of data—the types of service used, the prices paid for those services, and the resulting total spending—and these same basic measures are applicable across all health care settings. By contrast, health care quality has many important dimensions, including a range of different aspects of patients' experiences while receiving care and myriad health outcomes. Furthermore, the most relevant dimensions vary widely from one setting to another. As a result, indicators of health care quality are unavoidably less comprehensive than indicators of health care costs. In addition, whereas health care costs are measured in dollars and so can be readily aggregated and compared across domains, different dimensions of health care quality are measured in widely varying units, which makes aggregation effectively impossible.

For both of these reasons, all-encompassing indicators of health care quality like those that exist for health care costs do not exist. However, quality measures that capture particular important dimensions of care do exist, and a few of these are discussed below. These measures indicate that recent years' slow growth in health care costs has been accompanied by important improvements in health care quality, implying that ongoing changes in health care delivery system are not just reducing health care spending, but also increasing the total value that the health care system creates. Notably, these improvements in the quality of care appear to be attributable, at least in part, to reforms introduced by the ACA.

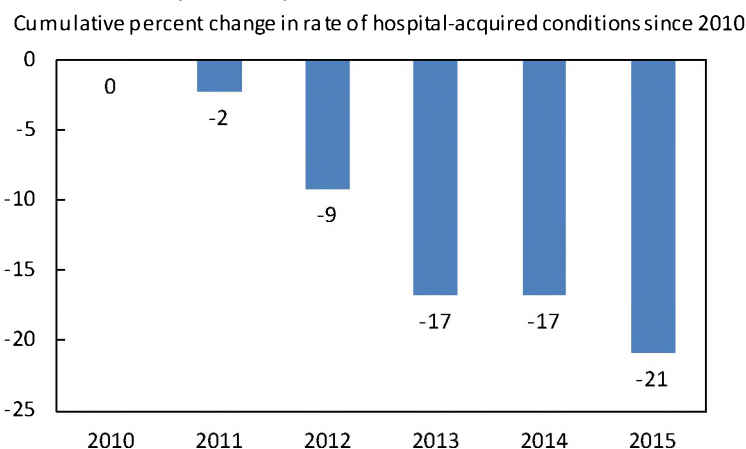
Declines in the Rate of Hospital-Acquired Conditions

One of the most comprehensive ongoing efforts to monitor health care quality on a system-wide basis is the Agency for Healthcare Research and Quality's (AHRQ) work to track the incidence of

28 different hospital-acquired conditions, including pressure ulcers, several types of infections, and complications due to medication errors, on a nationwide basis (AHRQ 2015; HHS 2016b). The AHRQ data series combines data from a variety of sources, including reviews of medical charts, administrative hospital discharge records, and hospital reports to the Centers for Disease Control and Prevention.

The AHRQ data indicate that the rate of hospital-acquired conditions has fallen significantly since this data series began in 2010, as illustrated in Figure 42. The rate of hospital-acquired conditions stood at 145 per 1,000 discharges in 2010 and had fallen to 115 per 1,000 discharges in 2015, a decline of 21 percent. Using prior research on the relationship between these hospital-acquired conditions and mortality, AHRQ estimates that the reduction in the rate of hospital-acquired conditions since 2010 corresponds to approximately 125,000 avoided deaths cumulatively from 2010 through 2015. AHRQ similarly estimates that these reductions in hospital-acquired conditions have generated cost savings of around \$28 billion through 2015.

Figure 42: Cumulative Percent Change in Rate of Hospital-Acquired Conditions Since 2010



Source: Agency for Healthcare Research and Quality; CEA calculations.

The factors that are driving the reduction in hospital-acquired conditions have been less thoroughly studied than the factors driving recent years' slow growth in health care costs, but there is reason to believe that the ACA has played an important role here as well. Two of the value-based purchasing reforms implemented under the ACA—the Hospital Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program—tie hospitals' Medicare payment rates to a range of quality measures, including rates of hospital-acquired conditions. The first year of incentive payments under these programs were based on performance during 2011 and 2013, respectively, and hospitals may also have begun adjusting their behavior even earlier. In addition, drawing on funding from CMMI, the Administration created the Partnership for Patients initiative, which set up mechanisms to help hospitals identify and share best practices for improving the quality of patient care. Hospital industry participants have reported that the Partnership was highly effective in achieving its goals (AHA/HRET 2014).

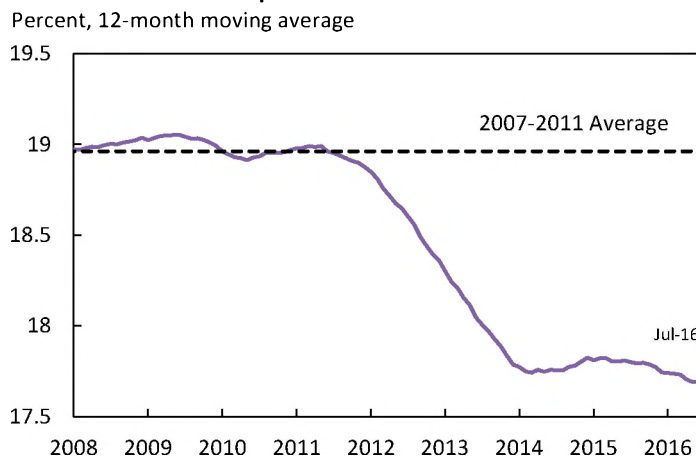
The Partnership was recently incorporated on a permanent basis into CMS' Quality Improvement Network-Quality Improvement Organization program.

Declines in the Rate of Hospital Readmissions

Another valuable indicator of health care quality is the rate of hospital readmissions, instances in which a patient returns to the hospital soon after discharge. Hospital readmissions often result from the occurrence of a serious complication after discharge, so hospital readmission rates are a useful indicator of the health outcomes patients achieve after leaving the hospital (Jencks, Williams, and Coleman 2009; Hines et al. 2014). Evidence suggests that many readmissions also reflect low-quality care during the initial hospital stay or poor planning for how a patient will receive care after discharge, which means that readmission rates are also a useful indicator of the quality of the care being provided during that initial stay (MedPAC 2007).

Hospital readmission rates have declined sharply in recent years. After several years of stability, the 30-day hospital readmission rate among Medicare patients began falling sharply starting in late 2011, as illustrated in Figure 43. This decline continued at a rapid pace through early 2014, with modest additional declines since then. The readmission rate for the 12 months that ended in July 2016 was 1.3 percentage points (7 percent) below the average rate recorded for 2007 through 2011. Cumulatively, the decline in hospital readmission rates from April 2010 through May 2015 corresponds to 565,000 avoided hospital readmissions (Zuckerman 2016).

Figure 43: Medicare 30-Day, All-Condition Hospital Readmission Rate



The ACA appears to have played a major role in reducing hospital readmission rates. The ACA's Hospital Readmissions Reduction Program (HRRP) reduces payment rates for hospitals in which a relatively large fraction of patients return to the hospital soon after discharge. Notably, the decline depicted in Figure 43 began around the time that the rules governing the payment

reductions under the HRRP were finalized in August 2011.³³ In addition, Zuckerman et al. (2016) also document that the reduction in readmission rates has been particularly large for the specific conditions targeted under the HRRP, which is also consistent with the hypothesis that the HRRP was the main driver of this decline. Alongside the changes in financial incentives created by the HRRP, the Partnership for Patients may also have helped reduce readmissions during this period by helping hospitals identify and adopt best practices for doing so.

Importantly, recent declines in hospital readmission rates reflect real reductions in patients' risk of returning to the hospital after discharge, not mere changes in how patients who return to the hospital are being classified, as some analysts have suggested (for example, Himmelstein and Woolhandler 2015). These analysts argued that some hospitals had tried to circumvent the HRRP's payment reductions by re-classifying some inpatient readmissions as outpatient observation stays. As a result, they argued, the observed decline in hospital readmissions rates substantially overstated the actual decline in patients' risk of returning to the hospital after discharge.

However, Zuckerman et al. (2016) demonstrate that no such shift to observation status has occurred. Although there has been a decade-long trend toward greater use of outpatient observation stays among patients who return to the hospital, there was no change in this trend after introduction of the HRRP, contrary to what would have been expected if the HRRP had caused inpatient readmissions to be re-classified as observations stays. Similarly, the authors find no correlation between the decline in a hospital's readmission rate and the increase in the share of a hospital's patients who experience an observation stay following discharge, which is also inconsistent with the re-classification hypothesis.

Quality Performance in Alternative Payment Models

Early evidence from evaluations of the APMs being deployed under the ACA also provides an encouraging picture of how these models will affect quality of care. The evaluation of the Medicare Shared Savings Program that was discussed in the last subsection found that ACOs improved quality of care along some dimensions, while not worsening it on others, at the same time as ACOs generated reductions in spending (McWilliams et al. 2016). Evaluations of the first two years of the Pioneer ACO model found broadly similar results: improvements on some measures of quality performance, with no evidence of adverse effects on others (McWilliams et al. 2015; Nyweide et al. 2015). Similarly, evidence from the first two years of CMMI's Bundled Payments for Care Improvement initiative, found that the savings achieved under that initiative came at no cost in terms of quality of care (Dummit et al. 2016). This evidence implies that APMs will be successful in improving the overall value of the care delivered, not just in reducing spending.

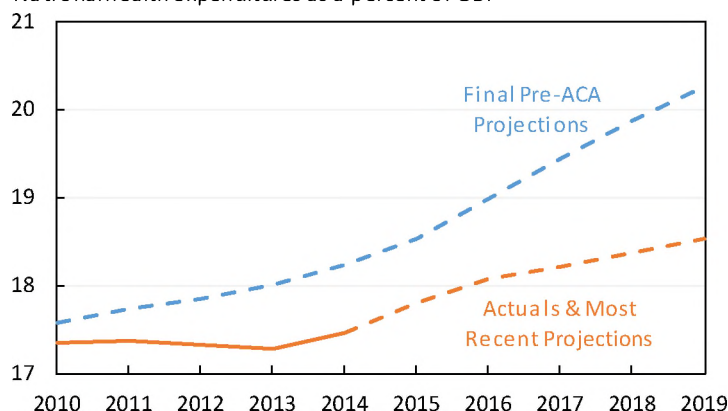
³³ While the first payment reductions under this program did not occur until October 2012, hospitals' incentives to reduce readmissions began as soon as the rules were finalized (or earlier, to the extent that hospitals anticipated the structure of the payment rules) because payment reductions are based on performance in prior years.

Economic Benefits of a Better Health Care Delivery System

Recent progress in improving the health care delivery system is already having major economic benefits. Most visibly, slower growth in the cost of health care generates large savings that are then available for other valuable purposes, raising Americans' overall standard of living. Recent shifts in projections of aggregate national health expenditures illustrate the magnitude of these savings. Relative to the projections issued just before the ACA became law, national health expenditures are now projected to be 1.7 percentage points lower as a share of GDP in 2019 than projected just before the ACA became law, as illustrated in Figure 44, despite the fact that tens of millions more Americans are now projected to have health insurance.³⁴ Over the ACA's entire first decade, national health expenditures are now projected to be \$2.6 trillion lower than projected before the ACA became law. The remainder of this subsection discusses the downstream consequences of lower health care costs, including increased employment in the short run, higher wages in both the short and long run, lower premiums and out-of-pocket costs, and an improved fiscal outlook for Federal and State governments.

Figure 44: Projected National Health Expenditures, 2010-2019

National health expenditures as a percent of GDP



Source: National Health Expenditures Accounts and Projections; CEA calculations.

Note: Pre-ACA projections have been adjusted to reflect a permanent repeal of the SGR following the methodology used by McMorrow and Holahan (2016). For consistency, actuals reflect the current estimates as of the most recently released projections.

While this subsection focuses primarily on the economic benefits of reductions in the cost of health care, it is important not to lose sight of the fact that improvements in the quality of care also have important economic benefits. Most importantly, higher-quality care ultimately allows people to live longer, healthier lives, which is immensely valuable in its own right. In addition, as noted in the discussion of the benefits of expanded insurance coverage in the first section of this report, better health also appears to improve the likelihood that individuals are able to work and increases their productivity on the job. These benefits, while not as readily quantifiable as the benefits discussed below, are also important.

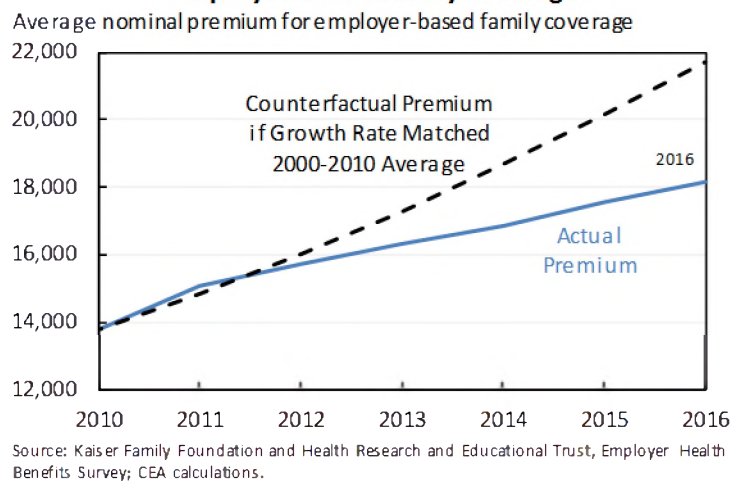
³⁴ The pre-ACA projections have been adjusted to reflect a permanent repeal of the Sustainable Growth Rate physician payment formula following the methodology used by McMorrow and Holahan (2016).

Higher Wages, Lower Premiums, and Lower Out-of-Pocket Costs for Workers

Roughly half of Americans see the benefits of a more efficient health care system in the form of lower costs for the coverage they get through an employer. Health care for individuals enrolled in employer coverage is financed through a combination of premiums and out-of-pocket costs, so when the underlying cost of health care falls, premiums and out-of-pocket costs fall as well. Reductions in out-of-pocket costs and the portion of premiums paid by employees accrue directly to workers. The remaining savings, which initially accrue to employers as lower premium contributions, ultimately benefits workers as well; economic theory and evidence demonstrate that reductions in the amounts employers pay toward premiums translate into higher wages in the long run (for example, Summers 1989; Baicker and Chandra 2006).

The slow growth in health costs under the ACA has generated substantial savings for workers. The average premium for employer-based family coverage was nearly \$3,600 lower in 2016 than it would have been if nominal premium growth since 2010 had matched the average rate recorded over the 2000 through 2010 period, as estimated using data from the KFF/HRET Employer Health Benefits Survey and illustrated in Figure 45. Incorporating data on out-of-pocket costs makes these savings considerably larger. Combining these KFF/HRET data on premiums with data on out-of-pocket costs from the Household Component of the Medical Expenditure Panel Survey using the methodology described in Figure 34 implies that the average total spending associated with an employer-based family policy is \$4,400 lower in 2016 than if trends had matched the preceding decade.³⁵

Figure 45: Average Nominal Premium for Employer-Based Family Coverage



As noted above, both economic theory and evidence imply that workers will receive the full amount of these savings in the long run. In practice, however, compensation packages take time to adjust, so it is conceivable that some of employers' savings on their portion of premiums have

³⁵ As depicted in Figure 39 and discussed in the main text, different data sources report somewhat different trends in the out-of-pocket share. However, this calculation is not very sensitive to which data source is used.

not fully translated into higher wages in the short run. To the extent that is the case, then slower growth in health care costs has had the effect of reducing employers' per-worker compensation costs in the short run, increasing their incentives to hire and potentially boosting overall employment. The empirical evidence on these effects is limited, but some studies have found evidence that slower growth in health care costs is associated with faster employment growth (Baicker and Chandra 2006; Sood, Ghosh, and Escarce 2009).

Lower Premiums and Out-of-Pocket Costs in Other Forms of Coverage

Slow growth in health care costs has also reduced premiums and out-of-pocket costs for people who get coverage outside the workplace. For example, due to recent years' slow health care cost growth, per beneficiary Medicare spending has come in well below earlier projections. As discussed in detail in the next section, this development is generating major savings for the Federal Government. However, this development is also reducing the premium and cost-sharing obligations borne by Medicare beneficiaries.

Focusing first on premiums, Medicare beneficiaries generally pay a premium to enroll in Medicare Part B, which covers outpatient services, and Medicare Part D, which covers prescription medications.³⁶ The standard Medicare Part B premium is set to cover approximately 25 percent of program costs, while the base Medicare Part D premium is set to cover 25.5 percent of the cost of a standard plan design. Consequently, when per beneficiary spending in those portions of the Medicare program falls, the Part B and Part D premiums fall roughly proportionally.

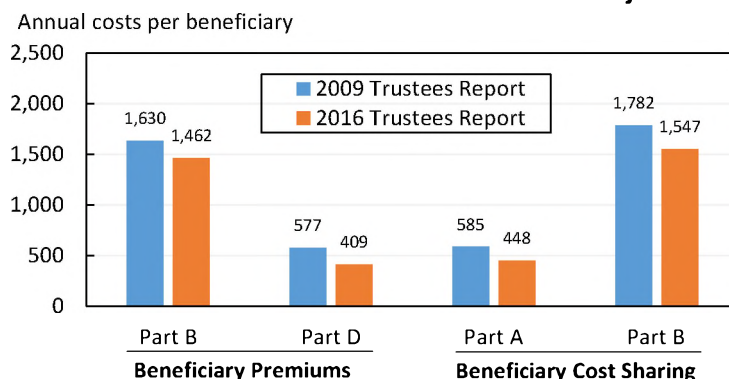
Indeed, 2016 premiums for both of these parts of Medicare are substantially below projections issued with the 2009 Trustees Report, the last report issued before the ACA became law, as illustrated in Figure 46. Whereas the standard monthly premium for Part B for 2016 was projected to be \$135.80 per month under the policies then in place, the actual 2016 Part B premium was \$121.80 per month, a reduction of 10 percent (Clemens, Lizonitz, and Murugesan 2009).^{37,38} Similarly, the base Medicare Part D premium was projected to be \$48.10 in the 2009 Trustees Report, but the actual 2016 Part D premium was \$34.10 per month, a reduction of 29 percent (Medicare Trustees 2009). For a typical beneficiary enrolled in both parts of the program, the annual premiums savings will total \$336 in 2016.

³⁶ Very few beneficiaries pay a premium to enroll in Medicare Part A (which covers inpatient hospital services and certain other services) because almost all beneficiaries are entitled to coverage based on their prior work history.

³⁷ This 2009 projection of the Part B premium cited here is from a scenario in which physician payment rates were assumed to remain fixed in nominal terms, rather than being cut sharply as prescribed under the Sustainable Growth Rate (SGR) formula then in law. Congress routinely blocked the SGR cuts, so this provides a more accurate picture of the spending trajectory under the policies in place in 2009. Projections for this alternative scenario are available in a supplemental memo published by the CMS Office of the Actuary alongside the 2009 Medicare Trustees Report (Clemens, Lizonitz, and Murugesan 2009).

³⁸ Most Medicare beneficiaries paid a lower Part B premium in 2016 because of the application of the Medicare program's "hold harmless" provision, which limits the Part B premium increases for certain beneficiaries when there is a low Social Security cost-of-living adjustment. The higher premium is used here because it is more reflective of underlying program costs. These estimates are therefore conservative.

Figure 46: Premiums and Cost Sharing for Medicare Beneficiaries Under 2009 and 2016 Trustees Projections



Source: Medicare Trustees; Centers for Medicare and Medicaid Services; CEA calculations.
 Note: Premium amounts reflect the standard Part B premium and the base Part D premium.
 The 2009 Trustees Projections were adjusted to reflect a scenario in which physician payment rates are held fixed in nominal terms, rather than being reduced sharply in accordance with the Sustainable Growth Rate formula then in law.

Medicare beneficiaries are also responsible for cost sharing when they access services. Enrollees receiving Part A services through traditional Medicare pay fixed dollar cost sharing amounts when they use specified services; these dollar amounts are updated annually based on changes in provider payment rates under Part A. For Part B, traditional Medicare enrollees are responsible for a deductible, which is updated annually based on the overall trend in Part B costs, and, once the deductible is met, 20 percent coinsurance for most services. Because of the structure of these cost sharing obligations, they vary roughly in proportion to average per beneficiary spending in these parts of the program.

The rightmost columns of Figure 46 reports estimates of the average Part A and Part B cost sharing obligations incurred by individuals enrolled in traditional Medicare under projections issued with the 2009 Trustees Report and the most recent estimates for 2016.³⁹ Cost sharing obligations through Medicare Part A in 2016 are on track to be 23 percent lower than projected in 2009 and cost sharing obligations through Medicare Part B are on track to be 13 percent lower.

³⁹ To create these estimates, projections of Medicare’s average cost of providing Part A and Part B coverage through traditional Medicare in 2016 were obtained from the 2009 and 2016 Medicare Trustees Reports, as were projections of the Part B deductible (Medicare Trustees 2009; Medicare Trustees 2016). For 2009, the estimates were then adjusted to reflect a scenario in which physician payment rates remained fixed in nominal terms, rather than being cut sharply as prescribed under the Sustainable Growth Rate formula then in law; projections for this alternative scenario were published by the CMS Office of the Actuary along with the 2009 Medicare Trustees Report (Clemens, Lizonitz, and Murugesan 2009). Congress routinely blocked the SGR cuts, so this provides a more accurate picture of the spending trajectory under the policies in place in 2009. To estimate Part A cost sharing obligations, it was then assumed that beneficiary cost sharing constituted 8 percent of the total cost of Part A services. This percentage was estimated using information included in CMS’ annual announcement of Part A cost sharing parameters; this approach slightly understates actual cost sharing obligations because it does not account for cost sharing for some small categories of services (CMS 2016c). To estimate Part B cost sharing liabilities, it was assumed that all beneficiaries use enough services to pay their full deductible and pay 20 percent coinsurance for all other services; this approach very slightly overstates actual cost sharing obligations.

Across both Parts A and B, the total estimated reduction in average cost-sharing obligations in 2016 is \$372, bringing the combined reduction in premium and cost sharing obligations to \$708.

The incidence of the cost sharing savings reported in Figure 46 will vary across beneficiaries depending on whether they have supplemental coverage in addition to their Medicare coverage that covers all or part of their cost sharing. Roughly a fifth of traditional Medicare beneficiaries have no supplemental coverage and will benefit directly from reduced cost sharing (KFF 2016). Another fifth of traditional Medicare beneficiaries purchase individual Medigap coverage and so will see a portion of the cost sharing savings through lower cost sharing and a portion through lower premiums for their Medigap plan. Around three-fifths of traditional Medicare beneficiaries receive supplemental coverage through a State Medicaid program or a former employer. In these cases, a portion of the cost sharing savings may accrue to the sponsor of that supplemental coverage, although the extent to which that occurs will depend on each individual's particular circumstances.

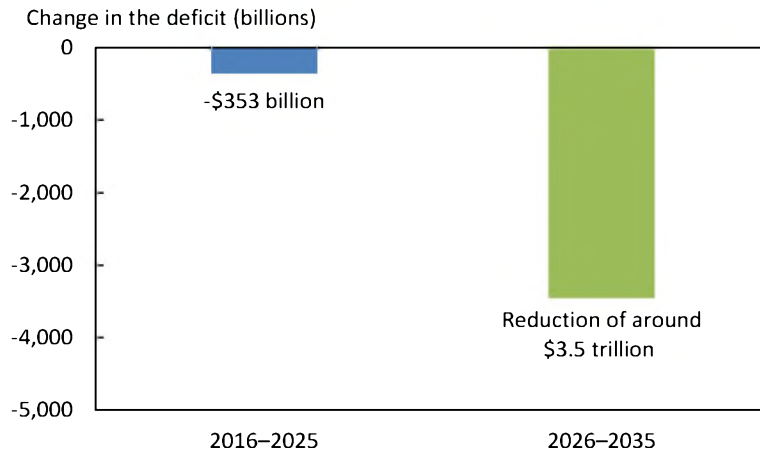
Medicare beneficiaries will see savings in scenarios beyond those considered here. Beneficiaries enrolled in Part D of Medicare are seeing substantial additional cost sharing savings due to the combination of the ACA's provisions closing the coverage gap, which were discussed earlier in this report, and lower-than-expected prescription drugs costs. Those amounts are not included here because cost sharing obligations vary among Part D plans, which makes quantifying these savings more challenging. Similarly, this analysis does not examine cost sharing obligations for Medicare Advantage enrollees because the structure of cost sharing obligations in Medicare Advantage varies from plan to plan. In general, however, lower health care costs will tend to reduce cost sharing obligations for Medicare Advantage enrollees as well.

A Better Long-Term Fiscal Outlook

Federal and State governments finance a substantial fraction of health care spending in the United States, primarily through the Medicare and Medicaid programs, so reductions in health care costs also generate major savings in the public sector. Indeed, in large part because of the ACA's provisions reducing health care spending over the long term, the law has generated major improvements in the Federal Government's fiscal outlook, as depicted in Figure 47. CBO estimates imply that the ACA will reduce deficits by more than \$300 billion over the 2016-25 period (CBO 2015a).⁴⁰ Those savings grow rapidly over time and average 1 percent of GDP—around \$3.5 trillion—over the subsequent decade.

⁴⁰ CBO (2015a) estimates how *repealing* the ACA would affect the deficit. CBO notes that the deficit increase due to ACA repeal is not exactly equal to the deficit reduction due to the ACA's enactment. Most importantly, CBO assumes that, even if the ACA were repealed, reductions in Medicare payment rates that have already been implemented under the ACA would remain in place. CBO estimates that these payment rate reductions will generate savings of \$160 billion over the 2016–2025 period. Thus, the estimates presented in Figure 47 likely understate the deficit reduction attributable to the ACA's enactment.

Figure 47: Effect of the Affordable Care Act on the Deficit



Source: Congressional Budget Office; CEA calculations.
Note: CBO reports second-decade effects as a share of GDP. Amounts are converted to dollars using GDP projections from CBO's long-term budget projections.

The slowdown in health care cost growth more broadly has led to additional large improvements in the fiscal outlook. Between August 2010 and August 2016, CBO reduced its projection of net Medicare spending under current policy in 2020 by \$125 billion or 15 percent (CBO 2010a; CBO 2016a).⁴¹ CBO has indicated that the reductions in its projections of Medicare spending in recent years largely reflect the persistent slow growth in health care costs (Elmendorf 2013). That \$125 billion reduction in projected spending constitutes 0.6 percent of CBO's current projection of 2020 GDP.

The combination of the deficit savings directly attributable to the ACA and the savings attributable to the broader slowdown in health care costs have greatly improved the United States fiscal outlook. In its most recent long-term budget projections, CBO estimated that the fiscal gap over the next 30 years—the amount of deficit reduction required to hold debt constant as a share of GDP over that period—was 1.7 percent of GDP (CBO 2016b). Without the ACA and the additional reductions in projected Medicare spending described above, the fiscal gap over this period would have been approximately 1.5 percent of GDP larger, nearly doubling the fiscal gap over that period.⁴²

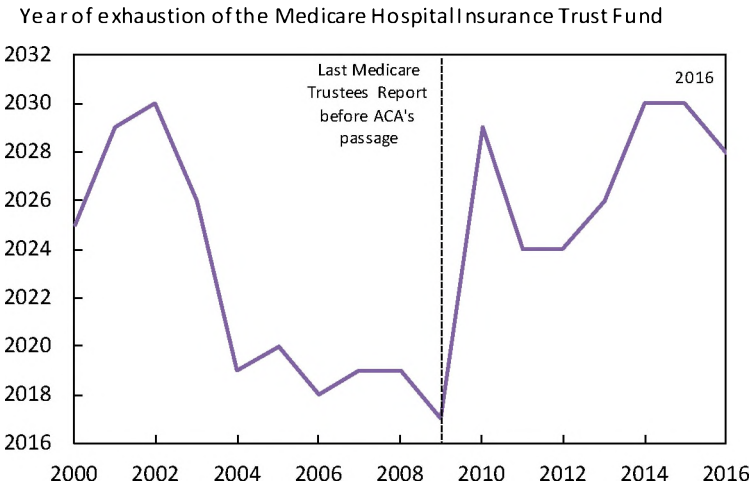
⁴¹ For the purposes of this comparison, CBO's August 2010 baseline projections were adjusted to reflect the continuation of routine fixes to the Sustainable Growth Rate formula used to set Medicare physician payment rates. This adjustment was based upon the nominal freeze scenario reported in CBO's April 2010 Sustainable Growth Rate menu (CBO 2010b).

⁴² For this calculation, the ACA's effect on the deficit was estimated based on CBO's June 2015 estimate of ACA repeal (CBO 2015a). For 2016-2025, the year-by-year deficit effects reported in the CBO estimate were used directly. For subsequent years, the ACA was assumed to reduce the deficit by 1 percent of GDP, consistent with CBO's statement that ACA repeal would increase the deficit by around 1 percent of GDP on average over the decade starting in 2026; this assumption is conservative since the ACA's deficit reducing effects are likely to continue to grow beyond the second decade. The path of deficit savings associated with the reductions in projected Medicare spending from August 2010 to August 2016 reflects the difference in the year-by-year savings through 2020. Thereafter, these savings are assumed to grow at the rate projected for net Medicare spending in CBO's most recent long-term budget

These improvements in the long-run fiscal outlook will have important benefits for the economy. Reductions in long-term deficits increase national saving, which increases capital accumulation and reduces foreign borrowing, and thereby increase national income and living standards over time. Alternatively, reduced spending on health care could obviate the need to take other steps that would damage overall economic performance and well-being, such as reducing spending on infrastructure, education, or scientific research or increasing taxes on low- and middle-income families.

The reforms included in the ACA and the broader slowdown in health care cost growth have also improved the fiscal outlook for the Medicare program. In 2009, the year before the ACA became law, Medicare’s Trustees forecast that the trust fund the Medicare Hospital Insurance Trust Fund would be exhausted in 2017. As of the Medicare Trustees most recent report, that date has been pushed back 11 years, to 2028, as depicted in Figure 48.

Figure 48: Forecasted Year of Medicare Trust Fund Exhaustion



Source: Medicare Trustees.

projections (CBO 2016b). All calculations reported here use the economic assumptions reported in those long-term budget projections.

Conclusion

The evidence presented in this report demonstrates that the United States has made historic progress in expanding health insurance coverage and reforming the health care delivery system and that those gains are due in large part to the ACA and other actions implemented under this Administration. Recent years' reforms have also succeeded in creating the tools needed to support further progress on both of these dimensions. As the President has noted, however, fully seizing that opportunity will require continued thoughtful implementation by the Executive Branch, targeted legislative improvements by Congress, and constructive engagement by states and localities (Obama 2016). Whether and how policymakers rise to that challenge will have profound implications for the health care system and, by extension, Americans' health and economic well-being in the years to come.

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 Blog

Challenges in Estimating the Number of People With Nongroup Health Insurance Coverage Under Proposals for Refundable Tax Credits

Posted by Susan Yeh Beyer and Jared Maeda on

December 20, 2016

Some policymakers have expressed interest in developing proposals to replace the current tax-based subsidies for the purchase of private health insurance in the nongroup (or individual) market under the Affordable Care Act (ACA) with refundable tax credits that would be structured differently from those under current law. Many such proposals would also eliminate or reduce the extent of current federal laws regulating the nongroup market, particularly the rules governing health insurance benefits. Two key questions for policymakers in developing such proposals are what type of insurance products would qualify for tax credits and what role states would have in making that determination.

CBO and the staff of the Joint Committee on Taxation (JCT) anticipate that insurers would respond to such legislation by offering new types of insurance products in the nongroup market, which are likely to differ from existing products in their depth and extent of health insurance benefits. If there were no clear definition of what type of insurance product people could use their tax credit to purchase, some of those insurance products would probably not provide enough financial protection against high medical costs to meet the broad definition of coverage that CBO and JCT have typically used in the past—that is, a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. (For a discussion about how CBO defines health insurance coverage, see CBO’s blog post on [how CBO defines and estimates coverage](#).)

If there were no clear definition of what type of insurance product people could use their tax credit to purchase, everyone who received the tax credit would have access to some limited set of health care services, at a minimum, but not everyone would have insurance coverage that offered financial protection against a high-cost or catastrophic medical event; CBO and JCT would not count those people with limited health benefits as having coverage. One could thus assess the effects of such proposals on insurance coverage in two different ways—how many people would obtain any type of insurance policy using the tax credit and how many people would obtain an insurance policy that meets the broad definition of coverage described above. If policymakers expressed interest in knowing the number of people who, under those proposals, would purchase private insurance in the nongroup market that met a broad definition of coverage, CBO and JCT would estimate separately the number of people who would receive the tax credits and the number of people who would obtain such coverage. In this blog post, we describe the challenges CBO and JCT would face in estimating the number of people who would purchase coverage in the nongroup market, and the scope of that coverage, under such proposals.

(Similar challenges could arise in the group market if tax credits were extended to people with employment-based coverage. However, that discussion is beyond the scope of this blog.) For context, we first provide some background about private insurance and summarize how the nongroup market is regulated under current law, including the changes that were made by the ACA. (For additional information about that market, see CBO’s report about [private health insurance premiums](#).)

- [What Features of Private Insurance Determine the Share of Medical Costs It Covers?](#)
- [How Is the Nongroup Market Regulated Under Current Law?](#)
- [What Are Some Alternative Proposals to the Current Tax-Based Subsidies to Purchase Private Insurance in the Nongroup Market?](#)
- [What Are the Challenges of Estimating the Number of People With Nongroup Coverage Under an Alternative Refundable Tax Credit Proposal?](#)

What Features of Private Insurance Determine the Share of Medical Costs It Covers?

The amount of financial protection against medical costs that private insurance covers can be described in terms of the depth and extent of coverage. (Another dimension by which private insurance coverage can vary is the size of the provider network. However, that discussion is beyond the scope of this blog post.)

The depth of coverage can be measured by examining the cost-sharing structure and any maximum benefits or limits that apply. The cost-sharing structure is the amount of out-of-pocket costs—typically in the form of deductibles, coinsurance, and copayments—that a person is required to pay when using medical services. Those out-of-pocket costs may be subject to a maximum limit (in a given year or over a lifetime) beyond which the insurer covers most or all remaining medical costs. Another limit may apply to the maximum dollar amount of medical costs that an insurer will pay for. When benefits reach their maximum allowed by the plan, the person is responsible for all remaining medical costs. In general, plans have only one of those two limits (or none at all).

The actuarial value of a health insurance plan is a summary measure of the depth of coverage for a given set of health care benefits. More specifically, the actuarial value measures the percentage of medical costs that an insurer would pay if it covered people with average health expenditures. For example, a plan with an actuarial value of 70 percent would, on average, pay 70 percent of the expected medical costs on covered benefits for a person with average health risks and patterns of use.

The extent of coverage can be measured by examining the scope of benefits—that is, the services and the types of providers whose services are covered by a health plan. Covered benefits for most plans include physicians’ and hospitals’ services and often laboratory services, radiology services, and prescription drugs. More extensive plans cover a broader range of services, such as behavioral health and substance abuse treatment and rehabilitative therapy. Less extensive plans limit the range of services covered and might exclude maternity benefits and prescription drugs.

How Is the Nongroup Market Regulated Under Current Law?

States have traditionally been responsible for regulating health insurance benefits in the nongroup market. Before enactment of the ACA, nongroup market regulations varied widely across states. In 2014, however, many federal regulations that governed the benefits that new policies sold in the nongroup market must provide went into effect as part of the ACA. The depth and extent of coverage in the nongroup market were standardized to a large degree under the ACA, which established a set of “essential health benefits” and a minimum actuarial value for insurance plans (along with a definition of that measure). In addition, plans sold in the nongroup market were no longer allowed to set maximum annual or lifetime limits on covered medical costs for the essential health benefits. The states’ role in defining the depth and extent of coverage in the nongroup market was, thus, substantially reduced after 2014.

The ACA also established several regulations that limit insurers’ ability to deny coverage to people with high expected medical costs. Three regulations, in particular, apply to such people: modified community rating rules, guaranteed issue, and requiring coverage of preexisting conditions. Modified community rating rules prohibit insurers from engaging in medical underwriting (pricing premiums on the basis of a person’s health) and limit the degree to which premiums are allowed to vary by age. Under guaranteed issue, insurers are required to sell coverage to a person regardless of his or her health. The prohibition on excluding coverage of preexisting conditions requires nongroup insurers to cover the treatment of those conditions.

What Are Some Alternative Proposals to the Current Tax-Based Subsidies to Purchase Private Insurance in the Nongroup Market?

Currently, tax credits for nongroup policies sold through the ACA marketplaces vary in relation to the premium of the second-lowest-cost “silver” plan in a market that offers the policies and in relation to certain characteristics of enrollees, including family size, income, age, and tobacco use. To qualify for tax credits under current law, a person must purchase a plan offered through a health insurance marketplace that covers 10 categories of benefits defined as essential and meets a minimum actuarial value, among other features. In addition, cost-sharing subsidies reduce the cost-sharing amounts for low-income people who select a silver plan.

Some policymakers want to replace the current tax-based subsidies to purchase private insurance in the nongroup market with alternative proposals. Under some proposals, refundable tax credits would generally be based on a fixed dollar amount and might vary by age or family size. The amount of such credits often does not depend on an enrollee’s income or a plan’s premium. A key question for federal policymakers is what types of insurance products would qualify for the tax credits. Often, such proposals would allow states to regulate the nongroup market. In that case, regulation of the nongroup market would probably vary widely from state to state. Without a federal standard, some states might not impose any regulations that would govern the depth and extent of coverage and that would define what insurance products qualify for tax credits.

What Are the Challenges of Estimating the Number of People With Nongroup Coverage Under an Alternative Refundable Tax Credit Proposal?

CBO and JCT face several challenges in estimating the number of people who would purchase private insurance coverage in the nongroup market under an alternative refundable tax credit proposal. It is difficult to predict what regulations states would impose on the nongroup market, what types of products insurers might offer given those regulations, and which types of insurance products people might purchase based on their preferences and their characteristics (such as age, income, and health).

One way to predict the types of plans that people might purchase is to look at the types of plans that existed in the nongroup market before enactment of the ACA. Before then, nongroup market regulations varied widely across states. Only a few states required guaranteed issue and implemented modified community rating rules. Although many states specified a set of services that insurers had to cover, no states regulated the depth of coverage or the amount of cost sharing. Most plans sold in the nongroup market included major medical benefits that provided comprehensive coverage for a range of services, including care by physicians and at hospitals. But certain services, such as maternity benefits and prescription drugs, were not always covered. Many of those plans also had very high deductibles and maximum annual or lifetime limits on benefits. Nevertheless, many of them would meet the broad definition of coverage that CBO and JCT have typically used in the past.

Other plans that were less commonly sold offered benefits that were even more limited. Such plans included fixed-dollar indemnity plans that paid a certain amount per day for illness or hospitalization, or plans that covered only preventive care and routine office-based physicians' services but did not cover hospitalizations. Such limited plans would generally not meet the broad definition of coverage.

Looking back at the pre-ACA nongroup market is not enough to determine what might happen under a tax credit proposal, however, because no such financial incentive to purchase health insurance existed in that market. Plans that were previously offered in that market might be offered again in the future, and new products might also be offered. In the absence of a clear definition of what type of plan qualifies for a tax credit, some plans would probably have premiums that covered minimal services and would be priced close to the amount of the tax credit. Such plans have been offered in the past in response to a similar incentive: They were used in conjunction with a tax credit related to child health that was in effect in 1992 and 1993, and the depth and extent of coverage that people purchased were often very limited.

In addition to the response by states and insurers, people at different income levels might have different preferences for the depth and extent of their insurance coverage. For example, low-income people might prefer coverage for preventive services and routine physicians' visits to keep their monthly expenses low, even if such a policy did not cover more costly services such as hospital care. High-income people might not care as much about predictable monthly expenses and might prefer catastrophic coverage to protect their assets against high medical costs.

People's preferences for insurance products might also vary with other characteristics, such as their sex or health. In states without regulations that limit insurers' ability to exclude people with high expected medical costs, however, those individuals would probably face high premiums or have access to insurance plans with only limited coverage.

In response to a future policy that had minimal federal or state regulations, CBO and JCT expect that some new insurance products would be offered that limited coverage to the amount of the tax credit. Some of those insurance products purchased by people using a tax credit would probably not offer much financial protection against high out-of-pocket costs. Depending on the size of the tax credit, however, the depth and extent of coverage and the premiums of plans could vary. As discussed in another blog post about [how CBO defines and estimates coverage](#), CBO does not count plans that have very limited benefits in measuring the extent of private insurance coverage; in such an assessment, it counts only people with a comprehensive major medical policy as having private insurance.

Under such proposals, CBO and JCT would separately estimate the number of people who would receive the tax credits and, if policymakers expressed interest in such estimates, the number of people who would purchase private insurance in the nongroup market that met a broad definition of coverage. In that case, the latter estimate of the number of people with coverage would probably be smaller than the estimate of the number of people who would receive the tax credit.

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How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums

A little more than a year ago, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimated the budgetary effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, which would repeal portions of the Affordable Care Act (ACA)—eliminating, in two steps, the law's mandate penalties and subsidies but leaving the ACA's insurance market reforms in place. At that time, CBO and JCT offered a partial assessment of how H.R. 3762 would affect health insurance coverage, but they had not estimated the changes in coverage or premiums that would result from leaving the market reforms in place while repealing the mandate penalties and subsidies.¹ This document—prepared at the request of the Senate Minority Leader, the Ranking Member of the Senate Committee on Finance, and the Ranking

Member of the Senate Committee on Health, Education, Labor, and Pensions—provides such an estimate.

In brief, CBO and JCT estimate that enacting that legislation would affect insurance coverage and premiums primarily in these ways:

- The number of people who are uninsured would increase by 18 million in the first new plan year following enactment of the bill. Later, after the elimination of the ACA's expansion of Medicaid eligibility and of subsidies for insurance purchased through the ACA marketplaces, that number would increase to 27 million, and then to 32 million in 2026.
- Premiums in the nongroup market (for individual policies purchased through the marketplaces or directly from insurers) would increase by 20 percent to 25 percent—relative to projections under current law—in the first new plan year following enactment. The increase would reach about 50 percent in the year following the elimination of the Medicaid expansion and the marketplace subsidies, and premiums would about double by 2026.

The ways in which individuals, employers, states, insurers, doctors, hospitals, and other affected parties would respond to the changes made by H.R. 3762 are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT have endeavored to

1. Congressional Budget Office, letter to the Honorable Mike Enzi regarding the budgetary effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as passed by the Senate on December 3, 2015 (December 11, 2015), www.cbo.gov/publication/51090. CBO and JCT later updated those budgetary estimates following enactment of the Consolidated Appropriations Act, 2016; see Congressional Budget Office, cost estimate for H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as passed by the Senate on December 3, 2015, and following enactment of the Consolidated Appropriations Act, 2016 (January 4, 2016), www.cbo.gov/publication/51107. The estimated effects on insurance coverage in that document did not substantially differ from those described in the letter transmitted on December 11, 2015.

develop estimates that are in the middle of the distribution of potential outcomes.

In an effort to make this information more useful, CBO and JCT have updated their estimates of H.R. 3762's effects on health insurance coverage and premiums using CBO's most recent baseline projections, which were released in March 2016, and adjusted the effective dates in the legislation to reflect an assumption that enactment would occur one year later.

The Restoring Americans' Healthcare Freedom Reconciliation Act of 2015

H.R. 3762 would make two primary sets of changes that would affect insurance coverage and premiums. First, upon enactment, the bill would eliminate penalties associated with the requirements that most people obtain health insurance (also known as the individual mandate) and that large employers offer their employees health insurance that meets specified standards (also known as the employer mandate). Second, beginning roughly two years after enactment, the bill would also eliminate the ACA's expansion of Medicaid eligibility and the subsidies available to people who purchase health insurance through a marketplace established by the ACA. H.R. 3762 also contains other provisions that would have smaller effects on coverage and premiums.

Importantly, H.R. 3762 would leave in place a number of market reforms—rules established by the ACA that govern certain health insurance markets. Insurers who sell plans either through the marketplaces or directly to consumers are required to:

- Provide specific benefits and amounts of coverage;
- Not deny coverage or vary premiums because of an enrollee's health status or limit coverage because of preexisting medical conditions; and
- Vary premiums only on the basis of age, tobacco use, and geographic location.

Analysis of H.R. 3762 Relative to CBO's March 2016 Baseline

According to CBO and JCT's analysis, upon enactment, H.R. 3762 would reduce the number of people with insurance; and in the first new plan year, premiums in the nongroup market would rise and participation by

insurers in that market would decline. Starting in the year following the elimination of the expansion of Medicaid eligibility and the marketplace subsidies, the increase in the number of uninsured people and premiums would be greater, and participation by insurers in the nongroup market would decline further.

Estimated Changes Before the Elimination of the Medicaid Expansion and Subsidies

Following enactment but before the Medicaid expansion and subsidies for insurance purchased through the marketplaces were eliminated, the effects of H.R. 3762 on insurance coverage and premiums would stem primarily from repealing the penalties associated with the individual mandate.

Effects on Insurance Coverage. CBO and JCT expect that the number of people without health insurance coverage would increase upon enactment of H.R. 3762 but that the increase would be limited initially, because insurers would have already set their premiums for the current year, and many people would have already made their enrollment decisions for the year. Subsequently, in the first full plan year following enactment, by CBO and JCT's estimates, about 18 million people would become uninsured. That increase in the uninsured population would consist of about 10 million fewer people with coverage obtained in the nongroup market, roughly 5 million fewer people with coverage under Medicaid, and about 3 million fewer people with employment-based coverage.

Most of those reductions in coverage would stem from repealing the penalties associated with the individual mandate. However, CBO and JCT also expect that insurers in some areas would leave the nongroup market in the first new plan year following enactment. They would be leaving in anticipation of further reductions in enrollment and higher average health care costs among enrollees who remained after the subsidies for insurance purchased through the marketplaces were eliminated. As a consequence, roughly 10 percent of the population would be living in an area that had no insurer participating in the nongroup market.

Effects on Premiums. According to CBO and JCT's analysis, premiums in the nongroup market would be roughly 20 percent to 25 percent higher than under current law once insurers incorporated the effects of H.R. 3762's changes into their premium pricing in the

first new plan year after enactment. The majority of that increase would stem from repealing the penalties associated with the individual mandate. Doing so would both reduce the number of people purchasing health insurance and change the mix of people with insurance—tending to cause smaller reductions in coverage among older and less healthy people with high health care costs and larger reductions among younger and healthier people with low health care costs. Thus, average health care costs among the people retaining coverage would be higher, and insurers would have to raise premiums in the nongroup market to cover those higher costs. Lower participation by insurers in the nongroup market would place further upward pressure on premiums because the market would be less competitive.

Estimated Changes After the Elimination of the Medicaid Expansion and Subsidies

The bill's effects on insurance coverage and premiums would be greater once the repeal of the Medicaid expansion and the subsidies for insurance purchased through the marketplaces took effect, roughly two years after enactment.

Effects on Insurance Coverage. By CBO and JCT's estimates, enacting H.R. 3762 would increase the number of people without health insurance coverage by about 27 million in the year following the elimination of the Medicaid expansion and marketplace subsidies and by 32 million in 2026, relative to the number of uninsured people expected under current law. (The number of people without health insurance would be smaller if, in addition to the changes in H.R. 3762, the insurance market reforms mentioned above were also repealed. In that case, the increase in the number of uninsured people would be about 21 million in the year following the elimination of the Medicaid expansion and marketplace subsidies; that figure would rise to about 23 million in 2026.)

The estimated increase of 32 million people without coverage in 2026 is the net result of roughly 23 million fewer with coverage in the nongroup market and 19 million fewer with coverage under Medicaid, partially offset by an increase of about 11 million people covered by employment-based insurance. By CBO and JCT's estimates, 59 million people under age 65 would be uninsured in 2026 (compared with 28 million under current law), representing 21 percent of people under age 65. By

2026, fewer than 2 million people would be enrolled in the nongroup market, CBO and JCT estimate.

According to the agencies' analysis, eliminating the mandate penalties and the subsidies while retaining the market reforms would destabilize the nongroup market, and the effect would worsen over time. The ACA's changes to the rules governing the nongroup health insurance market work in conjunction with the mandates and the subsidies to increase participation in the market and encourage enrollment among people of different ages and health statuses. But eliminating the penalty for not having health insurance would reduce enrollment and raise premiums in the nongroup market. Eliminating subsidies for insurance purchased through the marketplaces would have the same effects because it would result in a large price increase for many people. Not only would enrollment decline, but the people who would be most likely to remain enrolled would tend to be less healthy (and therefore more willing to pay higher premiums). Thus, average health care costs among the people retaining coverage would be higher, and insurers would have to raise premiums in the nongroup market to cover those higher costs. CBO and JCT expect that enrollment would continue to drop and premiums would continue to increase in each subsequent year.

Leaving the ACA's market reforms in place would limit insurers' ability to use strategies that were common before the ACA was enacted. For example, insurers would not be able to vary premiums to reflect an individual's health care costs or offer health insurance plans that exclude coverage of preexisting conditions, plans that do not cover certain types of benefits (such as maternity care), or plans with very high deductibles or very low actuarial value (plans paying a very low share of costs for covered services).

Effects on Participation by Insurers. In CBO and JCT's estimation, the factors exerting upward pressure on premiums and downward pressure on enrollment in the nongroup market would lead to substantially reduced participation by insurers and enrollees in many areas. Prior experience in states that implemented similar nongroup market reforms without a mandate penalty or subsidies has demonstrated the potential for market destabilization. Several states that enacted such market reforms later repealed or substantially modified those

reforms in response to increased premiums and insurers' departure from the market.

After weighing the evidence from prior state-level reforms and input from experts and market participants, CBO and JCT estimate that about half of the nation's population lives in areas that would have no insurer participating in the nongroup market in the first year after the repeal of the marketplace subsidies took effect, and that share would continue to increase, extending to about three-quarters of the population by 2026. That contraction of the market would most directly affect people without access to employment-based coverage or public health insurance.

Effects on Premiums. In total, as a result of reduced enrollment, higher average health care costs among remaining enrollees, and lower participation by insurers, CBO and JCT project that premiums in the nongroup market would be about 50 percent higher in the first year after the marketplace subsidies were eliminated—relative to projections under current law—and would about double by 2026.

Comparison With CBO and JCT's 2015 Cost Estimate

This analysis differs in a number of respects from the one CBO and JCT did in December 2015. In particular, the projected increase in the number of uninsured people is now greater largely because, at that time, the agencies had not estimated the changes in coverage from leaving the ACA's insurance market reforms in place while repealing the mandate penalties and subsidies. Moreover, the current estimates of how H.R. 3762 would affect coverage are measured relative to CBO's March 2016 baseline, rather than the March 2015 baseline, which was the basis for the earlier estimates. Those baselines differ in part

because CBO and JCT have reduced their projections of the number of people with health insurance coverage through the marketplaces and increased their projections of the number of people with coverage through Medicaid under current law.²

Future Legislation

If the Congress considers legislation similar to H.R. 3762 in the coming weeks, the estimated effects could differ from those described here. In particular, the response of individuals, insurers, and states would depend critically on the particular specifications contained in such legislation.

This document was requested by the Senate Minority Leader, the Ranking Member of the Senate Committee on Finance, and the Ranking Member of the Senate Committee on Health, Education, Labor, and Pensions. Kate Fritzsche and Sarah Masi prepared it with guidance from Jessica Banthin, Chad Chirico, and Holly Harvey and with contributions from Allison Percy and the staff of the Joint Committee on Taxation. An electronic version is available on CBO's website (www.cbo.gov/publication/52371).



Keith Hall
Director



2. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), www.cbo.gov/publication/51385.



ASPE

ISSUE BRIEF

Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act

January 5, 2017

The Affordable Care Act (ACA) put in place a range of nationwide protections for Americans with pre-existing health conditions. Under the ACA, insurance companies cannot deny coverage or charge higher premiums based on a person's medical history or health status. In addition, policies cannot exclude coverage for treating a pre-existing condition, must include limits on out-of-pocket spending, cannot include limits on annual or lifetime coverage, and, in the case of most individual and small group market policies, must cover essential health benefits.

In 2011, prior to the implementation of the ACA's major health insurance reforms in 2014, ASPE examined the impact of the ACA's pre-existing conditions protections.¹ The 2011 analysis found that between 50 and 129 million non-elderly Americans had pre-existing health conditions and would gain new protections under the ACA reforms.²

This analysis updates that earlier study. It confirms that a large fraction of non-elderly Americans have pre-existing health conditions: at least 23 percent of Americans (61 million people) using a narrow definition based on eligibility criteria for pre-ACA state high-risk pools, or as many as 51 percent (133 million people) using a broader definition closer to the underwriting criteria used by insurers prior to the ACA. Any of these 133 million Americans could have been denied coverage, or offered coverage only at an exorbitant price, had they needed individual market health insurance before 2014. This analysis also offers a first look at how health insurance coverage for people with pre-existing conditions actually changed when the ACA's major insurance market reforms took effect in 2014. It finds that, between 2010 and 2014, the share of Americans with pre-existing conditions who went without health insurance all year fell by 22 percent, a drop of 3.6 million people. The ACA's individual market reforms appear to have played a key role in these gains.

¹ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*. January 2011, available at <https://aspe.hhs.gov/sites/default/files/pdf/76376/index.pdf>.

² Non-elderly are defined as individuals age 0 to 64 who did not have Medicare coverage in any month.

After dropping by about a quarter between 2010 and 2014, the uninsured rate for all non-elderly Americans has fallen an additional 22 percent through the first half of 2016.³ While data for Americans with pre-existing conditions are available only through 2014, it is likely that this group has also seen continued gains in access to coverage and care over the past two years.

Key Findings:

- Up to 133 million non-elderly Americans—just over half (51 percent) of the non-elderly population—may have a pre-existing condition. This includes 67 million women and girls and 66 million men and boys.
- The likelihood of having a pre-existing condition increases with age: up to 84 percent of those ages 55 to 64—31 million individuals—have at least one pre-existing condition.
- Among the most common pre-existing conditions are high blood pressure (46 million people), behavioral health disorders (45 million people), high cholesterol (44 million people); asthma/chronic lung disease (34 million people), heart conditions (16 million people), diabetes (13 million people), and cancer (11 million people).
- Between 2010 and 2014, when the ACA's major health insurance reforms first took effect, the share of Americans with pre-existing conditions who went uninsured all year fell by 22 percent, meaning 3.6 million fewer people went uninsured.
- Tens of millions of Americans with pre-existing conditions experience spells of uninsurance. About 23 percent (31 million) experienced at least one month without insurance coverage in 2014, and nearly one-third (44 million) went uninsured for at least one month during the two-year period beginning in 2013.

How the ACA Reformed Coverage for People with Pre-Existing Conditions

A pre-existing condition is a health condition that predates a person applying for or enrolling in a new health insurance policy. Before the ACA, insurers generally defined what types of conditions could constitute a pre-existing condition. Their definitions frequently encompassed both serious conditions, such as cancer or heart disease, and less severe and more common conditions, such as asthma, depression, or high blood pressure.

Before the ACA, individual insurers in the vast majority of states could collect information on demographic characteristics and medical history, and then deny coverage, charge higher premiums, and/or limit benefits to individuals based on pre-existing conditions. An industry survey found that 34 percent of individual market applicants were charged higher-than-standard rates based on demographic characteristics or medical history.⁴ Similarly, a 2009 survey found

³ Emily P. Zammiti, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Insurance Survey, January-June 2016*, p. A1. National Center for Health Statistics, November 2016, available at <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf>.

⁴ AHIP Center for Policy Research (AHIP), *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits*, October 2009.

that, among adults who had individual market coverage or shopped for it in the previous three years, 36 percent were denied coverage, charged more, or had exclusions placed on their policy due to pre-existing conditions.⁵ A report by the Government Accountability Office estimated that, as of early 2010, the denial rate among individual market applications was 19 percent, and the most common reason for denial was health status.⁶

While some states attempted to offer some protection to people with pre-existing conditions, these efforts were generally not effective at ensuring access to affordable coverage.⁷ For example:

- Some states required that coverage be offered to people with pre-existing conditions, but imposed no restrictions on how much insurers could increase premiums based on health status.
- Some states required that coverage be offered to people with pre-existing conditions, but allowed insurers to exclude treatment for the pre-existing condition. Thus, a cancer survivor could have obtained coverage, but that coverage would not have paid for treatment if the cancer re-emerged.
- Some states required that coverage be offered to people with pre-existing conditions, but only to those who met continuity of coverage requirements. In practice, a high fraction of people with pre-existing conditions go uninsured for at least short spells due to job changes, other life transitions, or periods of financial difficulty. About 23 percent of people with pre-existing conditions (31 million people) experienced at least one month without insurance coverage in 2014. In the two-year period beginning in 2013, nearly one-third (44 million) of individuals with pre-existing conditions went uninsured for at least one month. About 93 percent of those who were ever uninsured went without coverage for a spell of two months or more, and about 87 percent went without coverage for a spell of three months or more.⁸

⁵ Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, *Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most US Families*, The Commonwealth Fund, July 2009, available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

⁶ U.S. Government Accountability Office, *Private Health Insurance: Data on Applications and Coverage Denials*, Report to the Secretary of Health and Human Services and the Secretary of Labor, March 16, 2011, available at <http://www.gao.gov/assets/320/316699.pdf>.

⁷ For a comparison of states' pre-ACA rules, see National Conference of State Legislatures, "Individual Health Insurance and States: Chronologies of Care," Updated August 2015, <http://www.ncsl.org/research/health/individual-health-insurance-in-the-states.aspx>.

⁸ HHS analysis of 2013 and 2014 MEPS.

- A few states sought to require that people with pre-existing conditions be offered coverage at the same price as other Americans. But without accompanying measures to ensure that healthy residents also continued to buy insurance, these states saw escalating premiums that made health insurance unaffordable for sick and healthy residents alike.⁹

In contrast, the ACA implemented a nationwide set of reforms in the individual health insurance market. The law requires individual market insurers to offer comprehensive coverage to all enrollees, on common terms, regardless of medical history. Meanwhile, the ACA also includes measures to ensure a balanced risk pool that keeps coverage affordable. To directly improve affordability while encouraging individuals to buy coverage, the ACA offers financial assistance for eligible taxpayers with household incomes up to 400 percent of the federal poverty level to reduce their monthly premium payments.¹⁰ The law also includes an individual shared responsibility provision that requires people who can afford coverage to make a payment if they instead elect to go without it.¹¹

Prevalence of Pre-Existing Conditions

Estimating the Number of Americans with Pre-Existing Conditions

This analysis updates earlier ASPE estimates of the number of non-elderly Americans potentially benefitting from the ACA's pre-existing conditions protections. As in the earlier study, we consider two definitions of pre-existing conditions. The narrower measure includes only conditions identified using eligibility guidelines from state-run high-risk pools that pre-dated the ACA. These programs were generally intended to cover individuals who would be outright rejected for coverage by private insurers. The broader measure includes additional common health conditions (for example, arthritis, asthma, high cholesterol, hypertension, and obesity) and behavioral health disorders (including alcohol and substance use disorders, depression, and Alzheimer's) that could have resulted in denial of coverage, exclusion of the condition, or higher premiums for individuals seeking individual market coverage before the ACA protections applied.¹²

⁹ Former insurance commissioners in Rhode Island and Washington described the problems created by partial reforms in their states. See, for example, Christopher Koller, "Why Republican Health Insurance Reform Ideas Are Likely to Fail," Politico, December 7, 2016, <http://www.politico.com/agenda/story/2016/12/republican-health-reform-ideas-obamacare-unlikely-work-000252>, and Harris Meyer, "What It Will Take to Stop Insurers From Fleeing After ACA Repeal," Modern Health Care, December 5, 2016, <http://www.modernhealthcare.com/article/20161205/NEWS/161209962>. The exception was Massachusetts, which enacted its own version of the ACA's insurance market reforms, subsidies, and individual responsibility provision in 2006.

¹⁰ Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace*, October 24, 2016, available at <https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.

¹¹ For an extended discussion of the ACA's insurance market reforms, see https://www.whitehouse.gov/sites/default/files/page/files/20161213_cea_record_health_care_reform.pdf.

¹² These conditions were selected based on underwriting guidelines identified using internet searches in the pre-ACA period.

We focus primarily on the broader measure, because individuals with any of these conditions were at risk of higher premiums and/or coverage carve-outs, if not outright coverage denials if they sought individual market health insurance before the ACA protections applied. The narrower measure is similar to that used in a recent Kaiser Family Foundation (KFF) analysis, which finds that 52 million non-elderly adults would have been “uninsurable” in the individual market in most states before the ACA. The KFF study notes that its analysis does not attempt to include “people with other health conditions that wouldn’t necessarily cause a denial, but could lead to higher insurance costs based on underwriting.”¹³

Both our narrow and broad estimates are based on the 2014 Medical Expenditure Panel Survey (MEPS), the most recent data available that provide both coverage and detailed health status information. The appendix provides a more detailed description of our methodology and supplemental tables.¹⁴

The Prevalence of Pre-Existing Conditions in 2014

As shown in Table 1, we find that the ACA is protecting between 23 and 51 percent of non-elderly Americans--61 to 133 million people--with some type of pre-existing health condition from being denied coverage, charged significantly higher premiums, subjected to an extended waiting period, or having their health insurance benefits curtailed should they need individual market health insurance coverage.

Certain groups are more likely than others to have pre-existing conditions. In particular, as people age, their likelihood of having—or ever having had—a pre-existing health condition increases steadily. Americans between ages 55 and 64 are particularly at risk: 49 to 84 percent of people in this age range—up to 31 million people—have some type of pre-existing condition. By comparison, 6 to 24 percent of Americans under the age of 18 have some type of pre-existing condition (see Figure 1). Approximately 56 percent of Non-Hispanic whites and individuals with family incomes above 400 percent of the federal poverty level have some type of pre-existing condition.

¹³ The authors also note that their analysis excludes certain conditions that likely would have led to coverage denials, including such as Hepatitis C and HIV/AIDS. See Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, and Karen Pollitz, *Pre-Existing Conditions and Medical Underwriting in the Individual Market Prior to the ACA*, Kaiser Family Foundation, December 2016 (available at <http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA>).

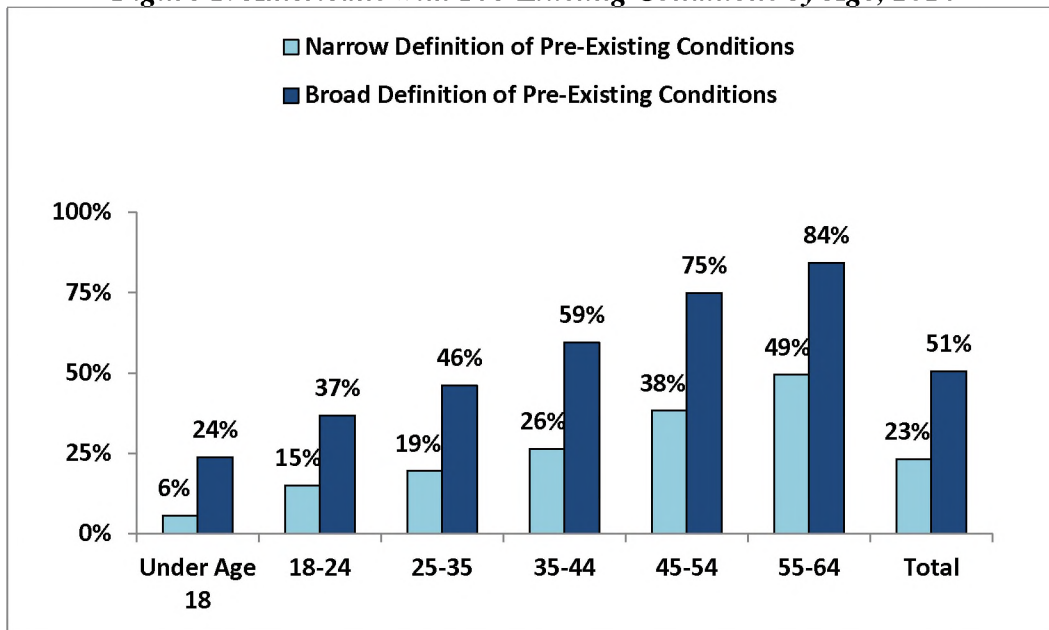
¹⁴ All estimates cover individuals age 0 to 64 who did not have Medicare coverage in any month. In addition to describing our methodology, the Appendix explains technical changes that account for the substantial revision to our lower-bound estimate from the 2011 brief.

Table 1: Prevalence of Pre-Existing Conditions, 2014				
	Number with Pre-Existing Condition (Millions)		Share with Pre-Existing Condition	
	Narrow Definition	Broad Definition	Narrow Definition	Broad Definition
All non-elderly	61	133	23%	51%
Male	26	66	20%	50%
Female	35	67	26%	51%
Under age 18	4	17	6%	24%
18-24	5	11	15%	37%
25-34	8	20	19%	46%
35-44	10	23	26%	59%
45-54	16	31	38%	75%
55-64	18	31	49%	84%
<=138% of poverty	13	27	24%	48%
139-400% of poverty	23	51	21%	47%
>400% of poverty	25	55	25%	56%
Hispanic	8	20	15%	39%
Non-Hispanic White	42	85	28%	56%
Non-Hispanic Black	7	17	20%	52%
Non-Hispanic Asian	2	5	14%	34%
Other race	2	5	21%	47%

Source: HHS analysis of the 2014 MEPS.

Note: Narrow Definition based on criteria for state high risk pools before the ACA; Broad Definition based on pre-ACA underwriting criteria used by insurers.

Figure 1: Americans with Pre-Existing Conditions by Age, 2014



Source: HHS analysis of the 2014 MEPS.

Common Pre-Existing Conditions Facing Americans

As shown in Table 2, we also examine the prevalence of specific pre-existing conditions faced by Americans (focusing on the broader insurer definition). The table lists the eleven conditions with prevalence of 1 million or more among non-elderly individuals with no Medicare enrollment during 2014. These conditions are listed from most to least prevalent, although differences between ranks may not be statistically significant.

	Number (Millions)
Hypertension (high blood pressure)	46
Behavioral health disorders	45
Hyperlipidemia (high cholesterol)	44
Asthma/chronic lung disease	34
Osteoarthritis or other non-traumatic joint disorders	34
Obesity	23
Heart conditions/heart disease	16
Diabetes mellitus	13
Cancer	11
Cerebrovascular disease	3
Infectious diseases	1

Source: HHS Analysis of the 2014 MEPS.
Notes: Estimates based on broad definition of pre-existing conditions. A single individual can have multiple pre-existing conditions. Differences in the estimated number of individuals with specific conditions are not necessarily statistically significant.

Among the most common pre-existing conditions for non-elderly Americans are high blood pressure, high cholesterol, behavioral health disorders (including, for example, alcohol and substance use disorders, depression, and Alzheimer's), asthma, arthritis, and obesity. Millions of Americans also have diabetes (13 million), heart conditions or heart disease (16 million), or have at some point been diagnosed with cancer (11 million).

The Impact of the ACA's Protections in 2014

As described above, the ACA put in place a range of new protections designed to give individuals with pre-existing conditions, along with other Americans, increased access to affordable health insurance. The 2014 MEPS data show that this is being borne out in practice, with significant improvements in health insurance coverage for Americans with pre-existing conditions.

As shown in Table 3, between 2010 and 2014, the share of Americans with pre-existing conditions who went uninsured all year fell from 13.8 percent to 10.7 percent, a drop of 22 percent. These gains translated into 3.6 million fewer individuals with pre-existing conditions without health insurance.

Table 3: Percent and Number of Non-Elderly Americans with Pre-Existing Conditions that Lacked Health Insurance All Year, 2010 and 2014

	Percent of People Without Coverage			Number of People Without Coverage (Millions)		
	2010	2014	Percent Change	2010	2014	Change
Total	13.8	10.7	-22	17.9	14.3	-3.6
Male	14.5	11.5	-23	9.4	7.5	-1.8
Female	13.1	10.0	-21	8.5	6.7	-1.8
Hypertension (high blood pressure)	15.3	12.8	-17	7.1	5.9	-1.1
Hyperlipidemia (high cholesterol)	11.6	10.1	-13	5.2	4.4	-0.8
Behavioral health disorders	11.7	8.5	-27	4.6	3.8	-0.7
Osteoarthritis	13.7	10.7	-22	4.3	3.6	-0.8
Asthma/chronic lung disease	11.9	8.7	-27	4.1	3.0	-1.2

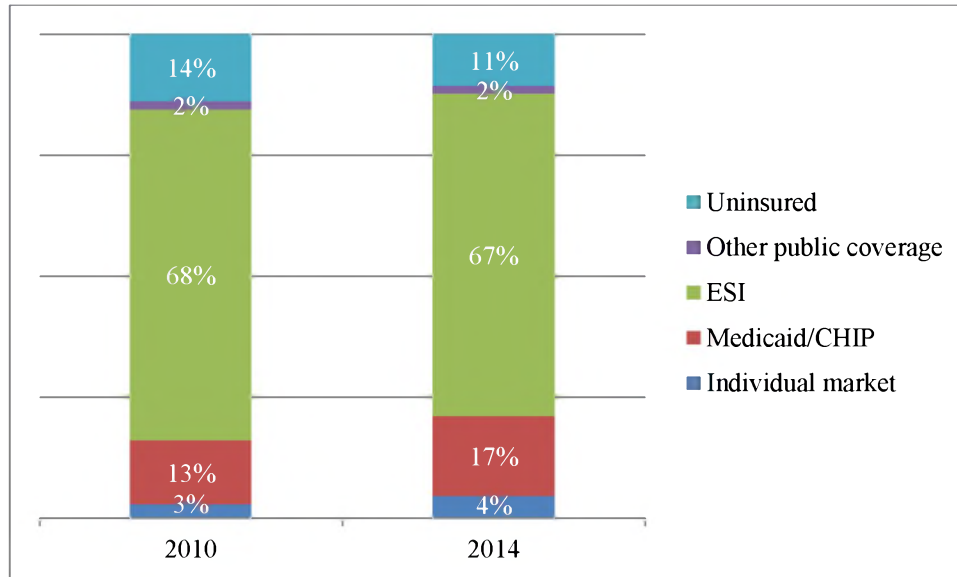
Source: HHS Analysis of the 2010 and 2014 MEPS.

Notes: Estimates based on broad definition of pre-existing conditions. A single individual can have multiple pre-existing conditions. Differences in the estimated number of individuals with specific conditions are not necessarily statistically significant.

Figure 2 shows the source of these gains. While the share of Americans with pre-existing conditions who had coverage through an employer remained roughly constant, the share with coverage through Medicaid rose, and the share with individual market coverage increased substantially as pre-ACA underwriting practices were phased out and Marketplace subsidies became available (see Appendix Table 5).¹⁵

¹⁵ Insurance category is assigned by an ever-on hierarchy based on coverage in any month. Individuals with employer-sponsored coverage in any month, for example, were assigned to that category, even if they had months of enrollment in Medicaid/CHIP, individual market coverage, or other public coverage, or were ever uninsured. Because people move across sources of coverage in a year, more individuals may have had Medicaid/CHIP, individual market coverage, or other public coverage than shown in Figure 2. Individual market coverage for 2014 includes both Marketplace and off-Marketplace coverage. Individuals categorized as uninsured were without coverage in any survey month.

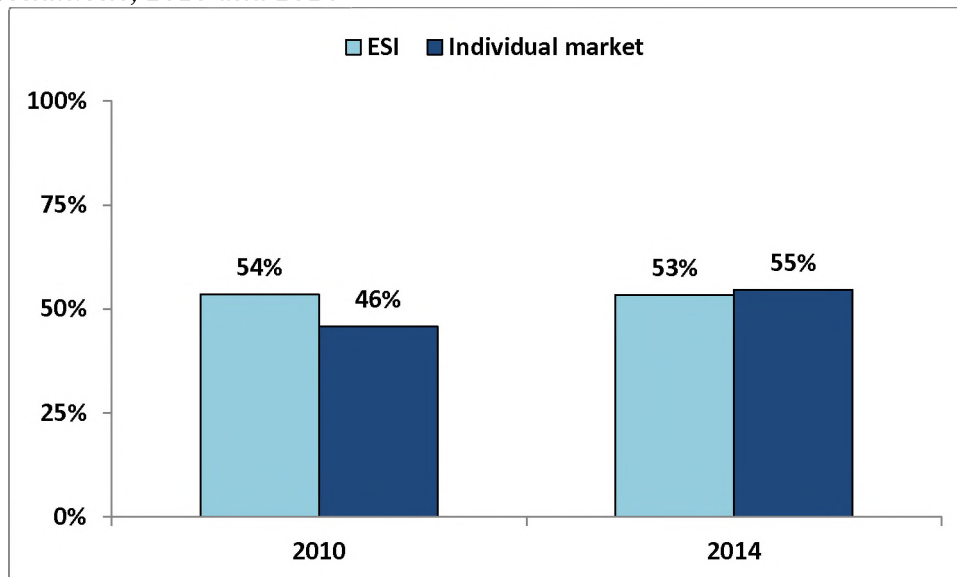
Figure 2: Coverage Status of Americans with Pre-Existing Conditions, 2010 and 2014



Source: HHS analysis of the 2010 and 2014 MEPS.

Figure 3 provides further confirmation that the ACA is eliminating barriers in the individual market for Americans with pre-existing conditions. In 2010, 54 percent of people with employer coverage had pre-existing conditions, similar to their share of the overall population. But in the individual market, only 46 percent of people had a pre-existing condition. By 2014, the composition of the individual market had shifted to nearly mirror the employer market, consistent with a market where insurers can no longer deny coverage based on health history.

Figure 3: Percent of Americans with Employer and Individual Market Coverage with Pre-Existing Conditions, 2010 and 2014



Source: HHS analysis of the 2010 and 2014 MEPS.

Conclusion

With data available only through 2014, this analysis provides a preliminary picture of how the ACA is helping individuals with pre-existing conditions. The uninsured rate for all Americans, which fell by 27 percent between 2010 and 2014, fell another 22 percent between 2014 and 2016, and people with pre-existing conditions have likely seen similar additional progress. Nonetheless, this initial snapshot confirms that the ACA's insurance market reforms are providing important protections to the up to half of Americans whose medical history previously put them at risk of being denied access to affordable health care.

APPENDIX: METHODOLOGY

We used the 2014 Medical Expenditure Panel Survey (MEPS) to identify individuals who would likely been denied coverage due to a pre-existing condition if they were to apply for coverage in the individual market without the protections provided by the Affordable Care Act. A multi-pronged approach was used to identify conditions that would certainly or likely exclude individuals from being offered coverage. A list of pre-existing conditions was generated from two sources: eligibility guidelines from 19 pre-Affordable Care Act high-risk pools and underwriting guidelines from seven major insurance carriers.¹⁶ The MEPS was used to identify whether individuals had a medical visit for any of these conditions, experienced any disability days (for the 2008 and 2010 data, as this information is no longer available in the 2014 data) as a result of any of these conditions, or reported that they were bothered by any of these conditions in the past year. Additional questions regarding whether individuals had ever been diagnosed with a smaller set of conditions from these lists were used to further refine our measure.

Two estimates of the share of non-elderly individuals with pre-existing conditions are presented. The first includes only conditions that were identified using eligibility guidelines from high-risk pools; the second includes five additional common conditions (arthritis, asthma, high cholesterol, hypertension, and obesity) and a number of common behavioral health conditions that would have resulted in an automatic decline, exclusion of the condition, or higher premiums according to the seven pre-Affordable Care Act insurer guidelines examined. The first estimate includes conditions that would have been very likely to cause an applicant to be denied coverage, and should be considered a lower bound estimate. The second estimate includes conditions that might result in a denial of coverage, but also might have resulted in a rate-up (that is, a higher premium) or a coverage rider (that is, a policy that excludes coverage for a pre-existing condition).

Analyses of the prevalence of particular conditions employ the categories used in the Clinical Classification Software (CCS) developed for the Healthcare Cost and Utilization Project (HCUP). A crosswalk between ICD-9 and CCS categories is available at https://meps.ahrq.gov/data_stats/download_data/pufs/h170/h170app3.html.

Appendix Tables 1-4 present the full set of estimates by age and insurance status for 2010 and 2014, using both pre-existing conditions measures. Appendix Table 5 shows the change between 2010 and 2014 in the distribution of insurance coverage among individuals with pre-existing conditions (broad definition only).

¹⁶ For a list of the included conditions and more detailed explanation of methods, please see the Methodology section of: “*At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*”; US Department of Health & Human Services, January 2011. Available online at: <https://aspe.hhs.gov/sites/default/files/pdf/76376/index.pdf>.

Appendix Table 1: Pre-Existing Conditions by Age, based on MEPS 2010

Age Category	Total Population	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions
<18	74,397,000	4,439,000	17,113,000	6%	23%
18-24	29,713,000	4,342,000	10,528,000	15%	35%
25-34	41,007,000	7,333,000	18,407,000	18%	45%
35-44	38,879,000	10,579,000	23,080,000	27%	59%
45-54	42,190,000	15,652,000	30,758,000	37%	73%
55-64	34,617,000	17,633,000	29,750,000	51%	86%
Total	260,803,000	59,979,000	129,635,000	23%	50%

Source: HHS analysis of the 2010 MEPS.

Note: All estimates rounded to thousands.

Appendix Table 2: Pre-Existing Conditions by Age, based on MEPS 2014

Age Category	Total Population	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions
<18	73,522,000	4,148,000	17,499,000	6%	24%
18-24	30,336,000	4,553,000	11,169,000	15%	37%
25-34	42,314,000	8,251,000	19,511,000	19%	46%
35-44	38,910,000	10,289,000	23,146,000	26%	59%
45-54	40,903,000	15,662,000	30,625,000	38%	75%
55-64	36,714,000	18,145,000	30,934,000	49%	84%
Total	262,699,000	61,048,000	132,884,000	23%	51%

Source: HHS analysis of the 2014 MEPS.

Note: All estimates rounded to thousands to account for impression of estimates.

Appendix Table 3: Pre-Existing Conditions by Insurance Status, based on MEPS 2010

Insurance Category	Total Population	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions
Employment-Based	165,736,000	40,535,000	88,676,000	24%	54%
Medicaid/CHIP	42,825,000	8,358,000	17,182,000	20%	40%
Individual Market	7,900,000	1,547,000	3,619,000	20%	46%
Other Public	4,117,000	1,308,000	2,283,000	32%	55%
Uninsured	40,225,000	8,230,000	17,875,000	20%	44%
Total	260,803,000	59,979,000	129,635,000	23%	50%

Source: HHS analysis of the 2010 MEPS.

Notes: All estimates rounded to thousands to account for impression of estimates. Insurance category is assigned by an ever-on hierarchy based on coverage in any month. Individuals with employer-sponsored coverage in any month, for example, were assigned to that category, even if they had months of enrollment in Medicaid/CHIP, individual market coverage, or other public coverage, or were ever uninsured. Because people move across sources of coverage in a year, more individuals may have had Medicaid/CHIP, individual market coverage, or other public coverage than shown. Individuals categorized as uninsured were without coverage in any survey month.

Appendix Table 4: Pre-Existing Conditions by Insurance Status, based on MEPS 2014

Insurance Category	Total Population	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions
Employment-Based	165,820,000	39,912,000	88,401,000	24%	53%
Medicaid/CHIP	51,275,000	10,894,000	22,177,000	21%	43%
Individual Market	10,904,000	2,936,000	5,948,000	27%	55%
Other Public	3,637,000	1,003,000	2,089,000	28%	57%
Uninsured	31,063,000	6,304,000	14,269,000	20%	46%
Total	262,699,000	61,048,000	132,884,000	23%	51%

Source: HHS analysis of the 2014 MEPS.

Notes: All estimates rounded to thousands to account for impression of estimates. Insurance category is assigned by an ever-on hierarchy based on coverage in any month. Individuals with employer-sponsored coverage in any month, for example, were assigned to that category, even if they had months of enrollment in Medicaid/CHIP, individual market coverage, or other public coverage, or were ever uninsured. Because people move across sources of coverage in a year, more individuals may have had Medicaid/CHIP, individual market coverage, or other public coverage than shown. Individual market coverage for 2014 includes both Marketplace and off-Marketplace coverage. Individuals categorized as uninsured were without coverage in any survey month.

Appendix Table 5: Change in Insurance Coverage of Individuals with Pre-Existing Conditions (Broad Definition), 2010-2014

Insurance Category	2010 Pre-ex Population	2014 Pre-ex Population	Percentage Change	2010 Share of pre-ex population	2014 Share of pre-ex population
Employment-Based	88,676,000	88,401,000	-0.3%	68.4%	66.5%
Medicaid/CHIP	17,182,000	22,177,000	29.1%	13.3%	16.7%
Individual Market	3,619,000	5,948,000	64.3%	2.8%	4.5%
Other Public	2,283,000	2,089,000	-8.5%	1.8%	1.6%
Uninsured	17,875,000	14,269,000	-20.2%	13.8%	10.7%
Total	129,635,000	132,884,000	2.5%	100.0%	100.0%

Source: HHS analysis of the 2010 and 2014 MEPS.

Notes: All estimates rounded to thousands to account for impression of estimates. Insurance category is assigned by an ever-on hierarchy based on coverage in any month. Individuals with employer-sponsored coverage in any month, for example, were assigned to that category, even if they had months of enrollment in Medicaid/CHIP, individual market coverage, or other public coverage, or were ever uninsured. Because people move across sources of coverage in a year, more individuals may have had Medicaid/CHIP, individual market coverage, or other public coverage than shown. Individual market coverage for 2014 includes both Marketplace and off-Marketplace coverage. Individuals categorized as uninsured were without coverage in any survey month.

Methodological Refinements to 2011 Analysis:

The current analysis includes several methodological improvements relative to our 2011 analysis that improve the precision of our estimates. First, we identified a subset of individuals who had a condition meeting our narrower definition of a pre-existing condition, but who were incorrectly excluded from our estimates due to an error in coding. As a result of this correction, 1,237 unweighted sample observations are newly classified as having a pre-existing condition under our narrower definition. When weighted these records correspond to approximately 13.4 million individuals.

Second, we adjusted the variable we used to define the age of individuals in the MEPS data, from AGE53X to AGE08X, to better capture the age of panel members during the year in which the data was collected. This change adds an additional 13 unweighted sample observations to the non-elderly population, which is eligible for both our first and second measures. When weighted, these observations represent nearly 200,000 additional eligible individuals.

Third, our current analysis uses full 5 digit ICD-9 codes to specify conditions included in our two measures, provides additional precision to our estimates. These codes are not included in the publicly available data file, which provides only 3 digit ICD-9 codes. This change reduces the number of unweighted sample observations included in the lower-bound measure by 230, representing nearly 2.4 million individuals, and 117 in the upper-bound measure, representing just over 1.1 million individuals.

Appendix Table 6 provides revised 2008 estimates of individuals with pre-existing conditions by age and Appendix Table 7 provides revised 2008 estimates by insurance status corresponding to those provided in the 2011 ASPE brief on this subject.

Appendix Table 6: Pre-Existing Conditions by Age, based on MEPS 2008

Age Category	Total Population	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions	Narrow Definition of Pre-Existing Conditions	Broad Definition of Pre-Existing Conditions
<18	73,677,000	4,623,000	17,123,000	6%	23%
18-24	28,501,000	4,263,000	9,715,000	15%	34%
25-35	40,334,000	7,486,000	18,089,000	19%	45%
35-44	40,947,000	10,939,000	23,948,000	27%	58%
45-54	41,512,000	15,862,000	30,301,000	38%	73%
55-64	33,383,000	17,516,000	28,609,000	52%	86%
Total	258,353,000	60,689,000	127,785,000	23%	49%

Source: HHS analysis of the 2008 MEPS.

Note: All estimates rounded to thousands to account for impression of estimates.

Appendix Table 7: Pre-Existing Conditions by Insurance Status, based on MEPS 2008

Insurance Category	Total Population	Narrow Definition of Pre-Ex Conditions	Broad Definition of Pre-Ex Conditions	Narrow Definition of Pre-Ex Conditions	Broad Definition of Pre-Ex Conditions
Employment-Based	169,467,000	42,213,000	89,536,000	25%	53%
Medicaid/CHIP	37,059,000	7,787,000	15,027,000	21%	41%
Non-group	7,010,000	1,327,000	3,060,000	19%	44%
Other Public	4,135,000	1,149,000	2,123,000	28%	51%
Uninsured	40,681,000	8,213,000	18,038,000	20%	44%
Total	258,353,000	60,689,000	127,785,000	23%	49%

Source: HHS analysis of the 2008 MEPS.

Notes: All estimates rounded to thousands to account for impression of estimates. Insurance category is assigned by an ever-on hierarchy based on coverage in any month. Individuals with employer-sponsored coverage in any month, for example, were assigned to that category, even if they had months of enrollment in Medicaid/CHIP, individual market coverage, or other public coverage, or were ever uninsured. Because people move across sources of coverage in a year, more individuals may have had Medicaid/CHIP, individual market coverage, or other public coverage than shown. Individuals categorized as uninsured were without coverage in any survey month.



Children's Health Fund

**UNFINISHED BUSINESS:
More than 20 Million Children in U.S. Still Lack
Sufficient Access to Essential Health Care**



NOVEMBER 2016

Children’s Health Fund would like thank the national experts represented in this white paper. Each of these thought leaders and practitioners generously contributed to this report, as well as took time to review its contents and provide feedback.

Children’s Health Fund is an organization committed to providing comprehensive health care to the nation’s most medically underserved children through the development and support of innovative primary care medical programs and the promotion of guaranteed access to appropriate health care for all children. To learn more, visit www.childrenshealthfund.org

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EXECUTIVE SUMMARY

The extraordinary effort to provide health insurance coverage and access to care for all children in the United States has made significant strides over the last five decades. The development and expansions of Medicaid, the founding and reauthorization of the State Children's Health Insurance Program (CHIP), and the recent implementation of the Patient Protection and Affordable Care Act (ACA) have combined to insure more American children than have been covered at any other time in our country's history.

However, more than 50 years after passage of Medicaid (the federal health insurance program designed to support health care for poor children and people with disabilities), almost two decades following passage of the Children's Health Insurance Program, and six years after the introduction of the Affordable Care Act (Obamacare), approximately 28% of children in the U.S. still do not have full access to essential health services.

There are approximately 73 million children under the age of 18 years in the United States. The fact that 20.3 million children lack access to care that meets modern pediatric standards and expectations should be a call for immediate and focused attention to (a) identify the reasons for persistently poor levels of access to care and (b) develop strategies that can close the access gaps that have defied existing policies and programs.

Not only does failing to address health care access barriers threaten and undermine the health and wellbeing of children, but it also may have a direct impact on a child's ability to succeed academically and enter the workforce at their full potential. Loss of later productivity and the extraordinary costs of remediation will clearly have deleterious consequences for the future economic strength and vibrancy of the United States. The stakes could not be higher.

As described in this report, the methodology for arriving at the conclusions is based on the analysis of three key factors:

- Children who remain uninsured or incompletely insured, either persistently or intermittently;
- Children who are insured but who regularly miss primary care visits due to affordability issues or non-insurance related reasons such as living in severe health professional shortage communities, lack of affordable accessible transportation, cultural and language barriers; and,
- Children who are insured, but have inordinate difficulty getting access to essential subspecialty services (e.g. pediatric cardiology), when needed.

The first two considerations are derived from analyses of national data sets. The third is extrapolated from the clinical experiences and programmatic data of the Children's Health Fund's national network of programs that provide healthcare to underserved children in more than two dozen urban and rural programs around the U.S.

Conclusions derived from the analysis as stated above are as follows:

NUMBER AND PERCENT OF CHILDREN IN THE US WHO LACK SUFFICIENT ACCESS TO ESSENTIAL HEALTHCARE

Category	Number of children	% of all children
Uninsured	3.3 million	4.5%
Insured but missing timely, well child checks (indicative of lack of access to primary care)	10.3 million	14%
Children on Medicaid/CHIP who have access to primary care but have unmet needs for pediatric subspecialty care	6.7 million	9%
TOTAL	20.3 million	28%

At minimum, 20.3 million children (over 1 in 4) face barriers.

Based on the collective reach and impact of Medicaid, CHIP, and ACA, the child uninsurance rate fell from 13.9 percent in 1997 (9.6 million) to 4.5 percent (3.3 million) in 2015—a drop of more than 67%. But there is still much to be done. We need to find ways to cover that remaining 4.5 percent—some 3.3 million children, many of whom are from the most marginalized communities and regions in the United States. And while important, uninsurance figures often promote the false dichotomy of “insured” versus “uninsured” children, ignoring the millions of children who are counted as insured but go without coverage for some portion of the year. Such coverage gaps matter. Discontinuous health coverage can negatively impact timely receipt of preventative and other crucial health care services.

Beyond the issue of coverage is an equally important question: Do children who receive some form of coverage actually access the care that that coverage is supposed to provide? The answer is often no. Based on data and our analysis, Children’s Health Fund believes that there are two main categories of barriers to obtaining health care: Financial and Non-financial.

Financial barriers refer to the costs imposed by a coverage plan that prevents children from accessing the care they need. Such barriers refer to costs such as high copays, high deductibles, and unaffordable prescription drug prices. CHF calculates that there are over 13.1 million children whose families report either having problems paying medical bills or being unable to pay medical bills. Provider-based barriers also contribute to the financial burden when clinics or providers won’t accept certain forms of insurance or create environments that promote insurance stigma.

Non-financial barriers most often take the form of either geographic barriers or informational barriers. Geographic barriers include issues of transportation, such as a lack of a car or poor public transit options, and federal - designated Health Professional Shortage Areas (HPSAs) where the number of health professionals in a given geographical area is insufficient for that population’s healthcare needs. CHF estimates that over 14 million children live in HSPAs. Informational barriers include parents’ health illiteracy, dauntingly complex language used in information about coverage eligibility and accessing care, and parents’ limited English proficiency.

Children’s Health Fund believes that there are a number of concrete strategies and specific steps that can be developed and implemented to ensure true access to healthcare for all children. These include:

1. ELIMINATE FINANCIAL BARRIERS TO HEALTH CARE ACCESS

a) *Reduce or eliminate copayments:* The ACA should be amended to reduce copayments, premiums, cost-sharing, and out of pocket payments for lower-income families, as well as increase subsidies and fix existing “glitches” that prevent families in need from gaining marketplace tax credits.

b) *Increase public insurance reimbursements:* The ACA and federal/state policies should increase reimbursement rates for providers treating underserved communities. This can help draw providers to HPSAs and reduce insurance-based access barriers and stigma.

2. ELIMINATE NON-FINANCIAL BARRIERS TO HEALTH CARE ACCESS

a) *Send more health providers to poor communities:* Policymakers must continue creating incentives that will draw providers to Health Professional Shortage Area and retain providers in those areas. An example of such an incentive is to provide tuition reimbursements for medical students agreeing to serve in shortage areas

b) *Create More Health Care Access Points:* This can be done in three immediate ways:

- i) Increase the number of Federally Qualified Health Centers and Rural Health Clinics
- ii) Increase School-Based Health Services through more school-based health centers and more school nurses
- iii) Increase the reimbursement allowability of telehealth for poor children and families
- iv) Increase utilization of mobile healthcare systems

c) *End transportation barriers:* Transportation services must be improved for low-income families seeking medical care. Targeted federal resources can help health clinics provide transportation services to augment public transit options; federal incentives can encourage states to facilitate improved coordination of federally subsidized transportation programs serving low-income communities. Federal health agencies can utilize quantitative measures of transportation disadvantage in low-income communities as criteria for enhanced reimbursement rate eligibility for community-based health providers. Interventions to increase families’ access to cars and increasing reimbursements for travel can also be effective.

d) *Eliminate health illiteracy:* Simpler and more widely available literature explaining public and private health plans can help parents ensure their children receive the care they need. Insurance representatives and healthcare professionals should be better sensitized to the health literacy needs of their patients; the number of staff dedicated solely to answering parents’ questions should be increased; and programs to train parent mentors should be boosted.

e) *Help parents with limited English proficiency:* Increasing clinics' bilingual/multilingual capacity is key to serving parents with limited English proficiency. Reimbursement for translation and interpreter services should be increased, especially in areas with large immigrant populations. Telehealth services (phone or video) can also be used to provide remote language services for areas where on-site interpreters are not available

Children's Health Fund (CHF) estimates that, at minimum, 20.3 million children in the United States (28% of all children) face barriers to accessing essential health care. This estimate covers children who are a) uninsured; b) children who don't receive routine primary care; and c) publicly insured children who are connected to primary care but have unmet needs for pediatric subspecialty care when needed, such as pediatric cardiology or pediatric endocrinology.



I. INTRODUCTION

Children’s Health Fund (CHF) estimates that, at minimum, 20.3 million children in the United States (28% of all children) face barriers to accessing essential health care. This estimate covers children who are a) uninsured; b) children who don’t receive routine primary care; and c) publicly insured children who are connected to primary care but have unmet needs for pediatric subspecialty care when needed, such as pediatric cardiology or pediatric endocrinology.

NUMBER AND PERCENT OF CHILDREN IN THE US WHO LACK SUFFICIENT ACCESS TO ESSENTIAL HEALTHCARE¹

Category	Number of children	% of all children
Uninsured ²	3.3 million	4.5%
Insured but missing timely, well child checks (indicative of lack of access to primary care) ³	10.3 million	14%
Children on Medicaid/CHIP who have access to primary care but have unmet needs for pediatric subspecialty care ⁴	6.7 million	9%
TOTAL	20.3 million	28%

Note that this estimate may not fully represent large groups of children who face health care access barriers such as the over 14 million children living in Health Professional Shortage Areas (HPSAs)⁵ or the estimated 1 million undocumented children⁶ living in the US. Additionally, when not overlapping with the other access barriers detailed above, the estimate does not capture the many children with further unmet needs for dental and mental health services.

The Affordable Care Act has made important advances in extending health care coverage for children, but much remains to be done to increase coverage, make coverage continuous, and ensure that children who are covered receive the care they need. This white paper details the strides the United States had made in providing health care for children and examines the remaining coverage, financial, and non-financial barriers that must be addressed if all children are to access adequate health care.

Advances in Insurance Coverage and the Remaining Challenges

Insurance is key to giving our children the opportunity to become healthy, productive adults. Children covered by insurance are more likely to benefit from preventative healthcare services, more likely to receive necessary vaccinations, and more likely to receive early treatment for illnesses.⁷ Insurance is particularly crucial for children from low-income families, as this group is at a heightened risk for a wide range of chronic illnesses (such as asthma, obesity, and developmental disabilities) and serious injuries (such as those caused by poorly constructed home environments). Medicaid eligibility for low-income children in the 1980s and 1990s was associated with an 8 percent reduction in child mortality and a 22 percent decline in preventable hospitalizations.⁸ A study in 2016 found that expanding Medicaid eligibility for school-age children (beyond birth) was closely linked to long-term educational attainment in that it decreased high school drop-out, increased likelihood of college enrollment and increased likelihood of getting a college degree.⁹ Haboush-Deloye et al. (2014) found that between 1988 and 2005, over 16,000 child deaths might have been prevented by the provision of insurance.¹⁰

The movement to provide insurance for all American children has made significant strides over the last three decades. Expansions of Medicaid eligibility, the founding and reauthorization of the State Children’s Health Insurance Program (CHIP), and the recent implementation of the Affordable Care Act (ACA) have combined to insure more American children than at any other time in our country’s history. The child uninsurance rate fell from 13.9 percent in 1997 (9.6 million)¹¹ to 4.5 percent in 2015.¹² But there is still much to be done. We need to find ways to cover that remaining 4.5 percent—some 3.3 million children, many of whom are from the most marginalized communities and regions in the United States.

While important, uninsurance figures often promote the false dichotomy of “insured” versus “uninsured” children, ignoring the millions of children who are counted as insured but go without coverage for some portion of the year. For example, according to 2015 national survey data, a total of 3.3 million children (4.5%) were uninsured at the time of the survey. However, the number of children with any gap in insurance in the past year is much higher at 5.7 million children (7.7%).¹³ Such coverage gaps matter. Discontinuous health coverage can negatively impact timely receipt of specialty care, vaccinations, oral health care, asthma care, and important clinical preventative services.¹⁴ Even short periods of uninsurance make children less likely to have a usual source of care and more likely to experience delays in needed care than children with continuous insurance.¹⁵

There are a wide range of causes for uninsurance and gaps in coverage,¹⁶ including: cut-off points for Medicaid and CHIP that exclude children from families that earn enough not to qualify for public coverage but too little to afford private insurance; citizenship requirements that exclude many immigrant children;¹⁷ waiting periods that leave children uninsured for a certain amount of time before they can gain or regain insurance;¹⁸ and other lacunas and “glitches” caused by law and policy structure.¹⁹ Obtaining continuous coverage for every child will only happen if we can comprehensively address such gaps.

Access Barriers

Beyond the issue of coverage is an equally important question: Do children who receive some form of coverage actually access the care that that coverage is supposed to provide? The answer is often no. For example, an estimated 10.3 million insured children don’t receive timely, preventive care, i.e. 15% of insured children.²⁰ Beyond preventive care, many children don’t receive the specialty care they may need, as illustrated by data from one of CHF’s largest clinics serving Medicaid-enrolled children which showed that about 23% (just under 1 in 4 children) had unmet needs for specialty care.²¹ In this paper, we focus on some of the biggest barriers to accessing care, and break them down into two categories: financial and non-financial.

Financial barriers refer to the costs imposed by a coverage plan that prevent children from accessing the care they need. Such financial barriers plague low-income children covered by every type of plan, and refer to costs such as high copays, high deductibles, and unaffordable prescription drug prices. The impacts of these barriers are significant. Parents faced with financial barriers might seek to save money by calling their doctor for advice, rather than seeing that doctor in person; rather than fill expensive prescriptions, a parent might rely on a limited supply of pharmaceutical samples.²² The medical debt incurred by such costs has been linked to reduced access to care, creating a vicious cycle.²³

While financial barriers are largely caused by the structure of health care laws and insurance policies, non-financial barriers stem from a much wider set of factors. Some of these factors are geographical—families living in remote areas often have to travel long distances to access care for their children. Some are

personal—parents lack the health literacy or English language proficiency necessary for them to fully access care for their children. Non-financial barriers should not be understood as merely what’s left over after financial barriers—non-financial barriers are powerful in their own right and can prevent families who do not experience financial barriers from obtaining care for their children.

We Must Act Now

Issues related to children are rarely central in discussions of health care reform. On the surface, this makes sense; the total cost of pediatric care in the United States is roughly \$300 billion per year, while adult costs can tally over \$2 trillion.²⁴ But when one considers that many of those adult costs could have been reduced—if not eliminated entirely—had those adults received adequate care when they were children, it becomes clear how counterproductive it is to prioritize adult health care over child health care.

Improving such access is not only a matter of sound health care policy; it is a vitally important means of strengthening America’s economic outcomes. By the time children born into poverty reach age 50, they are 46 percent more likely to have asthma, 75 percent more likely to have high blood pressure, 83 percent more likely to have been diagnosed with diabetes, 125 percent more likely to have experienced a heart attack or stroke, and 40 percent more likely to have heart disease compared with people whose incomes are twice the poverty line or greater.²⁵ The national cost of asthma in school children alone is nearly \$2 billion annually and the national cost of childhood obesity is \$14.1 billion annually.²⁶ The beginning of a new presidential administration provides us with the opportunity to seriously improve our approach to improve healthcare accessibility for our children; we conclude this paper with concrete recommendations that can help guide the incoming administration and Congress do exactly that.

II. FINANCIAL BARRIERS TO ACCESS

In spite of the considerable gains that have been made to subsidize the health care of low-income children, financial obstacles continue to force families to delay care, receive inadequate care, or go without care altogether. Data from the National Health Interview Survey show that even among children who are insured, there are about 13 million children whose families report either having problems paying medical bills or being unable to pay medical bills.²⁷ In a survey of parents seeking health care for their kindergarteners, 56.9 percent of those who indicated they experienced barriers cited a lack of financial resources.²⁸ Increased premiums are linked to lower-income children being disenrolled from insurance coverage.²⁹ And though the ACA has implemented measures to help reduce these costs—including removing copayments for preventive services and screenings—these measures have not been applied equally to all types of coverage. Further, wage growth continues to lag behind the cost of care:

The cost of employer-sponsored family coverage has climbed by 73 percent since 2003, while median family income has risen by only 16 percent. As a result, average annual premiums were 23 percent of median family income in 2013, up from 15 percent in 2003. Strikingly, average deductibles for an individual plan were 5 percent of median income in 2013, up from 2 percent in 2003.³⁰

Insurance Types

The type of insurance plan by which a low-income child is covered significantly influences the scale of financial barriers he/she will experience. Medicaid imposes the lowest costs for low-income families, with generally no premiums for children and individuals with income under 150 percent of the Federal Poverty Level (FPL), limited deductibles, and limited cost sharing.³¹ Medicaid enrollees have access to dental, vision, and developmental services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment program.³² Meanwhile, the coverage provided by CHIP programs varies substantially from state to state,³³ but when compared to private insurance, they do provide a relatively comprehensive set of benefits. The costs imposed by private insurance plans also vary widely, though tax credits and cost-sharing reductions are available for individuals and families who fall beneath certain income thresholds.³⁴

Yet cost burdens exist for children covered by every type of insurance, and low-income families often spend a high proportion of their income on care.³⁵ Though the financial burden of public insurance is capped at 5 percent of a family's income, researchers who modeled a scenario in which Medicaid and CHIP imposed no cost sharing or premiums found that 12.7% of families covered by those plans still spent more than 10 percent of their income on health services for all family members. Families below 100 percent of the FPL were likelier to have out of pocket costs and premiums exceeding 10 percent of family income than families at 200 percent of the FPL or above.

Meanwhile, in state exchanges created by the ACA to make coverage more affordable, families who miss the CHIP cutoffs can be faced with enormous burdens—in 36 states, children's premiums and cost sharing for CHIP averaged \$158, while children covered by a subsidized exchange plan on the silver level (second lowest) faced \$1,073 in annual out of pocket spending.³⁶ Overall, 77 percent of caregivers of privately insured children experience out of pocket costs, compared to 26 percent for Medicaid and 38 percent for CHIP.³⁷

Dental coverage for children has become a “loophole” for many families under the ACA. The law specifies that if a stand-alone dental plan exists in the Marketplace, qualified health plans are not required to offer dental benefits to children—families in turn are not required to purchase these plans, and many choose to go without them.³⁸ In a study of racial and ethnic disparities in care, 58 percent of white, 46 percent of

African-American, and 64 percent of Hispanic parents reported that the price of care was a major reason why their children have not received all the dental care they needed.³⁹ And while we report in this paper that 20.3 million children are not getting the services they need, this number does not include uniquely unmet dental needs of children.

The Effects of Financial Barriers

The effects of financial barriers can be significant. A 2010 study found that the most common reason for underinsurance was that costs not covered by insurance were either sometimes or always unreasonable, accounting for 12.1 million children.⁴⁰ Copayments have been found to reduce the number of health services used by low-income children; in Alabama, copayment increases of \$3 to \$5 per service significantly reduced the use of inpatient services and physician office visits.⁴¹ Premium increases are associated with significant reductions in public coverage enrollment, which in turn often leads to increased uninsurance for children.⁴² Cost-sharing at the point of service has been found to decrease access to certain services⁴³ while reducing the likelihood of receiving effective medical care and increasing out of pocket costs.⁴⁴ A recent survey of office-based pediatricians found that 51 percent of privately-insured patients covered by high-deductible health plans reduce or combine follow-up visits and use telephone consultations in lieu of office visits.⁴⁵

Families of children with special health needs are particularly affected by financial barriers. Publicly insured children with special needs spend more on premiums and care than other families—17.3 percent of families with special needs children have a 10 percent annual financial burden, compared to 10.5 percent of families without children with special needs.⁴⁶ For example, higher cost sharing was associated with delaying care and borrowing money to pay for care for children with asthma.⁴⁷

Underinsurance is common among children with special health needs, which is likely because these children use the system more often than children without these needs and so are disproportionately affected by things like high deductibles and copayments.⁴⁸ In addition, otherwise healthy children who experience an unexpected acute episode will incur significant jumps in health care spending—these economic shocks can knock families who are climbing out of poverty back into precarious financial positions.⁴⁹

Health Insurance Discrimination and Stigma

Families covered by Medicaid and CHIP are often faced with various forms of discrimination and stigma that stem from poor reimbursement and stereotypes attached to public insurance. Such stereotypes include: clinic administration's or providers' beliefs that these patients unreliably pay for the services they receive, beliefs that these patients are more litigious, and beliefs that these patients are unusually difficult to serve.⁵⁰ Fourteen percent of Florida Medicaid beneficiaries were found to have experienced discrimination by health care providers because of their insurance coverage; the figure was 9.3 of all adults surveyed in Minnesota.⁵¹ In addition to refusal of care, these stereotypes can also lead patients and patients' families to feel unwelcome in medical environments—discomfort that can lead them to not be as forthcoming with their providers as they need to be.

One survey respondent explained that:

I'm very thankful that we have [public insurance] and thankful that the Oregon Health Plan gave us what we needed at that time when we couldn't get it for ourselves, but it's not something I would want to stay on just because every time you have to go up to that window and hand in your Oregon Health Plan card, it's like you saying, "I can't do this on my own."

Another survey respondent said:

The first time I went to the hospital for a follow-up, I had the security guard following me around. He asked, "Sir, can I help you?" and I told him I had an appointment. The guard asked "Where is it? I'll take you." Take me he did.⁵²

Such experiences can lead to negative health outcomes for children and their families. Lower uptake of Medicaid in conservative states may be linked to the high prevalence of negative opinions of public insurance.⁵³ Clinic staff's negative attitudes lead to inadequate care and a decline in health among stigmatized patients.⁵⁴ In a study of Latino immigrants in North Carolina, insurance-based discrimination was associated with an increased likelihood of going without needed care.⁵⁵

Poor reimbursement rates are a primary disincentive for clinics and health systems to accept patients with Medicaid, as the lower rates often can't compete with private insurance. Additionally, in a recent survey, 59 percent of pediatricians said they have a harder time collecting patients' shares of deductibles and copayments from families covered by private high-deductible health plans.⁵⁶

Xinxin et al. (2015) raise the possibility that stigma and discrimination against public plans might fade as the ACA expands the number of people with public coverage and reimbursement rates rise; but they also caution that that might just transfer the stigma to uninsured people. It's also conceivable that people who purchase the cheapest, least comprehensive forms of private insurance in the ACA market might also become increasingly subject to stigma and discrimination.

III. NON-FINANCIAL BARRIERS

The most common non-financial barriers can be grouped into two broad categories: Geographic Barriers and Informational Barriers. Below, we detail some of the most pressing examples of each type and the effects they have on children's access to health care.

GEOGRAPHIC BARRIERS

Transportation

As researchers from Children's Health Fund highlight in a recent study, access to a car or public transportation can often determine whether a child accesses healthcare. Some 1.6 million rural households do not own a car and 40 percent of rural communities lack public transportation services.⁵⁷ A study of 12 rural North Carolina counties found that households with people who have a driver's license are at least twice as likely to attend regular checkups and follow-up appointments than those without one,⁵⁸ while another North Carolina-based study of migrant farm workers found that 80 percent of workers cited lack of transportation as the primary reason their child had an unmet medical need.⁵⁹

Urban areas are by no means free of transportation barriers. Public transportation does not exist in many mid-sized and small American cities (which are often sprawled over large geographic areas) while low-income populations in even the biggest cities often live in areas that are poorly served by public transportation. A study of urban clinics found that 21 percent of missed pediatric primary care appointments were attributed to transportation problems.⁶⁰ A study of urban children in Texas found that the use of a car increased the probability of keeping an appointment—respondents using non-car transportation had over three times the odds of not keeping their appointment as those who used a car.⁶¹

Health Professional Shortage Areas

CHF estimates that over 14 million children live in Health Professional Shortage Areas, or HPSAs (see Annex 1). Due to issues like remote geographical locations, low reimbursement rates, and insurance discrimination (discussed in detail below), practitioners can be reluctant to locate their practices in certain areas, imposing time and financial burdens on children and their families.⁶² The ACA, by expanding the National Health Service Corps, seeks to reduce this trend, and yet many areas continue to be classified as HPSAs, defined as areas that either have a low ratio of providers to population or that demonstrate a high level of need (such as areas with high poverty rates). Sixty-five percent of rural areas have been designated as HPSAs.⁶³ Children in HPSAs are often forced to go without a usual source of care, which some researchers believe can be just as important as having insurance in facilitating the receipt of healthcare.⁶⁴ An Oregon parent living in an HPSA told researchers:

Even though my children are eligible for dental coverage under OHP [Oregon's Medicaid and SCHIP Program], it is impossible to find a dentist that will take OHP. The only one I could find is 3 hours and at least 2 mountain passes away making getting there almost impossible, especially in the winter.⁶⁵

Hospitals and clinics are also often scarce in these areas, especially in rural regions.⁶⁶

INFORMATION BARRIERS

Health Illiteracy

Low-income parents are often overwhelmed by the complexity of their children's health plans and find themselves ill-equipped to know what they should be getting from their plans or how access care. Families can also lack information or an understanding of the importance of preventative or follow-up care. Literacy rates are lower for low-income families, and yet the reading material that is necessary to understanding coverage is typically not written at a suitable reading level.⁶⁷ A lack of basic health literacy is cited as a major reason for why minority children who are eligible for public insurance do not receive coverage—one study found that over half of parents of uninsured children are unaware that their children are eligible for Medicaid/CHIP.⁶⁸

Limited English Proficiency

Obstacles surrounding language become even more complex for parents who lack basic English. It is daunting enough for immigrant parents to get their eligible children insured (and still more difficult if that child is an immigrant) and the struggles only continue as they try to access services. Ku (2007) gives a comprehensive view of the difficulties that limited English proficiency causes for both providers and patients:

It is harder to get medical histories or descriptions of symptoms, to make diagnoses, to discuss treatment options, or to ensure that patients or parents understand and can adhere to their treatment regimens. Moreover, patients with limited English proficiency may experience problems at many stages of a medical encounter, including interactions with the receptionist, nurse, physician, lab technician, pharmacist, and billing clerk.⁶⁹

Children whose parents have limited English proficiency are less likely to visit a doctor or emergency room, more likely to report lower satisfaction with their health care, have poorer health status, and are likelier to be misdiagnosed.⁷⁰

IV. CONCLUSION AND RECOMMENDATIONS

Reducing, and ultimately eliminating, barriers to access is a pressing task for federal and state governments, insurers and providers alike. Though we have separated the barriers into two broad categories, it is important to emphasize that efforts to reduce financial and non-financial barriers must go hand in hand. As Kullgren et al. (2012) note, if we only succeed in reducing financial barriers, there is a chance we will just create new disparities by further disadvantaging those who struggle with non-financial barriers.⁷¹

In addition to the measures we list below, it is important for policymakers to create ways to monitor efforts to eliminate barriers. Kullgren et al. (2012) raise the possibility that the Accountable Care Organizations created by the ACA could in time be held accountable for advancing access to care; state health insurance agencies could also create special mechanisms to reduce access barriers including contractual benchmarks for Medicaid managed care insurers. Tools for measuring patient health care experiences could enable consumers to identify the insurance plans that help remove those barriers, and periodic health surveys could include extra questions on non-financial barriers to access.⁷²

ELIMINATE FINANCIAL BARRIERS

Increase Public Insurance Reimbursements

To eliminate financial barriers, Jost and Pollack (2015) recommend amending the ACA to expand eligibility for cost-sharing reduction payments, reducing out-of-pocket limits for moderate-income individuals or families, and reducing or eliminating premiums for Medicaid ineligible families below 150% FPL. Additional recommendations include fixing the “family glitch” so that working families are no longer excluded from marketplace tax credits, increasing subsidies for families below 400% FPL, and providing subsidies to families falling above that threshold to reduce coverage costs to a fixed percentage of household income.⁷³

It is also important not to take the advances we have achieved for granted; funding for CHIP is set to expire in 2017 while the ACA’s maintenance of effort provisions will end in 2019. These programs must be extended, or policymakers must otherwise ensure that replacement initiatives can provide comparable coverage.

Increase Public Insurance Reimbursements

A key means of reducing insurance-based discrimination/stigma and increasing the number of providers for publicly insured children is to support increased reimbursement rates for providers who participate in programs serving those children. Low provider reimbursement rates plague public insurance—especially Medicaid—leading many doctors to not accept publically insured patients.⁷⁴ The ACA has provided federal funding to increase Medicaid primary care reimbursement, but the increase has been relatively modest thus far.⁷⁵ These increases should utilize recent/current market rates and use electronic payment systems that ensure payments are delivered on time.⁷⁶ Increased reimbursement rates for providers treating underserved communities will help draw providers to HPSAs and reduce insurance-based discrimination and stigma.

ELIMINATE NON-FINANCIAL BARRIERS

Geographic Solutions

Policymakers must continue creating incentives that will draw providers to HSPAs and keep them in those areas. In addition to increasing loan repayment incentives and reimbursement rates, tax credits for capital projects and business tax abatements can help increase provider rates in HSPAs.⁷⁷ HSPAs are eligible to receive community health centers—Federally Qualified Health Centers (FQHCs) and Rural Health Clinics—that help make up for the health care services these areas lack.⁷⁸ Nearly half of these community health centers are located in rural areas and, taken together, serve one-third of children who live in poverty.⁷⁹ These centers have been found to reduce ambulatory care-sensitive inpatient admissions and emergency department visits, and patients who use them regularly incur significantly less in annual medical expenditures than non-users.⁸⁰ Community health centers show that to reduce financial barriers is to also reduce non-financial barriers: a study of patients who used these centers for the majority of their care incurred \$3,500 in annual medical expenditures, versus \$4,594 for nonusers.⁸¹

One particularly promising means of addressing HPSAs (as well as low-income children’s lack of a usual source of care) are School-Based Health Centers (SBHCs).⁸² SBHCs are health clinics located at schools or on school grounds that provide a wide range of preventative health services to students who live predominantly in underserved rural areas (28 percent of all SBHCs) and urban areas (54 percent). SBHCs reduce the various costs of health care for children in part by reducing the burden on parents to bring their children to a clinic. There are currently over 2,000 SBHCs in 41 States funded by a mix of private and public money. These centers have been found to have had significant impacts on minority children, including the reduction of teen birth rates by 3 percent.⁸³

Another recent development that holds significant potential for expansion of school-based services is the recent “Free Care” ruling enabling Medicaid reimbursement for school-based provision of health care services to Medicaid-eligible children. The ACA increased overall funding for these and other kinds of community health centers by \$11 billion and seeks to double their capacity by 2019. Additionally, mobile school-linked care services can increase providers’ capacity with less capital investment in a fixed site.

In addition to further increasing the numbers of health professionals and healthcare centers in health provider shortage areas, there are also ways to improve what resources are already in them. Health professionals in these areas can be trained to provide a broader range of services—for example, since dentists are particularly scant in these areas (or often do not accept many plans used by low-income families) some researchers propose doctors be trained to provide basic oral health care.⁸⁴ HPSAs are often caused by geographic maldistribution, rather than a shortage of children’s health care providers; in such cases, strategies to recruit and retain providers in areas can be more effective than trying to bring more short-term providers into an area.⁸⁵ Telehealth (see below) can also serve as a means of redistributing provider services and can also be based in schools.

As detailed in a 2016 CHF white paper,⁸⁶ telehealth is another potentially powerful avenue for addressing HPSAs. Advances in broadband coverage and affordable equipment are allowing more and more health care providers to use technologies such as videoconferencing and wireless communications to reach patients in remote and/or overburdened areas. Telehealth can help obviate transportation issues, difficulties in accessing remote communities, and shortages of health care providers, as well as the related costs.

Policymakers should continue providing support to pilot pediatric telehealth programs and appropriate reimbursement for telehealth services.

Reduce Transportation Barriers

There are several ways to improve transportation services for low-income families seeking medical care. Transportation planning officials can actively involve health sector officials to jointly plan ways to ensure that low-income parents are able to get to routine health care appointments. Increased or augmented Medicaid reimbursement can help health clinics to directly provide transportation services to supplement existing public transit infrastructure. With increased federal support, states can facilitate increased coordination of the federally subsidized transportation services that already serve low-income communities to expand transit options for those seeking medical care.⁸⁷

CHF strongly recommends that federal health and transportation agencies recognize and adopt a quantitative metric to assist in identification of “transportation-disadvantaged” communities. Designation as such should be a trigger for enhanced reimbursement to address transportation barriers to care. Additionally, telehealth services, interventions to increase families’ access to cars and increasing reimbursements for travel may be effective.⁸⁸

Eliminate Health Illiteracy

Simpler and more widely available literature explaining the importance of preventative and follow-up care and also nuances of public and private health plans can help ease the process of accessing care for children, but devoting human resources to this effort will pay even better dividends.⁸⁹ This could mean making insurance representatives and healthcare professionals more sensitive to the health literacy needs of their patients. It could also mean adding or increasing the number of staff who are dedicated solely to answering parents’ questions. Another possibility is to increase a specialized form of community health workers—parent mentors who themselves have children in the system. These mentors can be trained to assist and counsel parents of children who have similar conditions and risks. A study of mentors for minority children with asthma found that mentors are effective in reducing the various costs associated with the condition. For a cost of \$60 per patient a month for parent mentors, net cost savings reached \$597 per patient per asthma-exacerbation-free day that was gained.

Help Parents with Limited English Proficiency

Increasing clinics’ bilingual/multilingual capacity is key to serving parents with limited English proficiency. Such services are becoming more common, especially in areas with large immigrant populations, but progress is being slowed by the lack of reimbursement for translation and interpreter services. This further highlights the need for many more community health centers, which on which immigrants often rely for assistance with language issues (community health centers have been found to be particularly important for Hispanic communities).⁹⁰ As Call et al. (2014) write, “There is a need for more accessible and effective information (succinct and simplified mailings, help lines, navigators, and improved outreach) to facilitate understanding of available benefits.”⁹¹ Telehealth services (phone or video) can also be used to provide remote language services for areas where on-site interpreters are not available.

ANNEX 1

NUMBER AND PERCENT OF CHILDREN IN THE US WHO LACK SUFFICIENT ACCESS TO ESSENTIAL HEALTHCARE

Category	Number of children	% of all children
Uninsured	3.3 million	4.5%
Insured but missing timely, well child checks (indicative of lack of access to primary care)	10.3 million	14%
Children on Medicaid/CHIP who have access to primary care but have unmet needs for pediatric subspecialty care	6.7 million	9%
TOTAL	20.3 million	28%

METHODOLOGY

1) **Uninsured:** Data on the number (3.3 million) and percent (4.5%) of uninsured children comes from 2015 National Health Interview Survey 2015 and is based on the category “Uninsured at the time of the Interview.”⁹² This category does not fully capture those who may have been insured at the time of the interview but experienced a gap in insurance in the past year. About 7.7% (5.7 million) experienced a gap in insurance in the past year (either at the time of the interview and/or the year prior).⁹³ We are choosing to use the measure “Uninsured at the time of the interview” versus “Uninsured for at least part of the past year” to avoid overlap with the second category “Insured & missing timely routine checkups” which is specific to those who are insured at the time of the interview.

2) **Insured & missing timely routine checkups:** This number was calculated by applying the percent of insured children who miss timely well child checks from the 2014 National Health Interview Survey (14.7%) to the number of insured children from the 2015 National Health Interview Survey (70,033,333). What follows is a description of the steps taken. We inferred that the rate of children insured at the time of the interview was 95.5%, based on 4.5% rate of children uninsured at the time of the interview from the 2015 NHIS. The overall population of civilian, noninstitutionalized children aged 0 to 17 was back-calculated as 73,333,333, based on 2015 NHIS uninsurance rate of 4.5% and 3.3 million uninsured children. The number of children insured at the time of the interview is 70,033,333 (95.5% of the 73,333,333). Therefore, the estimated number of insured children who miss timely well child checks is 10,294,900 (14.7% of 70,033,333 insured children or 14% of ALL 73,333,333 children).⁹⁴

3) **Children on Medicaid/CHIP who have access to primary care but have unmet needs for pediatric subspecialty care:** This number was calculated by extrapolating findings from a primarily Medicaid pediatric population served by a clinic in a high-poverty neighborhood in New York City to all Medicaid-enrolled children in the United States. This clinic is affiliated with Children’s Health Fund and an academic children’s hospital.

Findings from the clinic show that about 23% of pediatric patients (915 out of 1424 children) who are primarily enrolled in Medicaid have at least 1 unmet need for subspecialty care (such as pediatric cardiology, pediatric endocrinology, etc.). Dental and mental health needs are not included, though there is likely some degree of overlap. Given that this data comes from an urban clinic affiliated with an academic medical center that provides high quality primary care and has above-average access to pediatric

subspecialists, we believe that this percent likely under-estimates the level of unmet need for pediatric subspecialty care in Medicaid-enrolled children across the nation, particularly for children who live in rural areas and Health Professional Shortage Areas.

The 23% rate from the clinic is substantially higher than the national rate of 8% of publicly insured children with problems accessing specialist care when needed as reported by parents in the 2011-2012 National Children's Health Survey.⁹⁵ We believe that the data reported by providers from the clinic is a better estimate of true level of need, versus data reported by parents, many of whom may not be fully aware of the child's medical specialty needs. The major caveat to this extrapolation is that findings from a small clinic sample of Medicaid-enrolled children may not be entirely generalizable to the entire population of Medicaid population.

Reviews of the literature on children's access to subspecialty care show that it is very difficult to estimate the number and percent of children who have unmet needs for subspecialty care due to considerable variation in methods across studies and lack of national data.⁹⁶ Publicly available national data reported by providers could not be easily found.

We did not include children living in HPSAs in the equation, as they could overlap with all or some of the above categories. Per our calculations, the estimated number of children living in HPSAs (derived from 2015 US Census data and 2016 HRSA data) is more than 14 million.⁹⁷

ENDNOTES

1. For the full Technical Note and detailed description of Data Sources for this table, see ANNEX 1 TECHNICAL NOTE.
2. “Uninsured” category: Data on the number (3.3 million) and percent (4.5%) of uninsured children comes from 2015 National Health Interview Survey and is based on the category “Uninsured at the time of the Interview”. This category does not fully capture those who may have been insured at the time of the interview but experienced a gap in insurance in the past year. About 7.7% (5.7 million) experienced a gap in insurance in the past year (either at the time of the interview and/or the year prior). We are choosing to use the measure “Uninsured at the time of the interview” versus “Uninsured for at least part of the past year” to avoid overlap with the second category “Insured & missing timely routine checkups” which is specific to those who are insured at the time of the interview.
3. “Insured & missing timely routine checkups”: This number was calculated by applying the percent of insured children who miss timely well child checks from the 2014 National Health Interview Survey to the number of insured children from the 2015 National Health Interview Survey.
4. “Children on Medicaid/CHIP who have access to primary care but have unmet needs for medical specialty care” category: This number was calculated by extrapolating findings from a primarily Medicaid pediatric population served by a clinic in a high-poverty neighborhood in New York City to all Medicaid-enrolled children in the United States. This clinic is affiliated with Children’s Health Fund and an academic children’s hospital. Findings from the clinic show that about 23% of pediatric patients who are primarily enrolled in Medicaid have at least 1 unmet need for pediatric subspecialty care (such as pediatric cardiology, pediatric endocrinology, etc.). Dental and mental health needs are not included. Given that this data comes from an urban clinic affiliated with an academic medical center that provides high quality primary care and has above-average access to pediatric subspecialists, we believe that this percent under-estimates the level of unmet need for subspecialty care in Medicaid-enrolled children across the nation, particularly children who live in rural areas and Health Professional Shortage Areas. Of note, the 23% rate from the clinic is substantially higher than the national rate of 8% of publicly insured children with problems accessing specialist care when needed as reported by parents in the 2011-2012 National Children’s Health Survey. We believe that the data reported by providers from the clinic is a better estimate of true level of need, versus data reported by parents, many of whom may not be fully aware of the child’s medical specialty needs. The major caveat to this extrapolation is that findings from a small clinic sample of Medicaid-enrolled children may not be generalizable to the entire population of Medicaid population. Reviews of the literature on children’s access to subspecialty care show that it is very difficult to estimate the number and percent of children who have unmet needs for specialty care due to considerable variation in methods across studies and lack of national data. Publicly available national data reported from providers could not be easily found.
5. Estimated number is: 14,351,144. This estimate is based on the proportion of the US population under 18 years of age (23%) multiplied by the number of people living in Health Professional Shortage Areas for primary medical care (62,396,277 people). Sources: 1) US Census. Persons under 18 years, percent, July 1, 2015, 22.9%. Available at <https://www.census.gov/quickfacts/table/PST045215/00>. 2) Bureau of Health Workforce Health Resources and Services Administration. Designated HPSA Statistics. (See “Shortage Areas, Health Professional Shortage Area (HPSA) - Basic Primary Medical Care” Available at: <http://datawarehouse.hrsa.gov/tools/hdwreports/Reports.aspx>.)
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97. Estimated number: 14,351,144. This estimate is based on the proportion of the US population under 18 years of age (23%) multiplied by the number of people living in Health Professional Shortage Areas for primary medical care (62,396,277 people). Sources: 1) US Census. Persons under 18 years, percent, July 1, 2015, 22.9%. (Available at <https://www.census.gov/quickfacts/table/PST045215/00>) 2) Bureau of Health Workforce Health Resources and Services Administration. Designated HPSA Statistics. (See "Shortage Areas, Health Professional Shortage Area (HPSA) - Basic Primary Medical Care" Available at: <http://datawarehouse.hrsa.gov/tools/hdwreports/Reports.aspx>.)
- Caveat: We have assumed that the percentage of children in HPSAs is the same as in the national population.



What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?

Sara Rosenbaum, Sara Schmucker, Sara Rothenberg, and Rachel Gunsalus

ABSTRACT

Issue: President-elect Trump and some in Congress have called for establishing absolute limits on the federal government's spending on Medicaid, not only for the population covered through the Affordable Care Act's eligibility expansion but for the program overall. Such a change would effectively reverse a 50-year trend of expanding Medicaid in order to protect the most vulnerable Americans. **Goal:** To explore the two most common proposals for reengineering federal funding of Medicaid: block grants that set limits on total annual spending regardless of enrollment, and caps that limit average spending per enrollee. **Methods:** Review of existing policy proposals and other documents. **Key findings and conclusions:** Current proposals for dramatically reducing federal spending on Medicaid would achieve this goal by creating fixed-funding formulas divorced from the actual costs of providing care. As such, they would create funding gaps for states to either absorb or, more likely, offset through new limits placed on their programs. As a result, block-granting Medicaid or instituting "per capita caps" would most likely reduce the number of Americans eligible for Medicaid and narrow coverage for remaining enrollees. The latter approach would, however, allow for population growth, though its desirability to the new president and Congress is unclear. The full extent of funding and benefit reductions is as yet unknown.

BACKGROUND

Over the past half-century, Medicaid has transformed from a niche program to become a linchpin of the U.S. health care system. It is today the largest single insurer, serving nearly 73 million low-income and medically vulnerable individuals, many of whom would go without needed care or face severe financial hardship without this coverage.¹

The growth in the number of Americans enrolled in Medicaid—up from just 4 million people in 1965, the program's first year—reflects its role as a health care "first responder" in the face of broad demographic, social, and economic trends.² These include: high poverty rates, which make it all but impossible for many people to pay anything above nominal amounts for their health coverage and care; an erosion in employer-sponsored coverage for low-wage workers; an aging population; and longer life spans for people with serious disabilities requiring ongoing care and support. Medicaid also has expanded to meet surging health care needs in the wake of natural and man-made disasters, ranging from the September 11th terrorist attacks to Hurricane Katrina, and to address public health crises such as infant mortality, HIV/AIDS and, most recently, the Zika virus.³ Finally, Medicaid is the largest source of financial support for health care providers serving medically underserved communities.

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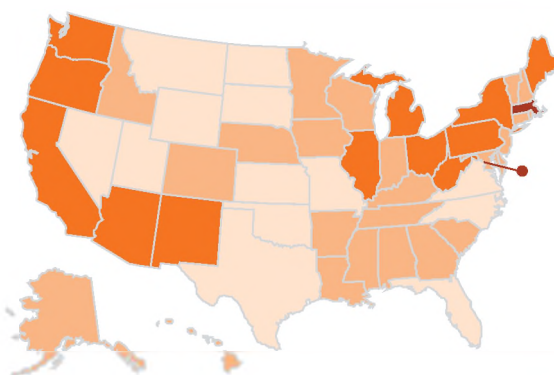
As the number of Americans enrolled in Medicaid has increased, so has the cost. Indeed, 70 percent of the growth in Medicaid spending is attributed to rising enrollment, especially in the wake of the Affordable Care Act's Medicaid eligibility expansion.⁴ On a per capita basis, however, Medicaid's annual spending growth rate remains relatively low, although recent evidence suggests that spending growth may be somewhat higher among newly eligible adults, who as a group are less healthy (at least partly owing to their previous lack of access to affordable care).⁵ To put this growth in perspective, in 1965 Medicaid cost a total cost of \$900 million, half of which the federal government paid. Looking ahead to 2024, when Medicaid is expected to cover 77.5 million Americans, the total bill will be \$920.5 billion. The federal government's share: 61 percent.⁶

To fulfill its mission as a health care safety net, Medicaid has relied on open-ended federal funding, as well as significant contributions from states (see box). But the high cost of Medicaid and the fear of uncontrolled growth has led some conservative policymakers to call for establishing absolute limits on spending—in effect, reversing a 50-year trend of expanding Medicaid to protect some of the most vulnerable Americans. This issue brief explores the two most common proposals: block grants that set strict limits on total annual spending regardless of enrollment, and per capita limits on spending.

COST-SHARING WITH STATES

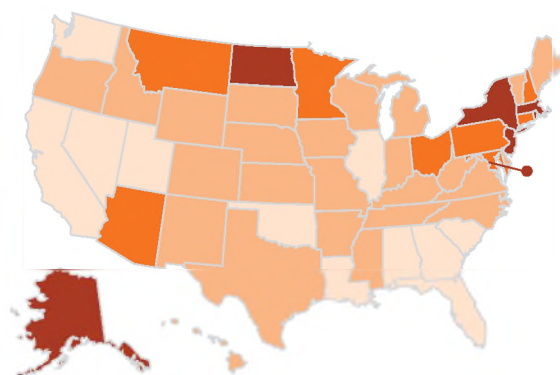
States share in the cost of Medicaid and must weigh these expenses against competing needs in an era of much tighter budgets. The pressures and choices are real, and states have acted aggressively to constrain annual increases in their share of Medicaid costs.⁷ As the maps illustrate, states already vary enormously in the proportion of low-income residents eligible for coverage and in the amount spent per enrollee. These variations reflect underlying social, economic, and financial conditions in each state as well as affirmative policy choices state officials make about whom to cover, what services and benefits to include in their plans, and how to pay participating health care providers and managed care plans.

Medicaid Coverage of the Nonelderly with Incomes Below 200 Percent FPL



- 30%–39% (13 states)
- 40%–49% (24 states)
- 50%–59% (12 states)
- 60%+ (1 state + DC)

Medicaid Spending per Enrollee



- <\$5,000 (11 states)
- \$5,000–\$6,499 (25 states)
- \$6,500–\$7,999 (8 states)
- \$8,000+ (6 states + DC)

Data: Coverage—Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of the Nonelderly (0–64) with Incomes up to 200% Federal Poverty Level (FPL), 2015, www.kff.org/other/state-indicator/nonelderly-up-to-200-fpl/; Spending—Kaiser Family Foundation, State Health Facts, Medicaid Spending per Enrollee (Full or Partial Benefit), FY2011, www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/.

CONTROLLING MEDICAID'S GROWTH: TARGETED STRATEGIES VERSUS ACROSS-THE-BOARD LIMITS ON SPENDING

Historically, federal and state policymakers have relied on targeted strategies to control Medicaid spending. These strategies zero in on specific drivers of cost, especially in areas where costs are escalating, and aim to reengineer services, making them more efficient and cost-effective. The approach reflects concerns that across-the-board spending limits would result in the denial of care to people in need. Notable examples of targeted cost-containment include reforms to lower outpatient prescription drug costs, expand access to preventive care, scale up managed care models, and create alternatives to long-term, costly institutional care. The approach also has included setting upper limits on certain expenditures, such as supplemental payments to hospitals that serve a disproportionate share of low-income people.

In addition, policymakers have imposed more stringent limits on the circumstances under which states can use health care provider taxes to finance their required share of Medicaid spending. These limits restrict the amount of money states have to invest in their Medicaid programs, which in turn restricts the amount of federal funding for which states can qualify.

Over the decades, these strategies have led to significant reductions in the cost of providing health care to individuals and eliminated unnecessary spending. For example, today about 80 percent of all Medicaid beneficiaries are served through some form of managed care.⁸ And cost-effective in-home and community-based care is now more common than long-term institutional care.⁹ The overall impact has been to make a growing national program more efficient, while still delivering quality health care.

Targeted cost-containment, however, does not address the primary source of increased spending on Medicaid: growing enrollment. Nor does it limit states' ability to deploy new technologies to improve coverage or the quality of care (like offering new vaccines or drug treatments), or introduce new efficiencies like electronic health records or updated management information systems. As a result, Republican leaders are calling for a very different approach to cost control.

In particular, President-Elect Donald Trump and House Speaker Paul Ryan have proposed to repeal the Affordable Care Act (ACA) and restructure Medicaid. The president-elect wants to replace Medicaid with block grants to states.¹⁰ Ryan's ideas are outlined in *A Better Way: Our Vision for a Confident America*, which devotes six of its 37 pages to Medicaid reform. While recognizing that Medicaid is a "critical lifeline for some of our nation's most vulnerable patients,"¹¹ *A Better Way* nonetheless proposes to substantially scale back the federal contribution. The first step would be to roll back eligibility. States that had not already expanded their Medicaid programs by 2016 to cover non-elderly poor adults (19 states as of November 2016) would have no access to federal funds to support such expansion.^{12,13} States would then have a choice of complying with "default" limits on per capita spending set by the federal government or receiving support in the form of a block grant.

Other proposed changes include restricting the extent to which federal funds can be used to cover certain populations or services while eliminating federal funding for others. One example would be to withdraw federal funding for people who have served time in prison or in jail.

Block Grants as an Alternative to Flexible Spending

The federal government helps fund an array of public services—from housing to public health, education, and law enforcement—through grant programs that give states annual fixed amounts to spend on activities permitted under the terms of the program. Because the federal funds available to states

are fixed amounts, they grow at a predictable, formula-driven rate from one year to the next—or not at all, if Congress does not appropriate funding increases. Such programs help support state health and social welfare activities; they do not entitle individuals to services, as does health insurance. Furthermore, they do not automatically take into account population growth, as would a per capita cap.

Providing federal funding for Medicaid using this type of approach (often referred to as a block grant) would disconnect the level of funding from the number of Medicaid beneficiaries and the cost of providing care. In other words, the federal contribution would remain the same, or grow only according to a preset formula, no matter how large the population in need becomes or how much a state actually must spend on health care for Medicaid recipients. To permit states to manage their Medicaid programs with a fixed amount of federal funding, the entitlement to coverage would need to be eliminated, and federal rules regarding eligibility, coverage, and payment would need to be substantially restructured or repealed. The Children's Health Insurance Program (CHIP) provides an example: The federal contribution is fixed and states are free to scale back enrollment and coverage as needed to avoid budget shortfalls. (A special maintenance-of-effort provision in the ACA prevents participating states from changing CHIP eligibility before October 2019, but states can roll back benefits or increase cost-sharing.)

Proposals to fund Medicaid through block grants have a long history. In 1981, President Ronald Reagan proposed state-specific block grants based on historical levels of spending in each state. Congress rejected the proposal but did temporarily tighten the federal funding formula. With the country in the midst of a recession, even this relatively modest downward adjustment in federal funding triggered widespread reductions in enrollment as well as benefits at a time when the opposite was needed.¹⁴ This temporary spending reduction was repealed in 1984 through bipartisan budget legislation.

A little more than a decade later, in 1995, both the House and Senate passed a bill that would have funded Medicaid through block grants to states based on historic average levels of spending nationally, coupled with a complex growth formula that would set future spending levels well below the expected rate of growth in Medicaid. President Clinton vetoed the legislation in the face of widespread evidence regarding its adverse financial impact on state Medicaid programs and underlying state economies.¹⁵

Since that time, block grant proposals have appeared intermittently. Most recently, in 2015, Senators Richard Burr of North Carolina and Orrin Hatch of Utah, both Republicans, and Congressman Fred Upton, a Republican from Michigan, introduced bills to repeal the Affordable Care Act.¹⁶ Both bills would have ended the ACA's Medicaid expansion funding for low-income adults and created block grants to states based on levels of spending prior to 2014.

The Congressional Budget Office (CBO) estimated that the proposed legislation would reduce federal spending by \$1 trillion over 10 years.¹⁷ Much of the savings would come from denying access to Medicaid for roughly 14 million people—the estimated number of low-income Americans who would have been eligible for Medicaid by 2026. Additional savings would be achieved by reducing federal spending for the traditional Medicaid program by 4.3 percentage points. By 2026, according to the CBO, federal spending on Medicaid was expected to be one-third below projected spending levels. Although the House bill offered no details regarding the level of flexibility states would have in order to absorb the significant reductions in federal funding, it had enough support to be incorporated into the 2017 fiscal year budget that was released in 2016.

A Better Way offers no formula for how block grants would be calculated or trended forward, or what growth factors would be considered, other than to note that the (undefined) base year for purposes of calibrating the block grant would exclude the ACA expansion population and would transition beneficiaries in expansion states to “other sources of coverage.” As a block grant, the formula presumably would be divorced from actual rises in enrollment and the cost of coverage, relying instead on a formula designed to produce predictable savings over time. Assuming that a new block grant proposal might mirror the 2017 House budget proposal, federal Medicaid funding could be expected to fall by a third in the tenth year of the proposal’s implementation.¹⁸

Per Capita Limits on Spending

Another way to control spending on Medicaid is to establish limits on per capita spending—per capita caps. These caps have the advantage of allowing funding to increase along with enrollment and underlying need, while setting an annual upper limit on federal spending per enrollee, and are supported by many advocates of Medicaid finance reform.¹⁹ President Clinton suggested this kind of cap prior to vetoing the 1995 congressional block grant proposal discussed above, but Congress rejected the idea.

Within this approach there are options: the federal government could set a single per-enrollee cap that applies to all Medicaid recipients, including children, adults, the elderly, and persons with disabilities; it could set different caps for each group; or it could exempt certain groups from the cap. However, since spending on elderly people and people with disabilities accounts for nearly two-thirds of total Medicaid spending,²⁰ the per-enrollee limits would need to apply to these populations in order to generate significant savings. In addition, the cap or caps could be structured to apply to all Medicaid services or only certain services, with others such as prescription drugs being exempt. And how much growth over time to allow in the caps themselves is also an open question.

Limits on per capita spending are more accommodating, at least in theory, to increases in enrollment reflecting underlying need, but a fundamental trade-off remains: To save money at the federal level, the caps must keep spending below projected levels—in effect shifting the burden to states in much the same way that block grants do. Under caps as well as block grants, states will face a gap between the costs of providing coverage and the federal funds available to offset those costs. And as with block grants, federal rules pertaining to eligibility, coverage, and payment to providers would have to be altered, allowing states to narrow their programs and avoid significant budget deficits.

The effects of per capita caps could have significant consequences for people’s health care and for insurers. For example, states might reduce already-low provider payment rates, forcing out many current providers and thus limiting access to care, a shift that research suggests would be especially detrimental for people who need specialized treatment and long-term care.²¹ If federal spending updates lag rising health care costs, states might reduce managed care payments below actuarially sound levels, triggering the demise of managed care plans. Or states might narrow eligibility to control costs, perhaps even eliminating coverage for the most needy and costly individuals.

Under Ryan’s plan outlined in *A Better Way*, states that choose to operate their Medicaid programs within the federal caps (as opposed to receiving a block grant) would transition to a new funding formula. That formula would take effect in 2019 but would be calculated based on enrollment and costs in 2016—three years earlier. The plan would apply separate caps to each of the four major beneficiary categories (children, adults, elderly people, and people with disabilities), which would be permitted to grow, but at an unstated rate below “current law.”²² Each state’s allotment would apply

the federal cap formula to the sum of its 2019 enrollment, adjusted for full-year equivalency (what the cost would be if every beneficiary remained enrolled in Medicaid for the full year) across all eligibility categories.

This plan does allow for population growth. But it fails to take into account that even within a single beneficiary category, some individuals are much more expensive to cover than others. In particular, the formula would treat people who are enrolled in Medicaid for part of the year as less expensive than full-time enrollees when, in fact, providing coverage to them can be more expensive if they enrolled because of a single, high-cost health episode. Nor does the plan explain how the high number of part-year enrollments would be taken into account in reaching an accurate picture of growth over time. Because the plan proposes to generate a *predictive* enrollment figure, rather than use actual enrollment, it could undercount enrollment. It also could fail to adequately adjust for short enrollment periods, which carry extremely high costs.

While *A Better Way* notes that the caps would reflect each state's expenditures for medical assistance and "non-benefit" expenditures, exactly which expenditures would be counted in the calculation is unclear. This is because the proposal notes that "[r]ecognizing the complexity of Medicaid financing, certain payment categories would be excluded . . . and would be calculated through a separate funding stream, such as payments to states for disproportionate share hospitals, graduate medical education payments, and other appropriate exclusions."

The proposal also would replace the actuarial soundness principles used to set managed care rates under current law with a new (undefined) "reasonable enforceable" premium test for nondisabled adults, as well as replace Medicaid's specific benefit and payment rules with state flexibility to adopt coverage designs that "promot[e] personal responsibility and healthy behaviors and encourag[e] a more holistic approach to care." The proposal does not explain which aspects of Medicaid's current coverage design would be eliminated or what an alternative design might look like.

What Counts as State Spending: An Unaddressed Issue

An important aspect of any proposal to reengineer federal funding for Medicaid is what will count as state spending for purposes of qualifying for federal funds. In fiscal year 2012, 69 percent of state Medicaid spending came from general revenues. States met their remaining obligations through local government contributions (16%), permissible health care–related taxes (10%), and other sources such as special dedicated revenues (5%).²³ If block grants or caps designated any of these forms of financing as impermissible, states would be in a position in which they would not qualify for every federal dollar otherwise available to them, causing federal outlays to fall even more than predicted. While easily overlooked, this crucial issue should be addressed in any proposal to create block grants or limit per capita spending—it remains unanswered in *A Better Way*.

CONCLUSION

As the country's largest insurer, Medicaid is subject to the same cost drivers that affect all providers of health insurance: population growth and demographic trends that increase enrollment, health trends that influence how often people need care and what kind of care they require, and advances in technology that drive up costs, among other factors. But unlike commercial insurers, government-funded Medicaid, in its role as first responder and safety net, is more vulnerable to these trends and to cost

increases. For more than 50 years, Medicaid has been rooted in a flexible federal–state partnership, constantly restructured over time to meet current challenges.

Any attempt to restructure federal financing for Medicaid and replace flexibility with strict spending limits—whether in the form of block grants, per capita limits on spending, restrictions on what counts as state expenditures, or a combination of all three—would divorce funding considerations from the real-life needs that have informed federal and state Medicaid policy for half a century. Crucially, a per capita cap would permit population growth to occur. But the limit of lawmakers’ appetite for continued growth in enrollment is unclear. Given how states responded to the relatively mild and temporary funding reductions the federal government enacted in 1981, sweeping changes like those currently under consideration are likely to produce far more substantial fallout.

NOTES

- ¹ Center for Medicaid and CHIP Services, “Medicaid and CHIP: June 2016 Monthly Applications, Eligibility Determinations and Enrollment Report” (Centers for Medicare and Medicaid Services, Aug. 25, 2016).
- ² Centers for Medicare and Medicaid Services, *2013 Actuarial Report on the Financial Outlook for Medicaid* (CMS, 2013).
- ³ L. H. Sun, “Planning Care for Zika Babies Challenges U.S. Officials,” *Washington Post*, July 25, 2016.
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- ⁵ Centers for Medicare and Medicaid Services, *2015 Actuarial Report on the Financial Outlook for Medicaid* (CMS, 2015), Table 3.
- ⁶ Ibid.
- ⁷ J. Holahan and S. McMorro, “Medicare and Medicaid Spending Trends and the Deficit Debate,” *New England Journal of Medicine*, Aug. 2, 2012 367(5):393–95.
- ⁸ Centers for Medicare and Medicaid Services, “Managed Care” (CMS, n.d.).
- ⁹ S. Eiken, K. Sredl, B. Burwell et al., Truven Health Analytics, *Medicaid Spending for Long Term Services and Supports (LTSS) in 2013: Home and Community-Based Services Were a Majority of LTSS Spending* (CMS, June 2015).
- ¹⁰ See “Healthcare Reform to Make America Great Again,” Trump/Pence 2016 website.
- ¹¹ P. Ryan, *A Better Way: Our Vision for a Confident America* (June 2016), p. 23.
- ¹² S. Rosenbaum, “Medicaid and Insuring the Poor: Where Are We Heading?” *New England Journal of Medicine*, Oct. 13, 2016 375(15):1405–7.
- ¹³ P. Ryan, *A Better Way: Our Vision for a Confident America* (June 2016), p. 26.
- ¹⁴ D. G. Smith and J. D. Moore, *Medicaid Politics and Policy*, 2nd ed. (Transaction Publishers, 2015).
- ¹⁵ Ibid.
- ¹⁶ See C. Eibner and S. Nowak, *Evaluating the CARE Act: Implications of a Proposal to Repeal and Replace the Affordable Care Act* (The Commonwealth Fund, May 2016).
- ¹⁷ E. Park, “Medicaid Block Grant Would Add Millions to Uninsured and Underinsured,” *Center on Budget and Policy Priorities Blog* (CBPP, March 15, 2016).
- ¹⁸ Ibid.
- ¹⁹ P. Ryan, *A Better Way: Our Vision for a Confident America* (June 2016), p. 26.
- ²⁰ J. Paradise, *Medicaid Moving Forward* (Henry J. Kaiser Family Foundation, March 2015).
- ²¹ S. Rosenbaum, “Medicaid Payments and Access to Care,” *New England Journal of Medicine*, Dec. 18, 2014 371(25):2345–47.
- ²² Ibid.
- ²³ Medicaid and CHIP Payment and Access Commission, “Non-Federal Financing” (MACPAC, n.d.).

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In New Survey of 11 Countries, U.S. Adults Still Struggle with Access to and Affordability of Health Care

Tags: [access to care \(/publications/in-the-literature#f.tagsfacet=\[access to care\]\)](#)

[International Health Policy Survey \(/publications/in-the-literature#f.tagsfacet=\[International Health Policy Survey\]\)](#)

November 16, 2016

Authors

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Also read a companion *To the Point* post, [Fewer Americans Say Cost Is a Barrier to Getting Care. But U.S. Still Has a Long Way to Go. \(http://www.commonwealthfund.org/publications/blog/2016/nov/americans-cost-barrier-decreasing-more-improvement-needed\)](http://www.commonwealthfund.org/publications/blog/2016/nov/americans-cost-barrier-decreasing-more-improvement-needed)

Synopsis

An 11-country survey finds that adults in the United States are far more likely than those in other countries to go without needed care because of costs and to struggle to afford basic necessities such as housing and healthy food. U.S. adults are also more likely to report having poor health and emotional distress. Bright spots for the U.S. include rates of timely access to specialist care, discussion with a physician about ways to lead a healthy life, and coordinated hospital discharge planning.

The Issue

"In comparison to adults in the other 10 countries, adults in the U.S. are sicker and more economically disadvantaged. The resulting challenge to the U.S. health system is compounded by higher health care costs, greater income disparities, and relatively low levels of spending on social services."

Asking people directly about their experiences with the health care system can reveal valuable information about how well a country is meeting the needs of its population. A new Commonwealth Fund study in *Health Affairs* examines patients' experiences based on responses to a 2016 survey of adults in 11 countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

Key Findings

- Adults in the U.S. are more likely than those in the 10 other countries to go without needed health care because of costs. One-third (33%) of U.S. adults went without recommended care, did not see a doctor when sick, or failed to fill a prescription because of costs. This percentage is down from the 2013 survey (37%). As few as 7 percent of respondents in the U.K. and Germany and 8 percent in the Netherlands and Sweden experienced these affordability problems.
- U.S. adults were also the most likely to report material hardship. Fifteen percent said they worried about having enough money for nutritious food and 16 percent struggled to afford their rent or mortgage.
- Half of U.S. adults struggled to get health care on the weekends and evenings without going to an emergency department. Between 40 percent and 64 percent of adults in the other countries reported the same. The Netherlands had the lowest rate on this measure, 25 percent.
- Adults in the U.S. (19%) and France (24%) were the most likely to say that their medical records or test results had not been available at the time of an appointment or that duplicate tests had been ordered in the past two years. These problems were reported less commonly in the other countries.
- Fourteen percent of chronically ill U.S. adults said they did not get the support they needed from health care providers to manage their conditions. This was twice the rate in Australia, Germany, the Netherlands, New Zealand, and Switzerland.
- U.S. health care performed comparatively well in the following areas: timely access to specialists, conversations with physicians about leading a healthy life, and coordinated hospital discharge planning.

The Big Picture

Although the U.S. has made significant progress in expanding insurance coverage under the Affordable Care Act, it remains an outlier among high-income countries in ensuring access to health care. The authors point out that all of the other countries surveyed provide universal insurance coverage, and many provide better cost protection and a more extensive safety net. To address the barriers to access and affordability identified in the survey, policymakers might consider expanding Medicaid eligibility in the 19 states that have not yet done so; limiting the amount people need to spend out of pocket on health care; and creating a stronger primary care system.

About the Study

Telephone surveys were conducted in each of the 11 countries between March and June 2016 among adults age 18 and older. Questions focused on people's experiences with their country's health care system in terms of access, quality, and affordability, as well as on self-reported health and well-being.

The Bottom Line

Despite progress since passage of the Affordable Care Act, adults in the United States remain more likely to go without needed health care because of costs compared to adults in other high-income countries.

U.S. Adults Struggle Financially, Skip Care Because of Costs, and Are Sicker

An 11-country survey shows that despite Americans' gains in access to care, the health system is not meeting patients' needs



Adults Reporting Stress About Paying for Housing and Healthy Food

Adults Who Faced Cost-Related Access Barriers to Care* in Past Year

Adults with Multiple Chronic Conditions, by Income



Chronic conditions asked about were:



JOINT PAIN OR
ARTHRITIS



ASTHMA OR CHRONIC
LUNG DISEASE



DIABETES



HEART DISEASE




HYPERTENSION

* Cost-related access barrier to care = had a medical problem but did not visit doctor; skipped medical test, treatment, or follow-up recommended by doctor; and/or did not fill prescription or skipped doses.

** Indicates differences are significant at $p < 0.05$.

Note: "Low income" defined as household income less than 50% the country median. Sample sizes are small ($n < 100$) in the Netherlands and UK.

Source: 2016 Commonwealth Fund International Health Policy Survey.

 Share



The Future of Health Care in the Post-Election Period: A View Through Polarized Lenses

Robert J. Blendon, ScD

Richard L. Menschel Professor of Public Health &
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Harvard T.H. Chan School of Public Health;

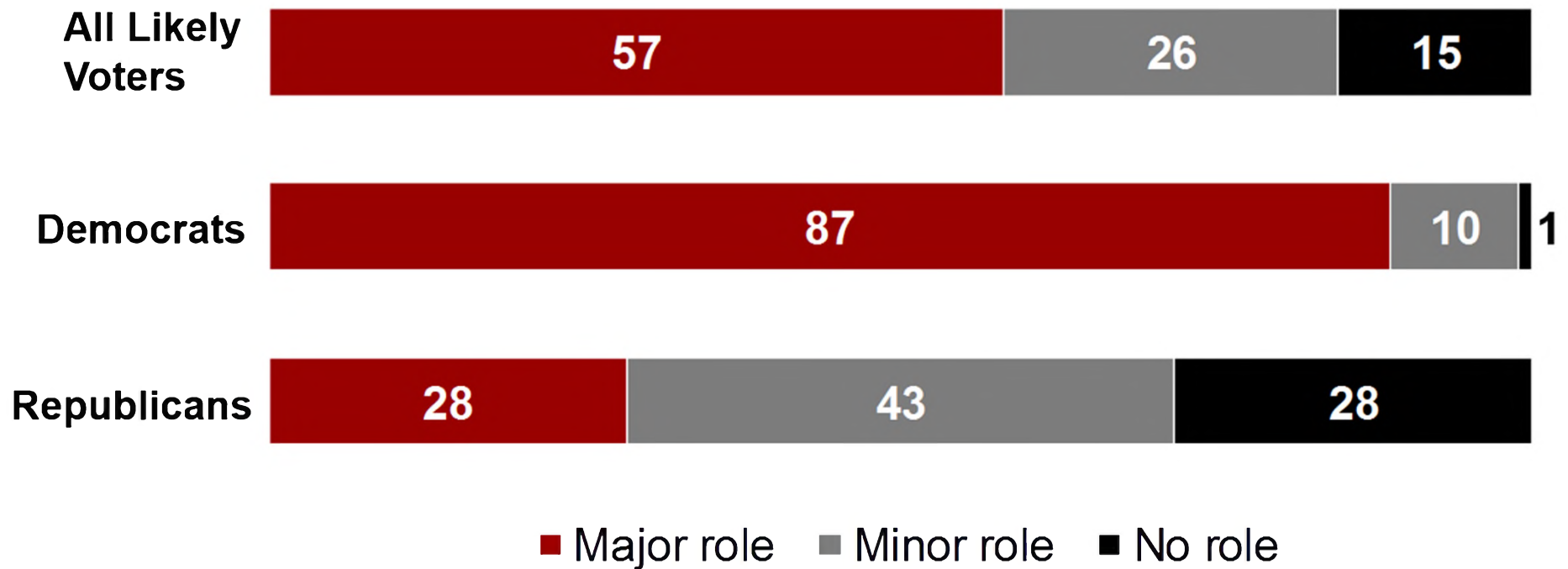
Professor of Health Policy and Political Analysis,
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Alliance for Health Reform Symposium
November 16, 2016

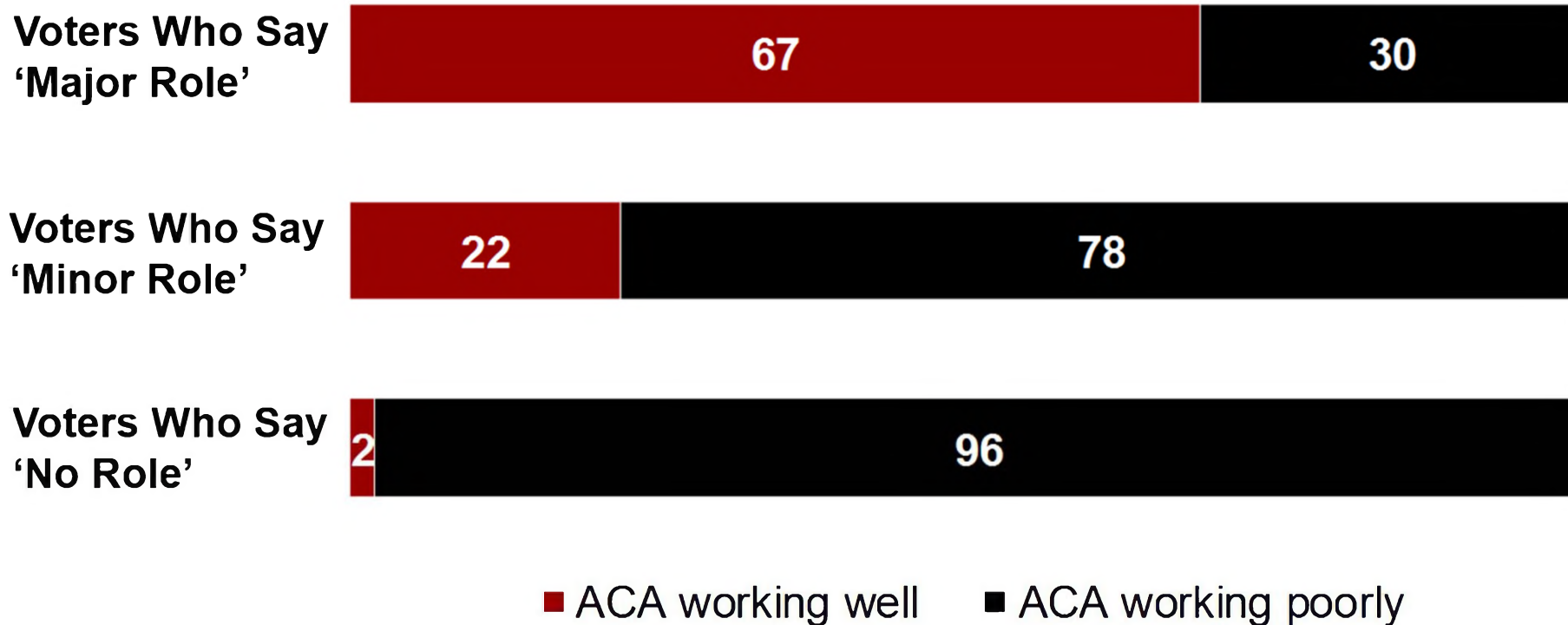


The Values Behind Health Care's Role in the Election

Voters' Beliefs About the Federal Government's Role in Improving Health System

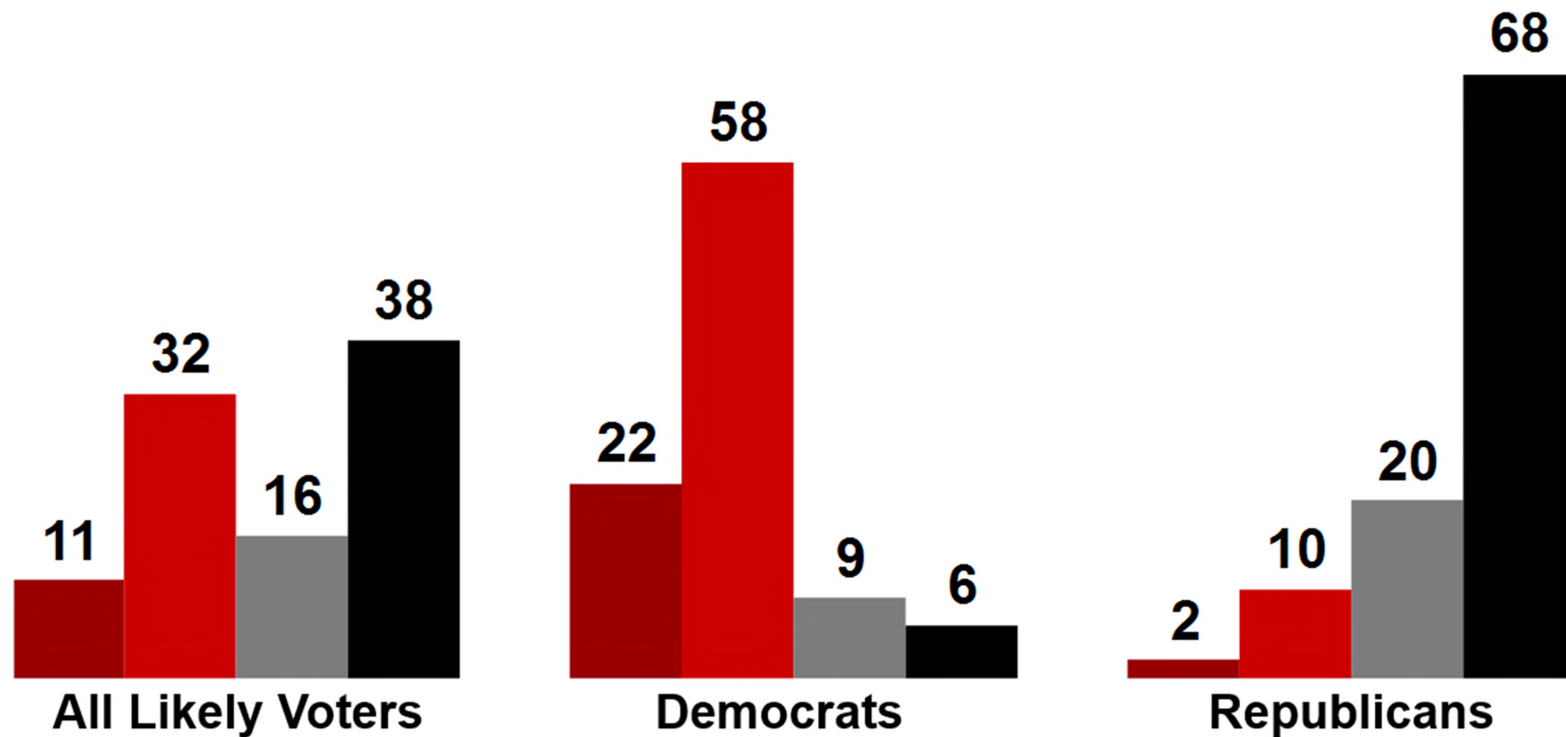


Voters' Views of the ACA Colored by Beliefs About the Government's Role in Improving Health System



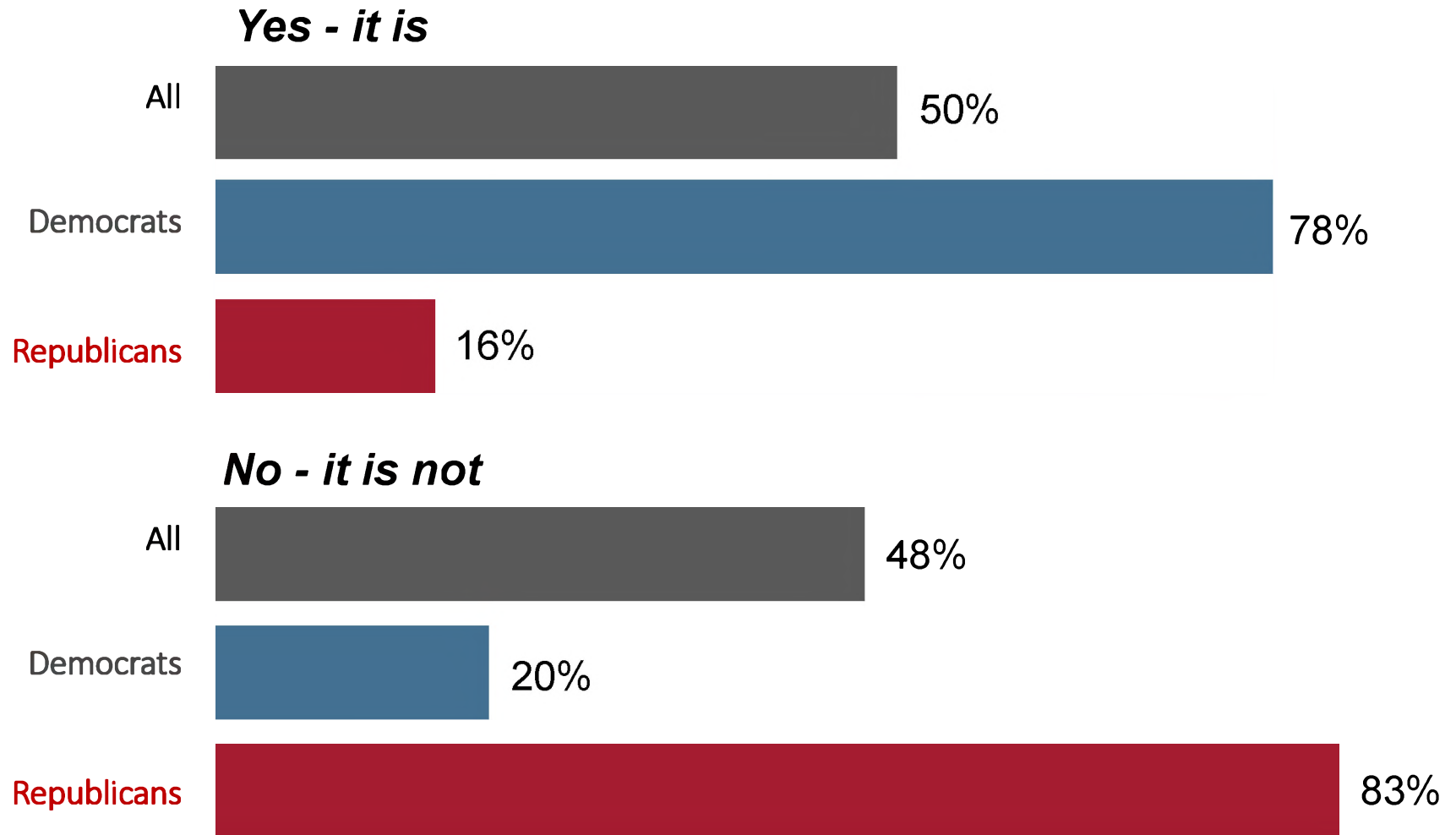
Voters' Views – How Well is the ACA Working?

■ Very well ■ Somewhat well ■ Somewhat poorly ■ Very poorly



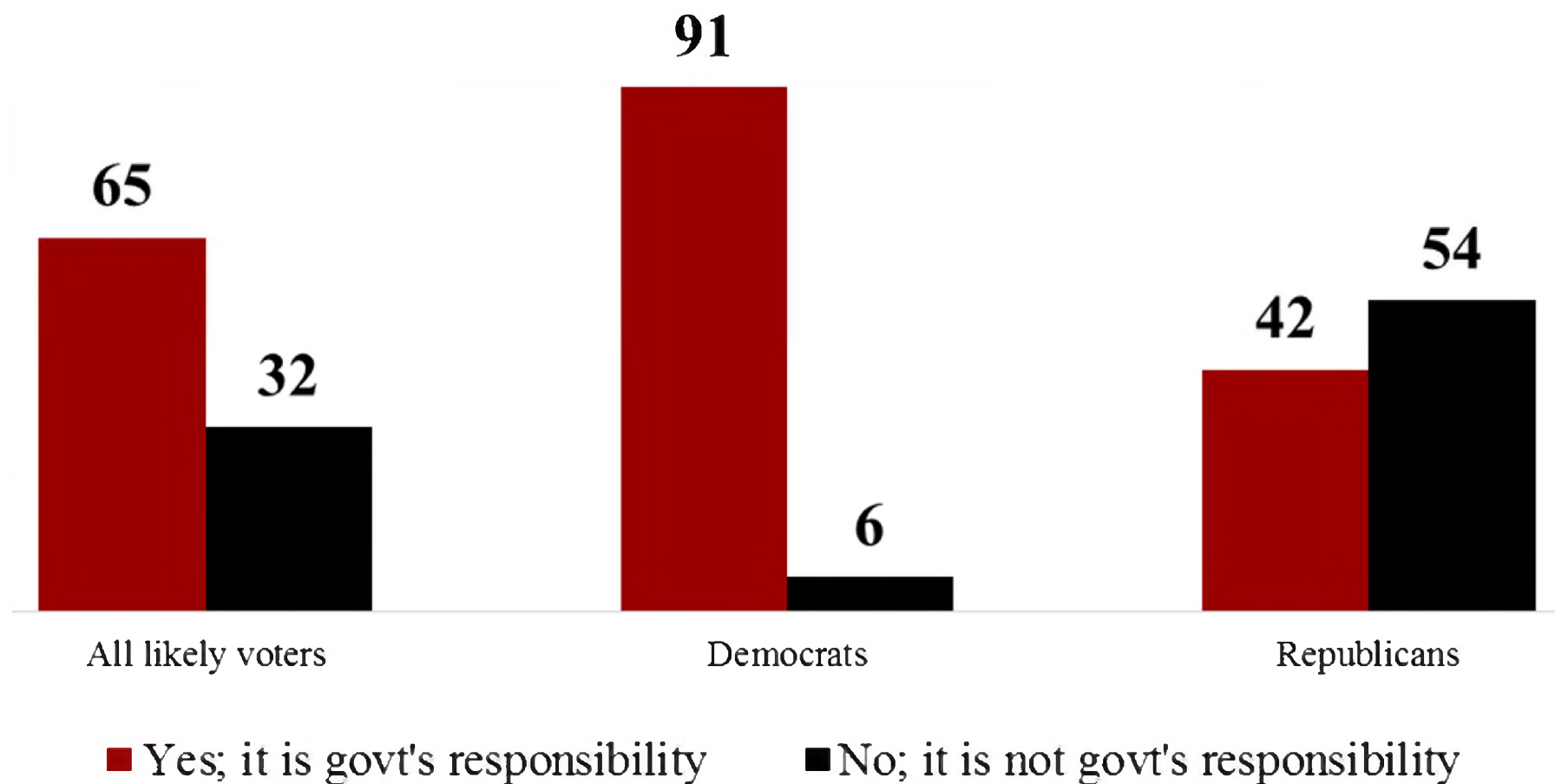
Responsibility of the Federal Government in Health Care

“Is it the responsibility of the federal government to ensure that all Americans have health coverage?”



Pew Poll of registered voters, March 2016.

Voters' Views on Government Responsibility to Ensure Rich and Poor Get Same Health Care

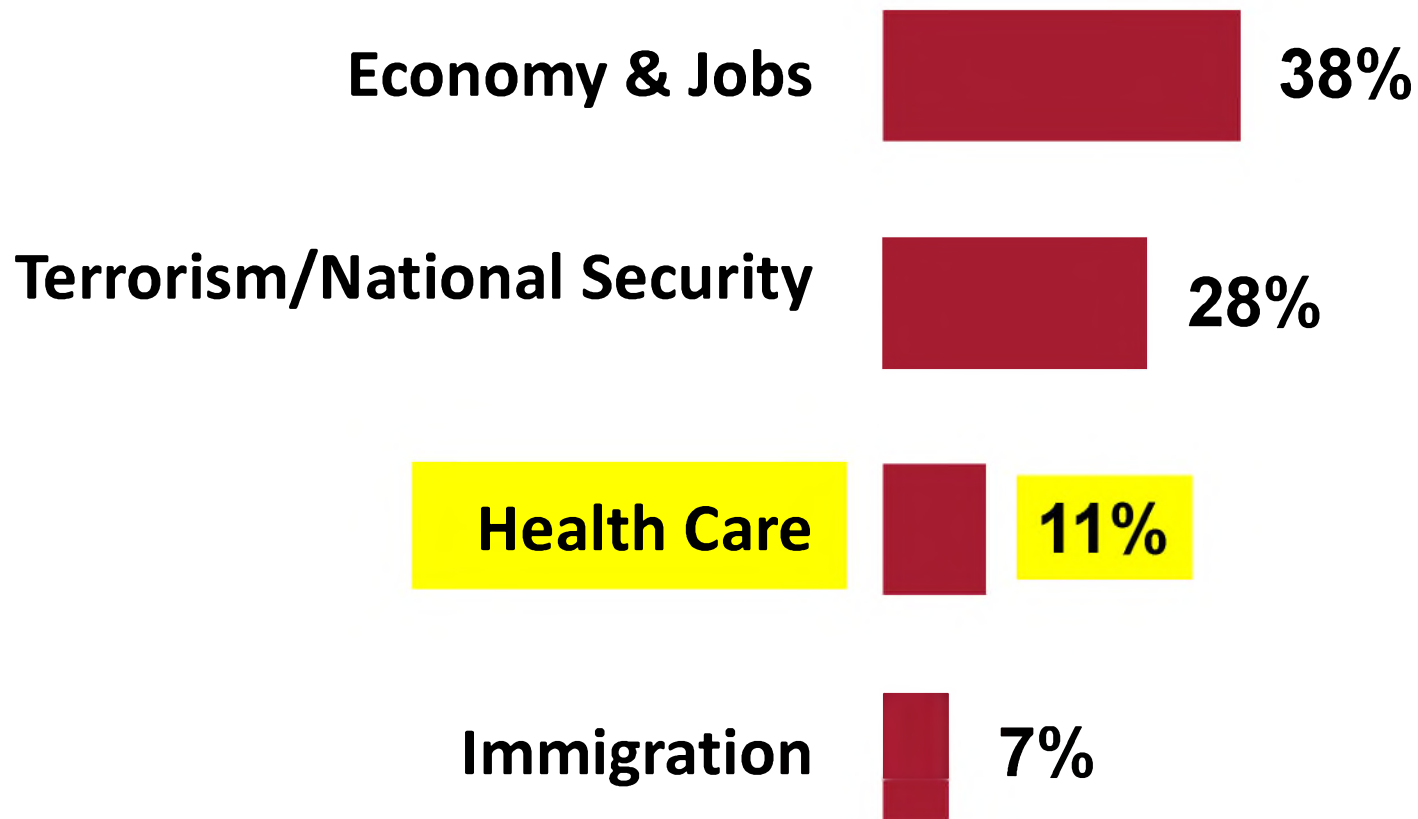




Health Care in the 2016 General Election

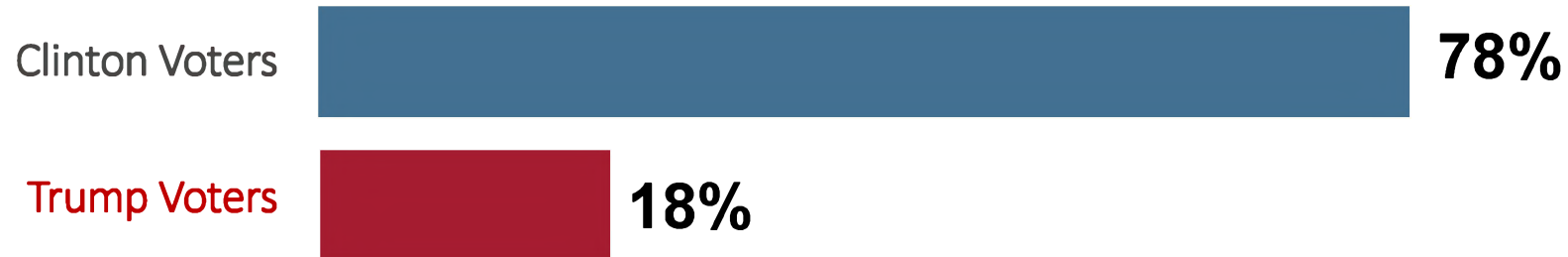
Top Four Policy Issues in 2016 Election

Percent of registered voters saying:
“Most important issue in presidential vote choice”



Voters Views on Obamacare (ACA)

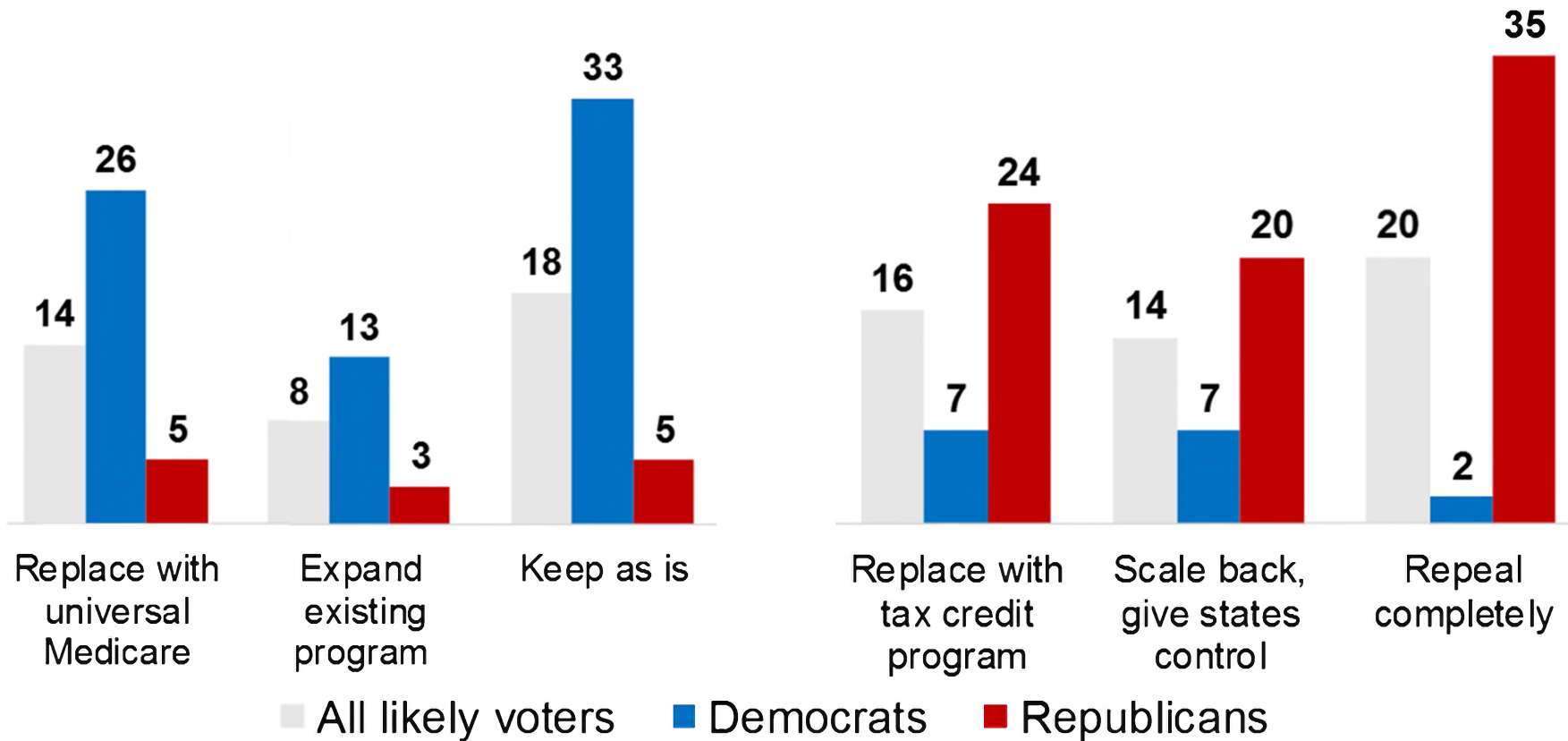
Did not go far enough



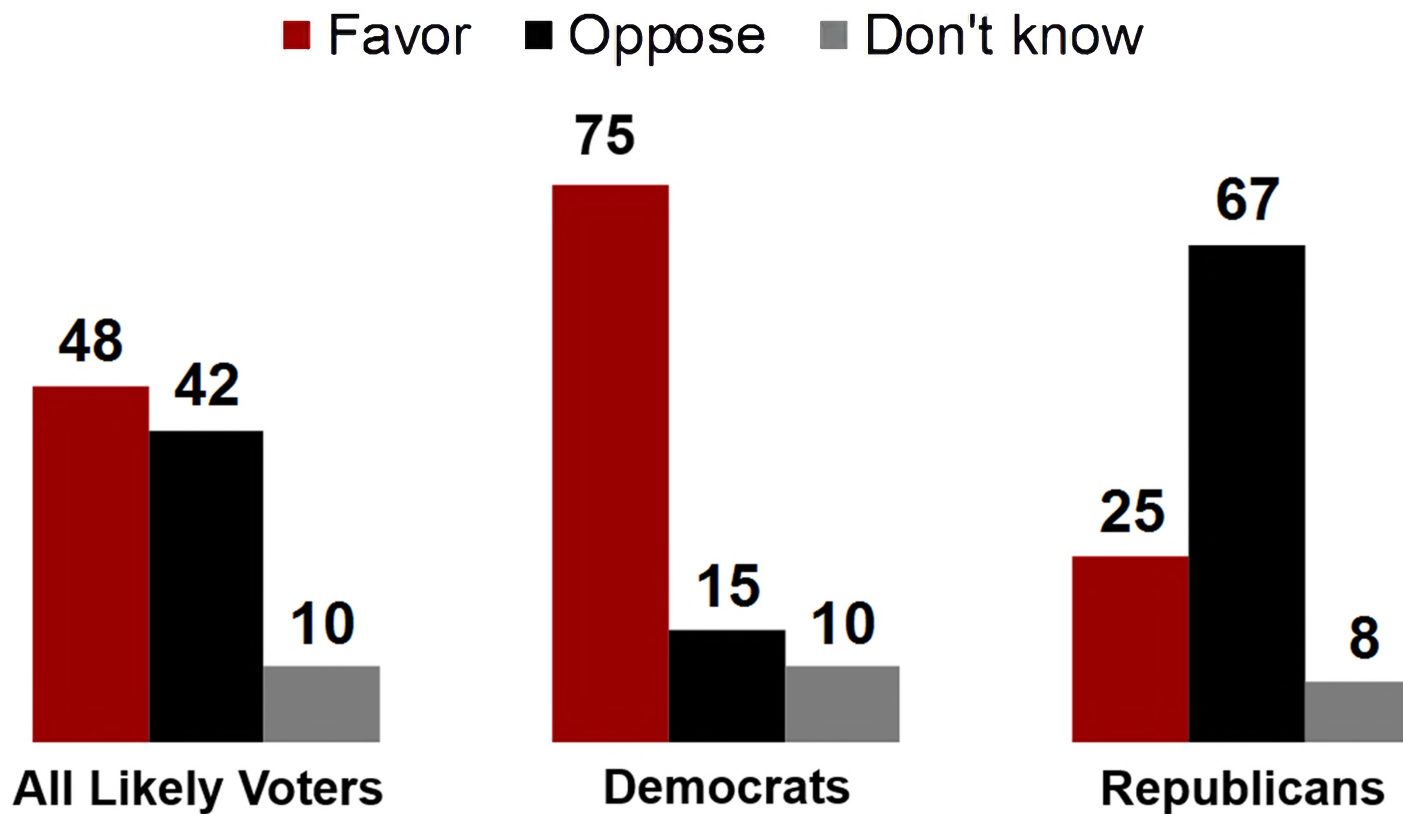
Went too far



Voters' Top Choice – What Should Happen to the ACA?



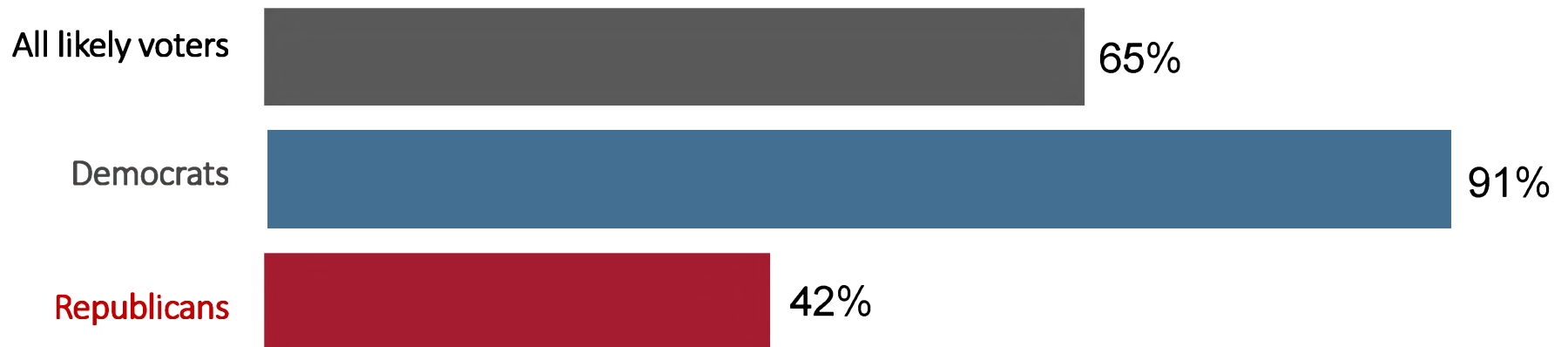
Voters' Beliefs About a Public Option in the ACA



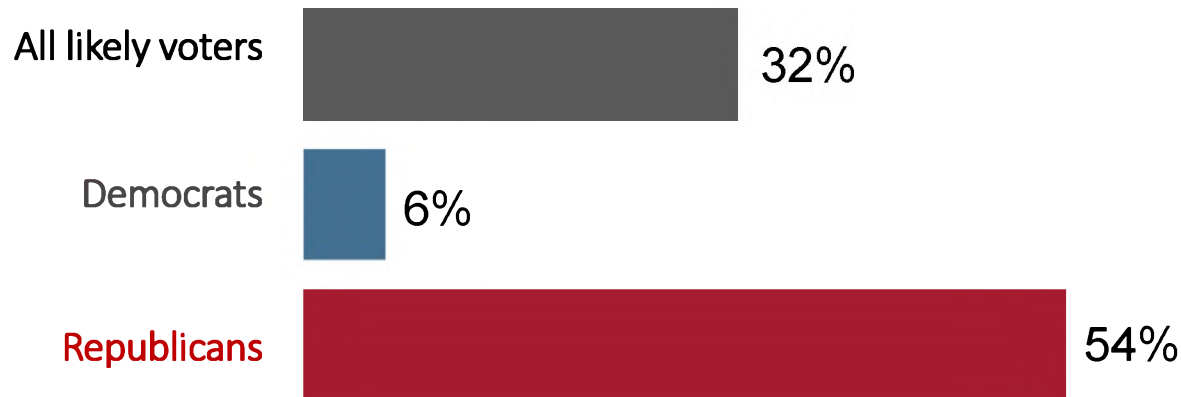
Voters and Inequality

“Is it the responsibility of the federal government to make sure the rich and poor get the same quality access to health care?”

Yes - it is

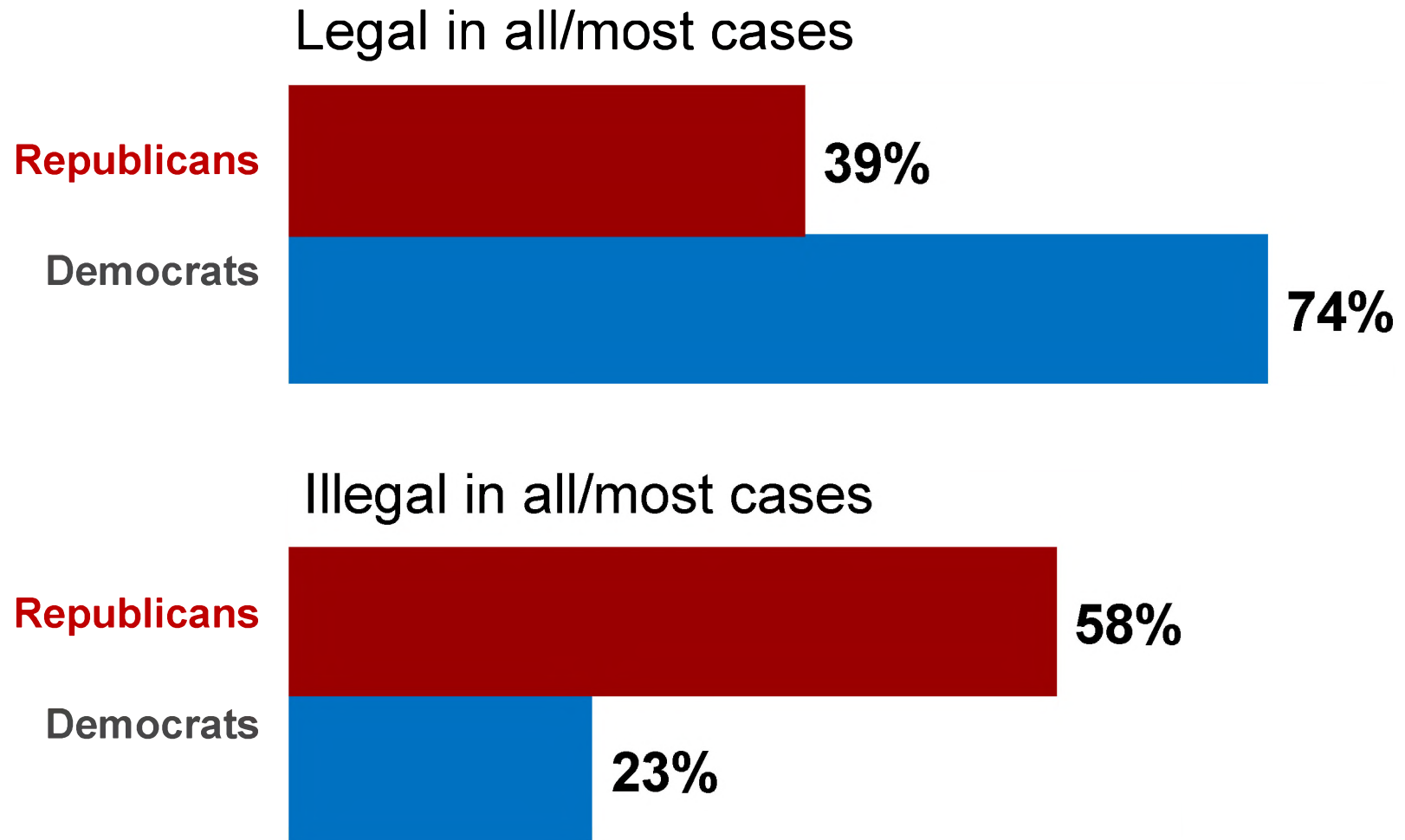


No - it is not



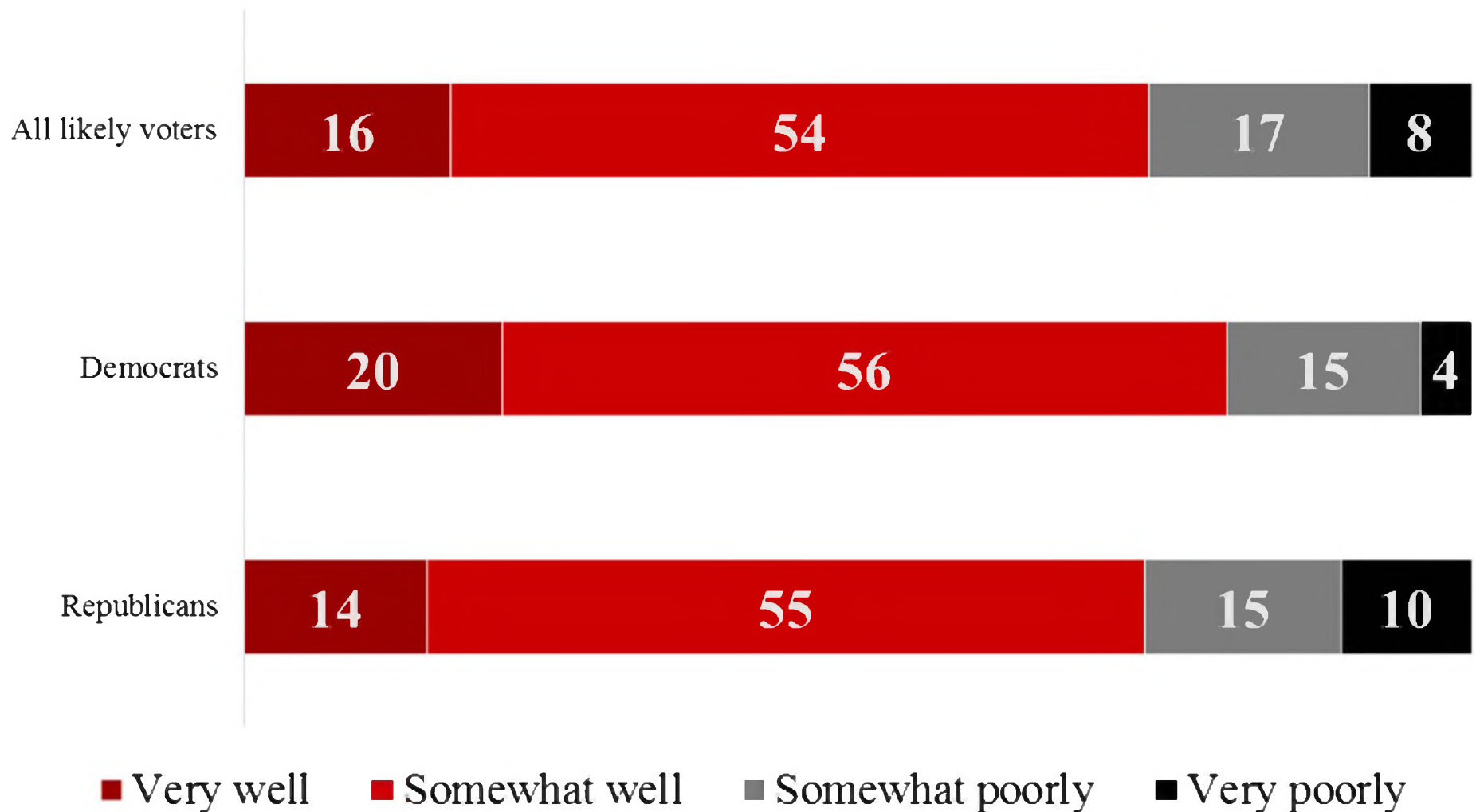
Public Opinion About Abortion, by Political Party

% Registered Voters

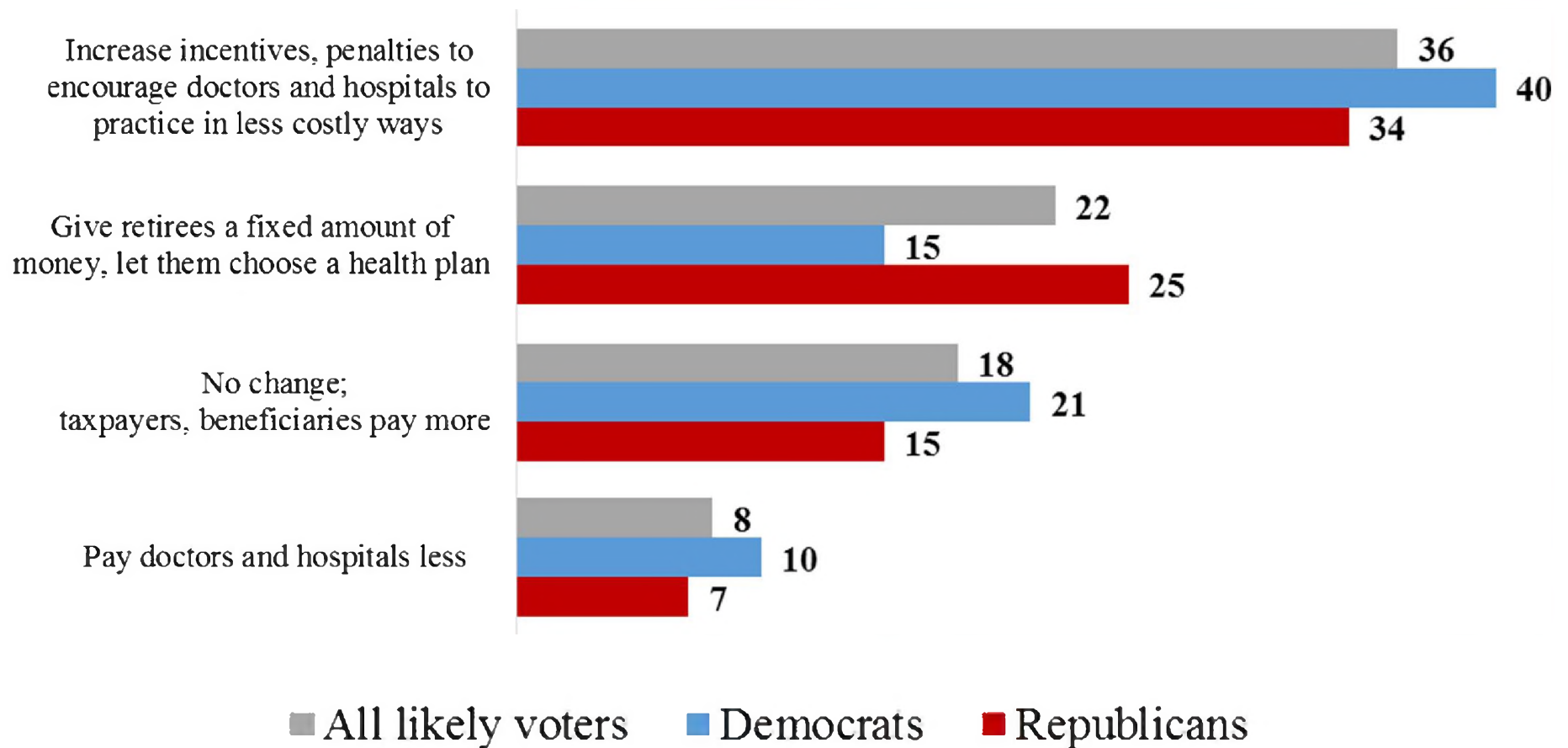


Pew Poll of registered voters, March 2016.

Voters' Evaluations of How Well Medicare is Working



Voters' Top Choice for How to Address Rising Medicare Costs



Responsibility for High Health Care Costs

“Who is to blame for the high costs of health care today?”

Top 3 ranked as “A lot”

All



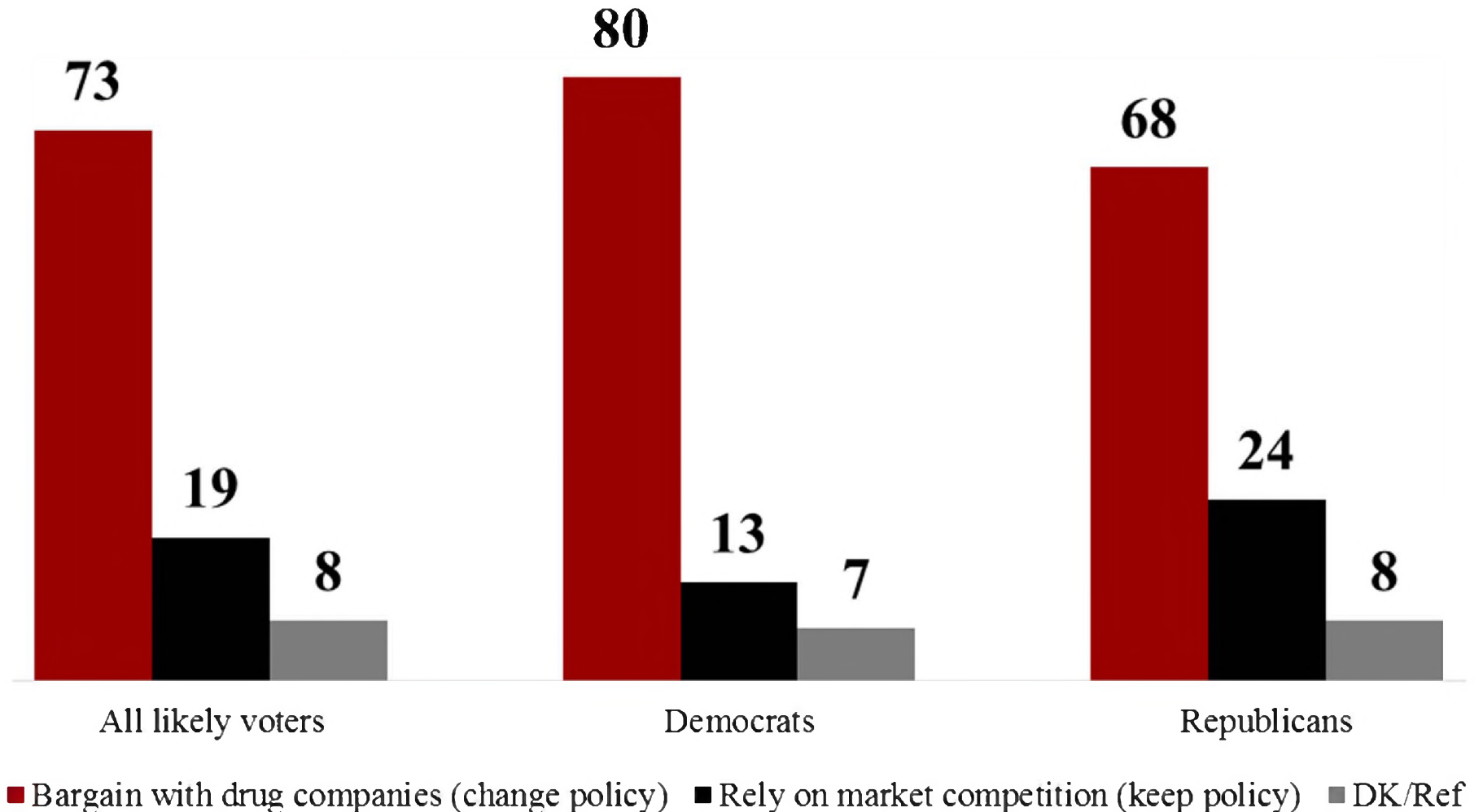
Democrats



Republicans



Voters' Views on Whether Medicare Should Use Bargaining Power to Lower Prescription Drug Prices



Questions?



State Health Reform Assistance Network

Charting the Road to Coverage

A Robert Wood Johnson Foundation program

ISSUE BRIEF

December 2016 Update

Repeal of the ACA Medicaid Expansion: Critical Questions for States

Prepared by *Jocelyn Guyer, Deborah Bachrach, Patricia Boozang, and Cindy Mann, Manatt Health*

Much of the post-election debate over the potential repeal of the Affordable Care Act (ACA) has focused on the fate of the Marketplaces, the mandate, and popular insurance reforms such as the ban on pre-existing conditions. Increasingly, however, it is clear that repeal could include elimination of the Medicaid expansion to low-income adults and other ACA Medicaid provisions, with far-reaching implications for states and the Medicaid program. This Q&A reviews available information on the potential repeal of the Medicaid expansion, and highlights the critical questions that states will want to ask as Congress and the new administration continue to debate when and how to repeal the ACA.

1. How likely is it that the repeal effort will include the Medicaid expansion?

Likely. Although the campaign debate over Obamacare was not focused on Medicaid, all of the key bills and proposals that serve as the starting point for “repeal” and “repeal and replace” plans include elimination of the Medicaid expansion. These include H.R. 3762, a budget reconciliation bill that was passed by the current Congress in late 2015 to repeal key elements of the ACA, but vetoed by President Barack Obama,¹ and the health care chapter of Speaker of the House Paul Ryan’s “Better Way” plan, a report of the House Health Care Reform Task Force, of which the nominee for Secretary of Health and Human Services (HHS), Rep. Tom Price, is a member.² It seems likely that elimination of expansion will come with a transition period (e.g., a January 1, 2018 implementation); a repeal effort is also likely to address whether additional states would be able to expand in the interim period.

2. What would repeal of the Medicaid expansion look like?

The best guide to what repeal of the Medicaid expansion could look like is H.R. 3762, the repeal bill adopted by Congress and vetoed by President Obama. It strikes both the eligibility category for low-income adults with income up to 133 percent of the federal poverty line and the enhanced federal funding provided for

ABOUT STATE NETWORK

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

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¹ 114th Congress. “H.R. 3762 – To provide for reconciliation pursuant to section 2002 of the concurrent resolution on the budget for fiscal year 2016.” (January 2016). Available online at: <https://www.congress.gov/114/bills/hr3762/BILLS-114hr3762enr.pdf>.

² Speaker of the House Paul Ryan. “A Better Way: Our Vision for a Confident America.” (June 2016). Available online at: http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

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newly-eligible adults. By eliminating the eligibility category and not just the funding, the bill precludes states from receiving even a regular Medicaid matching rate for low-income adults.

3. What process will Congress use for repeal and replace?

Congress has not yet settled on the process it will use to enact repeal, but it will likely move quickly in early 2017 to retract key elements of the ACA using a budget reconciliation bill. By using reconciliation, Congress can adopt repeal with only 51 votes in the Senate, making it unnecessary to secure Democratic support. Congress is under pressure to offer a replacement plan at the same time as repeal, but the reality is that it will be extraordinarily complex and time-consuming to do so. If it does not act quickly, the incoming administration risks losing the “honeymoon period” often afforded a new president and faces the prospect of a better organized opposition. In light of these dynamics, the most likely scenario at this point is that Congress adopts repeal early in 2017 with a delayed effective date and comes back later with a replacement plan.

4. What are the likely implications for coverage?

Without federal Medicaid funding, the vast majority of the 31 states that cover an estimated 14.5 million people through a Medicaid expansion—including more than 11.2 million newly eligible adults—will likely be forced to eliminate coverage (see Table 1 for state-specific enrollment estimates). The vast majority of these people lack a route to affordable coverage in the absence of expansion, especially if ACA subsidies are also eliminated.³ The losses will hit state budgets (see Question 5), low-income families, hospitals, community health centers, and other providers across the country.

5. What is the likely impact on state budgets of eliminating the Medicaid expansion?

The Medicaid expansion provides an estimated \$73 billion in federal funding to the 31 states and Washington, D.C. in calendar year 2016, including more than \$1 billion in more than half of expansion states (Table 1).⁴ In a real-time look at the effect of expansions on state budgets for the Robert Wood Johnson Foundation, a Manatt analysis found that expansion allowed states to reduce state general funds and local spending on uncompensated care, mental health and substance use disorder programs, and a range of other initiatives, as well as to increase revenue from hospital and issuer taxes.⁵ The unraveling of expansion funding can be expected to have the opposite effect, creating disruption to state budgets and potentially requiring new tax revenues or cuts to other state and local programs.⁶

6. What happens to the money that the federal government saves by eliminating expansion? Can it be used to finance a new approach to coverage?

After the federal dollars committed to financing the Medicaid expansion are eliminated, there is no easy way to get them back. Under standard congressional budget procedures, if the expansion is eliminated, the money is removed from the Medicaid baseline. It is not available to finance a replacement or for a new version of Medicaid coverage in the future. Congress, of course, can decide if it wants to raise taxes, increase the debt, or cut spending on other programs to restore the funding, but it is not obligated to do so. Medicaid has no special “right” in the future to federal savings generated by elimination of the expansion.

Similarly, several major repeal proposals strike most of the revenue provisions of the Affordable Care Act such as the tax on “Cadillac plans,” the fee imposed on health insurers, and the medical device tax, eliminating the vast majority of money used to finance the Medicaid expansion and other parts of the ACA. The proposals also eliminate the reductions in disproportionate share hospital (DSH) payments included in the ACA on the grounds that coverage gains would reduce the need for these payments. Congress can elect to re-impose these taxes and the DSH cuts when it comes time to craft a replacement proposal, but it will face strong opposition from affected industry groups and hospitals, especially if they are concerned that the replacement proposal fails to provide adequate coverage.

³ Of the 14.5 million individuals covered by Medicaid expansion, more than 3 million would have qualified under the Medicaid eligibility rules in place prior to Medicaid expansion. Some early (pre-ACA) expansion states receive an incremental increase in the federal match for these enrollees while others receive the regular Medicaid matching rate, rather than the enhanced matching rate, for the cost of providing services to these “already-eligible” adults. In many states, the pre-ACA waivers and eligibility categories that they were covered under have been eliminated, but it is possible that some will be able to retain coverage.

⁴ This federal funding supports newly eligible adults (\$60 billion) and also sustains state program expansions that were implemented before the ACA.

⁵ For example, the expansion has allowed individuals with disabilities to secure coverage as low-income adults without going through the time-consuming and challenging process of receiving a disability determination. Without the expansion, many such individuals may again seek a disability determination as a route into Medicaid coverage.

⁶ State Health Reform Assistance Network. “States Expanding Medicaid See Significant Budget Savings and Revenue Gains.” (March 2016.) Available online at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

7. Will states be able to secure the regular matching rate to cover (or continue to cover) low-income adults?

No, it doesn't look likely. As noted above, repeal proposals strip both funding and the eligibility category for low-income adults. Moreover, prior to the ACA, states had the option to expand coverage for low-income parents/custodial relatives at the regular Medicaid matching rate using less restrictive income methodologies. The ACA, however, eliminated this option as it was no longer needed when expansion was put into place and none of the repeal proposals advanced to date would restore it.⁷ This means that there will be even less flexibility to cover low-income adults than existed prior to the ACA.

8. Will states be able to use a Medicaid 1115 waiver to cover low-income adults?

Possibly, but they will need to cut spending on other Medicaid beneficiaries to cover the cost or generate offsetting savings through other means. This is because Medicaid 1115 waivers must be budget neutral to the federal government. Since low-income adults no longer can be covered without a waiver, the cost of covering them via a waiver must be fully offset. During the Bush administration, states were allowed to expand coverage to groups not otherwise eligible, but only if they reduced benefits or increased cost-sharing for existing Medicaid beneficiaries to pay for it.⁸ Some of the other tools used by states in the past to generate budget neutrality for expansion, such as claiming savings from implementing Medicaid managed care or relying on unspent Children's Health Insurance Program (CHIP) funds, are no longer available.⁹

9. What might replace the Medicaid expansion provisions of the ACA?

We don't know yet. There is no specific information available on what might replace the Medicaid expansion provisions of the ACA. The incoming administration's platform calls for a block grant of Medicaid, and since the election, Vice President-Elect Mike Pence has highlighted this proposal before the Republican Governors Association. Secretary nominee Price is also a strong proponent of block grants. Another key player, Speaker Ryan, has proposed giving states the choice of a block grant or a per capita cap. Regardless of the specific proposals put forth, a key question for expansion states is whether it will create a new pathway for covering low-income adults and, even more importantly, whether it will provide adequate federal funding for their costs.

10. Will states that already expanded Medicaid be able to keep their funding?

Even states that expanded prior to repeal may not be able to keep their spending on low-income adults in a block grant or per capita cap structure. As discussed above, if expansion funding is eliminated during repeal, it will not necessarily be available to finance Medicaid initiatives in the future; and it is not clear that even if some or all of the funding is made available that it would be directed to the states that had expanded coverage under the ACA. Moreover, influential groups such as the Heritage Foundation have explicitly said that states with expansions "will have to consider adjustments to accommodate elimination of the enhanced federal match rate," suggesting it would be risky to assume that any repeal package will include funding comparable to the ACA for low-income adults.

11. Will states that have not yet expanded Medicaid be able to receive new funding in the future to cover the costs of low-income adults?

It is even more unlikely that states that have not yet expanded will be given the flexibility and funds to do so under a replacement plan. In his "Better Way" proposal, Speaker Ryan explicitly says that states that have not expanded as of January 1, 2016 will "not be able to do so" under his per capita cap option. Moreover, block grant proposals often use historical spending as the starting point for state allotments which, for non-expansion states, will not include the costs of covering low-income adults. Congress, of course, could elect to include an adjustment for non-expansion states, but doing so will cost money and funds would

⁷ Specifically, the flexibility was based on the state option to use less restrictive income methodologies for the Section 1931 eligibility category for parents and caretaker relatives. In Section 1902(e)(14) of Title XIX, the ACA required the use of "Modified Adjusted Gross Income" ("MAGI") to evaluate eligibility for the 1931 category (and for a number of eligibility categories, including most categories for children and pregnant women) and precluded the use of less restrictive income or expense disregards.

⁸ Kaiser Commission on Medicaid and the Uninsured. "The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward." (March 2009.) Available online at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7874.pdf>.

⁹ Now that most states already have managed care and the remaining states can readily implement via a state plan amendment, it does not appear likely that a state could "claim" Medicaid managed care savings to offset a Medicaid expansion. Unspent CHIP funds are no longer an option; Congress imposed a statutory ban on the unspent funds being used for adults via waiver.

need to be provided. Congress could also elect to use a formula that does not rely on historical spending, but doing so will require a high-stakes and controversial redistribution of Medicaid funds among states.

Finally, it should be noted that one of the major repeal proposals to date, H.R. 3762, did leave the window on expansion open until January 1, 2018. Non-expansion states are likely to be unwilling to implement a new expansion that would be terminated within a matter of months. One exception might be if states believe that expanding would put them in a better position for future funding formula fights in the context of a block grant or per capita cap.

12. What questions should states ask about the implications of repealing the Medicaid expansion?

As Congress and the new administration continue to decide when and how to repeal the ACA Medicaid expansion and funding, it will be important for states to ask the following:

- What is the replacement plan? How can states be assured before a repeal vote that they will have the financing and flexibility needed to cover their low-income population?
- Will the savings associated with repeal of expansion be available to finance a replacement plan for the Medicaid provisions?
- Will any replacement plan provide a pathway to cover low-income adults? As important, will it provide the funding to do so and, if so, at what matching rate/level of support?
- Will states that already expanded be able to continue their expansions? Will they face a cut in the matching rate or even elimination of federal support?
- Will non-expansion states be able to expand in the future? And if not, how will any replacement plan address the inequities created by freezing states in place based on decisions made about expansion during the Obama administration?

Conclusion

If the Medicaid expansion is repealed, it will have sweeping implications for coverage, state budgets, and future opportunities in Congress to finance Medicaid restructuring and new approaches to providing care for low-income Americans. Repeal—particularly without a plan for replacement—leaves states vulnerable to the loss of funds with no assurance that they will be able to maintain coverage, benefits, or payment rates to providers or other key features of the Medicaid program. In the weeks and months ahead, it will be important for states and other stakeholders to work closely with Congress and the new administration to ensure that the implications of the repeal of Medicaid expansion are fully understood and key questions are answered.

Table 1: Medicaid Expansion: Key Data on Coverage, Enrollment and Federal Funding

State	Percentage Point Change in Nonelderly Adult Uninsurance Rate 2013 - 2015 ¹	Estimated Federal Funding for New Adult Group Enrollees 2016 ^{2**}	Estimated New Adult Group Enrollment ^{3**}
Alaska*	-	<i>Not Yet Available</i>	24,354 ⁴
Arizona	-9.6%	\$2,104,024,184	416,349
Arkansas	-11.8%	\$1,409,941,724	303,944
California	-12.6%	\$20,849,462,356	3,466,100 ⁵
Colorado	-9.8%	\$1,400,753,867	347,761 ⁶
Connecticut	-5.6%	\$1,304,296,439	207,625
Delaware	-5.5%	\$340,559,391	66,730
District of Columbia	-	\$349,757,059	61,993
Hawaii	-	\$539,929,165	108,072
Illinois	-7.9%	\$3,826,886,937	664,124
Indiana	-4.2%	\$1,216,384,523	381,631
Iowa	-4.2%	\$748,584,965	148,896
Kentucky	-15.7%	\$3,049,945,680	443,200
Louisiana*	-4.3%	<i>Not Yet Available</i>	304,684 ⁷
Maryland	-7.1%	\$1,728,229,389	248,237
Massachusetts	-3.0%	1,533,991,889	394,943
Michigan	-7.4%	\$3,425,889,383	633,013
Minnesota	-3.3%	\$1,652,984,611	187,060
Montana*	-	<i>Not Yet Available</i>	61,233 ⁸
Nevada	-14.2%	\$948,049,524	293,929
New Hampshire	-7.8%	\$319,693,087	52,892
New Jersey	-7.3%	\$2,983,553,961	532,917 ⁹
New Mexico	-	\$1,436,602,715	243,110
New York	-6.6%	\$8,151,895,901	2,094,895
North Dakota	-	\$254,701,368	<i>Not Available</i> ¹⁰
Ohio	-7.0%	\$3,564,222,956	677,540
Oregon	-8.7%	\$2,715,297,388	550,610
Pennsylvania	-5.5%	\$2,471,341,896	702,758
Rhode Island	-6.8%	\$461,962,623	60,455
Vermont	-	\$217,701,729	63,281
Washington	-12.3%	\$2,873,351,397	592,910
West Virginia	-19.9%	\$731,599,483	179,972
TOTAL		\$72,611,718,139	14,515,218

* Louisiana expanded in July 2016, Montana expanded in January 2016, and Alaska expanded in September 2015. Uninsurance rate data does not reflect expansion impacts in these states, and expenditure data on expansion enrollees is not yet available.

** These figures include spending and enrollment for previously eligible adults now covered under the expansion eligibility group. Of these, 11.3 million individuals were newly eligible because of expansion, and 2016 estimated federal funding for these enrollees is \$60.4 billion.

Data sources:

- ¹ National Health Interview Survey, 2013 – 2015. Available online at: http://www.cdc.gov/nchs/nhis/releases.htm#health_insurance_coverage
- ² Manatt analysis based on CMS-64 expenditure data posted as of December 2016. Data available online at: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/state-expenditure-reporting/expenditure-reports/index.html>.
- ³ Unless otherwise noted, March 2016 CMS-64 enrollment data posted as of December 2016. Available online at: <https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf>.
- ⁴ Data shows "lives covered by Medicaid expansion"; October 31, 2016 Medicaid in Alaska Dashboard. Available online at: <http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx>.
- ⁵ Kaiser Family Foundation estimate of new adults based on December 2015 Department of Health Care Services Medi-Cal monthly enrollment data. Kaiser estimate available online at: <http://files.kff.org/attachment/Issue-Brief-What-Coverage-and-Financing-is-at-Risk-Under-a-Repeal-of-the-ACA-Medicaid-Expansion>; Data available online at: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_June_2016_ADA.pdf.
- ⁶ March 2015 CMS-64 enrollment data. Available online at: <https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2015.pdf>.
- ⁷ Data shows "adult group" enrollment; September 2016 Louisiana Medicaid Enrollment Report. Available online at: <http://new.dhh.louisiana.gov/assets/medicaid/MedicaidEnrollmentReports/EnrollmentTrends/EnrollmentTrends-09.2016.pdf>.
- ⁸ Data shows "HELP Program enrolled" expansion adults; November 15, 2016 HELP Program Enrolled by County. Available online at: <http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/Enrollment%20by%20County.pdf>.
- ⁹ January 2015 CMS-64 enrollment data. Available online at: <https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2015.pdf>.
- ¹⁰ No CMS or state data source is publicly available for North Dakota's Medicaid expansion enrollment.

By Anne B. Martin, Micah Hartman, Benjamin Washington, Aaron Catlin, and the National Health Expenditure Accounts Team

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National Health Spending: Faster Growth In 2015 As Coverage Expands And Utilization Increases

ABSTRACT Total nominal US health care spending increased 5.8 percent and reached \$3.2 trillion in 2015. On a per person basis, spending on health care increased 5.0 percent, reaching \$9,990. The share of gross domestic product devoted to health care spending was 17.8 percent in 2015, up from 17.4 percent in 2014. Coverage expansions that began in 2014 as a result of the Affordable Care Act continued to affect health spending growth in 2015. In that year, the faster growth in total health care spending was primarily due to accelerated growth in spending for private health insurance (growth of 7.2 percent), hospital care (5.6 percent), and physician and clinical services (6.3 percent). Continued strong growth in Medicaid (9.7 percent) and retail prescription drug spending (9.0 percent), albeit at a slower rate than in 2014, contributed to overall health care spending growth in 2015.

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The National Health Expenditure Accounts Team is recognized in the acknowledgments at the end of the article.

Total US health care spending increased 5.8 percent and reached \$3.2 trillion in 2015, or \$9,990 per person (Exhibit 1). Following five consecutive years of historically low growth, from 2009 through 2013, health spending growth accelerated in 2014 (to 5.3 percent) and 2015 (to 5.8 percent). The faster growth in 2014 and 2015 occurred as the Affordable Care Act (ACA) expanded health insurance coverage for individuals through Marketplace health insurance plans and the Medicaid program.

Following the Great Recession, which extended from December 2007 through June 2009, growth in the overall economy and in health spending converged from 2010 through 2013. During this period, gross domestic product (GDP) and total health spending increased at similar average annual rates—3.7 percent and 3.6 percent, respectively—and the health spending share of GDP stabilized at an average of 17.3 percent (Exhibit 2). In 2014 and 2015, while growth in GDP averaged 4.0 percent, health spending growth accelerated, increasing at an

average annual rate of 5.5 percent. As a result, the health spending share of GDP increased by 0.6 percentage point over the two-year period, reaching 17.8 percent in 2015. In 2015 alone, the health spending share of GDP increased 0.4 percentage point, as an acceleration in health spending growth (from 5.3 percent in 2014 to 5.8 percent in 2015) was accompanied by a slowdown in overall economic growth (from 4.2 percent in 2014 to 3.7 percent in 2015).

Over the fifty-five-year history of the National Health Expenditure Accounts, the largest increases in the health spending share of the economy have typically occurred around periods of economic recession.¹ However, the increase in the health spending share of GDP in 2014 and 2015 occurred more than five years after the end of the last recession and coincided with millions of people gaining health insurance coverage after 2013 and with rapid growth in retail prescription drug spending.

In 2013 the insured share of the population was 86.0 percent (Exhibit 3), which is approximately where it had been in 2008. However, from 2013 to 2015 the number of uninsured in-

EXHIBIT 1

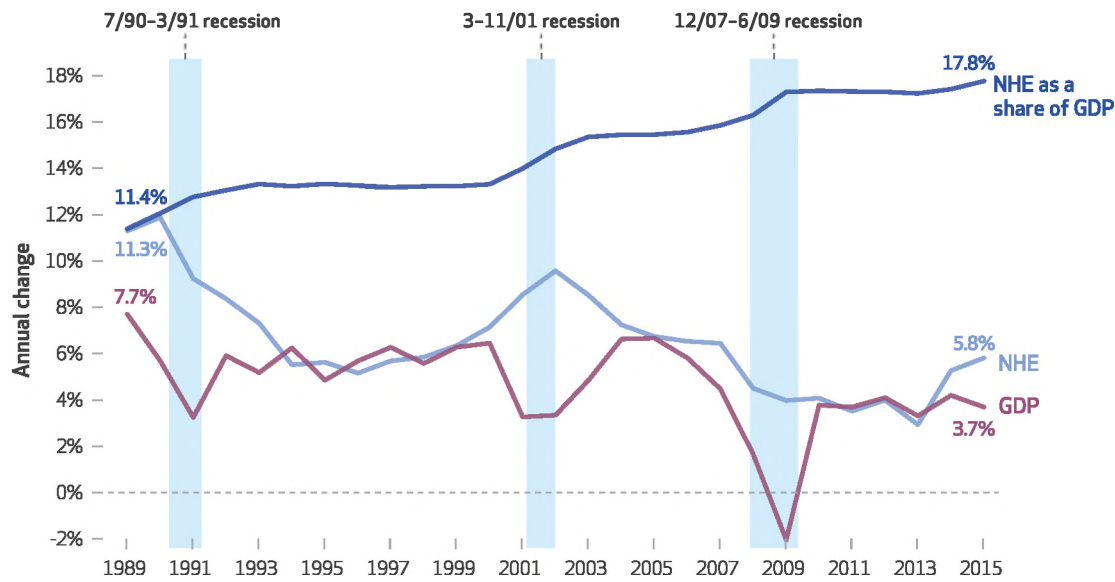
National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and annual growth, by source of funds, calendar years 2009–15

Source of funds	2009 ^a	2010	2011	2012	2013	2014	2015
EXPENDITURE AMOUNT							
NHE, billions	\$2,494.7	\$2,596.4	\$2,687.9	\$2,795.4	\$2,877.6	\$3,029.3	\$3,205.6
Health consumption expenditures	2,355.7	2,453.7	2,538.4	2,642.2	2,724.5	2,878.4	3,050.8
Out of pocket	293.1	298.7	308.5	317.6	325.1	329.7	338.1
Health insurance	1,796.1	1,875.1	1,948.2	2,019.6	2,086.3	2,228.2	2,384.5
Private health insurance	832.6	863.1	895.1	925.1	944.9	1,000.0	1,072.1
Medicare	498.9	519.3	546.3	569.5	590.4	618.5	646.2
Medicaid	374.4	397.2	406.7	422.7	445.4	497.2	545.1
Federal	247.3	266.4	247.1	243.3	256.9	305.5	344.0
State and local	127.1	130.9	159.6	179.5	188.5	191.7	201.1
Other health insurance programs ^b	90.3	95.6	100.1	102.2	105.6	112.6	121.1
Other third-party payers and programs and public health activity	266.5	279.8	281.8	305.0	313.1	320.5	328.2
Investment	139.0	142.7	149.5	153.2	153.0	150.9	154.7
Population (millions) ^c	306.4	309.0	311.2	313.5	315.9	318.4	320.9
GDP, billions of dollars	\$14,418.7	\$14,964.4	\$15,517.9	\$16,155.3	\$16,691.5	\$17,393.1	\$18,036.6
NHE per capita	\$8,141	\$8,404	\$8,638	\$8,915	\$9,110	\$9,515	\$9,990
GDP per capita	\$47,053	\$48,436	\$49,870	\$51,525	\$52,843	\$54,631	\$56,210
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	100.0	102.7	105.2	106.9	108.3	110.2	111.5
GDP price index	100.0	101.2	103.3	105.2	106.9	108.8	110.0
Real spending							
NHE, billions of chained dollars	\$2,495	\$2,528	\$2,556	\$2,614	\$2,657	\$2,749	\$2,874
GDP, billions of chained dollars	\$14,419	\$14,784	\$15,021	\$15,355	\$15,612	\$15,982	\$16,397
NHE as percent of GDP	17.3	17.4	17.3	17.3	17.2	17.4	17.8
ANNUAL GROWTH							
NHE	4.0%	4.1%	3.5%	4.0%	2.9%	5.3%	5.8%
Health consumption expenditures	4.6	4.2	3.5	4.1	3.1	5.6	6.0
Out of pocket	-0.6	1.9	3.3	2.9	2.4	1.4	2.6
Health insurance	5.9	4.4	3.9	3.7	3.3	6.8	7.0
Private health insurance	3.7	3.7	3.7	3.4	2.1	5.8	7.2
Medicare	6.8	4.1	5.2	4.3	3.7	4.8	4.5
Medicaid	8.8	6.1	2.4	3.9	5.4	11.6	9.7
Federal	21.8	7.7	-7.2	-1.6	5.6	18.9	12.6
State and local	-9.9	3.0	22.0	12.4	5.0	1.7	4.9
Other health insurance programs ^b	10.1	5.9	4.7	2.2	3.3	6.6	7.5
Other third-party payers and programs and public health activity	2.5	5.0	0.7	8.2	2.7	2.4	2.4
Investment	-6.1	2.7	4.7	2.5	-0.1	-1.4	2.6
Population ^c	0.9	0.8	0.7	0.8	0.7	0.8	0.8
GDP, billions of dollars	-2.0	3.8	3.7	4.1	3.3	4.2	3.7
NHE per capita	3.1	3.2	2.8	3.2	2.2	4.4	5.0
GDP per capita	-2.9	2.9	3.0	3.3	2.6	3.4	2.9
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	2.4	2.7	2.4	1.7	1.3	1.8	1.2
GDP price index	0.8	1.2	2.1	1.8	1.6	1.8	1.1
Real spending							
NHE, billions of chained dollars	1.5	1.4	1.1	2.3	1.6	3.5	4.6
GDP, billions of chained dollars	-2.8	2.5	1.6	2.2	1.7	2.4	2.6

SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services National Health Accounts methodology paper, 2015: definitions, sources, and methods [Internet]. Baltimore (MD): CMS, 2016 [cited 2016 Dec 2]. Available from: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-15.pdf>. Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. ^aAnnual growth, 2008–09. ^bIncludes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI, Department of Defense, and Department of Veterans Affairs. ^cEstimates reflect the Bureau of the Census's definition of *resident-based population*, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, members of the US Armed Forces overseas, and US citizens whose usual place of residence is outside of the United States. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts.

EXHIBIT 2

Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989–2015



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, US Department of Commerce, Bureau of Economic Analysis, and National Bureau of Economic Research Inc.

dividuals fell by 15.0 million, and the insured share of the population reached 90.9 percent.

Over the two-year period 2014–15, 9.7 million people gained private health insurance coverage (average growth of 2.5 percent), while an estimated 10.3 million more people enrolled in the Medicaid program (average growth of 8.4 percent).^{2,3} This increased coverage was largely due to provisions of the ACA that expanded coverage through Marketplace plans, provided subsidies for some enrollees in those plans, and expanded eligibility for Medicaid.

The acceleration in total health care spending growth in 2015 was primarily driven by faster growth in spending on private health insurance, hospital care, and physician and clinical services. Private health insurance spending increased 7.2 percent in 2015 (up from 5.8 percent in 2014) (Exhibit 1), as enrollment increased 2.6 percent (Exhibit 3). Faster growth in spending on private health insurance benefits occurred largely as a result of increased spending for hospital care and physician and clinical services.

Total spending for hospital care (by all payers) increased at a faster rate in 2015 than in 2014 (5.6 percent versus 4.6 percent), as did spending for physician and clinical services (6.3 percent versus 4.8 percent) (Exhibit 4). Increased use and intensity, associated in part with expanded insurance coverage,⁴ drove the growth in spending for hospital care and physician and clinical

services, which together accounted for 52 percent of total national health spending in 2015.

Factors Accounting For Growth

Per capita national health spending grew 5.0 percent in 2015 (Exhibit 1). Changes in the age and sex mix of the population accounted for 0.6 percent of the per capita spending growth in 2015 (Exhibit 5). Increases in medical prices and residual use and intensity of health care goods and services accounted for 1.2 percent and 3.2 percent, respectively, of the growth in 2015.

Growth in medical prices, which includes both overall economywide price inflation and medical-specific price inflation, was slower in 2015 (1.2 percent) than in 2014 (1.8 percent). All of the slowdown was in economywide price inflation, as measured by the GDP price index—which increased 1.1 percent in 2015 compared to 1.8 percent in 2014 (Exhibit 1). Medical-specific price inflation increased 0.1 percent in 2015, after experiencing no growth in 2014. Medical price growth can be decomposed into personal health care and non-personal health care, and in 2015, price growth decelerated in both categories.⁵ Among personal health care services, prices increased at a slower rate in 2015 than in 2014 for hospital care and other professional services, while prices declined for physician and clinical services, durable medical equipment, and other nondurable medical products.

EXHIBIT 3

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and annual growth, by source of funds, calendar years 2009-15

Source of funds	2009 ^a	2010	2011	2012	2013	2014	2015
PRIVATE HEALTH INSURANCE							
Expenditure (billions)	\$832.6	\$863.1	\$895.1	\$925.1	\$944.9	\$1,000.0	\$1,072.1
Expenditure growth	3.7%	3.7%	3.7%	3.4%	2.1%	5.8%	7.2%
Per enrollee expenditure	\$4,389	\$4,647	\$4,839	\$4,925	\$5,036	\$5,200	\$5,433
Per enrollee expenditure growth	7.1%	5.9%	4.1%	1.8%	2.2%	3.3%	4.5%
Enrollment (millions)	189.7	185.7	185.0	187.8	187.6	192.3	197.3
Enrollment growth	-3.2%	-2.1%	-0.4%	1.5%	-0.1%	2.5%	2.6%
MEDICARE							
Expenditure (billions)	\$498.9	\$519.3	\$546.3	\$569.5	\$590.4	\$618.5	\$646.2
Expenditure growth	6.8%	4.1%	5.2%	4.3%	3.7%	4.8%	4.5%
Per enrollee expenditure	\$10,971	\$11,146	\$11,442	\$11,462	\$11,514	\$11,702	\$11,904
Per enrollee expenditure growth	4.3%	1.6%	2.7%	0.2%	0.4%	1.6%	1.7%
Enrollment (millions)	45.5	46.6	47.7	49.7	51.3	52.8	54.3
Enrollment growth	2.4%	2.5%	2.5%	4.1%	3.2%	3.1%	2.7%
MEDICAID							
Expenditure (billions)	\$374.4	\$397.2	\$406.7	\$422.7	\$445.4	\$497.2	\$545.1
Expenditure growth	8.8%	6.1%	2.4%	3.9%	5.4%	11.6%	9.7%
Per enrollee expenditure	\$7,354	\$7,361	\$7,233	\$7,271	\$7,553	\$7,585	\$7,869
Per enrollee expenditure growth	0.9%	0.1%	-1.7%	0.5%	3.9%	0.4%	3.8%
Enrollment (millions) ^b	50.9	54.0	56.2	58.1	59.0	65.5	69.3
Enrollment growth	7.8%	6.0%	4.2%	3.4%	1.4%	11.1%	5.7%
UNINSURED AND POPULATION							
Uninsured (millions)	45.9	48.1	45.6	44.8	44.2	35.6	29.2
Uninsured growth	8.9%	4.7%	-5.1%	-1.9%	-1.3%	-19.5%	-17.9%
Population (millions) ^c	306.4	309.0	311.2	313.5	315.9	318.4	320.9
Population growth	0.9%	0.8%	0.7%	0.8%	0.7%	0.8%	0.8%
Insured share of total population	85.0%	84.4%	85.3%	85.7%	86.0%	88.8%	90.9%

SOURCES Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, and US Department of Commerce, Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. ^aAnnual growth, 2008-09. ^bBased on an unpublished analysis by the CMS Office of the Actuary of the following sources: (1) enrollment data from the Medicaid Statistical Information System state summary database. Medicaid.gov. Medicaid Statistical Information System (MSIS) [Internet]. Baltimore (MD): CMS; [cited 2016 Nov 3]. Available from: <http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/msis/medicaid-statistical-information-system.html>; and (2) CMS-64 quarterly expense reports. Medicaid.gov. Medicaid enrollment data collected through MBES (Note 2 in text). ^cEstimates are explained in Exhibit 1 Notes.

Growth in the residual use and intensity of health care goods and services reflects changes in utilization, such as the quantity of goods and services purchased, as well as changes in the mix (intensity) of those goods and services. It is measured as growth in nominal expenditures minus the effects of population growth, changes in the age and sex mix of the population, and medical price growth. Because it is a residual, it also includes any potential measurement errors. In 2015 the growth rate for residual use and intensity was 3.2 percent—greater than in 2014, when this factor's growth rate was 2.1 percent—and it was the primary driver of per capita health spending growth (Exhibit 5). Growth in residual use and intensity of services accelerated for almost all personal health care services, most notably for hospital care and physician and clinical services, while it slowed for nursing care facilities and prescription drugs.

Sponsors Of Health Care

Households, private businesses, and federal and state and local governments are the main sponsors of health care spending and are responsible for financing the nation's health care bill. In 2015 the federal government accounted for the largest share of spending (29 percent), followed by households (28 percent), private businesses (20 percent), and state and local governments (17 percent) (Exhibit 6).

Over the past two years, spending by the federal government on health care grew faster than spending by any other sponsor, increasing 8.9 percent in 2015 after an 11.0 percent increase in 2014. Although increasing at a slower rate than in 2014, the federal government's share of health spending continued to move upward, from 26 percent in 2013 to 28 percent in 2014 and 29 percent in 2015. Federal health spending growth in 2015 remained high mainly because of

EXHIBIT 4
National health expenditures (NHE) amounts and annual growth, by spending category, calendar years 2009-15

Spending category	2009 ^a	2010	2011	2012	2013	2014	2015
EXPENDITURE AMOUNT							
NHE, billions	\$2,494.7	\$2,596.4	\$2,687.9	\$2,795.4	\$2,877.6	\$3,029.3	\$3,205.6
Health consumption expenditures	2,355.7	2,453.7	2,538.4	2,642.2	2,724.5	2,878.4	3,050.8
Personal health care	2,114.2	2,194.6	2,272.6	2,365.9	2,435.6	2,562.8	2,717.2
Hospital care	779.7	822.4	852.0	902.7	937.9	981.0	1,036.1
Professional services	668.2	688.0	716.2	743.2	758.5	792.8	840.2
Physician and clinical services	498.7	513.1	536.4	558.0	569.5	597.1	634.9
Other professional services	67.2	69.8	72.7	76.4	78.8	82.8	87.7
Dental services	102.3	105.0	107.1	108.8	110.1	112.8	117.5
Other health, residential, and personal care	123.4	129.1	131.7	139.1	144.3	151.5	163.3
Home health care	67.3	71.0	73.8	77.1	80.0	83.6	88.8
Nursing care facilities and continuing care retirement communities	134.9	140.0	145.0	147.4	149.2	152.6	156.8
Retail outlet sales of medical products	340.8	344.2	353.8	356.5	365.8	401.4	432.0
Prescription drugs	252.7	253.0	258.7	259.1	265.1	297.9	324.6
Durable medical equipment	37.8	39.9	42.3	43.7	45.1	46.6	48.5
Other nondurable medical products	50.3	51.2	52.8	53.7	55.7	56.9	59.0
Government administration	29.6	30.1	32.4	33.5	37.2	41.2	42.6
Net cost of health insurance	137.9	153.5	159.3	165.5	173.8	195.3	210.1
Government public health activities	74.1	75.5	74.2	77.2	77.9	79.0	80.9
Investment	139.0	142.7	149.5	153.2	153.0	150.9	154.7
Noncommercial research	45.4	49.2	49.6	48.4	46.7	45.9	46.7
Structures and equipment	93.6	93.5	99.8	104.8	106.4	105.0	108.0
ANNUAL GROWTH							
NHE	4.0%	4.1%	3.5%	4.0%	2.9%	5.3%	5.8%
Health consumption expenditures	4.6	4.2	3.5	4.1	3.1	5.6	6.0
Personal health care	5.1	3.8	3.6	4.1	2.9	5.2	6.0
Hospital care	7.4	5.5	3.6	5.9	3.9	4.6	5.6
Professional services	2.9	3.0	4.1	3.8	2.1	4.5	6.0
Physician and clinical services	3.3	2.9	4.5	4.0	2.1	4.8	6.3
Other professional services	4.0	4.0	4.2	5.1	3.1	5.1	5.9
Dental services	0.4	2.7	2.0	1.6	1.3	2.4	4.2
Other health, residential, and personal care	7.7	4.6	2.0	5.6	3.7	5.0	7.8
Home health care	8.3	5.5	4.0	4.4	3.7	4.5	6.3
Nursing care facilities and continuing care retirement communities	3.5	3.8	3.6	1.6	1.3	2.3	2.7
Retail outlet sales of medical products	3.7	1.0	2.8	0.8	2.6	9.7	7.6
Prescription drugs	4.7	0.1	2.3	0.2	2.3	12.4	9.0
Durable medical equipment	0.4	5.6	5.8	3.4	3.2	3.5	3.9
Other nondurable medical products	1.7	1.8	3.1	1.7	3.6	2.2	3.7
Government administration	1.4	1.7	7.7	3.5	11.0	10.9	3.2
Net cost of health insurance	-1.3	11.3	3.8	3.9	5.0	12.4	7.6
Government public health activities	3.6	1.9	-1.8	4.2	0.9	1.4	2.4
Investment	-6.1	2.7	4.7	2.5	-0.1	-1.4	2.6
Noncommercial research	2.5	8.5	0.9	-2.5	-3.7	-1.7	1.8
Structures and equipment	-9.8	-0.1	6.7	5.0	1.5	-1.3	2.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. ^aAnnual growth, 2008-09

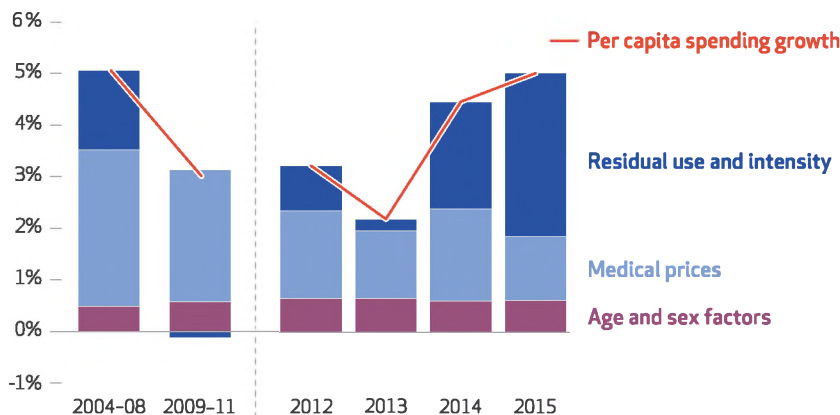
the continuation of enrollment increases in Medicaid, as newly eligible adults are fully financed by the federal government. Federal Medicaid payments, which accounted for 37 percent of total federal health spending, increased 12.6 percent in 2015—following an even higher growth rate of 18.9 percent in 2014 (Exhibit 1).

In 2015, health spending by households grew

at a rate of 4.7 percent, accelerating from 2.6 percent in 2014 (Exhibit 6). Household health spending includes out-of-pocket spending, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and payment of premiums. Households accounted for 28 percent of total health spending in 2015, a share that was unchanged from

EXHIBIT 5

Factors accounting for growth in per capita national health expenditures (NHE), selected calendar years 2004–15



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted NHE deflator. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

2014. Although out-of-pocket spending represented the largest share of household health spending (38 percent), the acceleration in 2015 was driven mostly by households' contributions to employer-sponsored private health insurance premiums (from a decline of 0.5 percent in 2014 to growth of 6.9 percent in 2015). These contributions were linked, in part, to increased enrollment in employer-sponsored health insurance.

Health spending by private businesses accounted for 20 percent of total health spending in 2015, a share that has remained stable since 2010 (Exhibit 6). Growth in this spending accelerated slightly in 2015, increasing at a rate of 5.3 percent compared to 4.7 percent in 2014. Just over three-quarters of private business health spending stems from contributions to employer-sponsored private health insurance premiums; in 2014 and 2015 these contributions increased 4.9 percent per year, on average.

State and local governments accounted for 17 percent of health spending in both 2014 and 2015 (Exhibit 6). Growth in this spending accelerated from 3.2 percent in 2014 to 4.6 percent in 2015, driven by faster growth in state and local Medicaid spending (which represented 37 percent of state and local government health spending). The faster growth resulted from increased reimbursement rates, as states' financial conditions improved, and from increased efforts to expand care in home and community settings.^{6,7}

Private Health Insurance

Total expenditures for private health insurance reached \$1.1 trillion and increased 7.2 percent in 2015, compared to 5.8 percent in 2014 and 2.1 percent in 2013. Private health insurance continued to be the largest payer of health care in the United States, accounting for 33 percent of total health care spending.

Strong growth in 2014 and 2015 was due, in part, to increased enrollment in private health insurance in both years associated with coverage expansions under the ACA. Additionally, in 2015 there was a notable increase in enrollment in employer-sponsored plans (1.4 percent) as the labor market continued to improve.⁸ Over the two-year period, the number of people enrolled in private health insurance increased by 9.7 million (average growth of 2.5 percent): Directly purchased private health insurance, which includes insurance in the Marketplaces, added 6.6 million enrollees (average growth of 15.4 percent), and employer-sponsored insurance added 3.0 million enrollees (average growth of 0.9 percent).⁹ However, even with the overall gain in private health insurance enrollment, the share of the total population that was privately insured in 2015 (61 percent) was still below the most recent peak of 66 percent in 2007, just before the start of the Great Recession of 2007–09.

Private health insurance benefit payments increased 7.9 percent in 2015—faster than the growth of 5.5 percent in 2014—and reached \$944.7 billion. The strong growth in 2015 was largely due to accelerated growth in hospital and physician and clinical services spending, which increased 9.1 percent and 6.5 percent, respectively. This result reflected, in part, an increase in both the number of enrollees and per enrollee spending. Moreover, some of the newly insured individuals may have been sicker, used more services, and had higher medical costs, compared to previously insured individuals.¹⁰ On a per enrollee basis, private health insurance spending for medical benefits increased 5.2 percent in 2015, faster than the growth of 3.0 percent in 2014.

The net cost of private health insurance, or the portion of total private health insurance spending that paid for nonmedical benefit expenses (such as administrative costs, taxes, and net gains or losses to reserves and profits), grew more slowly in 2015, increasing just 2.0 percent after growth of 8.0 percent in 2014. This slower growth caused the net cost of private health insurance share of total private health insurance spending to fall from 12.5 percent in 2014 to 11.9 percent in 2015.

EXHIBIT 6

National health expenditures (NHE) amounts, annual growth, and percent distribution, by type of sponsor, calendar years 2009–15

Type of sponsor	2009 ^a	2010	2011	2012	2013	2014	2015
EXPENDITURE AMOUNT							
NHE, billions	\$2,494.7	\$2,596.4	\$2,687.9	\$2,795.4	\$2,877.6	\$3,029.3	\$3,205.6
Businesses, households, and other private revenues	1,409.4	1,444.6	1,496.4	1,576.2	1,611.1	1,662.8	1,739.4
Private businesses	513.7	518.0	541.9	567.0	578.5	605.6	637.5
Household	728.1	750.2	773.6	807.2	824.9	846.6	886.8
Other private revenues	167.6	176.3	181.0	201.9	207.7	210.5	215.1
Governments	1,085.3	1,151.8	1,191.5	1,219.2	1,266.5	1,366.5	1,466.2
Federal government	680.2	730.3	731.4	731.2	759.4	843.1	918.5
State and local governments	405.1	421.6	460.0	488.1	507.1	523.4	547.7
ANNUAL GROWTH							
NHE	4.0%	4.1%	3.5%	4.0%	2.9%	5.3%	5.8%
Businesses, households, and other private revenues	0.1	2.5	3.6	5.3	2.2	3.2	4.6
Private businesses	0.3	0.8	4.6	4.6	2.0	4.7	5.3
Household	0.7	3.0	3.1	4.4	2.2	2.6	4.7
Other private revenues	-2.7	5.2	2.6	11.6	2.9	1.4	2.2
Governments	9.5	6.1	3.4	2.3	3.9	7.9	7.3
Federal government	17.1	7.4	0.2	0.0	3.9	11.0	8.9
State and local governments	-1.3	4.1	9.1	6.1	3.9	3.2	4.6
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private revenues	56	56	56	56	56	55	54
Private businesses	21	20	20	20	20	20	20
Household	29	29	29	29	29	28	28
Other private revenues	7	7	7	7	7	7	7
Governments	44	44	44	44	44	45	46
Federal government	27	28	27	26	26	28	29
State and local governments	16	16	17	17	18	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. ^aAnnual growth, 2008–09.

Out-Of-Pocket Spending

Total out-of-pocket spending—which consists of direct consumer payments such as copayments, deductibles, coinsurance, and any spending on noncovered services—reached \$338.1 billion and increased 2.6 percent in 2015, following growth of 1.4 percent in 2014. Out-of-pocket spending was affected in both years by changes in health care coverage, as there was a decrease in the number of people without coverage who were paying their expenses out of pocket. At the same time, however, faster growth in utilization associated with expanded insurance enrollment and increased cost sharing associated with a larger percentage of workers enrolled in high-deductible health plans¹¹ led to more out-of-pocket spending. On balance, in 2015 these factors contributed to the acceleration in out-of-pocket spending.

From 2008 through 2015, average annual growth in out-of-pocket spending was 1.9 percent, lower than the average annual growth in

overall health care spending of 4.3 percent during the same period. As a result, the out-of-pocket spending share of total health care expenditures fell from roughly 13 percent in 2007 to 11 percent in 2015.

Medicaid

Total Medicaid spending by federal and state and local governments reached \$545.1 billion in 2015 (Exhibit 1) and accounted for 17 percent of total national health expenditures. Medicaid spending continued to grow at a strong rate of 9.7 percent in 2015, following growth of 11.6 percent in 2014 (Exhibit 1).

The slightly slower growth in Medicaid spending in 2015 was driven by slower growth in Medicaid enrollment. Changes in Medicaid eligibility related to the ACA drove an 11.1 percent increase in enrollment in 2014, followed by slower estimated growth of 5.7 percent in 2015 (Exhibit 3). On a per enrollee basis, Medicaid spending grew

just 0.4 percent in 2014, reflecting changes in the mix of the Medicaid population: On average, newly eligible enrollees tended to have lower costs.¹² In 2015, however, Medicaid per enrollee spending grew 3.8 percent as many states adopted higher reimbursement rates.⁶

Slower Medicaid spending growth for physician and clinical services and prescription drugs in 2015, compared to 2014, was partially offset by faster growth in spending on hospital care and other health, residential, and personal care services.¹³ The slower growth in physician and clinical services expenditures of 9.6 percent in 2015 followed stronger growth of 22.3 percent in 2014 and was due, in part, to the expiration of the temporary ACA provision that increased Medicaid payments to primary care physicians in 2013 and 2014. Growth in Medicaid spending for prescription drugs slowed to 13.6 percent in 2015 after growth of 24.6 percent in 2014, the highest rate since 1986. The faster growth in 2014 was primarily due to increased spending for hepatitis C drugs, while in 2015 spending growth was tempered by a higher amount of total rebates on prescription drugs, compared to 2014.¹⁴ Medicaid hospital spending grew 9.5 percent in 2015, up from growth of 8.6 percent in 2014—in part as a result of increases in supplemental payments, which some states continued to use to drive delivery system reforms.¹⁵ Spending growth for other health, residential, and personal care services accelerated in 2015, as nearly every state took steps to expand care in the home and community.⁶

Medicare

Total Medicare spending reached \$646.2 billion in 2015 (Exhibit 1) and accounted for 20 percent of total health care spending. Medicare spending grew 4.5 percent in 2015, slightly slower than the growth of 4.8 percent in 2014 (Exhibit 1), as a result of trends in Medicare enrollment. Overall, Medicare enrollment increased 2.7 percent in 2015 (slower than the growth of 3.1 percent in 2014), reaching 54.3 million beneficiaries (Exhibit 3).

Medicare per enrollee spending growth remained fairly steady in 2015 (1.7 percent, compared to 1.6 percent in 2014). Mixed trends among services contributed to the relatively stable growth in 2015, as Medicare hospital and prescription drug spending growth slowed, while spending growth for nursing home and home health care accelerated. Physician and clinical services spending, which accounted for just over one-fifth of all Medicare spending, grew at about the same rate in 2015 as in 2014 (4.6 percent and 4.4 percent, respectively).

The slowdown in Medicare hospital spending growth (from 2.6 percent in 2014 to 1.7 percent in 2015) was driven both by reductions in disproportionate-share hospital payments and by a continued decline in utilization that was partially due to reductions in hospital readmissions from 2011 to 2015.¹⁶ For Medicare prescription drug spending, which slowed from growth of 14.5 percent in 2014 to 11.0 percent in 2015, spending associated with covering beneficiaries' prescription drug costs after they have reached the Medicare Part D catastrophic threshold increased at a slower rate than in 2014. Despite this slowdown, spending for catastrophic coverage has grown at double-digit rates in recent years primarily because of beneficiaries' use of higher-cost specialty drugs, such as those used to treat hepatitis C.¹⁷

Slightly offsetting the slowdown in Medicare hospital and prescription drug spending growth was faster growth in Medicare spending for nursing home care (which increased 5.6 percent in 2015, compared to growth of 2.5 percent in 2014) and home health care (which increased 2.6 percent in 2015 after growth of 1.7 percent in 2014).

Fee-for-service Medicare expenditures accounted for 68 percent of total Medicare spending in 2015 and increased 1.9 percent, which was slower than the growth of 2.6 percent in 2014. Fee-for-service enrollment grew 0.7 percent in 2015 (up slightly from the growth of 0.4 percent in 2014). Medicare Advantage expenditures accounted for a larger share of total Medicare spending in 2015 than in 2014—32 percent versus 30 percent. In 2015, Medicare Advantage expenditures increased 10.6 percent, a slightly faster rate than the growth of 10.2 percent in 2014. Medicare Advantage enrollment increased 7.6 percent in 2015, after growing 10.0 percent in 2014.

Hospital Care

Growth in expenditures for hospital care increased from 4.6 percent in 2014 to 5.6 percent in 2015, reaching \$1.0 trillion (Exhibit 4). The faster growth in hospital spending reflected continued strong growth in nonprice factors, such as the use and intensity of services. The number of inpatient days and hospital discharges increased by 1.8 percent and 1.2 percent, respectively, in 2015.^{18,19} This was the first time there have been two consecutive years of growth for both measures since the Census Bureau began tracking these utilization categories in 2005. On the other hand, hospital price growth, as measured by the Hospital Producer Price Index, was just 0.9 percent in 2015, slower than the growth

in 2014 of 1.3 percent and the slowest rate since 1998.²⁰

From the payer perspective, the main drivers of faster growth in hospital spending in 2015 were private health insurance and Medicaid. After growth of 5.7 percent in 2014, private health insurance spending for hospital care increased 9.1 percent in 2015, as enrollment grew 2.6 percent. Medicaid spending for hospital services increased 9.5 percent in 2015, following growth of 8.6 percent in 2014; the increase was primarily due to expanded Medicaid coverage and strong growth in supplemental payments.

Slower growth in Medicare hospital spending somewhat offset the accelerations in growth for private health insurance expenditures and Medicaid spending for hospital services. Medicare spending for hospital services increased just 1.7 percent in 2015 (the smallest increase in seventeen years), compared to growth of 2.6 percent in 2014. The low growth was driven, in part, by Medicare inpatient spending—which declined 1.9 percent in 2015 as a result of reductions in hospital readmissions and disproportionate-share hospital payments under certain provisions of the ACA.¹⁶

Physician And Clinical Services

Total expenditures for physician and clinical services grew 6.3 percent in 2015, reaching \$634.9 billion (Exhibit 4). This was an increase from the growth of 4.8 percent in 2014 and the first growth rate above 6.0 percent in ten years.

The faster growth in spending on physician and clinical services was driven by growth in nonprice factors, such as residual use and intensity of services. Increased insurance coverage through private health insurance and Medicaid contributed to this growth in nonprice factors. Conversely, price growth for physician and clinical services declined 1.1 percent in 2015 (compared to growth of 0.6 percent in 2014),²¹ driven by the expiration of temporary increases in Medicaid payments to primary care physicians.

For private health insurance, spending growth for physician and clinical services increased 6.5 percent in 2015, up from 2.6 percent growth in 2014. Medicare spending growth for physician and clinical services remained fairly stable (4.6 percent in 2015 and 4.4 percent in 2014), while Medicaid spending growth slowed from 22.3 percent in 2014 (the highest rate since 1992) to 9.6 percent in 2015.

Spending for physician services accounted for 79 percent of total physician and clinical services expenditures in 2015, a share that fell consistently over the past decade (it was 83 percent in 2005) as expenditure growth for clinical services

outpaced that for physician services. This pattern continued in 2015, though the trends converged: Spending for physician services increased 6.1 percent (from growth of 4.2 percent in 2014), while spending for clinical services increased 7.2 percent (the same growth rate as in 2014). In 2015, growth in clinical services spending was driven by continued fast growth in outpatient care centers, such as community health centers, kidney dialysis centers, and outpatient mental health and substance abuse centers.

Retail Prescription Drugs

In 2015, total retail prescription drug spending grew 9.0 percent, reaching \$324.6 billion, and represented 10 percent of overall health spending (Exhibit 4). Although slower than the rate of 12.4 percent in 2014, growth in prescription drug spending was faster than that of any other service in 2015. Its recent rapid growth was primarily due to increased spending on new medicines, price growth for existing brand-name drugs, increased spending on generics, and a decrease in the number of expensive blockbuster drugs whose patents expired.²²

Spending on new brand-name medications (defined by IMS Health as drugs launched in the past twenty-four months) continued to drive overall growth in prescription drug spending in 2015, as it did in 2014. Strong growth in new specialty medications such as those used to treat hepatitis C, cancer, autoimmune diseases, and multiple sclerosis, as well as in more traditional (nonspecialty) brand-name medications such as those used to treat diabetes, contributed to the rapid growth in drug spending in 2014 and 2015.²² An increase in the number of new drugs approved for use in 2015 also contributed to the strong growth in spending on new brand-name drugs. In 2015, forty-five new drugs were approved, more than in any one year over the past decade and more than the forty-one in 2014—when new drugs for the treatment of rare diseases and cancer were introduced.²³

Price growth for existing brand-name drugs remained strong in 2015 (albeit slower than in 2014), reaching a double-digit rate for the fourth consecutive year.²⁴ Prices of generic prescription drugs increased less than 1 percent in 2015 following many years of declines,²⁴ and the use of generics continued to climb. In 2015 the generic dispensing rate (excluding brand-name generics) was 83.0 percent, up from 81.7 percent in 2014.²² Increased spending on generics was driven, in part, by recent expirations of patents for certain blockbuster drugs in 2014 and 2015.²⁵

Retail prescription drug utilization, measured

by the number of retail prescriptions dispensed, increased 1.2 percent in 2015 after growing at a slightly higher rate in 2014 (1.8 percent).²² The increase in the number of prescriptions dispensed for Medicaid patients drove overall utilization growth in both 2014 and 2015, as the number of prescriptions dispensed for Medicaid increased faster than for other payers (cash, commercial third parties, and Medicare) because of enrollment expansion under the ACA.²²

Although growth was slower than observed in 2014, Medicare and Medicaid prescription drug spending continued to increase at double-digit rates in 2015—11.0 percent and 13.6 percent, respectively. Private health insurance spending growth for prescription drugs slowed from 12.9 percent in 2014 to 9.0 percent in 2015. Increased insurance coverage as a result of the ACA contributed to the growth in prescription drug spending by Medicaid and private health insurance in 2014 and 2015.

Conclusion

The health sector experienced dramatic changes in 2014 and 2015, as the main coverage provisions of the ACA were implemented. Over those two years, the insured share of the population increased 4.9 percentage points and reached

90.9 percent. In addition, the federal share of health spending increased by 3 percentage points, from 26 percent in 2013 to 29 percent in 2015. These changes played a major role in determining the overall growth in health spending, and they influenced the mix of payers and sponsors as well. Faster health spending growth in 2014 and 2015 (5.3 percent and 5.8 percent, respectively), combined with lower growth in the overall economy (4.2 percent in 2014 and 3.7 percent in 2015), resulted in a 0.6-percentage-point increase in the health spending share of GDP—from 17.2 percent in 2013 to 17.8 percent in 2015. Increases of this magnitude in the health spending share of the overall economy typically occur around periods of economic recession. However, coverage expansions in 2014 and 2015, along with rapid increases in retail prescription drug spending, contributed to the increased share more than five years after the end of the Great Recession of 2007–09. While the 2014–15 period is unique, given the significant changes in health insurance coverage that took place, health spending is projected to increase as a share of the overall economy over the next ten years and will be influenced by the aging of the population, changing economic conditions, and faster medical price growth.²⁶ ■

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Implications of Partial Repeal of the ACA through Reconciliation

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In Brief

Congress is now considering partial repeal of the Affordable Care Act (ACA) through the budget reconciliation process. Since only components of the law with federal budget implications can be changed through reconciliation, this approach would permit elimination of the Medicaid expansion, the federal financial assistance for Marketplace coverage (premium tax credits and cost-sharing reductions), and the individual and employer mandates; it would leave the insurance market reforms (including the nongroup market's guaranteed issue, prohibition on preexisting condition exclusions, modified community rating, essential health benefit requirements, and actuarial value standards) in place. There is currently no consensus around alternative health policies to enact as the ACA is repealed; consequently, partial repeal via reconciliation without replacement is possible and merits analysis.

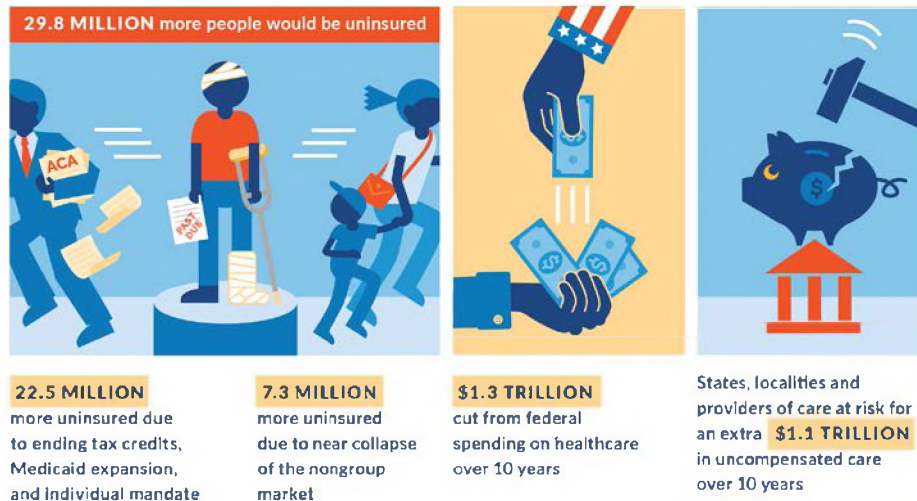
In this brief, we compare future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.

- Federal government spending on health care for the nonelderly would be reduced by \$109 billion in 2019 and by \$1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.
- State spending on Medicaid and CHIP would fall by \$76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional \$1.1 trillion in uncompensated care between 2019 and 2028.
- The 2016 reconciliation bill did not increase funding for uncompensated care beyond current levels. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.
- If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about \$3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.
- Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the *House v. Burwell* case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

Using the Budget Reconciliation Process to Repeal the Affordable Care Act



URBAN INSTITUTE

Introduction

Congress passed a reconciliation bill repealing substantial portions of the Affordable Care Act (ACA) in January 2016; however, the bill was vetoed by President Obama.¹ Congress is now poised to pass a similar bill in early 2017.² The bill Congress passed did not contain policies intended to replace the ACA, presumably because a consensus did not exist on what form such an alternative should take. It is unlikely that supporters of ACA repeal will have agreed on an alternative before voting on repeal. In the absence of agreement on an alternative to the ACA, Congress is likely to delay the repeal of most, if not all, provisions in the bill for two or three years, giving members time to try developing an alternative set of policies. This was the approach taken by Congress last year.

Under Senate rules, reconciliation bills can only make legislative changes that affect the federal budget.³ In the context of the ACA, rules permit repeal of the Medicaid expansion; the premium tax credits and cost-sharing assistance provided to people with modest income through the Marketplaces; the tax on some people who do not carry minimum creditable health insurance (a.k.a. the individual mandate); and the employer responsibility requirement (a.k.a. the employer mandate), which assesses a penalty on some employers whose workers obtain subsidized coverage through the Marketplaces. Because provisions that do not directly affect spending or revenues cannot be included in reconciliation bills, the 2016 bill did not eliminate the insurance market reforms, which include the extension of family coverage for adult children up to age 26, prohibitions on preexisting condition exclusions, and requirements for modified community rating, essential health benefits, and actuarial value standards. An attempt to repeal these provisions through normal legislative channels would be subject to a filibuster. For that reason, we assume that these provisions would remain in effect, at least in the near term.

This brief considers the effect of partial repeal of the ACA in the context of reconciliation. Since the 2016 reconciliation bill delayed its repeal of most budget-related components of the ACA for two years, we simulate the cost and coverage implications of a similar 2017 reconciliation bill in 2019. We also provide 10-year estimates for 2019 to 2028. However, even with most components delayed two years, such a reconciliation bill would substantially alter the nation's private nongroup insurance markets during 2017, with even larger effects on the 2018 plan year. Insurers could decide to stop offering insurance through the ACA-compliant nongroup insurance markets for 2018, knowing that enrollment will drop and the markets will soon be disassembled. A substantial drop in insurer participation is even more likely if Marketplace cost-sharing assistance is discontinued in 2017 or 2018 (as related to the *House v. Burwell* case) or if some additional financial support to insurers is not provided to offset their increased risk. A delay of the repeal provisions for three years instead of two would delay our estimated effects an additional year, changing the size of the estimated effects somewhat over 10 years.

The 2016 reconciliation bill would have eliminated the individual and employer mandates immediately upon passage.⁴ If, under a 2017 reconciliation bill, the individual mandate penalties are not enforced beginning in 2017, people would have less incentive to pay premiums (especially people who are healthy and not eligible for premium tax credits); nongroup coverage would decline as enrollment falls almost immediately; the average health care costs of enrollees in the market would increase; and

these increased costs would create financial issues for insurers participating in 2017. As the number of uninsured people increases, providers would face increasing financial pressures because of higher demand for uncompensated care. Changes like these implemented *during a plan year* would seriously disrupt insurance markets for consumers, insurers, and providers. Thus, in addition to providing 2019 estimates for the reconciliation bill, we provide separate estimates of the immediate consequences of repealing the individual and employer mandates in 2017.

Results

We estimate insurance coverage in 2019 under the ACA and under the partial repeal expected to be included in a January 2017 reconciliation bill. We present coverage estimates for the nation as a whole and changes in the number of people uninsured for each state. We also provide detailed socioeconomic characteristics of those losing insurance coverage. We estimate the change in federal spending under each scenario in the same year, breaking out the total decrease in federal spending by Medicaid/CHIP and Marketplace financial assistance, nationally and by state. We provide estimates of the effects of elimination of the Medicaid expansion on state spending. We also show the implications of the increase in uncompensated care that would be sought as the number of uninsured increases. Finally, we estimate the financial losses of insurers if the 2017 bill, like that passed in 2016, eliminates the individual and employer mandates immediately, affecting enrollment decisions during 2017 once nongroup health insurance premiums are already fixed. Additional state-by-state detail on changes in federal and state spending in 2019 and over the 2019 to 2028 period is provided in appendix tables.

Insurance Coverage

The anticipated reconciliation bill would dramatically affect public insurance and private nongroup insurance for people covered through the Medicaid expansions, the ACA's Marketplaces, and ACA-compliant plans outside the Marketplaces. We estimate that the partial ACA repeal would increase the number of uninsured people by 29.8 million by 2019 (table 1, figure 1), raising the total number of uninsured to 58.7 million people—21 percent of the nonelderly population—compared with 28.9 million people uninsured if the ACA remains in effect. More people would be uninsured in 2019 than the 50.0 million who were uninsured in 2009, just before passage of the ACA (Holahan 2011).

The market for nongroup coverage would virtually collapse, causing 7.3 million of the additional 29.8 million people to become uninsured. Full repeal of all components of the ACA, including the insurance market reforms, would increase the number of uninsured by 22.5 million by 2019 (data not shown). The nongroup market would unravel because of three factors:

- Eliminating premium tax credits and cost-sharing assistance would make coverage unaffordable for many of the people currently enrolled, causing them to drop coverage. Those with the fewest health problems would drop their coverage fastest.

- Eliminating the individual mandate penalty would reduce the incentive to enroll for healthy people who can afford coverage.
- Insurers would remain subject to the requirement to sell coverage that meets adequacy standards to all would-be purchasers, and they would remain subject to the prohibition against charging higher premiums or offering reduced benefits to those with health care needs.

TABLE 1

Health Insurance Coverage Distribution of the Nonelderly with the ACA and an Anticipated Reconciliation Bill, 2019

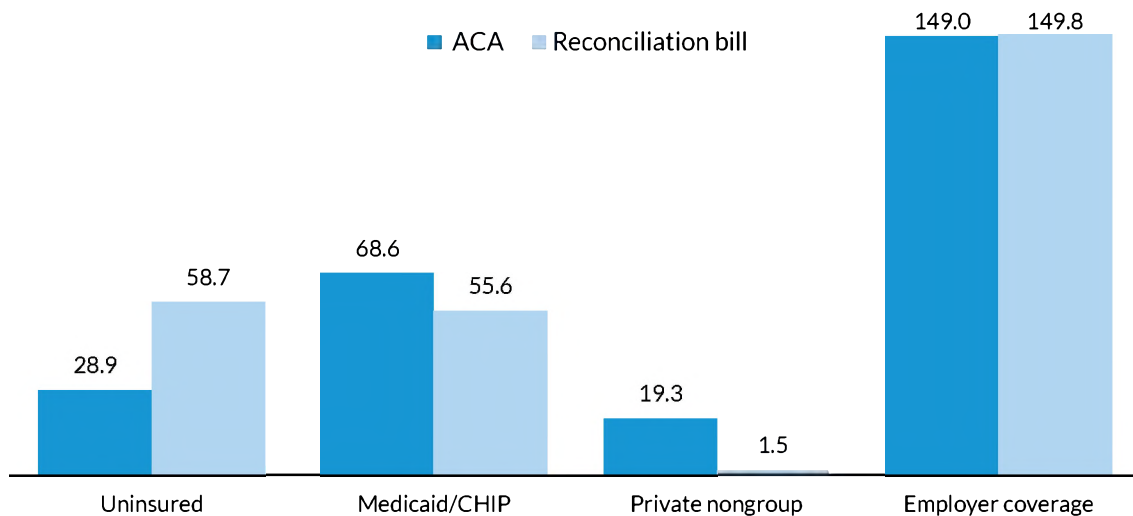
	ACA (current law)		Reconciliation Bill		Difference (thousands)
	People (thousands)	Share of US total (%)	People (thousands)	Share of US total (%)	
<i>Insured</i>	245,380	89	215,598	79	-29,782
Employer	148,974	54	149,832	55	858
Nongroup (eligible for tax credit)	9,322	3	0	0	-9,322
Nongroup (other)	9,955	4	1,560	1	-8,395
Medicaid/CHIP	68,556	25	55,632	20	-12,924
Other (including Medicare)	8,574	3	8,574	3	0
<i>Uninsured</i>	28,936	11	58,718	21	29,782
Total	274,316	100	274,316	100	0

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Columns may not sum to totals because of rounding.

FIGURE 1

Health Insurance of the Nonelderly in 2019, under the ACA and an Anticipated Reconciliation Bill
Millions of people



Source: Urban Institute analysis using HIPSM 2016.

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

As increasing numbers of people continued to drop their insurance (with healthier people leaving coverage fastest), the situation would threaten the nongroup insurers both inside and outside the Marketplaces with insupportable losses, would force insurers to raise premiums by increasingly large amounts, and would drive many insurers out of the nongroup market entirely. That is why the increase in the number of uninsured due to a reconciliation bill would exceed the gains in insurance coverage achieved under the ACA.

Table 2 gives a state-by-state breakdown of where the losses of insurance coverage would occur. The effects are uneven. The hardest hit, on average, would be states that expanded Medicaid, as those states averaged the largest coverage gains under reform. In those states, the number of people uninsured would more than double, from 14.0 to 32.5 million people, an increase of 18.5 million people. The number of uninsured would increase by 11.3 million people, from 14.9 to 26.2 million, in the states that did not expand Medicaid eligibility. In California, 4.9 million people would become uninsured; over 1 million people in Illinois and New York each would also become uninsured. Over 2 million people in Florida and 2.6 million people in Texas would become uninsured, as would over 1 million people in Georgia and North Carolina each.

TABLE 2

Uninsured under the ACA and an Anticipated Reconciliation Bill and Their Eligibility for Financial Assistance, by State and Medicaid Expansion Status, 2019

State	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
National total	28,936	42%	58,718	15%	29,782	103%
<i>Expansion states</i>						
Alaska	117	78%	178	12%	62	53%
Arizona	750	53%	1,459	18%	709	95%
Arkansas	211	58%	572	12%	361	171%
California	3,349	33%	8,236	14%	4,887	146%
Colorado	438	54%	1,026	13%	588	134%
Connecticut	200	47%	448	25%	248	124%
Delaware	60	58%	113	32%	52	86%
District of Columbia	31	56%	63	33%	32	103%
Hawaii	88	70%	174	12%	86	99%
Illinois	896	48%	2,046	14%	1,150	128%
Indiana	552	70%	1,119	16%	566	103%
Iowa	153	63%	383	14%	230	150%
Kentucky	244	66%	730	16%	486	200%
Louisiana	363	62%	921	12%	558	154%
Maryland	385	37%	861	10%	476	123%
Massachusetts	135	43%	504	8%	369	273%
Michigan	508	70%	1,394	13%	887	175%
Minnesota	309	67%	690	31%	380	123%
Montana	85	79%	227	15%	142	168%
Nevada	391	51%	762	18%	371	95%

State	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
New Hampshire	62	63%	180	9%	118	190%
New Jersey	644	37%	1,443	14%	799	124%
New Mexico	196	50%	462	15%	266	136%
New York	1,524	55%	2,662	31%	1,139	75%
North Dakota	45	69%	114	10%	69	154%
Ohio	621	71%	1,585	14%	964	155%
Oregon	256	50%	731	11%	475	186%
Pennsylvania	711	73%	1,667	13%	956	134%
Rhode Island	57	44%	153	15%	96	170%
Vermont	27	68%	62	35%	35	129%
Washington	508	51%	1,283	12%	775	153%
West Virginia	88	71%	272	13%	184	208%
Expansion states total	14,002	51%	32,519	16%	18,516	132%
<i>Nonexpansion states</i>						
Alabama	484	32%	841	14%	357	74%
Florida	2,482	26%	4,711	12%	2,230	90%
Georgia	1,427	31%	2,433	15%	1,006	71%
Idaho	183	36%	366	11%	184	101%
Kansas	289	39%	508	12%	219	76%
Maine	78	40%	173	12%	95	122%
Mississippi	351	40%	580	16%	229	65%
Missouri	544	38%	1,048	15%	504	93%
Nebraska	149	36%	314	12%	165	111%
North Carolina	1,140	27%	2,166	12%	1,025	90%
Oklahoma	529	43%	842	16%	313	59%
South Carolina	606	42%	959	17%	353	58%
South Dakota	81	55%	155	12%	74	92%
Tennessee	664	37%	1,190	15%	526	79%
Texas	4,377	32%	6,927	13%	2,550	58%
Utah	328	45%	601	15%	273	83%
Virginia	863	35%	1,548	9%	685	79%
Wisconsin	299	63%	731	17%	431	144%
Wyoming	61	49%	108	10%	47	76%
Nonexpansion states total	14,933	33%	26,199	13%	11,266	75%

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Financial assistance under the ACA includes Medicaid/CHIP and Marketplace premium tax credits and cost-sharing reductions. Financial assistance under the anticipated reconciliation bill consists of Medicaid/CHIP. Columns may not sum to totals because of rounding.

Overall, the elimination of the Medicaid expansion would decrease coverage through that program by 12.9 million people in 2019 as people lose eligibility for the program. The near “death spiral” in the private nongroup market described earlier is likely to occur immediately after the reconciliation bill's provisions take effect. Insurers would recognize the unsustainable financial dynamics of broad-based pooling policies (e.g., guaranteed issue, no preexisting condition exclusions, essential health benefits,

modified community rating) combined with no individual mandate and no financial assistance to spur enrollment. Similar near market collapse has occurred in the past under similar conditions. When New York’s and New Jersey’s state governments implemented community rating and guaranteed issue in their private nongroup markets without also providing for an individual requirement to obtain coverage or financial assistance to make coverage affordable for people with modest incomes, the nongroup markets unwound (Monheit et al. 2004).

We estimate that the number of people with nongroup insurance would drop from 19.3 million people to 1.6 million by the beginning of the 2019 plan year, concurrent with elimination of the premium tax credits. A small number of people otherwise covered by this market—fewer than 1 million—would obtain employer-sponsored insurance. Some insurers, such as Blue Cross-affiliated insurers, may continue to offer ACA-compliant plans at much higher premiums in the nongroup market, but without federal financial assistance, relatively few people—we estimate approximately 8 percent of those who have such coverage now—would enroll.

After the large increase in uninsured people that would result from a reconciliation bill, a much smaller share of the uninsured would be eligible for any financial assistance compared with the share eligible under the ACA (table 3). In the reconciliation bill scenario, only 15 percent of the 58.7 million uninsured would be eligible for any financial assistance (all under Medicaid or CHIP), given the elimination of both the Marketplace tax credits and the Medicaid eligibility expansion. As a consequence, there would be a much higher number of uninsured and very little room to significantly reduce that number absent substantial policy initiatives. In contrast, under the ACA, 42 percent of the remaining 28.9 million uninsured would be eligible for either Medicaid/CHIP or tax credits through the ACA’s Marketplaces in 2019. That high rate of eligibility means that additional outreach and enrollment assistance could significantly increase the number of uninsured obtaining coverage under the ACA.

TABLE 3
Uninsured Eligible for Financial Assistance to Obtain Coverage, Nationally and by State Medicaid Expansion Status, 2019

	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change
National total	28,936	42%	58,718	15%	29,782	103%
Expansion states	14,002	51%	32,519	16%	18,516	132%
Nonexpansion states	14,933	33%	26,199	13%	11,266	75%

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act. Under the ACA, assistance can take the form of Medicaid, CHIP, or Marketplace tax credits; under reconciliation, assistance can take the form of Medicaid or CHIP. Columns may not sum to totals because of rounding.

Characteristics of Those Becoming Uninsured

Table 4 provides income, age, employment, race/ethnicity, and educational attainment characteristics of the 29.8 million people becoming uninsured under the anticipated reconciliation bill. We find that approximately 53 percent of those becoming uninsured would be people with family income between 100 and 400 percent of the federal poverty level (FPL). The remaining increase in the number of uninsured would be almost evenly split between those with lower and higher incomes, 25 percent with income below 100 percent of FPL and 23 percent with income over 400 percent of FPL. These newly uninsured people would be spread broadly through the age distribution: 13 percent children under age 18, 38 percent young adults ages 18 to 34, and 49 percent adults ages 35 to 64.

The vast majority of those becoming uninsured would be members of working families (82 percent), and more than half (56 percent) would be non-Hispanic whites. The vast majority of adults becoming uninsured would lack college degrees (80 percent).

Uninsurance rates for people of all characteristics measured would increase by at least 50 percent under the reconciliation approach. For example, 10 percent of those with family income from 150 to 200 percent of the FPL are uninsured under the ACA, but that rate would increase to 26 percent under the reconciliation approach. Under the ACA, 7 percent of white, non-Hispanic people would be uninsured in 2019, but 18 percent would be uninsured under the reconciliation approach. Uninsurance rates for adults with a high school diploma would increase from 16 percent under the ACA to 30 percent.

TABLE 4

Characteristics of Those Losing Coverage under an Anticipated Reconciliation Bill and Uninsurance Rates under the ACA and an Anticipated Reconciliation Bill, 2019

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Income level				
< 100% of FPL	7,357	25%	14%	27%
100-150% of FPL	5,004	17%	8%	28%
150-200% of FPL	3,792	13%	10%	26%
200-300% of FPL	4,059	14%	10%	20%
300-400% of FPL	2,836	10%	6%	15%
> 400% of FPL	6,733	23%	11%	18%
Total	29,782	100%	11%	21%
Age group (years)				
< 18	3,998	13%	4%	9%
18-24	4,842	16%	14%	31%
25-34	6,341	21%	18%	32%
35-44	4,967	17%	14%	26%
45-54	5,103	17%	11%	23%
55-64	4,532	15%	8%	19%
Total	29,782	100%	11%	21%

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Family employment status				
No worker	5,400	18%	16%	29%
Part-time only	4,690	16%	16%	33%
At least one full-time worker	19,692	66%	9%	18%
Total	29,782	100%	11%	21%
Race and ethnicity				
White, non-Hispanic	16,623	56%	7%	18%
Black, non-Hispanic	3,497	12%	11%	20%
Hispanic	6,501	22%	21%	32%
Asian	2,033	7%	9%	22%
American Indian/Alaska Native	654	2%	14%	26%
Other, non-Hispanic	475	2%	7%	16%
Total	29,782	100%	11%	21%
Educational attainment				
Less than high school	3,493	14%	31%	47%
High school	10,222	40%	16%	30%
Some college	6,906	27%	11%	24%
College	3,665	14%	7%	17%
Graduate school	1,497	6%	4%	12%
Total	25,785	100%	13%	26%

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act; FPL = federal poverty level. Columns may not sum to totals because of rounding.

Government Spending on Health Care and Uncompensated Care

Under reconciliation, the federal government would spend \$67 billion less on Medicaid/CHIP for the nonelderly and \$42 billion less on Marketplace financial assistance (premium tax credits and cost-sharing reductions) in 2019.⁵ This reduces spending on these programs by \$109 billion that year (table 5 and figure 2) and by \$1.3 trillion from 2019 to 2028 (table 5). State governments would reduce their spending on Medicaid/CHIP by \$4 billion in 2019 (table 5 and figure 3) and by \$76 billion from 2019 to 2028 (table 5). Total government spending on these programs would therefore be \$1.4 trillion below the levels estimated under the ACA.

Table 6 shows state-specific estimates for 2019 to 2028 changes in federal spending on Medicaid/CHIP and Marketplace financial assistance. States that expanded Medicaid and enrolled larger numbers of residents in the Marketplaces would lose the most federal funding under the reconciliation bill. For example, California would lose \$160 billion in federal funding over the 10 years, and New York would lose \$57 billion. Although they had not expanded Medicaid eligibility, Florida and Texas would lose \$87 and \$62 billion in federal funding for health care, respectively, because of their large populations and high rates of Marketplace enrollment. (State-by-state 2019 federal spending estimates and 2019–28 state Medicaid/CHIP spending estimates are provided in appendix tables.)

TABLE 5

Government Spending on Medicaid/CHIP for the Nonelderly and Marketplace Financial Assistance, 2019 and 2019–28

Billions of dollars

	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Medicaid/CHIP spending	\$525	\$453	-\$72	\$6,643	\$5,740	-\$902
Federal	\$330	\$263	-\$67	\$4,153	\$3,327	-\$826
State	\$195	\$191	-\$4	\$2,489	\$2,413	-\$76
Federal Marketplace financial assistance	\$42	\$0	-\$42	\$465	\$0	-\$465
<i>Total federal spending</i>	<i>\$372</i>	<i>\$263</i>	<i>-\$109</i>	<i>\$4,618</i>	<i>\$3,327</i>	<i>-\$1,291</i>
<i>Total state spending</i>	<i>\$195</i>	<i>\$191</i>	<i>-\$4</i>	<i>\$2,489</i>	<i>\$2,413</i>	<i>-\$76</i>
Total federal and state spending	\$567	\$453	-\$114	\$7,107	\$5,740	-\$1,367

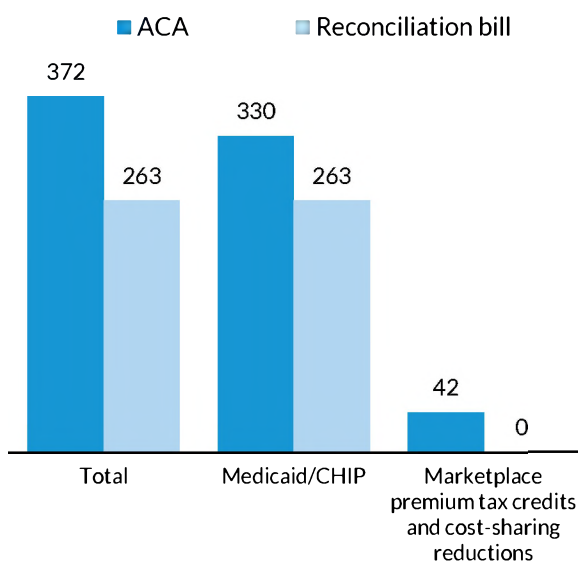
Source: Urban Institute analysis using HIPSMS 2016.

Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

FIGURE 2

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019

Billions of dollars



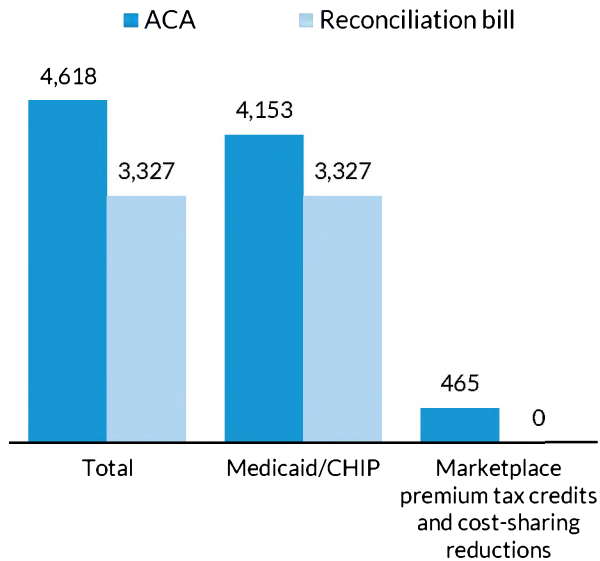
Source: Urban Institute analysis using HIPSMS 2016.

Note: ACA = Affordable Care Act.

FIGURE 3

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019–28

Billions of dollars



Source: Urban Institute analysis using HIPSMS 2016.

Note: ACA = Affordable Care Act.

TABLE 6

Federal Spending on Medicaid/CHIP and Marketplace Financial Assistance under the ACA and under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Billions of dollars

State	ACA			Reconciliation Bill		Difference	
	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/CHIP	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total
<i>Expansion states</i>							
Alaska	\$12	\$2	\$13	\$10	-\$1	-\$2	-\$3
Arizona	\$142	\$10	\$152	\$110	-\$32	-\$10	-\$42
Arkansas	\$42	\$2	\$44	\$34	-\$8	-\$2	-\$10
California	\$364	\$61	\$425	\$265	-\$99	-\$61	-\$160
Colorado	\$74	\$2	\$77	\$44	-\$31	-\$2	-\$33
Connecticut	\$52	\$4	\$56	\$41	-\$10	-\$4	-\$15
Delaware	\$15	<\$1	\$16	\$12	-\$3	<-\$1	-\$4
District of Columbia	\$18	<\$1	\$18	\$17	-\$2	<-\$1	-\$2
Hawaii	\$15	<\$1	\$16	\$12	-\$4	<-\$1	-\$4
Illinois	\$158	\$12	\$170	\$120	-\$37	-\$12	-\$50
Indiana	\$81	\$5	\$86	\$67	-\$14	-\$5	-\$19
Iowa	\$34	\$2	\$36	\$29	-\$5	-\$2	-\$7
Kentucky	\$106	\$3	\$108	\$59	-\$47	-\$3	-\$50
Louisiana	\$74	\$4	\$78	\$52	-\$23	-\$4	-\$27
Maryland	\$80	\$4	\$84	\$57	-\$23	-\$4	-\$28
Massachusetts	\$95	\$5	\$100	\$78	-\$17	-\$5	-\$23
Michigan	\$149	\$8	\$157	\$119	-\$30	-\$8	-\$38
Minnesota	\$82	\$2	\$84	\$68	-\$15	-\$2	-\$16
Montana	\$23	\$1	\$24	\$14	-\$9	-\$1	-\$10
Nevada	\$35	\$4	\$39	\$22	-\$13	-\$4	-\$16
<i>New</i>							
Hampshire	\$14	\$1	\$15	\$10	-\$4	-\$1	-\$5
New Jersey	\$135	\$7	\$142	\$82	-\$53	-\$7	-\$60
New Mexico	\$72	\$1	\$74	\$46	-\$27	-\$1	-\$28
New York	\$348	\$10	\$358	\$301	-\$47	-\$10	-\$57
North Dakota	\$7	<\$1	\$8	\$5	-\$2	<-\$1	-\$3
Ohio	\$177	\$6	\$183	\$135	-\$42	-\$6	-\$48
Oregon	\$83	\$3	\$86	\$47	-\$35	-\$3	-\$38
Pennsylvania	\$154	\$13	\$167	\$131	-\$23	-\$13	-\$36
Rhode Island	\$21	<\$1	\$22	\$14	-\$7	<-\$1	-\$7
Vermont	\$11	<\$1	\$12	\$9	-\$2	-\$1	-\$3
Washington	\$90	\$5	\$95	\$52	-\$38	-\$5	-\$43
West Virginia	\$35	\$2	\$37	\$23	-\$12	-\$2	-\$14
<i>Expansion states total</i>							
	\$2,799	\$184	\$2,983	\$2,085	-\$715	-\$184	-\$899

State	ACA			Reconciliation Bill		Difference	
	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/CHIP	Medicaid/CHIP	Premium tax credits and cost-sharing reductions	Total
<i>Nonexpansion states</i>							
Alabama	\$47	\$12	\$59	\$43	-\$3	-\$12	-\$15
Florida	\$181	\$68	\$249	\$162	-\$19	-\$68	-\$87
Georgia	\$101	\$20	\$121	\$88	-\$12	-\$20	-\$33
Idaho	\$26	\$4	\$29	\$23	-\$3	-\$4	-\$6
Kansas	\$24	\$4	\$28	\$22	-\$2	-\$4	-\$6
Maine	\$17	\$4	\$21	\$17	<-\$1	-\$4	-\$5
Mississippi	\$44	\$5	\$49	\$40	-\$4	-\$5	-\$9
Missouri	\$80	\$13	\$93	\$75	-\$6	-\$13	-\$18
Nebraska	\$15	\$4	\$19	\$15	<-\$1	-\$4	-\$5
North Carolina	\$146	\$38	\$184	\$125	-\$21	-\$38	-\$59
Oklahoma	\$48	\$8	\$56	\$47	-\$2	-\$8	-\$9
South Carolina	\$54	\$11	\$65	\$53	-\$1	-\$11	-\$12
South Dakota	\$8	\$1	\$9	\$8	<-\$1	-\$1	-\$1
Tennessee	\$98	\$11	\$108	\$82	-\$16	-\$11	-\$27
Texas	\$323	\$46	\$369	\$307	-\$17	-\$46	-\$62
Utah	\$33	\$3	\$36	\$31	-\$1	-\$3	-\$5
Virginia	\$56	\$15	\$72	\$54	-\$3	-\$15	-\$18
Wisconsin	\$49	\$11	\$60	\$47	-\$2	-\$11	-\$13
Wyoming	\$5	\$2	\$6	\$4	<-\$1	-\$2	-\$2
<i>Nonexpansion states total</i>	<i>\$1,354</i>	<i>\$280</i>	<i>\$1,634</i>	<i>\$1,242</i>	<i>-\$112</i>	<i>-\$280</i>	<i>-\$392</i>
National estimate	\$4,153	\$465	\$4,618	\$3,327	-\$826	-\$465	-\$1,291

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Numbers are rounded to the nearest \$1 billion, so columns might not sum precisely to totals.

As the number of uninsured increases under the reconciliation bill, the amount of uncompensated care sought would increase as well. But the source of financing this increased demand is very unclear. The uninsured use less medical care than they would if they had health insurance coverage, but they do use some care. This care is financed in different ways: some care is paid for directly by the uninsured, some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital [DSH] programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid DSH, funding for public hospitals), and some is financed by providers (e.g., hospitals, physicians, pharmaceutical companies) delivering free or reduced-price care. We assume that newly uninsured people will contribute to the costs of their own care consistent with the patterns of spending by uninsured people with similar characteristics and health needs under current law.

No source of uncompensated care funding increases automatically with an increase in the number of uninsured, so it is unclear whether funding would increase to meet the demand. We estimate that under current law, the federal government would spend \$23 billion on uncompensated care in 2019 and \$262 billion from 2019 to 2028 (table 7). State and local governments would spend \$14 billion on uncompensated care in 2019 and \$164 billion over 10 years. Providers would contribute \$20 billion in services for the uninsured in 2019 and \$230 billion over 10 years. These amounts are consistent with total demand for uncompensated care of \$57 billion in 2019, \$656 billion over 10 years.

With the uninsured increasing by almost 30 million by 2019, uninsured people would seek an additional \$88 billion in uncompensated care in 2019 and an additional \$1.1 trillion from 2019 to 2028. However, the federal DSH programs would not increase beyond current levels without explicit federal action, and that action was not part of the January 2016 reconciliation bill.⁵ Therefore, we assume federal uncompensated care funding would remain fixed. State and local governments could increase revenue to address the uncompensated care funding shortfall, providers could increase their provision of free services to the uninsured, unmet medical need could increase because the shortfall is not financed, or some combination of these possibilities could occur.

We provide two scenarios in table 7: the first assumes the uncompensated care shortfall is addressed by providers increasing their delivery of free and reduced price care, and the second assumes the shortfall is financed by state and local governments. While neither state and local governments nor providers are likely to be able to finance the extra care sought on their own, these scenarios show the large financing challenge facing the health care system under the reconciliation bill. If state and local governments were to assume all costs related to the increase in uncompensated care sought, their support for uncompensated care would have to increase more than sixfold. If providers were to assume all the increase in demand, their support for uncompensated care would have to more than quadruple. While some combination of increases from state and local governments and providers may occur, the large increase in services sought by the uninsured is unlikely to be met, and the increased burden on the uninsured will produce even greater financial burdens and more unmet need for health care services.

TABLE 7

Alternative Scenarios for Financing Uncompensated Care, 2019 and 2019–28

Billions of dollars

	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Total demand for uncompensated care	\$57	\$145	\$88	\$656	\$1,723	\$1,067
Scenario 1: No increase in federal or state/local uncompensated care funds; all increase in demand borne by providers						
Federal government	\$23	\$23	\$0	\$262	\$262	\$0
State/local government	\$14	\$14	\$0	\$164	\$164	\$0
Providers	\$20	\$108	\$88	\$230	\$1,296	\$1,067
Scenario 2: No increase in federal uncompensated care funds or provider contributions; all increase in demand borne by states and localities						
Federal government	\$23	\$23	\$0	\$262	\$262	\$0
State/local government	\$14	\$102	\$88	\$164	\$1,231	\$1,067
Providers	\$20	\$20	\$0	\$230	\$230	\$0

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

Elimination of the Individual and Employer Mandates in 2017

So far, our analysis has focused on the 2019 effects of the reconciliation approach. In this section, we analyze the implications of eliminating the individual and employer mandates immediately after passage in 2017. We do this because the 2016 reconciliation bill would have immediately stopped collections of these penalties.

ACA-compliant nongroup premiums for 2017 were set in 2016 before the start of the open enrollment period, following months of review by state departments of insurance and, in some cases, the federal government. Before the governmental review process, insurers assess and refine their product offerings for the coming year, and their actuaries and others prepare their proposed premiums based on last year's experiences, expected changes in the nongroup risk pool for the coming year, and other considerations. Once premiums are approved, they are locked in for the coming plan year.

Eliminating the individual mandate (and, to a much smaller degree, the employer mandate) in the middle of a plan year would change the rules of the insurance market after the year's premiums have been set. Fewer people would keep their health insurance for the remainder of the year. Once they are informed that there would no longer be a tax penalty for remaining uninsured, some people would drop their coverage after the start of the plan year. As healthier people drop coverage, premium collections across the nongroup market would be lower than the health care costs incurred by those who remain insured. This type of pricing disconnect would affect not only those insurers providing Marketplace coverage but also those selling nongroup coverage outside the Marketplaces, since the entire ACA-compliant nongroup market is treated as a single risk pool.

If the individual and employer mandates are eliminated while the ACA's Medicaid expansion, Marketplace tax credits and cost-sharing reductions, insurance market reforms, and other components are left in place in 2017, 4.3 million people would drop their ACA-compliant nongroup insurance coverage and become uninsured (table 8). Average health insurance claims for those remaining in the ACA-compliant private nongroup insurance markets would be about 10 percent higher than if the 4.3 million people stayed in the pool as they would under the ACA (data not shown); this would place financial pressure on the markets' insurers. The continuation of Marketplace financial assistance is critical to averting even higher short-run increases in average claims because the lower-priced coverage provided to many modest-income people is attractive even without a mandate in place.

TABLE 8

Nonelderly Coverage Distribution and Insurers' Premium Revenue in 2017

Thousands of people

	Current law	Elimination of individual and employer mandates early in year	Difference
<i>Coverage</i>			
Medicaid	67,950	67,950	0
Medicare	3,953	3,953	0
Employer-sponsored insurance	149,511	149,511	0
Other public	4,505	4,505	0
Nongroup	18,418	14,085	-4,334
<i>Uninsured</i>	28,342	32,676	4,334
Total	272,680	272,680	
Premium revenue (billions)			
Total premium revenue: current law			\$46
Total premium revenue: no mandates, fixed premiums			\$37
Actuarially fair premiums necessary to cover insurer costs if mandates eliminated			\$40
Shortfall in insurer revenue caused by eliminating mandates mid-plan year			\$3

Source: Urban Institute analysis using HIPSM 2016.

Note: Premium revenue includes direct payments by enrollees and premium tax credits financed by the federal government.

Under current law, insurers would collect an estimated \$46 billion in premiums (combining those paid directly by enrollees and the premium tax credits provided by the federal government). If the individual mandate is eliminated early in 2017, insurer premium revenue would drop almost \$10 billion to \$37 billion, yet this revenue would fall more than \$3 billion short of covering insurers' claims and administrative costs. Facing significant financial losses, insurers could request midyear premium adjustments, absorb the financial losses and remain in the markets, or exit the markets entirely. Midyear premium adjustments are likely unfeasible because the standard premium development, review, and approval processes require several months. Some larger insurers could decide to remain in the markets and internalize the losses, but others would surely leave. As a result, even if some insurers remain in some areas, more people would become uninsured in 2017, insurers would suffer financial

losses, and many consumers would be displaced from coverage and provider networks they chose during 2017 open enrollment. Financial burdens for consumers with insurers that leave the market during the year would increase because enrollees would lose credit for deductibles and cost-sharing already paid, even if they are able to enroll with a different insurer. The number of insurers leaving the nongroup market and the effect on consumers would likely be significantly larger in 2018 than in 2017. The 2016 reconciliation bill would have immediately stopped the reinsurance program as well. That would cause further financial losses to insurers than we have estimated here.

The bottom line is that eliminating the individual mandate penalties midyear would lead to a much faster unwinding of private nongroup insurance markets than would occur if the mandate were repealed in 2019. The 2019 estimates presented earlier would still hold, but the effects would begin earlier if the mandates were eliminated prior to the other changes. The effects would begin in 2017 but would likely accelerate in 2018. Any changes to the market rules, mandate, or financial assistance after premiums are set for the plan year would significantly disrupt coverage and care and would cause private financial losses for households and insurers.

Our analysis does not include the additional disruptions to insurers and consumers that would occur if the federal government immediately ceased paying cost-sharing reductions on behalf of low-income Marketplace enrollees. This is the issue under consideration in the *House v. Burwell* case. We have analyzed the potential implications of the case elsewhere (Blumberg and Buettgens 2016) but not in combination with the issues analyzed here. Eliminating the cost-sharing reductions immediately would impose greater losses on Marketplace insurers than estimated here and would force more insurers out of the Marketplaces, resulting in much broader immediate disruptions for consumers.

Discussion

We estimate that the effects of passing and implementing the reconciliation bill would be large and swift. Yet actual effects would likely be larger, for the following reasons.

- We assume that no additional states would adopt Medicaid expansions if the ACA remains in effect. If additional states expanded Medicaid, the drop in coverage relative to what would occur under current law would be greater than we estimate here.
- The ACA's individual mandate penalties increase in 2016 to their maximum level. These higher penalties, which will be felt in early 2017 when taxpayers file their returns, could lead to more people enrolling in coverage the next plan year. We do not include this possible bump in insurance coverage in our ACA estimates. Therefore, we may be underestimating the future coverage gains under the ACA as well as the decline in coverage resulting from partial repeal using a reconciliation approach.
- Many of those remaining uninsured under the ACA are eligible for Medicaid or subsidized private Marketplace coverage. Additional targeted outreach and enrollment assistance could increase health coverage further if the ACA remains in place (Blumberg et al. 2016); by ignoring

this pool of potential coverage expansion, we likely understate the decline in coverage relative to what might occur under current law.

- Repeal would mean that states that had expanded insurance coverage before the ACA using Medicaid waivers would likely need to renegotiate those waivers to keep program eligibility where it was before 2014. However, the new administration may not grant such waivers or may require substantial changes to them that would affect states' ability to provide coverage to the same number of people that they had before the ACA.

In addition, this analysis only covers the decrease in federal health care spending and does not provide a complete picture of the effect of the anticipated reconciliation bill on the federal budget. Specifically, we do not estimate the revenue consequences of eliminating the high-cost plan or "Cadillac" tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. Therefore, our estimates cannot be interpreted as federal budget effects, only decreases in spending on health care. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending estimated in this analysis. As a number of states have reported, the Medicaid expansion has led to additional state budgetary spending, and its repeal could have significant negative economic consequences for states.⁷

It is also possible that particular states would raise revenues to offset some of the coverage losses created by such a federal approach. But the state revenue required makes this response unlikely, and any state action of this sort would likely be concentrated in the highest-income states. Massachusetts was the only state that had significantly expanded coverage through its own reforms prior to the ACA, and even that state relied heavily on federal Medicaid dollars via a waiver to finance the financial assistance that was provided. Given those caveats, our central findings are that the anticipated reconciliation bill would have the following effects:

- The number of uninsured people would increase by 29.8 million by 2019.
- The number of people with Medicaid or CHIP coverage would decrease by 12.9 million, and 17.7 million fewer people would have private nongroup insurance by 2019.
- About 56 percent of those losing coverage would be non-Hispanic whites, 82 percent would be in working families, and 80 percent of adults would have less than a college degree.
- Federal spending on health care would be \$109 billion lower in 2019 and \$1.3 trillion lower between 2019 and 2028.
- State and local spending on Medicaid and CHIP would be \$4 billion lower in 2019 and \$76 billion lower between 2019 and 2028. However, uncompensated care pressures on state and local governments and on health care providers would increase significantly with the growing number of uninsured. The newly uninsured would seek an additional \$1.1 trillion in uncompensated care between 2019 and 2028. Increases in uncompensated care funding would not occur automatically, and if governments or providers do not increase the funding of care for

the uninsured substantially from current levels, unmet medical need would increase even further and fiscal pressures on providers would intensify significantly.

- Eliminating the individual mandate in 2017 would lead to a significant erosion of the private nongroup insurance markets inside and outside the Marketplaces that year, with lower coverage (an additional 4.3 million uninsured), some midyear insurer exits, substantial financial losses for insurers (\$3 billion), and displacement and financial losses for consumers having to change plans.

These changes in coverage and spending add up to substantial decreases in health care spending on nonelderly adults and children, with a disproportionate share of that decrease falling on middle- and low-income people, although we have not included these estimated effects here. The decrease in spending would reduce hospital admissions, visits to doctors and other health care providers, prescriptions filled, and other forms of health care, despite possible increases in public spending on uncompensated care. This scenario does not just move the country back to the situation before the ACA. Because it would lead to a near-collapse of the nongroup insurance market, it moves the country to a situation with higher uninsurance rates than before the ACA's reforms. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

Methods

Our estimates are based on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). The model has been used in a broad array of analyses of the ACA at the federal and state levels. The Supreme Court majority cited HIPSM analysis in the *King v. Burwell* case. The model has accurately forecast the stability of employer-based health insurance under the ACA. The model's estimates of the effect of the ACA on overall coverage and federal government costs compare favorably in accuracy to that of other microsimulation models, including that of the Congressional Budget Office (Glied, Arora, and Solis-Roman 2015).

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey. Its large sample size enables state-level analysis. We use the latest available enrollment data from the Marketplaces and Medicaid to impute new coverage. As a result, our estimates of enrollees in each state match actual enrollment. After calibrating HIPSM to reproduce 2016 Medicaid and Marketplace enrollment, we estimate that 10.3 percent of the nonelderly are uninsured in that year. This estimate almost exactly matches the National Health Interview Survey's January–June 2016 estimate of 10.4 percent of the nonelderly uninsured at the time of interview (Zammiti, Cohen, and Martinez 2016, 13). HIPSM coverage estimates represent an annual average number of people in each coverage status.

Our estimates of coverage under the ACA after 2016 do not assume notably higher take-up of Medicaid or Marketplace coverage than in 2016. We recognize that participation rates could increase over time. Nonetheless, we ignore this possibility because we choose to base our estimate of ACA effects on what has already happened. We also adopt conservative assumptions for the cost of health care. Although some studies have found that the ACA contributed to the slowing growth of health care costs in recent years, there is no generally accepted estimate of how large that contribution was

(McMorrow and Holahan 2016). Accordingly, we assume that the underlying growth rate of health care costs would be the same with or without the ACA.

The methods used here are generally consistent with those described in our earlier analysis of full repeal of the ACA (Buettgens et al. 2016). Additional detail on our methods can be found in that document. We have made three changes in our methods. First, this analysis leaves the ACA components with no budgetary implications (i.e., the insurance market reforms in the nongroup insurance market and the small group insurance market) in place. As explained in the results section of this paper, this difference has substantial ramifications for the viability of the private nongroup insurance market and leads to larger coverage effects than our earlier simulations. Second, this analysis focuses on 2019 and the 10-year budget window of 2019 to 2028 instead of 2017 to 2026.

Third, we take a somewhat different approach to allocating the costs associated with increased demand for uncompensated care. We compute the demand for uncompensated care in the same way as prior analyses, but we present the implications for federal, state, and local governments and providers differently than in the last report. We calculate the demand for uncompensated care for each uninsured person based upon their characteristics and health risk. We calibrate uncompensated care costs so that the uncompensated care provided to the uninsured in 2013 matches the estimated amount spent on uncompensated care that year. We inflate the value of uncompensated care over time for each person by the projected per capita growth in medical costs. We also assume that newly uninsured people will spend money on their own care and that their levels of spending will be consistent with those of people of similar health circumstances and characteristics observed under current law. However, in the current analysis we recognize that policy changes would be required in order for federal or state/local spending on uncompensated care to increase significantly beyond current levels. In the prior analysis, we assumed all sources of uncompensated care funding would increase proportionately with the increase in demand for such care. Given that Congress did not include an increase over current levels in federal spending on uncompensated care programs in the 2016 reconciliation bill, we assume a 2017 reconciliation bill would keep federal spending at current levels as well. Therefore, we show the estimated increase in uncompensated care sought due to the increase in the uninsured and compute the relative increase in spending that it would require from states and localities or the relative increase in free care provided by doctors, hospitals, and other providers if they were to finance an increase of that magnitude.

This analysis does not include estimates of the revenue reductions of eliminating the Cadillac tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. We provide decreases in federal spending on health programs, but we do not provide overall federal budget effects. The latter would be considerably smaller than the former. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending shown here. As a number of states have reported, the Medicaid expansion has led to additional state budgetary savings, and its repeal could have significant negative economic consequences for states; those consequences are not included in this analysis.

APPENDIX TABLE A.1

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019
Millions of dollars

State	ACA			Reconciliation Bill			Difference		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
National	330,191	194,951	525,142	262,720	190,654	453,374	-67,471	-4,298	-71,768
<i>Expansion states</i>									
Alaska	903	756	1,659	795	795	1,591	-107	40	-68
Arizona	11,138	4,594	15,732	8,567	4,176	12,743	-2,571	-418	-2,989
Arkansas	3,328	1,215	4,544	2,699	1,151	3,850	-629	-64	-693
California	29,016	23,213	52,229	20,963	20,963	41,927	-8,053	-2,250	-10,302
Colorado	5,920	3,402	9,322	3,412	3,269	6,681	-2,508	-134	-2,642
Connecticut	4,156	3,123	7,279	3,290	3,220	6,511	-866	97	-769
Delaware	1,192	687	1,879	970	765	1,735	-222	78	-144
District of Columbia	1,455	521	1,977	1,316	564	1,880	-139	43	-97
Hawaii	1,220	818	2,038	914	849	1,764	-306	31	-274
Illinois	12,618	8,954	21,572	9,543	9,051	18,594	-3,074	97	-2,978
Indiana	6,450	2,433	8,883	5,304	2,581	7,885	-1,146	148	-998
Iowa	2,726	1,513	4,239	2,280	1,594	3,874	-446	81	-365
Kentucky	8,512	2,257	10,769	4,679	1,998	6,677	-3,834	-259	-4,092
Louisiana	5,986	2,819	8,805	4,126	2,618	6,744	-1,860	-201	-2,062
Maryland	6,379	4,466	10,846	4,472	4,472	8,943	-1,908	5	-1,903
Massachusetts	7,593	6,166	13,759	6,179	5,976	12,155	-1,414	-190	-1,604
Michigan	12,023	4,525	16,548	9,510	4,785	14,295	-2,513	260	-2,253
Minnesota	6,485	4,907	11,392	5,292	5,292	10,583	-1,193	385	-808
Montana	1,797	621	2,418	1,099	535	1,634	-698	-86	-784
Nevada	2,758	1,063	3,821	1,730	995	2,725	-1,028	-68	-1,096
New Hampshire	1,144	780	1,924	815	815	1,630	-329	35	-295
New Jersey	10,906	5,916	16,822	6,544	6,265	12,809	-4,363	350	-4,013
New Mexico	5,808	1,735	7,544	3,608	1,606	5,213	-2,201	-130	-2,330
New York	27,846	21,110	48,956	23,880	23,235	47,116	-3,966	2,126	-1,840
North Dakota	559	336	895	390	386	776	-169	49	-119
Ohio	14,233	6,156	20,389	10,735	6,299	17,034	-3,498	143	-3,355
Oregon	6,624	2,115	8,739	3,747	2,115	5,861	-2,877	-1	-2,878
Pennsylvania	12,257	7,912	20,169	10,373	8,614	18,987	-1,883	702	-1,182

State	ACA			Reconciliation Bill			Difference		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
Rhode Island	1,691	1,228	2,920	1,136	1,131	2,267	-556	-98	-653
Vermont	917	554	1,471	746	608	1,354	-171	54	-117
Washington	7,221	4,131	11,352	4,121	4,043	8,164	-3,100	-88	-3,188
West Virginia	2,860	782	3,642	1,849	726	2,575	-1,011	-56	-1,067
Expansion states total	223,722	130,811	354,533	165,085	131,492	296,576	-58,638	681	-57,956
<i>Nonexpansion states</i>									
Alabama	3,710	1,642	5,353	3,439	1,525	4,964	-271	-117	-388
Florida	14,230	9,728	23,958	12,719	8,732	21,452	-1,511	-996	-2,507
Georgia	7,834	3,929	11,763	6,881	3,454	10,334	-953	-475	-1,428
Idaho	2,006	777	2,784	1,798	698	2,496	-208	-79	-288
Kansas	1,877	1,363	3,240	1,734	1,258	2,992	-143	-105	-248
Maine	1,376	839	2,215	1,335	820	2,155	-41	-19	-60
Mississippi	3,498	1,263	4,761	3,185	1,150	4,335	-313	-112	-426
Missouri	6,389	3,784	10,173	5,946	3,534	9,480	-444	-250	-694
Nebraska	1,162	960	2,122	1,149	950	2,100	-12	-10	-22
North Carolina	11,436	5,817	17,254	9,803	5,009	14,811	-1,634	-808	-2,442
Oklahoma	3,810	2,141	5,951	3,675	2,065	5,740	-135	-76	-211
South Carolina	4,287	1,788	6,075	4,200	1,751	5,951	-88	-37	-124
South Dakota	645	555	1,200	624	537	1,162	-21	-18	-39
Tennessee	7,717	3,961	11,678	6,457	3,346	9,803	-1,260	-615	-1,875
Texas	25,288	17,257	42,545	23,978	16,363	40,341	-1,310	-894	-2,204
Utah	2,529	1,041	3,569	2,412	992	3,405	-116	-48	-165
Virginia	4,415	4,299	8,713	4,210	4,100	8,311	-204	-198	-403
Wisconsin	3,899	2,643	6,542	3,742	2,533	6,276	-157	-109	-266
Wyoming	360	353	713	350	343	692	-10	-10	-21
Nonexpansion states total	106,469	64,141	170,609	97,636	59,162	156,798	-8,833	-4,979	-13,812

Source: Urban Institute analysis using HIPSIM 2016.

APPENDIX TABLE A.2

Number of People Losing Federal Financial Assistance for Marketplace Coverage, Average Assistance Forgone, and Aggregate Federal Assistance Forgone under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

State	People who would receive tax credits under the ACA (thousands)	Average tax credit and cost-sharing assistance per recipient (\$)	Premium tax credits (\$ millions)	Cost-sharing reductions (\$ millions)	Total federal assistance forgone (\$ millions)
National	9,322	\$4,480	35,338	6,427	41,765
<i>Expansion states</i>					
Alaska	19	\$8,810	150	21	171
Arizona	126	\$6,975	827	49	877
Arkansas	55	\$3,516	159	35	194
California	1,403	\$3,945	4,783	752	5,534
Colorado	78	\$2,840	190	33	223
Connecticut	74	\$5,272	348	43	391
Delaware	20	\$4,025	71	10	81
District of Columbia	3	\$2,368	7	0	8
Hawaii	11	\$4,351	42	6	47
Illinois	258	\$4,355	1,001	122	1,122
Indiana	104	\$4,448	385	78	463
Iowa	42	\$4,281	156	24	180
Kentucky	57	\$4,547	213	46	259
Louisiana	70	\$5,230	316	50	366
Maryland	129	\$2,981	332	53	385
Massachusetts	126	\$3,881	415	75	491
Michigan	232	\$3,230	633	118	750
Minnesota	47	\$3,512	163	2	165
Montana	23	\$4,776	97	12	109
Nevada	63	\$4,956	262	50	312
New Hampshire	29	\$2,898	70	16	85
New Jersey	193	\$3,152	513	94	607
New Mexico	33	\$2,805	77	16	93
New York	310	\$2,869	771	120	891
North Dakota	17	\$3,182	47	7	54
Ohio	155	\$3,446	438	97	535
Oregon	111	\$2,656	255	41	296
Pennsylvania	239	\$4,996	1,074	121	1,195
Rhode Island	30	\$2,002	50	10	60

State	People who would receive tax credits under the ACA (thousands)	Average tax credit and cost-sharing assistance per recipient (\$)	Premium tax credits (\$ millions)	Cost-sharing reductions (\$ millions)	Total federal assistance forgone (\$ millions)
Vermont	24	\$3,888	83	9	91
Washington	142	\$3,005	352	73	425
West Virginia	29	\$5,668	143	21	164
<i>Expansion states total</i>	4,254	\$3,908	14,423	2,203	16,626
<i>Nonexpansion states</i>					
Alabama	151	\$7,156	931	147	1,078
Florida	1,366	\$4,481	5,106	1,013	6,119
Georgia	437	\$4,148	1,430	381	1,811
Idaho	79	\$4,178	276	56	331
Kansas	78	\$4,999	329	60	389
Maine	67	\$5,788	331	57	388
Mississippi	72	\$6,642	390	85	475
Missouri	225	\$5,216	960	212	1,172
Nebraska	70	\$5,671	345	52	397
North Carolina	493	\$6,943	2,947	475	3,421
Oklahoma	110	\$6,260	601	87	689
South Carolina	163	\$5,842	787	164	951
South Dakota	20	\$5,243	90	15	105
Tennessee	173	\$5,573	834	132	966
Texas	941	\$4,310	3,234	822	4,057
Utah	83	\$3,468	242	46	288
Virginia	326	\$4,218	1,122	252	1,374
Wisconsin	197	\$4,953	837	139	976
Wyoming	19	\$8,190	122	30	152
<i>Nonexpansion states total</i>	5,068	\$4,961	20,914	4,225	25,139

Source: Urban Institute analysis using HIPSMS 2016.

Notes: Average assistance per recipient is calculated as the total of premium tax credits and cost-sharing reductions provided in each state, divided by the number of people in families receiving assistance. All those receiving Marketplace assistance receive tax credits; some receive both tax credits and cost-sharing assistance. For example, a family of four receiving a tax credit through a Marketplace would count as four people in tallies of those receiving assistance.

APPENDIX TABLE A.3

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

State	ACA		Reconciliation Bill		Difference	
	Federal	State	Federal	State	Federal	State
<i>Expansion states</i>						
Alaska	\$11,516	\$9,756	\$10,198	\$10,198	-\$1,318	\$442
Arizona	\$142,127	\$59,683	\$110,043	\$53,638	-\$32,084	-\$6,044
Arkansas	\$41,909	\$15,586	\$34,148	\$14,565	-\$7,761	-\$1,021
California	\$363,744	\$295,051	\$264,676	\$264,676	-\$99,068	-\$30,375
Colorado	\$74,434	\$44,204	\$43,583	\$41,713	-\$30,851	-\$2,491
Connecticut	\$51,903	\$39,643	\$41,431	\$40,547	-\$10,472	\$904
Delaware	\$14,978	\$8,821	\$12,287	\$9,687	-\$2,690	\$866
District of Columbia	\$18,223	\$6,671	\$16,564	\$7,099	-\$1,659	\$427
Hawaii	\$15,314	\$10,506	\$11,586	\$10,759	-\$3,728	\$253
Illinois	\$157,567	\$113,855	\$120,198	\$113,893	-\$37,369	\$38
Indiana	\$81,176	\$31,465	\$67,268	\$32,725	-\$13,908	\$1,260
Iowa	\$34,394	\$19,436	\$28,998	\$20,265	-\$5,396	\$829
Kentucky	\$105,571	\$29,683	\$58,774	\$25,098	-\$46,797	-\$4,585
Louisiana	\$74,411	\$35,939	\$51,729	\$32,817	-\$22,682	-\$3,122
Maryland	\$80,069	\$57,286	\$56,627	\$56,627	-\$23,443	-\$660
Massachusetts	\$95,075	\$78,018	\$77,912	\$75,343	-\$17,163	-\$2,675
Michigan	\$148,780	\$57,731	\$118,792	\$59,758	-\$29,988	\$2,026
Minnesota	\$82,245	\$63,400	\$67,686	\$67,686	-\$14,559	\$4,286
Montana	\$22,512	\$8,091	\$13,945	\$6,790	-\$8,568	-\$1,302
Nevada	\$35,236	\$14,091	\$22,328	\$12,835	-\$12,908	-\$1,256
New Hampshire	\$14,138	\$9,874	\$10,172	\$10,172	-\$3,966	\$299
New Jersey	\$135,378	\$76,052	\$82,380	\$78,785	-\$52,998	\$2,733
New Mexico	\$72,465	\$22,723	\$45,594	\$20,293	-\$26,871	-\$2,430
New York	\$347,954	\$267,729	\$300,605	\$292,248	-\$47,349	\$24,520
North Dakota	\$7,043	\$4,357	\$4,980	\$4,928	-\$2,063	\$571
Ohio	\$176,730	\$78,643	\$134,545	\$78,951	-\$42,185	\$308
Oregon	\$82,541	\$27,876	\$47,423	\$26,745	-\$35,118	-\$1,131
Pennsylvania	\$154,018	\$101,149	\$131,365	\$109,020	-\$22,654	\$7,871
Rhode Island	\$21,045	\$15,610	\$14,316	\$14,254	-\$6,728	-\$1,357

State	ACA		Reconciliation Bill		Difference	
	Federal	State	Federal	State	Federal	State
Vermont	\$11,281	\$6,956	\$9,346	\$7,612	-\$1,935	\$656
Washington	\$90,347	\$53,511	\$52,283	\$51,284	-\$38,064	-\$2,227
West Virginia	\$35,274	\$10,101	\$23,027	\$9,047	-\$12,247	-\$1,054
<i>Expansion states total</i>	<i>\$2,799,399</i>	<i>\$1,673,497</i>	<i>\$2,084,808</i>	<i>\$1,660,058</i>	<i>-\$714,591</i>	<i>-\$13,439</i>
<i>Nonexpansion states</i>						
Alabama	\$46,751	\$20,673	\$43,341	\$19,203	-\$3,410	-\$1,470
Florida	\$180,752	\$123,567	\$161,626	\$110,954	-\$19,126	-\$12,613
Georgia	\$100,670	\$50,498	\$88,488	\$44,414	-\$12,182	-\$6,084
Idaho	\$25,670	\$9,944	\$23,025	\$8,936	-\$2,645	-\$1,008
Kansas	\$23,772	\$17,247	\$21,975	\$15,922	-\$1,797	-\$1,325
Maine	\$17,064	\$10,412	\$16,566	\$10,179	-\$498	-\$233
Mississippi	\$43,816	\$15,814	\$39,928	\$14,420	-\$3,888	-\$1,393
Missouri	\$80,482	\$47,643	\$74,971	\$44,535	-\$5,510	-\$3,108
Nebraska	\$14,733	\$12,181	\$14,581	\$12,056	-\$152	-\$126
North Carolina	\$145,642	\$74,079	\$124,923	\$63,824	-\$20,719	-\$10,255
Oklahoma	\$48,324	\$27,159	\$46,666	\$26,227	-\$1,659	-\$932
South Carolina	\$54,112	\$22,566	\$53,036	\$22,118	-\$1,075	-\$448
South Dakota	\$8,248	\$7,103	\$7,979	\$6,871	-\$269	-\$232
Tennessee	\$97,562	\$50,078	\$81,654	\$42,303	-\$15,908	-\$7,775
Texas	\$323,489	\$220,741	\$306,920	\$209,439	-\$16,568	-\$11,303
Utah	\$32,712	\$13,459	\$31,221	\$12,842	-\$1,492	-\$617
Virginia	\$56,263	\$54,756	\$53,659	\$52,232	-\$2,604	-\$2,524
Wisconsin	\$49,352	\$33,442	\$47,447	\$32,108	-\$1,905	-\$1,334
Wyoming	\$4,555	\$4,467	\$4,432	\$4,343	-\$123	-\$124
<i>Nonexpansion states total</i>	<i>\$1,353,966</i>	<i>\$815,830</i>	<i>\$1,242,436</i>	<i>\$752,926</i>	<i>-\$111,530</i>	<i>-\$62,904</i>
National estimate	\$4,153,365	\$2,489,327	\$3,327,244	\$2,412,984	-\$826,121	-\$76,342

Source: Urban Institute analysis using HIPSMS 2016.

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

APPENDIX TABLE A.4

Forgone Federal Spending on Marketplace Financial Assistance under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

State	Federal Marketplace financial assistance	State	Federal Marketplace financial assistance
<i>Expansion states</i>		<i>Nonexpansion states</i>	
Alaska	1,900	Alabama	11,944
Arizona	10,017	Florida	68,139
Arkansas	2,147	Georgia	20,484
California	61,116	Idaho	3,710
Colorado	2,479	Kansas	4,316
Connecticut	4,305	Maine	4,212
Delaware	898	Mississippi	5,232
District of Columbia	85	Missouri	12,909
Hawaii	532	Nebraska	4,398
Illinois	12,483	North Carolina	38,239
Indiana	5,095	Oklahoma	7,682
Iowa	1,982	South Carolina	10,580
Kentucky	2,861	South Dakota	1,166
Louisiana	4,048	Tennessee	10,777
Maryland	4,338	Texas	45,594
Massachusetts	5,361	Utah	3,262
Michigan	8,177	Virginia	15,400
Minnesota	1,875	Wisconsin	10,722
Montana	1,205	Wyoming	1,681
Nevada	3,529	<i>Nonexpansion states total</i>	280,449
New Hampshire	927		
New Jersey	6,694		
New Mexico	1,027		
New York	9,853		
North Dakota	592		
Ohio	5,842		
Oregon	3,286		
Pennsylvania	13,276		
Rhode Island	653		
Vermont	989		
Washington	4,691		
West Virginia	1,794		
<i>Expansion states total</i>	184,058		
National total	464,507	National total	464,507

Source: Urban Institute analysis using HIPSM 2016.

Note: ACA = Affordable Care Act.

APPENDIX TABLE A.5

Total Federal and State Spending on Medicaid/CHIP and Marketplace Assistance under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

State	ACA		Reconciliation Bill		Difference	
	Federal	State	Federal	State	Federal	State
<i>Expansion states</i>						
Alaska	\$13,416	\$9,756	\$10,198	\$10,198	-\$3,218	\$442
Arizona	\$152,144	\$59,683	\$110,043	\$53,638	-\$42,101	-\$6,044
Arkansas	\$44,056	\$15,586	\$34,148	\$14,565	-\$9,908	-\$1,021
California	\$424,860	\$295,051	\$264,676	\$264,676	-\$160,184	-\$30,375
Colorado	\$76,913	\$44,204	\$43,583	\$41,713	-\$33,330	-\$2,491
Connecticut	\$56,209	\$39,643	\$41,431	\$40,547	-\$14,778	\$904
Delaware	\$15,876	\$8,821	\$12,287	\$9,687	-\$3,589	\$866
District of Columbia	\$18,308	\$6,671	\$16,564	\$7,099	-\$1,744	\$427
Hawaii	\$15,846	\$10,506	\$11,586	\$10,759	-\$4,261	\$253
Illinois	\$170,051	\$113,855	\$120,198	\$113,893	-\$49,852	\$38
Indiana	\$86,271	\$31,465	\$67,268	\$32,725	-\$19,003	\$1,260
Iowa	\$36,376	\$19,436	\$28,998	\$20,265	-\$7,378	\$829
Kentucky	\$108,432	\$29,683	\$58,774	\$25,098	-\$49,658	-\$4,585
Louisiana	\$78,459	\$35,939	\$51,729	\$32,817	-\$26,730	-\$3,122
Maryland	\$84,408	\$57,286	\$56,627	\$56,627	-\$27,781	-\$660
Massachusetts	\$100,435	\$78,018	\$77,912	\$75,343	-\$22,523	-\$2,675
Michigan	\$156,956	\$57,731	\$118,792	\$59,758	-\$38,164	\$2,026
Minnesota	\$84,119	\$63,400	\$67,686	\$67,686	-\$16,434	\$4,286
Montana	\$23,717	\$8,091	\$13,945	\$6,790	-\$9,773	-\$1,302
Nevada	\$38,765	\$14,091	\$22,328	\$12,835	-\$16,437	-\$1,256
New Hampshire	\$15,065	\$9,874	\$10,172	\$10,172	-\$4,893	\$299
New Jersey	\$142,073	\$76,052	\$82,380	\$78,785	-\$59,693	\$2,733
New Mexico	\$73,492	\$22,723	\$45,594	\$20,293	-\$27,899	-\$2,430
New York	\$357,807	\$267,729	\$300,605	\$292,248	-\$57,202	\$24,520
North Dakota	\$7,635	\$4,357	\$4,980	\$4,928	-\$2,655	\$571
Ohio	\$182,572	\$78,643	\$134,545	\$78,951	-\$48,027	\$308
Oregon	\$85,826	\$27,876	\$47,423	\$26,745	-\$38,403	-\$1,131
Pennsylvania	\$167,294	\$101,149	\$131,365	\$109,020	-\$35,930	\$7,871

Rhode Island	\$21,698	\$15,610	\$14,316	\$14,254	-\$7,382	-\$1,357
Vermont	\$12,269	\$6,956	\$9,346	\$7,612	-\$2,924	\$656
Washington	\$95,038	\$53,511	\$52,283	\$51,284	-\$42,755	-\$2,227
West Virginia	\$37,068	\$10,101	\$23,027	\$9,047	-\$14,042	-\$1,054
<i>Expansion states total</i>	<i>\$2,983,457</i>	<i>\$1,673,497</i>	<i>\$2,084,808</i>	<i>\$1,660,058</i>	<i>-\$898,649</i>	<i>-\$13,439</i>
<i>Nonexpansion states</i>						
Alabama	\$58,695	\$20,673	\$43,341	\$19,203	-\$15,353	-\$1,470
Florida	\$248,890	\$123,567	\$161,626	\$110,954	-\$87,265	-\$12,613
Georgia	\$121,154	\$50,498	\$88,488	\$44,414	-\$32,666	-\$6,084
Idaho	\$29,380	\$9,944	\$23,025	\$8,936	-\$6,355	-\$1,008
Kansas	\$28,087	\$17,247	\$21,975	\$15,922	-\$6,113	-\$1,325
Maine	\$21,276	\$10,412	\$16,566	\$10,179	-\$4,710	-\$233
Mississippi	\$49,048	\$15,814	\$39,928	\$14,420	-\$9,120	-\$1,393
Missouri	\$93,391	\$47,643	\$74,971	\$44,535	-\$18,420	-\$3,108
Nebraska	\$19,131	\$12,181	\$14,581	\$12,056	-\$4,550	-\$126
North Carolina	\$183,881	\$74,079	\$124,923	\$63,824	-\$58,958	-\$10,255
Oklahoma	\$56,006	\$27,159	\$46,666	\$26,227	-\$9,341	-\$932
South Carolina	\$64,691	\$22,566	\$53,036	\$22,118	-\$11,655	-\$448
South Dakota	\$9,414	\$7,103	\$7,979	\$6,871	-\$1,435	-\$232
Tennessee	\$108,339	\$50,078	\$81,654	\$42,303	-\$26,685	-\$7,775
Texas	\$369,083	\$220,741	\$306,920	\$209,439	-\$62,162	-\$11,303
Utah	\$35,975	\$13,459	\$31,221	\$12,842	-\$4,754	-\$617
Virginia	\$71,664	\$54,756	\$53,659	\$52,232	-\$18,004	-\$2,524
Wisconsin	\$60,074	\$33,442	\$47,447	\$32,108	-\$12,627	-\$1,334
Wyoming	\$6,236	\$4,467	\$4,432	\$4,343	-\$1,804	-\$124
<i>Nonexpansion states total</i>	<i>\$1,634,415</i>	<i>\$815,830</i>	<i>\$1,242,436</i>	<i>\$752,926</i>	<i>-\$391,979</i>	<i>-\$62,904</i>
National total	\$4,617,872	\$2,489,327	\$3,327,244	\$2,412,984	-\$1,290,628	-\$76,218

Source: Urban Institute analysis using HIPSIM 2016.

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

Notes

1. Alex Moe, "Congress Sends Obamacare Repeal to President for First Time," NBC News, January 6, 2016, <http://www.nbcnews.com/news/us-news/congress-send-obamacare-repeal-president-n491316>.
2. Steven T. Dennis and Billy House, "GOP Eyes Lightning Strike on Obamacare to Kick Off Trump Era," Bloomberg, November 29, 2016, <http://www.bloomberg.com/politics/articles/2016-11-29/gop-eyes-lightning-strike-on-obamacare-to-kick-off-trump-era>; and Lisa Mascaró, "Repeal and Replace Obamacare? It Won't Happen on Trump's First Day," *Los Angeles Times*, November 29, 2016, <http://www.latimes.com/nation/politics/trailguide/la-na-trailguide-updates-1480442605-htmstory.html>.
3. "Summary of the Byrd rule," US House of Representatives Committee on Rules, accessed November 22, 2016, http://archives.democrats.rules.house.gov/archives/byrd_rule.htm.
4. A number of other provisions of the 2016 reconciliation bill that would have affected coverage would have taken effect immediately or before two years. These include the early repeal of the maintenance-of-effort requirement for eligibility of children under Medicaid/CHIP and the elimination of the tax credit reconciliation caps. These provisions are not included in the estimates presented here.
5. We assume that federal DSH payments increase very modestly over the 10-year period. The Medicare DSH cuts in the ACA were left in place in the prior reconciliation bill, as were all Medicare savings provisions. We assume that would still be the case. The ACA's Medicaid DSH cuts have never been implemented, and we assume that they are restored permanently and held constant and that there would be no congressional interest in increasing them. Medicaid supplemental payments contribute in part to funding uncompensated care, and states could increase their use of them, but there would be fewer Medicaid patients to attach them to. Other sources of federal funding for uncompensated care could increase, but these would be modest given the new administration's commitment to budget cuts.
6. The Congressional Budget Office (2016) estimates Marketplace premium tax credits in the amount of \$60 billion and cost-sharing reductions in the amount of \$12 billion in 2019. Those larger federal spending estimates are the result of an estimate of subsidized Marketplace enrollment of 16 million people in 2019. This level of subsidized enrollment is significantly higher than that produced by HIPSM and would represent a very large increase in enrollment relative to administrative data. According to the Department of Health and Human Services, subsidized Marketplace enrollment was 9.4 million people in March 2016 (US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "March 31, 2016 Effectuated Enrollment Snapshot," media release, June 30, 2016, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html>), and Marketplace enrollment has fallen somewhat over the course of each calendar year from March levels. Our 2019 subsidized Marketplace enrollment of 9.3 million represents an average for calendar year 2019; thus, while conservative, it represents a modest increase in coverage between 2016 and 2019.
7. See, for example, Brian Fanne, Michael R. Wickline, and Spencer Williams, "Arkansas House Speaker Details Cuts if Medicaid Plan Fails," *Arkansas Online*, April 12, 2016, <http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/>. Medicaid expansion in Arkansas was extended on April 21, 2016; see David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," *Kaiser Health News*, April 21, 2016, <http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion>; and Dorn et al. (2015).

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Linda Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a “Roadmap to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.



Matthew Buettgens is a senior research associate in the Health Policy Center, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state by state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments, small firm self-insurance under the Affordable Care Act and its effect on the fully insured market, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage.



John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

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Addenda

This brief was updated at 10:00 a.m. December 8, 2016. Two additional data columns were added to appendix table A.2. No previous data were altered.



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SUMMARY

This brief details changes in insurance coverage and access to care under the Affordable Care Act. About 20 million individuals gained coverage under the law and access to care improved. Despite these gains, more than 27 million individuals are still uninsured, and many others face barriers in accessing care. As a result of the 2016 elections, the future of the ACA is uncertain. As the next Administration and policymakers debate further health system reforms, they should consider the scope of the ACA's effects on their constituents.

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ACA Impact Series

INSURANCE COVERAGE AND ACCESS TO CARE UNDER THE AFFORDABLE CARE ACT

Stacey McMorrow, PhD

Daniel Polsky, PhD

The 2010 Patient Protection and Affordable Care Act (ACA) was designed to reduce the number of uninsured Americans and ultimately improve access to health care services and population health. Nearly three years after the major coverage provisions took effect, this brief assesses the ACA's impact on coverage and access to care through mid-2016. It also considers remaining barriers to coverage and care under the law as well as the implications of repealing some or all of the ACA's major provisions. Finally, it recommends research and policy priorities going forward.

KEY ACA PROVISIONS

The ACA expanded coverage through two key mechanisms: Medicaid expansion for those with the lowest incomes, and federal subsidies to purchase private coverage in new health insurance Marketplaces for those with moderate incomes. In addition, the law required private insurers to allow young adults to remain on a parent's plan until their 26th birthday. The ACA also included several insurance market reforms to ensure that individuals could get comprehensive insurance regardless of their health status, as well as a requirement that individuals obtain insurance or pay a penalty.

The law included provisions aimed at improving access to care for key services and special populations. Longstanding concerns about provider participation in Medicaid and large expected increases in enrollees led to the inclusion of a temporary increase in the Medicaid reimbursement rate to primary care providers. Community health centers received additional funding to ensure that those gaining coverage in medically underserved areas would have some place to seek care and to maintain the safety net for those without coverage. The ACA also emphasized the importance of preventive care by requiring coverage for a selected set of recommended screenings and immunizations without cost-sharing, with a subset of these services specific to women, including all FDA-approved methods of contraception.

TIMELINE

The expansion of dependent coverage to young adults and the preventive service requirements for private insurers were implemented in late 2010, with the women's health service requirements following in August 2012. In addition, several states chose to expand Medicaid to childless adults before the required January 2014 start date. These states included California, Connecticut, DC, Minnesota, New Jersey and Washington, and while the states received a federal match for these

THE YOUNG ADULT PROVISION, MEDICAID EXPANSION AND MARKETPLACE SUBSIDIES PLAYED AN IMPORTANT ROLE IN COVERING THE UNINSURED.

early expansions, they did not receive the ACA-enhanced match until 2014. Before the 2014 Medicaid and Marketplace expansions, however, the Supreme Court ruled that requiring states to expand Medicaid under the ACA was not constitutional and thereby left the decision up to states on whether to participate.

Ultimately, 24 states and DC expanded Medicaid in January 2014 with seven states following by the end of 2016. Several states received federal waivers to expand in alternative ways. The first was Arkansas, which uses Medicaid funding to purchase private insurance for eligible individuals in the federal health insurance Marketplace. Other states with waivers include Iowa, Indiana, Michigan, Montana and New Hampshire. Pennsylvania received a waiver, but transitioned to a traditional expansion shortly after implementation. Like Arkansas, New Hampshire is using Medicaid funds to purchase coverage in the Marketplace. The other waiver states are requiring eligible individuals to pay premiums or copayments above statutory limits, providing healthy behavior incentives, eliminating transportation benefits, and waiving retroactive eligibility in various combinations.

In addition to the Supreme Court decision, there have been a number of delays and deviations from the law's intended implementation structure and timeline. Nevertheless, despite a rocky start for Healthcare.gov and several state-based exchange websites, millions of individuals have gained access to affordable coverage under the ACA. Given the outcome of the 2016 presidential and Congressional elections, however, the future of the ACA is now in question. Proposals to repeal and replace the law provide few specifics, but significant changes to key coverage provisions seem likely.

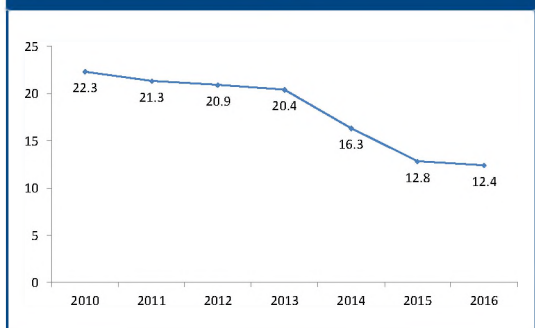
KEY FINDINGS ON COVERAGE AND ACCESS

Coverage

Overall. The [Gallup-Healthways Well-Being Index](#), the [Health Reform Monitoring Survey](#) (HRMS), the [National Health Interview Survey](#) (NHIS), and others have found steady declines in the uninsured rate between late 2013 and mid-2016.¹⁻³ The most recent NHIS data show that the uninsurance rate among nonelderly adults in the US has dropped from more than 20% in 2010 to 12.4% in 2016. See Figure 1. This translates to about [20 million fewer uninsured](#) individuals in the first six months of 2016, compared to 2010.⁴ While it is difficult to attribute all of these coverage gains to the ACA, the evidence suggests that the expansion to young adults, the Medicaid expansion and subsidies to purchase Marketplace coverage each played an important role in covering the uninsured. Importantly, [employer-sponsored coverage](#) remained relatively stable over this period.⁵

Young Adults. The 2010 dependent coverage expansion reduced the number of uninsured young adults substantially between late 2010 and 2012.^{6,7} Among young adults, stronger coverage gains under the dependent coverage provision were found among [higher income](#) and [white adults](#), presumably due to a higher likelihood of having parents with employer coverage.^{8,9} Larger gains were also found among young adult men, but no differences in coverage gains were found by [disability status](#) or [urban residence](#).^{10,11} An estimated [two million young adults](#) gained coverage through the dependent coverage provision from 2010 to 2013.¹²

Figure 1
Percent Uninsured Among Nonelderly Adults (18-64), 2010-2016



Source: National Health Interview Survey, 2016 is January-June. Zammitti E, Cohen R, Martinez M. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2016. National Center for Health Statistics; 2016 Nov. Available from: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf>

VARIOUS SURVEYS FOUND IMPROVEMENTS IN SELF-REPORTED ACCESS AND AFFORDABILITY OF CARE, WITH MORE PRONOUNCED EFFECTS IN MEDICAID EXPANSION STATES.

Medicaid expansion. Between 2010 and 2013, early Medicaid expansions reduced uninsurance in [California](#) and [Connecticut](#), while coverage gains in DC were modest because the early expansion largely shifted enrollees to Medicaid from an existing state-funded program.^{13,14}

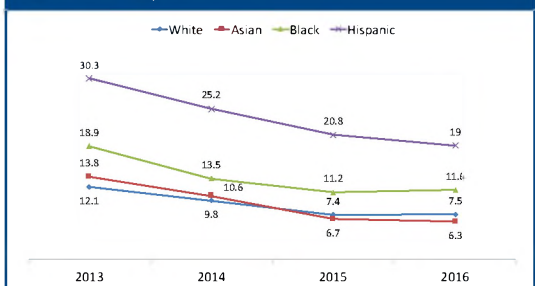
A variety of [studies](#) indicate that the 2014 ACA Medicaid expansions increased Medicaid coverage and reduced uninsurance.¹⁵ The strongest studies have confirmed large gains in Medicaid and declines in uninsured through 2014 and into 2015, though the results on crowd-out of private insurance are less consistent across studies.¹⁶⁻²¹ [Surveys](#) show continued coverage gains in expansion states throughout 2015 and into 2016.⁴ In addition, two studies examining expansions in [Arkansas and Kentucky](#), have found that both the premium assistance model in Arkansas and the traditional expansion in Kentucky produced significant coverage gains compared to no expansion in Texas.^{22,23}

The Marketplace, insurance reforms, and other provisions. Evidence of the impact of other ACA coverage provisions, such as Marketplace subsidies and the individual mandate, is more limited. Two studies have tried to disentangle the effects of the Medicaid expansion from the other ACA provisions and found that the Marketplace and other reforms were responsible for about [40-50% of the ACA coverage gains](#) in 2014.^{17,18} Descriptive evidence continues to show coverage gains in the income bracket eligible for Marketplace subsidies, and administrative data found strong growth in Marketplace enrollment in [2015](#), and sustained enrollment in [2016](#).^{24,25} As of March 2016, 11.1 million people were enrolled in Marketplace plans. [Evidence](#) also suggests that Marketplace coverage gains were larger in states that did not expand Medicaid, with more lower-income adults enrolled in the Marketplace in those states.²⁶

Racial and Ethnic Coverage Disparities.

The [NHIS](#) found significant increases in coverage among all racial and ethnic groups, as shown in Figure 2.⁴ Additional studies have found significant reductions in coverage disparities for black and Hispanic adults, although disparities remain.²⁷⁻²⁹

Figure 2
Percent Uninsured Among Nonelderly Population by Race and Ethnicity, 2010-2016



Source: National Health Interview Survey 2016 is January-June. Zammitti E, Cohen R, Martinez M. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2016. National Center for Health Statistics; 2016 Nov. Available from: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf>

Access

Various [surveys](#) have found improvements in self-reported access and affordability of care since 2014, with more pronounced effects in Medicaid expansion states.^{30, 31} Such studies have also examined access and [affordability](#) for various subgroups categorized by age, [sex](#), race/ethnicity, income, [parental status](#), and health status.³²⁻³⁴

Young adults. For young adults, a wealth of evidence finds that the ACA dependent coverage expansions increased [access to care](#), [utilization](#) of a wide variety of [services](#), and [reduced out-of-pocket spending](#).³⁵⁻³⁸

Medicaid expansion and Marketplace coverage. Several studies have found that Medicaid expansion was associated with improvements in having a personal physician or [usual source of care](#) and easy access to medicine;^{20,21,39} increased visits to general doctors, overnight hospital stays, and cholesterol and diabetes diagnoses;¹⁶ [increased prescription use](#);⁴⁰ more visits to [community health centers](#);⁴¹ and [reduced OOP spending](#).⁴² These studies are generally limited to access measures reported in 2014 and early 2015 and thus reflect relatively early evidence on access changes under the ACA.

WE FIND STRONG EVIDENCE OF GROWTH IN COVERAGE AND IMPROVEMENTS IN ACCESS AND SERVICE USE. HOWEVER, MANY GAPS IN COVERAGE REMAIN AND BARRIERS TO CARE PERSIST.

Different approaches to Medicaid expansion seemed to result in similar changes in access and use based on comparisons of expansions in Arkansas and Kentucky,²³ but additional [evidence](#) suggests that appointment availability was better for those with private option coverage in Arkansas compared to those who remained covered by traditional Medicaid.⁴³

Coverage gains through the Marketplace have also been associated with improvements in access to a usual source of care, receipt of an [annual checkup and blood pressure screening](#).³⁹ and Marketplace enrollees experienced [gains in affordability](#) of care in 2015 as their continuity of coverage improved.²⁶

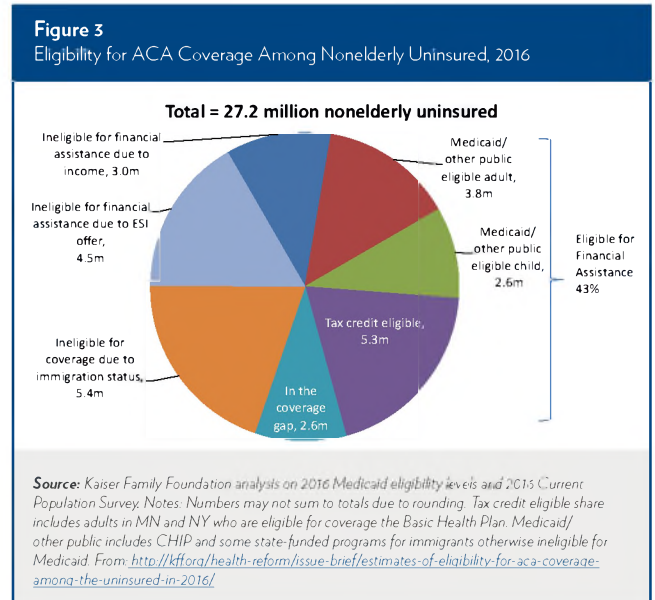
Other provisions. Only a few studies have examined the effects on access of provisions other than the major coverage expansions. One [study](#) in 10 states found an increase in appointment availability as a result of the Medicaid primary care fee bump,⁴⁴ and another study found reduced out of pocket spending on [contraception](#) following the requirement that private insurers cover these services without cost-sharing.⁴⁵

WHERE ARE WE NOW?

Consistent with other recent [reviews](#),^{46, 47} we find strong evidence of growth in coverage and improvements in access and service use through mid-2016. However, many gaps in coverage remain and barriers to care persist.

As of March 2016, an estimated [27.2 million](#) nonelderly individuals remained uninsured.⁴⁸ See Figure 3. About 43% were likely eligible for Medicaid or Marketplace subsidies. About 10% of the remaining uninsured fell into the coverage gap in states that did not expand Medicaid under the ACA, while another 17% were ineligible for Marketplace subsidies due to the presence of an affordable ESI offer. About 11% of the uninsured had incomes too high to be eligible for any financial assistance, and roughly 20% of the remaining uninsured were undocumented immigrants. [Uninsurance rates](#) were highest among Hispanics, those with low incomes and education, and those living in the South.⁴⁹ The most commonly reported reason for not having insurance is the cost of coverage,⁵⁰ but many uninsured are also unaware of the ACA coverage options and have [low health insurance literacy](#).^{51,52}

The remaining uninsured are likely to face continued barriers to access and service use. But access and affordability problems persist even for many individuals with coverage. [Gallup estimates](#) for Q1 2016 find that 15.5% of adults reported not having enough money to pay for health care at some point in the past year, (42% of uninsured adults and 12% of insured adults).⁵³ [HRMS estimates](#) from late 2015 found that among adults with incomes below 400% of poverty, 28% of those without coverage reported problems paying



THE RESEARCH DESCRIBED
HERE PROVIDES
CONSIDERABLE EVIDENCE
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EXPANSIONS FOR COVERAGE
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family medical bills, compared to 16% for those with Medicaid and about 25% for those with ESI and Marketplace coverage.⁵⁴ Moreover, about 46% of Marketplace enrollees reported a deductible of \$1,500 or more, compared to 33% of adults with ESI. High deductibles and cost-sharing can contribute to the uninsured problem because people may not see the value in obtaining insurance, and to access problems because obtaining care can create financial burdens for some insured individuals.

Further access problems can arise if insured individuals face narrow provider networks that create barriers to needed care. One [study](#) found that, in 10 states, 60% or more of the networks in Marketplace plans were considered narrow, while in another 9 states, 40-60% of networks were narrow.⁵⁵ While narrow networks are not limited to Marketplace plans, in late 2015, about 14% of Marketplace enrollees on the [HRMS](#) reported being at least somewhat dissatisfied with their choice of providers, compared to 5% of adults with ESI.⁵⁴ Access to providers can also prove problematic for Medicaid enrollees. In late 2015, 19% of Medicaid enrollees reported trouble getting a doctor's appointment in the past year, a rate higher than adults with any other type of coverage. This reflects longstanding concerns about provider participation in the Medicaid program.

RESEARCH AND POLICY PRIORITIES

Prior to the 2016 election, much of the focus in health policy circles was on improving the ACA to build upon its early successes, including efforts to enhance outreach to the uninsured who were eligible for Medicaid or Marketplace subsidies and to stabilize the Marketplace in the face of rising premiums. For researchers, there was an emphasis on providing evidence to inform states still considering Medicaid expansion, including information on enrollment for newly versus previously eligible adults and the implications for state budgets. Moreover, researchers were beginning to focus on more nuanced issues such as [churning](#) between Medicaid and Marketplace coverage to inform efforts to improve continuity of coverage.⁵⁶

The uncertainty surrounding the future of the ACA has now shifted the conversation to the consequences of repealing the law's key coverage expansions. Estimates by the [Congressional Budget Office](#) and the [Urban Institute](#) project that a complete repeal of the ACA would reduce insurance coverage by 24 million by 2021.^{57,58} Furthermore, the research described here provides considerable evidence on the consequences of repealing the Medicaid and Marketplace expansions for coverage and access to care. If the literature that has evolved based on the dependent coverage expansion is any indication, we should expect to see a wealth of studies over the next several years on the effects of the Medicaid expansion across subgroups and on a wide variety of access, service use and health status measures. It will be important, however, for researchers to further explore the impacts of the law on vulnerable subgroups as well as its impacts on downstream effects such as financial security, physical and mental health, labor market outcomes, and state budgets. Such evidence will reinforce the potential implications of changes to the law.

Additional research on specific state policy and implementation strategies, especially the effects of various waiver programs, will be particularly important if states are given more flexibility under the new administration. Moreover, any modification or replacement of the ACA will likely need to grapple with the issues currently facing the health insurance Marketplaces. The difficulty of providing universal and affordable access to coverage for individuals regardless of their health status has been made clear as insurers continued to exit the health insurance Marketplaces and premiums rose an average of nearly 25% in the fourth open enrollment period. Research is needed to consider how changes in the size and structure of subsidies, mandate penalties, rating restrictions and other factors could affect the stability of the individual market.

ABOUT LDI

Since 1967, the Leonard Davis Institute of Health Economics (LDI) has been the leading university institute dedicated to data-driven, policy-focused research that improves our nation's health and health care. Originally founded to bridge the gap between scholars in business (Wharton) and medicine at the University of Pennsylvania, LDI now connects all of Penn's schools and the Children's Hospital of Philadelphia through its more than 200 Senior Fellows.

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With high and rising health spending likely to be a focus of the next administration, it will be important to investigate affordability problems for insured individuals associated with high deductibles and cost-sharing, which may reveal broader problems with these crude cost containment measures. One recent [study](#) has shown that these mechanisms do not result in more price-shopping by consumers, but do reduce the quantity of both high and low-value care received.⁵⁹ This suggests the need for more nuanced value-based insurance design as well as supply-side mechanisms to rein in health care costs. The strategy of narrow networks can be useful in containing costs, but their transparency and adequacy must be evaluated and ensured. As we consider the uncertain future of the ACA, we must continue to provide robust evidence to inform policymakers as they make critical decisions that will affect the health and economic well-being of millions of Americans.

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A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013–2015

Tags: [access to care \(/publications/issue-briefs#f:tagsfacet=\[access to care\]\)](/publications/issue-briefs#f:tagsfacet=[access to care])
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S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, and S. Beutel, *A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013–2015*, The Commonwealth Fund, December 2016.

Abstract

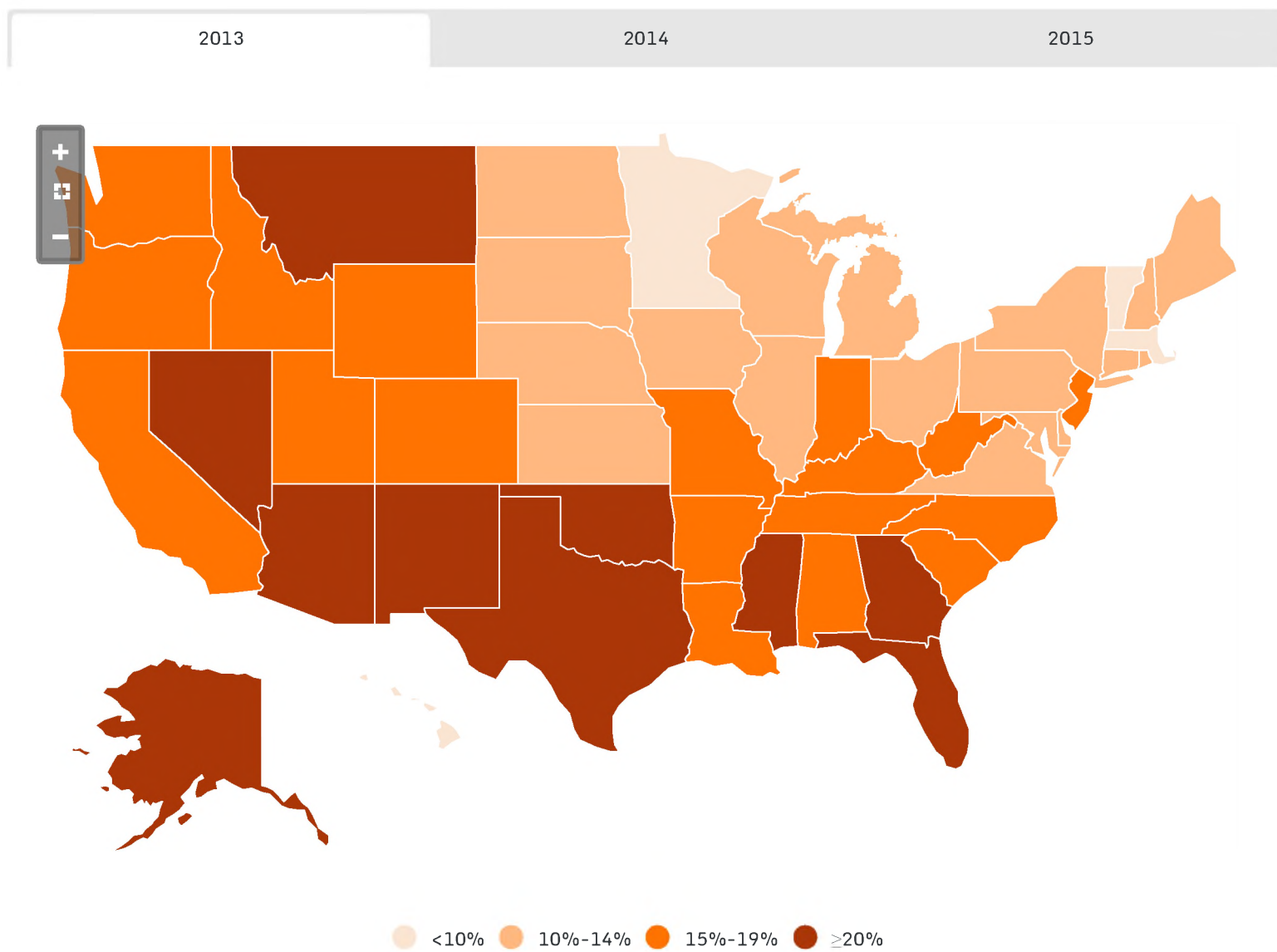
Issue: The Affordable Care Act's policy reforms sought to expand health insurance coverage and make health care more affordable. As the nation prepares for policy changes under a new administration, we assess recent gains and challenges. **Goal:** To compare access to affordable health care across the U.S. between 2013 and 2015. **Methods:** Analysis of most recent publicly available data from the U.S. Census Bureau and the Behavioral Risk Factor Surveillance System. **Key findings and conclusions:** Between 2013 and 2015, uninsured rates for adults ages 19 to 64 declined in all states and by at least 3 percentage points in 48 states and the District of Columbia. For children, uninsured rates declined by at least 2 percentage points in 28 states. The share of adults age 18 and older who reported forgoing a visit to the doctor when needed because of costs dropped by at least 2 percentage points in 38 states and D.C. In contrast, there was little progress in expanding access to dental care for adults, which is not a required benefit under the ACA. These findings illustrate the impact that policy can have on access to care and offer a focal point for assessing future policy changes.

INTRODUCTION

In 2013, the year before the implementation of the Affordable Care Act's (ACA) major coverage expansions, 17 percent of the U.S. population under age 65, about 45 million people, lacked health insurance ([Appendix Table 1 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).¹ By the end of 2015, two years after implementation, the uninsured rate had declined to 11 percent, according to data recently released by the U.S. Census Bureau. In those two years, the ACA's major health insurance reforms caused the states' uninsured rates to shift dramatically, resulting in a new coverage map of the country (Exhibit 1).

We examine this shift by comparing states' performance between 2013 and 2015 on five indicators of health care access (Exhibit 2).² Additionally, we examine the share of all individuals under age 65 with high out-of-pocket costs relative to their income.

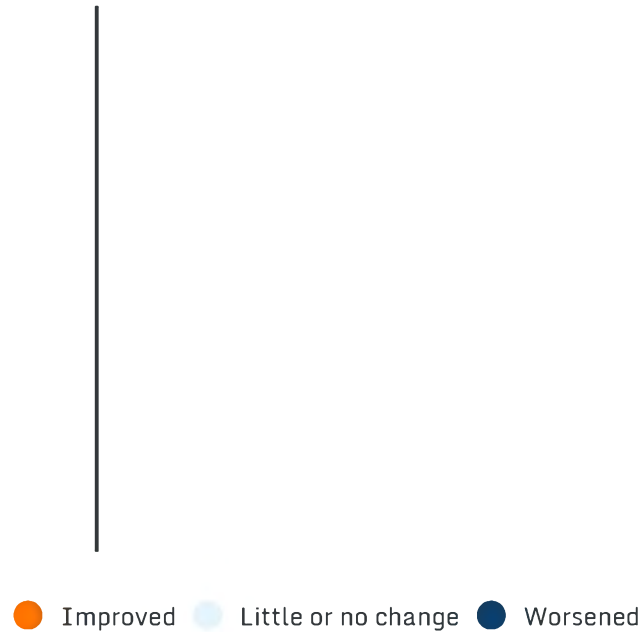
Exhibit 1 Percent of Population Under Age 65 Uninsured, 2013, 2014, and 2015



Data: U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS).


Exhibit 2 Change in Health System Performance by Access Indicator, 2013-2015

Number of states (a)



Notes: This exhibit measures change from 2013 to 2015, the most recently available data year, except in the case of the dental indicator, for which the most recently available data year and comparable data year are 2014 and 2012. (a) For the purposes of this exhibit, we treat the District of Columbia as a state, creating a total of 51. “Improved” or “Worsened” refers to a change of at least 0.5 standard deviations between the two time periods. “Little or no change” includes states with changes of less than 0.5 standard deviations as well as states with no change or without sufficient data to assess change over time. (b) Improvement also occurred at the national level. (c) At-risk adults defined as all adults age 50 or older, or adults ages 18 to 49 in fair or poor health, or ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma.

Data: U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS); and Behavioral Risk Factor Surveillance System (BRFSS), 2012, 2013, 2014, and 2015.

 Share

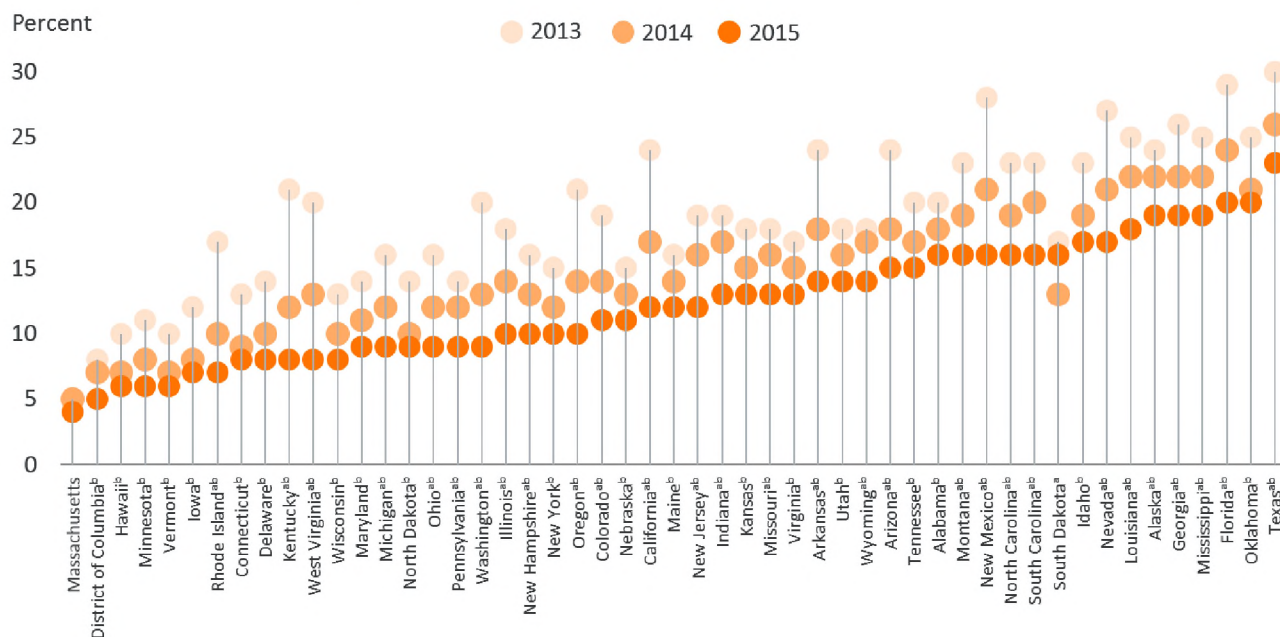
These measures align with those reported in The Commonwealth Fund’s ongoing series of [Health System Performance Scorecards](#) ([~/link.aspx?id=45CDD5018B62498297D28777C056DBE0&z=z](#)). Launched a decade ago, the scorecards help policymakers, health system leaders, and the public track progress and set targets for improvement. It seems especially important now, as a new administration and Congress prepare to take office and the ACA faces an uncertain future, to take stock of the changes in coverage and access that have taken place across states, as well as the challenges that remain.

FINDINGS

Uninsured Rates Among Adults Decline in Every State

Uninsured rates for adults ages 19 to 64 declined in all states from 2013 to 2015, and by 3 percentage points or more in 48 states and the District of Columbia (Exhibit 3, [Appendix Table 1](#) ([~/media/12a4ba25e6dd4efabb01587608d87625.ashx](#))). Nearly all states experienced two consecutive years of decline in their adult uninsured rate. The only exceptions were Massachusetts, which had the lowest uninsured rate of any state to begin with, and South Dakota.

Percent of Adults Ages 19–64 Uninsured, 2013, 2014, and 2015



Note: States are arranged in rank order based on their current data year (2015) value.

^a At least a -0.5 standard deviation change (at least 3 percentage points) between 2014 and 2015.

^b At least a -0.5 standard deviation change (at least 3 percentage points) between 2013 and 2015.

Data: U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS).

Source: S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, and S. Beutel, *A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013–2015*, The Commonwealth Fund, December 2016.



The greatest cumulative gains came in states that had expanded eligibility for their Medicaid programs as soon as federal resources became available in January 2014. Nine such states experienced 10 to 13 percentage-point reductions in their adult uninsured rate from 2013 to 2015. Six of these states—California, Kentucky, Oregon, Rhode Island, Washington, and West Virginia—sliced their uninsured rates by at least half over the two years. Some states that did not expand Medicaid as of the beginning of 2015 had declines of as much as 7 to 9 percentage points, including Florida, Georgia, Louisiana, Montana, North Carolina, South Carolina, and Texas.³ [\(##3\)](#) The ACA’s premium subsidies and insurance marketplaces were available in every state, leading to the decline in uninsured rates in states without the Medicaid expansion.

By the end of 2015, more than a third of states (17 states and D.C.) had adult uninsured rates below 10 percent, compared to six states and D.C. in 2014 and only Massachusetts and D.C. in 2013. Despite these gains, uninsured rates remained high in some states, including Florida, Oklahoma, and Texas, where at least one of five adults was uninsured. Still, this marks an improvement over 2014, when 10 states had an adult uninsured rate of 20 percent or more, and 2013, when 22 states did.

Substantial Coverage Gains for Low-Income Adults, Especially in States That Expanded Medicaid

In the United States, people with low incomes have been at greatest risk for being uninsured.⁴ [\(##4\)](#) In 2013, nearly two of five adults (38%) with incomes below 200 percent of the federal poverty level (\$22,980) lacked health insurance. By 2015, this rate had dropped to 25 percent. Between 2013 and 2015, the uninsured rate for low-income adults declined in every state, led by Kentucky with a 25

percentage-point reduction, closely followed by California, Oregon, Rhode Island, Washington, and West Virginia, which all had 20-to-23 percentage-point declines (Exhibit 4 [[see slider above \(###slider\)](#)], [Appendix Table 2 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).

With a handful of exceptions, states that expanded their Medicaid programs by January 1, 2015, had lower uninsured rates among low-income adults than states that did not expand. Notably, several states that expanded Medicaid at the beginning of 2014, and had experienced relatively large declines in 2014, continued to drive down their uninsured rate among low-income adults in 2015. From 2014 to 2015, California and New Mexico each had 9 percentage-point declines in the share of low-income adults without insurance, New Jersey and West Virginia each had 8 percentage-point declines, and Arkansas, Illinois, Kentucky, and Rhode Island each had 7 percentage-point declines.

Further Gains in Covering Children

Even before the ACA's coverage expansions took effect, uninsured rates for children were much lower than the rates for working-age adults because of federal and state actions to expand public health insurance programs for children, including the Children's Health Insurance Program (CHIP) and expanded eligibility under Medicaid.^{5 (###5)}

Still, between 2013 and 2015, the share of children uninsured dropped by at least 2 percentage points in 28 states (Exhibit 5 [[see slider above \(###slider\)](#)], [Appendix Table 1 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).^{6 (###6)} As with adults, coverage gains among children reflect the ACA's expanded coverage options and the "welcome mat effect," in which people who were previously eligible but not enrolled for Medicaid or CHIP signed up, as a result of increased outreach efforts and awareness of insurance coverage.^{7 (###7)}

By the end of 2015, in half of states, the rate of uninsured children was below 5 percent. The rate of uninsured children was highest in Texas (10%). In 2013, the child uninsured rate in eight states was 10 percent or higher.

Fewer Adults Face Cost-Related Barriers to Care

One of the central aims of the ACA's insurance expansions is to enable people to get timely access to health care. Between 2013 and 2015, the share of adults age 18 and older who reported that they had not gone to the doctor when needed because of costs dropped by at least 2 percentage points in 38 states and D.C. (Exhibit 6 [[see slider above \(###slider\)](#)], [Appendix Table 1 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).^{8 (###8)}

Kentucky—the state with the largest improvement in adult uninsured rates—experienced the greatest improvement of any state in this measure (19% in 2013 vs. 12% in 2015). Arkansas and Oregon, also among the states with the greatest gains in insurance coverage, had the second-greatest improvements (5 percentage points each).

Looking only at states' low-income adult populations over the two-year period, there was at least a 2-percentage-point decline in the share of people who went without care because of costs in 37 states, including double-digit declines (10 to 14 points) in Kentucky, New Hampshire, Oregon, Washington, and West Virginia. These states all expanded Medicaid by January 2015 ([Appendix Table 2 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).

Better Access to Care for At-Risk Adults Across the Country

We also assessed access to routine care for "at-risk" adults—that is, those who could be at greater risk for adverse health outcomes if they do not receive care. This at-risk group includes everyone age 50 or older, since this age group needs recommended preventive care and many have chronic conditions. It also includes adults ages 18 to 49 who report having chronic illnesses or being in poor or fair health.

Between 2013 and 2015, a third of states (16 states and D.C.), representing all regions of the country, experienced at least a 2 percentage-point drop in the share of at-risk adults who had not visited a doctor for a routine check-up in at least two years ([Appendix Table 1 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)). The largest declines (4 percentage points) were seen in Kentucky, Oklahoma, and Rhode Island. Three states (Louisiana, Nevada, and Tennessee) experienced a worsening of 2 to 3 percentage points in this rate over the two-year period.

No Gains in Access to Dental Care for Adults

In contrast to our other measures, access to dental care for adults age 18 and older between 2012 and 2014 (the most recent years for which data were available) showed little progress. In the United States, dental care is traditionally covered under a separate policy than medical care. ACA marketplace plans are not required to provide dental coverage for adults, and state Medicaid and CHIP programs can choose whether to extend dental benefits to adults. Most state Medicaid programs currently do provide at least some dental benefits for adults, but their comprehensiveness varies widely by state, and because these benefits are optional, they often rise and fall on the fortunes of state budgets.⁹ ([9](#))

In 2014, in all states, at least one of nine adults age 18 and older (11%) had gone a year or more without a dental visit. In the worst-performing states on this indicator (Louisiana, Mississippi, Texas, and West Virginia), one of five (20%) went without a visit. Both the lowest and highest state rates and the U.S. average (16%) in 2014 were essentially unchanged from 2012 ([Appendix Table 1 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).

Many People Spend a Large Share of Their Income on Health Care

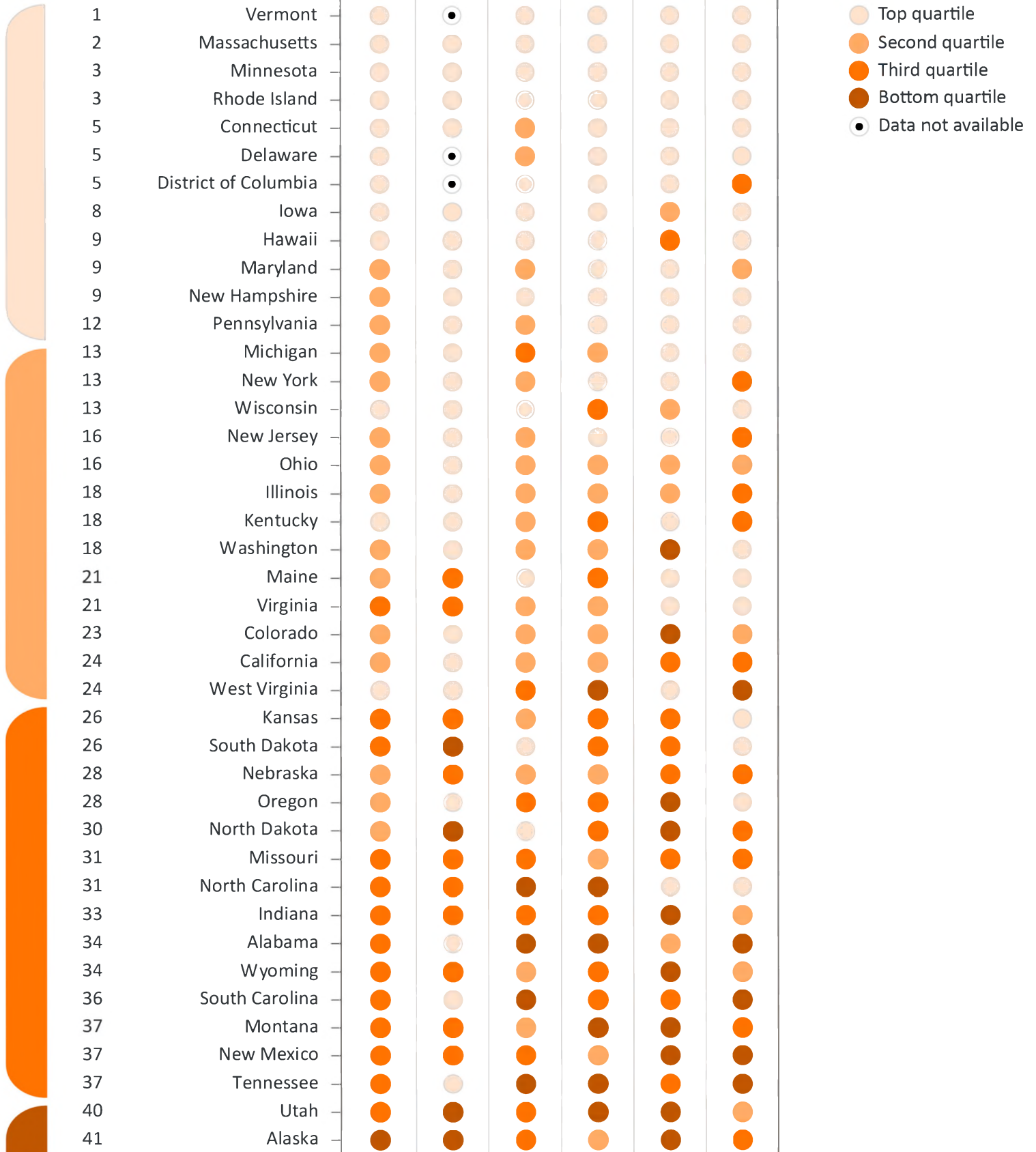
People without health insurance receive significantly less health care than people with insurance do.¹⁰ ([10](#)) When they do get health care, uninsured people and their families face the full amount of their medical bills.¹¹ ([11](#)) But the growing proliferation of deductibles in both employer plans and in plans that people buy on their own is leaving many insured people also increasingly exposed to costs.¹² ([12](#)) We examined the share of individuals under age 65, both uninsured and insured, who lived in households that spent a high portion of annual household income on medical care. We used two thresholds to identify such individuals: people living in households that spent 10 percent or more of their income on health care; or 5 percent or more, if their annual income was below 200 percent of the federal poverty level.

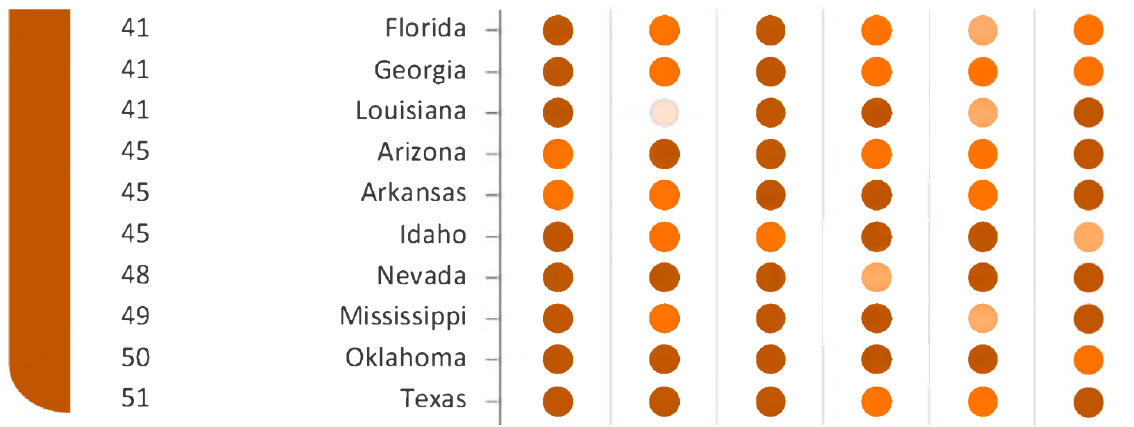
During 2014–2015, 10 percent to 19 percent of people under age 65 lived in households where out-of-pocket spending on medical care was high relative to annual income ([Appendix Table 1 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)).¹³ ([13](#)) A regional pattern is discernable. States with the lowest shares (10% to 11%) of people under age 65 with high out-of-pocket spending were in the Northeast and mid-Atlantic region (including Connecticut, Delaware, District of Columbia, Maryland, Massachusetts, New York, Rhode Island, and Vermont)—the one exception was Minnesota. States with the largest share of people with high out-of-pocket costs (18% to 19%) were in the South and West. These states included Arkansas, Idaho, Louisiana, Mississippi, Montana, Oklahoma, and Tennessee. These states also have higher rates of uninsurance and lower median incomes.

How States Stack Up

Looking at the states' rankings in terms of health care access and affordability, the states (including the District of Columbia) that were in the top quartile of the 2015 scorecard were also in the top quartile in 2016, although there was some reordering within the quartile ([Exhibit 7](#)).¹⁴ ([14](#)) In 2016, the top-ranked states were Vermont (first); Massachusetts (second); Minnesota and Rhode Island (tied for third); and Connecticut, Delaware, and the District of Columbia (all tied for fifth). The bottom-ranked states in 2016 were Arizona, Arkansas, and Idaho (all tied for 45th); Nevada (48th); Mississippi (49th); Oklahoma (50th); and Texas (51st). The states that had the most dramatic shifts in ranking between last year and this year were Kentucky, which moved from 28th to 18th place (tied with Illinois and Washington), and New Mexico, which moved from 46th to 37th (tied with Montana and Tennessee).

State Scorecard Summary of Health System Performance Across the Access Dimension





Several states in the bottom quartile showed the greatest improvement between 2013 and 2015 on some indicators. For example, Arizona, Arkansas, and Nevada were among the states with the largest percentage point declines in the uninsured rate for working-age adults (9 to 10 points each). Nevada, along with Florida, also had among the largest reductions in the share of uninsured children (6 and 5 percentage points, respectively). In addition, Arkansas, Florida, Georgia, and Louisiana were among only a dozen states that saw declines of at least 4 percentage points in the share of adults who went without care because of costs.

IMPLICATIONS

Six years after the passage of the Affordable Care Act in 2010, the United States is closer than it has ever been to achieving near-universal coverage, an essential component of a high-performing health system. More than 20 million Americans have gained coverage under the law, although variation in health care access and affordability across states remains.^{15 (##15)} The historic decline in uninsured rates has been accompanied by widespread reductions in cost-related access problems and improvements in access to routine care for at-risk adults.

President-elect Trump and Republican leaders in the new Congress have proposed repealing and replacing the Affordable Care Act. The effect on the number of uninsured will depend on the replacement, but a straight repeal of the law would result in nearly 20 million people losing insurance by 2018, according to an analysis by researchers at RAND.^{16 (##16)}

The future of federal funding for CHIP and Medicaid, which as of September 2016 provided coverage to 73.1 million people, is also unclear at this time.^{17 (##17)} Funding for CHIP is slated to end in September 2017 and must be reauthorized by Congress; federal funding for Medicaid may be significantly altered under the new administration and Congress.

These findings illustrate the impact that policy can have on coverage and access to care and offer a baseline for assessing future policy changes. Continued monitoring of state trends in health care coverage and access will be necessary to determine whether in the coming months and years the nation continues to make progress toward a high-performing health system.

EYE ON DISPARITIES

Historically, uninsured rates within the working-age population have been much higher for black and Hispanic adults than for white adults. In 2013, almost one of four black adults ages 19 to 64 (24%) and two of five Hispanic adults (40%) did not have health insurance compared to 14 percent of white adults ([Appendix Table 2 \(~/media/12a4ba25e6dd4efabb01587608d87625.ashx\)](#)). But uninsured rates for both minority groups declined significantly at the national level since the ACA's coverage expansions took effect, dropping to 15 percent among black adults and to 28 percent among Hispanic adults in 2015 (see chart).

Black and Hispanic Adults Made Significant Coverage Gains Under the Affordable Care Act, but Wide State Variation Persists


Black, non-Hispanic adults, ages 19-64, uninsured

Hispanic adults, ages 19-64, uninsured

● 2013 ● 2015

Notes: Data not available for black or for Hispanic adults in Alaska, Hawaii, Maine, Montana, New Hampshire, North Dakota, South Dakota, and Vermont, or for black adults in Idaho, Utah, and Wyoming, or for Hispanic adults in the District of Columbia and West Virginia, for 2013 and 2015. Data also not available for black adults in Iowa, New Mexico, Oregon, Rhode Island, or West Virginia in 2015. Lowest "state" rate for black non-Hispanic adults in 2015 is in the District of Columbia.

Data: U.S. Census Bureau, 2013 and 2015 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS).

 Share

The national average masks the impact of state decisions to expand Medicaid. In states that expanded Medicaid as of January 2015, the average uninsured rate for nonelderly black adults was 11 percent compared to 19 percent in states that did not expand. For Hispanics, the difference was even greater: the average uninsured rate was 22 percent in states that expanded Medicaid and 36 percent in states that did not (data not shown). There are large black and Hispanic populations in some states that have not expanded Medicaid, including Florida, Georgia, North Carolina, and Texas.^{[18 \(###18\)](#)}

These decisions on Medicaid expansion are likely contributing to the wide variation among states. In 2015, there was a 19-percentage-point difference between the uninsured rate of black adults in the District of Columbia (5%) and Oklahoma (24%), and a 45-percentage-point difference between the uninsured rate among Hispanic adults in Massachusetts (8%) and Mississippi (53%).

METHODS

The six health care access and affordability indicators reported here align with those reported in The Commonwealth Fund's ongoing series of [Health System Performance Scorecards \(~link.aspx? id=45CDD5018B62498297D28777C056DBE0& z=z\)](#). For purposes of this analysis, we treat the District of Columbia as a state, unless otherwise indicated.

Indicators and Data Sources

1. *Percent of uninsured adults ages 19–64.* Source: Authors' analysis of U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys, Public Use Microdata Sample (ACS PUMS).
2. *Percent of uninsured children ages 0–18.* Source: Authors' analysis of U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys, Public Use Microdata Sample (ACS PUMS).
3. *Percent of adults age 18 and older who went without care because of cost during past year.* Source: Authors' analysis of 2013, 2014, and 2015 Behavioral Risk Factor Surveillance System (BRFSS).
4. *Percent of at-risk adults without a routine doctor visit in past two years.* (At-risk adults include adults age 50 and older and adults ages 18–49 who are in fair or poor health or who were ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma). Source: Authors' analysis of 2013, 2014, and 2015 Behavioral Risk Factor Surveillance System (BRFSS).
5. *Percent of adults age 18 and older without a dental visit in the past year.* Source: Authors' analysis of 2012 and 2014 Behavioral Risk Factor Surveillance System (BRFSS).
6. *Percent of individuals under age 65 with high out-of-pocket medical spending relative to their annual income.* (This measure includes both insured and uninsured individuals. Two years of data are combined to ensure adequate sample size for state-level estimation. Trends over time are not reported here because of changes in the way the Current Population Survey (CPS) records respondents' income in the 2013 sample year.) Source: Ougni Chakraborty, Robert F. Wagner School of Public Service, New York University, analysis of 2015 and 2016 Current Population Survey, Annual Social and Economic Supplement (CPS ASEC).

Measuring Change over Time

We considered an indicator's value to have changed if it was at least one-half (0.5) of a standard deviation larger than the difference in rates across all states over the two years being compared.

Scoring and Ranking

We averaged state rankings for the six indicators to determine a state's access and affordability dimension rank. More information on scorecard methodology and indicator descriptions and source notes can be found in [Aiming Higher: Results from a Scorecard on State Health System Performance. 2015 Edition \(~link.aspx? id=5620F5CC3CC84B0DAD83831DD848450D& z=z\)](#).

Notes

¹ People estimate is authors' analysis of U.S. Census Bureau, 2013 1-Year American Community Survey, Public Use Micro Sample (ACS PUMS).

² Throughout this brief, we report the number of states in which we found a change in performance from 2013 to 2015 (or 2012 to 2014 for the dental indicator). We count changes that are at least one-half of a standard deviation larger than the difference in rates across all states over the two years being compared. In addition, we treat the District of Columbia as a state, unless indicated otherwise.

³ Montana's Medicaid expansion waiver was approved in November 2015 and coverage under the expansion was effective January 1, 2016. Louisiana expanded Medicaid under an executive order by its Governor in January 2016, with coverage under the expansion effective July 1, 2016.

⁴ S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings From the Commonwealth Fund Biennial Health Insurance Survey. 2014* ([publications/issue-briefs/2015/ian/biennial-health-insurance-survey](#)) (The Commonwealth Fund, Jan. 2015).

⁵ Since 1997, CHIP has provided federal matching funds to states to insure children whose families earn too much to qualify for Medicaid, but too little to afford private coverage. See <https://www.medicaid.gov/about-us/program-history/index.html> (<https://www.medicaid.gov/about-us/program-history/index.html>).

⁶ This count excludes Delaware, where data were not available for 2015, and the District of Columbia and Vermont, where data were not available for 2013, 2014, and 2015.

⁷ M. Frean, B. D. Sommers, and J. Gruber, “[Understanding ACA’s Coverage Gains: Welcome Mat Effect & State Marketplaces Keys to Success](http://cf.georgetown.edu/2016/05/18/understanding-acas-coverage-gains-welcome-mat-effect-state-marketplaces-keys-successful-expansion/) (<http://cf.georgetown.edu/2016/05/18/understanding-acas-coverage-gains-welcome-mat-effect-state-marketplaces-keys-successful-expansion/>).” Say Ahhh!, Georgetown University Health Policy Institute Center for Children & Families, May 18, 2016.

⁸ The Commonwealth Fund’s [2016 International Survey](http://publications/blog/2016/nov/americans-cost-barrier-decreasing-more-improvement-needed) ([/publications/blog/2016/nov/americans-cost-barrier-decreasing-more-improvement-needed](http://publications/blog/2016/nov/americans-cost-barrier-decreasing-more-improvement-needed)) also found that the share of adults in the United States reporting cost-related access problems decreased between 2013 and 2016. Additionally, The Commonwealth Fund’s [2014 Biennial Health Insurance Survey](http://publications/issue-briefs/2015/jan/biennial-health-insurance-survey) ([/publications/issue-briefs/2015/jan/biennial-health-insurance-survey](http://publications/issue-briefs/2015/jan/biennial-health-insurance-survey)) found the number of Americans reporting they did not receive needed health care because of its cost declined from 2012 to 2014.

⁹ E. Hinton and J. Paradise, [Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults](http://kff.org/report-section/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults-issue-brief/) (<http://kff.org/report-section/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults-issue-brief/>) (Kaiser Commission on Medicaid and the Uninsured, March 17, 2016).

¹⁰ Institute of Medicine, [Hidden Costs. Value Lost: Uninsurance in America](https://www.nationalacademies.org/hmd/Reports/2003/Hidden-Costs-Value-Lost-Uninsurance-in-America.aspx) (<https://www.nationalacademies.org/hmd/Reports/2003/Hidden-Costs-Value-Lost-Uninsurance-in-America.aspx>) (National Academies Press, June 2003).

¹¹ S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, [The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings From the Commonwealth Fund Biennial Health Insurance Survey, 2014](http://publications/issue-briefs/2015/jan/biennial-health-insurance-survey) ([/publications/issue-briefs/2015/jan/biennial-health-insurance-survey](http://publications/issue-briefs/2015/jan/biennial-health-insurance-survey)) (The Commonwealth Fund, Jan. 2015).

¹² S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel, [The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch](http://publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth) ([/publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth](http://publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth)) (The Commonwealth Fund, Oct. 2016).

¹³ This measure includes both insured and uninsured individuals. Two years of data are combined to ensure adequate sample size for state-level estimation. Trends over time are not reported here because of changes in the way the Current Population Survey records respondents’ income in the 2013 sample year.

¹⁴ For the 2015 state rankings on access and affordability, see S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, S. Beutel, and J. Kiszla, [The Changing Landscape of Health Care Coverage and Access: Comparing States’ Progress in the ACA’s First Year](http://publications/issue-briefs/2015/dec/changing-landscape) ([/publications/issue-briefs/2015/dec/changing-landscape](http://publications/issue-briefs/2015/dec/changing-landscape)) (The Commonwealth Fund, Dec. 2015).

¹⁵ D. Blumenthal and S. R. Collins, “[The Affordable Care Act in 2017: Challenges for President-Elect Trump and Congress](http://publications/blog/2016/nov/challenges-for-president-elect-trump-and-congress) ([/publications/blog/2016/nov/challenges-for-president-elect-trump-and-congress](http://publications/blog/2016/nov/challenges-for-president-elect-trump-and-congress)).” *To the Point*, The Commonwealth Fund, Nov. 10, 2016.

¹⁶ S. R. Collins and S. Beutel, “[The Health Care Reform Proposals of Hillary Clinton and Donald Trump](http://publications/blog/2016/trump-clinton-presidential-health-care-proposals) ([/publications/blog/2016/trump-clinton-presidential-health-care-proposals](http://publications/blog/2016/trump-clinton-presidential-health-care-proposals)).” *To the Point*, The Commonwealth Fund, Sept. 23, 2016. See also E. Saltzman and C. Eibner, [Donald Trump’s Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit](http://publications/issue-briefs/2016/sep/trump-presidential-health-care-proposal) ([/publications/issue-briefs/2016/sep/trump-presidential-health-care-proposal](http://publications/issue-briefs/2016/sep/trump-presidential-health-care-proposal)) (The Commonwealth Fund, Sept. 2016).

¹⁷ Medicaid.gov, September 2016 Medicaid and CHIP Enrollment Data Highlights, <https://www.medicaid.gov/medicaid-program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> (<https://www.medicaid.gov/medicaid-program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>).

¹⁸ S. Rastogi, T. D. Johnson, E. M. Hoeffel et al., [The Black Population: 2010](http://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf) (<http://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf>), 2010 Census Briefs (U.S. Census Bureau, Sept. 2011); and S. R. Ennis, M. Rios-Vargas, and N. G. Albert, [The Hispanic Population: 2010](http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf) (<http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>), 2010 Census Briefs (U.S. Census Bureau, May 2011).

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Adults Are More Likely To Become Eligible For Medicaid During Future Recessions If Their State Expanded Medicaid

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ABSTRACT Eligibility for and enrollment in Medicaid can vary with economic recessions, recoveries, and changes in personal income. Understanding how Medicaid responds to such forces is important to budget analysts and policy makers tasked with forecasting Medicaid enrollment. We simulated eligibility for Medicaid for the period 2005–14 in two scenarios: assuming that each state's eligibility rules in 2009, the year before passage of the Affordable Care Act (ACA), were in place during the entire study period; and assuming that the ACA's expanded eligibility rules were in place during the entire period for all states. Then we correlated the results with unemployment rates as a measure of the economy. Each percentage-point increase in the unemployment rate was associated with an increase in the share of people eligible for Medicaid of 0.32 percentage point under the 2009 eligibility rules and 0.77 percentage point under the ACA rules. Our simulations showed that the ACA expansion increased Medicaid's responsiveness to changes in unemployment. For states that have not expanded Medicaid eligibility, our analysis demonstrates that increased responsiveness to periods of high unemployment is one benefit of expansion.

Medicaid has often been characterized as a countercyclical program, with enrollment increasing during recessions and falling during recoveries in the business cycle.¹ One rationale for Medicaid and other publicly financed health insurance programs for low-income populations is to provide a safety net for people who lose their jobs or take low-paying jobs and cannot afford to purchase coverage on their own.

Many of the individuals who lost their jobs during the Great Recession (2007–09) did not become eligible for Medicaid. This is because Medicaid eligibility for nonelderly adults in most states was limited to people with disabilities, pregnant women, and parents of poor children. Before the passage of the Affordable Care Act

(ACA), the median income eligibility threshold across the fifty states and the District of Columbia for full Medicaid benefits for non-working parents was 38 percent of the federal poverty level.² In most states, childless adults of any income level were not eligible for Medicaid. In 2009 only six states were using federal waivers to offer full Medicaid benefits to childless adults, and although twelve states offered limited benefits, many of their programs were closed to new applicants.³ Studies have found that during recessions before the one in 2007–09, the number of adults without any health insurance rose more quickly than the number of adults enrolled in Medicaid.^{4,5}

The ACA changed the Medicaid program in at least two ways that could increase its responsiveness to economic conditions. First, the ACA gen-

erously subsidizes states' expansions of Medicaid eligibility to most residents with incomes below 138 percent of poverty. As of October 14, 2016, thirty-one states and the District of Columbia had expanded their Medicaid programs under the ACA.⁶ Second, for all states, the ACA eliminated asset tests for most eligibility pathways. Depending upon a state's eligibility rules in place before March 2010, when the ACA was signed into law, these changes have the potential to dramatically increase the percentage of nonelderly adults eligible for Medicaid in states adopting the expansion.⁷

We investigated how the relationship between the Medicaid eligibility rate among nonelderly, nondisabled adults and the business cycle may have changed with implementation of the ACA Medicaid expansion. Specifically, we examined the association between the Medicaid eligibility rate and a key aspect of the business cycle that especially affects lower-income families: the unemployment rate.

States' Medicaid eligibility rules often change, which makes it difficult to study how the business cycle is associated with eligibility or enrollment. For our study, we held eligibility rules constant across years to examine changes in the percentage of nonelderly, nondisabled adults who would have been eligible for Medicaid (the eligibility rate) over the business cycle. We compared the following two scenarios for eligibility: assuming that the rules each state had in place in 2009, immediately before passage of the ACA, remained in effect; and assuming that all states expanded eligibility under the ACA rules. Using a nationally representative household survey, we assessed how eligibility rates would have responded in each scenario to changes in economic circumstances in the period 2005–14.

During the study period, the unemployment rate rose from 5.2 percent in 2005 to 9.9 percent, its peak, in 2010. That rate fell to 6.7 percent in 2014, but the percentage of people without a job (including those who are not in the labor force) stayed roughly constant from 2010 (41.5 percent) to 2014 (41.0 percent).⁸ By simulating Medicaid eligibility over the study period, we were able to demonstrate the change in Medicaid responsiveness associated with the ACA Medicaid expansions.

Budget analysts and federal and state policy makers regularly face the challenge of forecasting Medicaid enrollment, which is particularly important during recessions—when Medicaid enrollment increases and tax revenues fall. Therefore, we compared our estimates of changes in the Medicaid eligibility rate from 2005 to 2014 with contemporaneous changes in the nationwide unemployment rate. Using

previous studies of the proportion of adults eligible for Medicaid who enrolled in it (also known as the participation or take-up rate), we also showed how enrollment might change during future recessions.^{9,10}

Additionally, we present results separately for states that have expanded eligibility for Medicaid and those that have not done so. These results show the extent to which states that are not participating in the Medicaid expansion would broaden eligibility to adults during a recession if they chose to expand. Because the federal government pays a very high proportion of Medicaid spending for newly eligible Medicaid beneficiaries¹¹—leaving the states to cover at most 10 percent of the spending, starting in 2020—a relatively small share of the costs of increased Medicaid enrollment during future recessions would be borne by the states. While it may seem intuitive that Medicaid eligibility would vary with changes in the economy, we quantified the association using simulation methods.

Study Data And Methods

We used the Medical Expenditure Panel Survey—Household Component (MEPS-HC) and the PUBSIM model of Medicaid eligibility to estimate eligibility rates, and we compared these with rates of unemployment.

MEDICAL EXPENDITURE PANEL SURVEY MEPS-HC is a nationally representative household survey of the civilian noninstitutionalized population of the United States. MEPS collects detailed information that facilitates simulating Medicaid eligibility, such as sample members' earned and unearned income, assets, family relationships, state of residence, and enrollment in other programs. We limited our sample to nonelderly, nondisabled adults ages 19–64, regardless of insurance status. Our final sample consisted of 182,237 observations across the study period, 2005–14.

All of our estimates used sampling weights to generate nationally representative estimates. For confidence intervals accounting for the complex design of MEPS, but not for additional variation associated with simulation, see online Appendix Exhibit A.2.¹²

PUBSIM ELIGIBILITY SCENARIOS The PUBSIM model uses detailed, state-specific Medicaid eligibility rules to simulate eligibility for MEPS sample members.^{7,13} The model uses information from the first interview of the calendar year. We excluded adults simulated as eligible for Medicaid because of a disability, because eligibility expansions under the ACA did not target this group.

We simulated Medicaid eligibility in two different scenarios for all sample members in each year in the study period. First, we simulated the eligibility rate under the Medicaid rules in place in each state in 2009 (the year before passage of the ACA) as if those rules were in place from 2005 through 2014. PUBSIM simulates the numerous pathways to Medicaid eligibility before the ACA, which varied across states. For example, states varied in whether gross or net income (or both) were used to determine eligibility, the amount of income that was disregarded, and which family members were counted to determine family size.

Second, we simulated eligibility as if all states had expanded eligibility under the ACA, and as if those rules had been in place from 2005 through 2014. For example, if a state's actual income eligibility threshold for parents of minor children was 100 percent of poverty from 2005 through 2014, then in this scenario, parents whose income was above 100 percent of poverty but equal to or below 138 percent of poverty would also be eligible. This scenario used the ACA's definition of household income. For states that expanded Medicaid eligibility beyond 138 percent of poverty, we used those thresholds in this scenario. For additional details about the simulation methodology, see Appendix Exhibit A.1.¹²

We compared how Medicaid eligibility rates in these two scenarios changed over the business cycle from 2005 through 2014, which allowed us to compare eligibility rates implied by ACA rules to the rates implied by the thresholds that existed before passage of the ACA. Because the eligibility rules in the two scenarios were fixed over time, the eligibility rate changed only because of changes in personal circumstances, such as employment status or income. Our analysis excluded any effects arising from states' having changed eligibility rules over time. For example, while states could have expanded coverage under the ACA before 2014, we intentionally excluded transitional eligibility scenarios so that we could highlight the full effect of adopting the Medicaid expansion.

For our estimates of eligibility rates in expansion versus nonexpansion states, we used each state's expansion status as of October 2016.⁶

MEASURES OF UNEMPLOYMENT We compared changes in Medicaid eligibility to changes in national unemployment rates. We used Bureau of Labor Statistics estimates of the unemployment rate and the percentage of individuals who were not working.⁸ The March estimates for these unemployment measures were used to align the data with the midpoint of the MEPS collection period for the first interview of each year.

The unemployment rate is a common metric for how the US economy affects workers. The

When states expand Medicaid eligibility, the eligibility rate appears to expand proportionately with unemployment measures.

percentage not working captures both those who are unemployed and those who are not in the labor force, and thus it is a broader measure of labor-force participation than the unemployment rate is. For instance, individuals who lost their jobs but are no longer looking for another one are present in measures of those "not working" but not in the unemployment rate. We defined the proportion of people not working as 1 minus the proportion of the civilian noninstitutionalized population ages sixteen and older that is employed.¹⁴

As a sensitivity analysis, we also calculated eligibility for Medicaid in our two scenarios for individuals in MEPS who lost their jobs. Because MEPS follows sample respondents over time, we were able to limit our sample to the 6,474 sample members who had a job in the first interview of the survey in each year but who were no longer employed at their second or third interview. For these estimates, we pooled data across nine panels to increase precision (and because eligibility rates did not vary over time for this subgroup).

BUSINESS CYCLE We calculated changes over two time periods: from before the recession (2005–07) to the peak of unemployment in 2010, and from before the recession to 2014 (the last year in our study period). While the recession ended in 2009, we compared changes as of 2010 because the unemployment rate was highest in that year.^{8,15} We calculated three-year averages of eligibility and unemployment rates before the recession to increase the stability of our estimates. Additionally, we tested for linear and nonlinear trends in eligibility rates during the period before the recession for both of the eligibility scenarios and found no such trends (for the results of these tests, see Appendix Exhibit A.3).¹²

LIMITATIONS The study had five limitations.

First, the Bureau of Labor Statistics measures do not capture shifts from full-time to part-time employment or reductions in wages, which may be correlated with Medicaid eligibility. Furthermore, these measures were defined using individuals ages sixteen and older, which differs from how we defined adults for our Medicaid eligibility simulations (ages 19–64). Nonetheless, our focus was not on levels of unemployment but on changes in unemployment, and using changes in consistent measures over time mitigated any potential bias. As a sensitivity analysis, we compared eligibility estimates for individuals in MEPS who were not employed after losing or leaving a job. The findings from this analysis were quite similar to those using the Bureau of Labor Statistics measures.

Second, we estimated eligibility at a single point in time, but income—and thus Medicaid eligibility—can change throughout the year.¹⁶ Third, we did not analyze Medicaid enrollment decisions. Fourth, because of limited sample sizes, we were unable to produce estimates for individual states. Finally, our simulated eligibility rates depended on respondents' answers to MEPS questions, which were subject to misreporting.

Study Results

If each state's 2009 eligibility rules had been in effect during the entire study period, an average of 8.6 percent of nonelderly adults would have been eligible for Medicaid before the recession (2005–07), a share that rose modestly to 10.2 percent in 2014 ($p < 0.05$). If the ACA rules had been in effect the entire time, 17.8 percent would have been eligible before the recession, rising to 22.4 percent in 2014 (Exhibit 1). In addition, 57.3 percent of those who would have been eligible under ACA rules in 2014 were childless adults, compared to only 38.4 percent in the alternative scenario (data not shown).

Under the 2009 rules, while eligibility rates increased modestly from the pre-recession period to 2010, rates would have remained unchanged between 2010 and 2014 (10.2 percent in both years). In contrast, if all states had expanded Medicaid under the ACA throughout the study period, eligibility rates would have been noticeably higher in the later years of the period than before the Great Recession, which reflects the increased share of the population with lower incomes during and after the recession.¹⁷ Specifically, the eligibility rate would have increased by 4.0 percentage points between the pre-recession period and 2010 ($p < 0.05$) and by an additional 0.6 percentage point between 2010 and 2014.

The cumulative increase in eligibility rates of

4.6 percentage points is 3.0 percentage points larger than the 1.6-percentage-point increase under 2009 rules ($p < 0.05$). Those 3.0 percentage points amounted to 8.5 million more nonelderly adults being eligible in 2014 than in the period before the recession.

EXPANSION VERSUS NONEXPANSION STATES

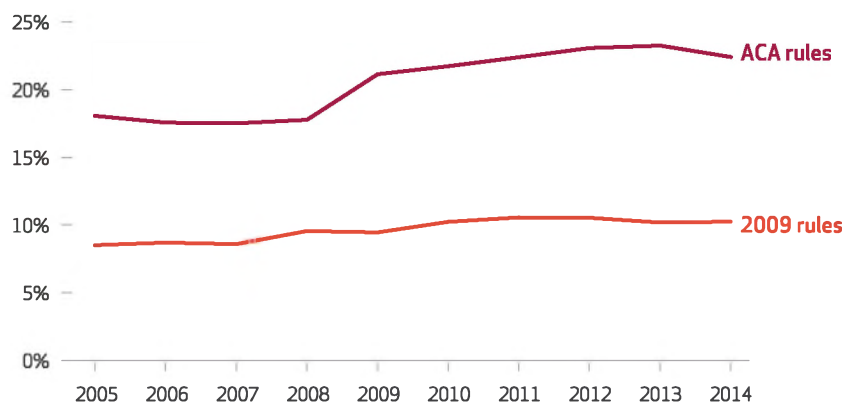
We examined eligibility rates in both of our scenarios for states that adopted the Medicaid expansion as of July 2016 and for those that did not. In 2014, 62 percent of nonelderly, nondisabled adults lived in a state that had expanded Medicaid as of 2016.

The pattern of increased eligibility over time if all states had expanded eligibility throughout the study period was remarkably similar for both expansion and nonexpansion states (Exhibit 2). From the pre-recession period (2005–07) to 2014, the increase in the eligibility rate would have been 4.9 percentage points in expansion states and 4.2 percentage points in nonexpansion states (data not shown), a difference that was not significant. Eligibility rates under 2009 rules throughout the study period did not appear very responsive to larger economic conditions in either set of states. Increases from before the recession to 2014 would have been 2.0 percentage points in expansion states ($p < 0.05$) and 1.2 percentage points in nonexpansion states ($p > 0.10$).

States that opted to expand coverage under the ACA tended to have higher eligibility thresholds in 2009. Under 2009 rules, the simulated eligi-

EXHIBIT 1

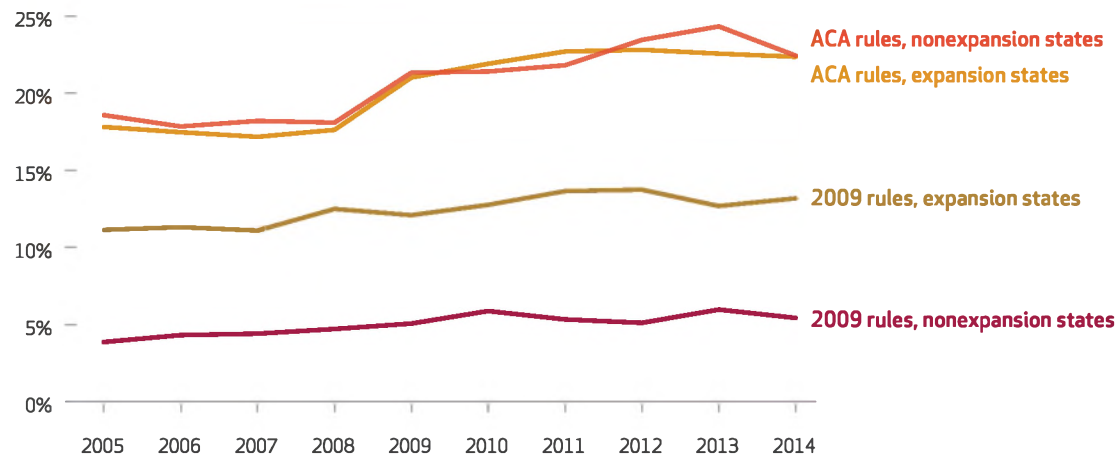
Percentages of nonelderly adults who would have been eligible for Medicaid in 2005–14, using Affordable Care Act (ACA) rules or 2009 rules



SOURCE Authors' analysis of data for 2005–14 from the Medical Expenditure Panel Survey–Household Component (MEPS-HC). **NOTES** The sample consisted of adults ages 19–64 who were not eligible for Medicaid because of a disability. Income was measured at the time of the first MEPS interview of the calendar year. Percentages under the 2009 rules were calculated as if the 2009 eligibility thresholds in each state were in effect throughout the study period. Percentages under the ACA rules were calculated as if all states had adopted the ACA Medicaid expansion thresholds for the whole study period. More details about the simulations are available in Appendix Exhibit A.1 (see Note 12 in text).

EXHIBIT 2

Percentages of nonelderly adults who would have been eligible for Medicaid in 2005–14, by scenario and state Medicaid expansion status



SOURCE Authors' analysis of data for 2005–14 from the Medical Expenditure Panel Survey–Household Component (MEPS-HC) **NOTES** The sample consisted of adults ages 19–64 who were not eligible for Medicaid because of a disability. Income was measured at the time of the first MEPS interview of the calendar year. Percentages under the 2009 rules and the ACA rules were calculated as explained in the Notes to Exhibit 1. Expansion states are those that expanded eligibility for Medicaid under the ACA as of October 2016; nonexpansion states are those that did not. More details about the simulations are available in Appendix Exhibit A.1 (see Note 12 in text).

bility rates for expansion states would have been noticeably higher than those in nonexpansion states for all years in the study period ($p < 0.05$).

CHANGES IN ELIGIBILITY AND ECONOMIC CONDITIONS Comparing eligibility rates under 2009 rules with eligibility rates if all states had expanded Medicaid shows how eligibility rates responded to the Great Recession and its aftermath. But the comparison does not necessarily offer guidance to those who must forecast future Medicaid eligibility rates. Therefore, we compared eligibility changes in both of these scenarios with changes in two measures of unemployment: the unemployment rate and the percentage of the population that is not working.

As noted above, under the 2009 rules, eligibility would have increased by 1.6 percentage points from 2005–07 to 2010. This corresponded with an increase in the unemployment rate over the same period of 5.1 percentage points and an increase in the share of people who were not working of 4.4 percentage points (Exhibit 3). Thus, in this scenario, the magnitude of the increase in eligibility was roughly a third of the increases in the economic measures (32 percent for the unemployment rate and 37 percent for the percentage not working). In contrast, eligibility rates if all states had expanded Medicaid would have increased 4.0 percentage points from before the recession to 2010, which corresponded to 77 percent of the increase in the unemployment rate and 89 percent of the increase in the per-

centage of people who were not working.

While the unemployment rate fell 3.2 percentage points from 2010 to 2014, the share of people who were not working fell only by 0.5 percentage point because a growing proportion of individuals dropped out of the labor force. Thus, if all states had expanded Medicaid throughout the study period, the increase in the eligibility rate from before the recession to 2014 (4.6 percentage points) would be rather large compared with the increase in the unemployment rate over that period (1.9 percentage points). However, the change in the eligibility rate in this scenario corresponded more closely to the net increase in the share of people who were not working (3.9 percentage points). Under the 2009 rules, the pattern was reversed: The increase in the eligibility rate from before the recession to 2014 (1.6 percentage points) roughly corresponded to the increase in the unemployment rate (1.9 percentage points) but was only 42 percent of the increase in people not working (3.9 percentage points).

Finally, we conducted a sensitivity analysis focused on individuals who were employed at their first MEPS interview and were not employed at their second or third interview (for details, see Appendix Exhibit A.5).¹² Under 2009 rules, we estimated that 21.4 percent (95% confidence interval: 19.9, 22.9) of nonelderly adults who lost their job would have gained Medicaid eligibility. If all states had expanded eligibility, 49.9 percent (95% CI: 48.2, 51.6) of those who lost their job

EXHIBIT 3

Changes in Medicaid eligibility rates and unemployment measures, selected years 2005-14

	2005-07			Percentage-point change from 2005-07 to:	
	average	2010	2014	2010	2014
Eligibility rate, 2009 rules	8.6%	10.2%	10.2%	1.6	1.6
Eligibility rate, ACA rules	17.8	21.7	22.4	4.0	4.6
Unemployment rate	4.8	9.9	6.7	5.1	1.9
Rate of people not working	37.1	41.5	41.0	4.4	3.9
Percentage-point change in eligibility arising from a 1-percentage-point change in unemployment rate					
2009 rules	— ^a	— ^a	— ^a	0.32	0.85
ACA rules	— ^a	— ^a	— ^a	0.77	2.39
Percentage-point change in eligibility arising from a 1-percentage-point change in rate of people not working					
2009 rules	— ^a	— ^a	— ^a	0.37	0.42
ACA rules	— ^a	— ^a	— ^a	0.89	1.17

SOURCE Authors' analysis of data for 2005-14 from the Medical Expenditure Panel Survey-Household Component (MEPS-HC) and from the 2006-15 Current Population Survey of the Bureau of Labor Statistics. **NOTES** The MEPS sample consisted of adults ages 19-64 who were not eligible for Medicaid because of a disability. Income was measured at the time of the first MEPS interview of the calendar year. Percentages under the 2009 rules and the ACA rules were calculated as explained in the Notes to Exhibit 1. Unemployment measures were taken from March of each calendar year to align with the midpoint of the MEPS collection period. More details about the simulation of Medicaid eligibility are available in Appendix Exhibit A.1 (see Note 12 in text). 2010 was the year of peak unemployment during the study period. Differences between percentages may not equal percentage-point changes because of rounding. ^aNot applicable.

would have gained eligibility—more than twice the share under 2009 rules. In other words, the roughly twofold difference in these estimates (49.9 percent versus 21.4 percent) is similar to the differences in the estimates from the scenarios shown in Exhibit 3 (for example, 0.77 percentage point versus 0.32 percentage point, and 1.17 percentage point versus 0.42 percentage point).

Discussion

Our primary objective was to analyze how the Medicaid program—both before and after passage of the ACA—was structured to protect low-income adults during fluctuations in the economy. The pattern of our results suggests that in states that adopted the ACA Medicaid expansion, more low-income adults are likely to become eligible for Medicaid during future periods of high unemployment than would be the case if pre-ACA eligibility rules were still in place. The eligibility rate if all states had expanded eligibility for the period 2005-14 would have increased 4.6 percentage points from before the Great Recession to 2014. This increase was much larger than the increase in the eligibility rate in the same period under the 2009 eligibility rules. This difference was likely due to limited eligibility under those rules for nondisabled childless

adults and low income eligibility thresholds for parents, which dampened increases in eligibility during recessions. These results strongly suggest that increases in the percentage of adults eligible for Medicaid during future periods of high unemployment will be larger than was true historically.

Our results also highlight an overlooked benefit of Medicaid expansion: When states expand Medicaid eligibility, the eligibility rate appears to expand proportionately with unemployment measures. If all states expanded Medicaid, then simulated eligibility rates would likely move in tandem with macroeconomic measures. For example, in that scenario we found that from 2005-07 (before the Great Recession) to 2010 (the year of peak unemployment), the eligibility rate rose by 0.77 percentage point for each percentage-point increase in the unemployment rate. Similarly, the eligibility rate rose 0.89 percentage point for each percentage-point increase in the share of people not working. For states that expanded eligibility under the ACA, these estimates suggest that their programs will provide a relatively well-targeted response to cyclical economic changes.

Our results are directly relevant for considering how much Medicaid eligibility rates would increase in a future recession. Using estimates of Medicaid take-up among nonelderly adults from

other studies,^{9,10} we were also able to extrapolate possible increases in Medicaid enrollment as the unemployment rate increases. Estimates of Medicaid take-up among adults vary roughly between 50 and 80 percentage points, depending on the subgroup.^{9,10} Because our sample excluded adults eligible because of a disability and had a higher proportion of childless adults than previous studies of take-up rates, the appropriate take-up rate may be at the lower end of that range. Assuming a Medicaid take-up rate of 50 percent, and assuming that all states expanded Medicaid eligibility, our findings suggest that there would be an increase in Medicaid enrollment among the nonelderly adult population of about 0.4 percentage point for each percentage-point increase in the unemployment rate.¹⁸

These extrapolations imply a nominal increase of roughly 700,000 Medicaid beneficiaries per percentage-point increase in the unemployment rate, based on 2014 MEPS data. These estimates are roughly twice as large as previous estimates of how Medicaid enrollment varies with the unemployment rate, which is consistent with the roughly twofold increase in eligibility rates if all states had expanded eligibility under the ACA.⁴ These extrapolations can be useful to federal and state policy makers, who face considerable pressure to anticipate enrollment increases during periods of high unemployment, in particular to increase the accuracy of budget projections.

For states considering whether to expand Medicaid, our results show that their residents would experience patterns of increased eligibility similar to those in expansion states if eligibility were expanded. Of the 9.8 million nonelderly adults in nonexpansion states who would gain Medicaid eligibility if their state expanded coverage, 30 percent (2.9 million) would be eligible because of lower family income since the onset of the Great Recession (data not shown). The sizable fraction that would become eligible as a result of cyclical patterns in the economy underscores the importance of considering broader economic patterns when projecting eligibility.

When Medicaid enrollment increases during recessions and revenues decline, state finances become stretched. States may be reasonably concerned about the budgetary implications of expanding eligibility now, only to face unmanageable costs from increased enrollment during a future recession. As our results show, however, many beneficiaries who would become eligible under an ACA Medicaid expansion during a period of high unemployment would not have been

Our results are directly relevant for considering how much Medicaid eligibility rates would increase in a future recession.

eligible under pre-ACA rules, and thus the federal government would pay most of their Medicaid expenses.¹⁹ Compared with a historical average of 57 percent, in 2016 the federal government paid 100 percent of the Medicaid expenses of these newly eligible beneficiaries. Starting in 2017, that share will decline gradually, falling to 90 percent for 2020 and beyond.

During recessions, states should compare their costs of additional Medicaid enrollees with increased uncompensated care costs when people go without coverage. Our results show that the higher federal share of Medicaid expenses would likely apply to the vast majority of those becoming eligible during a recession. States that have not yet expanded Medicaid eligibility may want to consider this when examining the costs and benefits of expansion.

Conclusion

With the implementation of the ACA's Medicaid coverage provisions in most states, Medicaid's role as a safety-net program has changed considerably. Before passage of the ACA, most nondisabled adults would not have become eligible for Medicaid even after losing a job. For states that expanded their Medicaid programs, the ACA has reshaped eligibility so that family income as a percentage of poverty is the prime determinant of eligibility for nondisabled, nonelderly adults. Our analysis of the increased responsiveness of Medicaid to unemployment provides useful information for policy makers concerned about how the program will respond during future recessions, as well as for those concerned about whether or not to expand their state's existing Medicaid program. ■

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the authors, and no official endorsement by MACPAC, the Department of Health and Human Services, or AHRQ is intended or should be inferred.

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- 17 We verified that the increase in the simulated eligibility rate from 2005 to 2014 if all states had expanded Medicaid (4.6 percentage points) is not statistically different than the increase over the same time period in the share of nonelderly adults in the Current Population Survey with incomes below 138 percent of poverty (3.3 percentage points). Results from this analysis are in Appendix Exhibit A.4 (see Note 12).
- 18 Our estimate of 0.4 percentage point corresponds to 50 percent of 0.77, which is the percentage-point change in eligibility under ACA rules arising from a 1-percentage-point increase in the unemployment rate (Exhibit 3).
- 19 Of the individuals in nonexpansion states who were eligible in 2014 under ACA rules but not eligible under 2009 rules, we calculated that 94 percent would be eligible for the enhanced federal matching percentage.

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Lower- Versus Higher-Income Populations In The Alternative Quality Contract: Improved Quality And Similar Spending

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ABSTRACT As population-based payment models become increasingly common, it is crucial to understand how such payment models affect health disparities. We evaluated health care quality and spending among enrollees in areas with lower versus higher socioeconomic status in Massachusetts before and after providers entered into the Alternative Quality Contract, a two-sided population-based payment model with substantial incentives tied to quality. We compared changes in process measures, outcome measures, and spending between enrollees in areas with lower and higher socioeconomic status from 2006 to 2012 (outcome measures were measured after the intervention only). Quality improved for all enrollees in the Alternative Quality Contract after their provider organizations entered the contract. Process measures improved 1.2 percentage points per year more among enrollees in areas with lower socioeconomic status than among those in areas with higher socioeconomic status. Outcome measure improvement was no different between the subgroups; neither were changes in spending. Larger or comparable improvements in quality among enrollees in areas with lower socioeconomic status suggest a potential narrowing of disparities. Strong pay-for-performance incentives within a population-based payment model could encourage providers to focus on improving quality for more disadvantaged populations.

Across the United States, public and private payers are increasingly entering population-based payment arrangements with accountable care organizations (ACOs). These payment arrangements reward providers for improving the quality of care for a defined population of patients and establish accountability for spending. They may also influence disparities in quality of care that exist along socioeconomic and demographic lines.¹⁻⁴ On the one hand, population-based payment models that reward high-quality care could motivate physician organizations to focus on improving quality for more disadvantaged patients who have a greater op-

portunity for improvement, given that populations in areas with lower socioeconomic status may have lower quality scores at baseline.^{5,6} On the other hand, these payment models could fail to address—or could even exacerbate—disparities, because physicians who serve more disadvantaged populations could face greater social or health care system-level challenges in achieving higher quality performance. Provider groups that serve areas with lower socioeconomic status might also be less likely than provider groups in other areas to join population-based payment models. To date, evidence related to the impact of population-based payment models on disparities in quality is lacking. Evidence is also lacking

on whether medical spending differs by socioeconomic status under such payment models.

We evaluated changes in quality of care and medical spending among populations in areas with lower and higher socioeconomic status before and after their physicians entered the Alternative Quality Contract (AQC) with Blue Cross Blue Shield of Massachusetts. The AQC, launched in 2009, is a multiyear, population-based global budget model that has two-sided incentives: It rewards physicians for savings below the risk-adjusted budget (shared savings) but also requires them to share in deficits with Blue Cross Blue Shield of Massachusetts for spending above the budget (shared risk). During the first four years of the AQC, the enrollee population comprised primarily those in health maintenance organization plans.

The Alternative Quality Contract rewards performance on sixty-four quality measures across ambulatory and inpatient settings and within both process and outcome domains. While the measures are similar to those in ACO contracts used by Medicare and other private insurers, rewards under the AQC tend to be substantially larger.⁷⁻¹⁰ The contract grew from seven provider organizations in 2009 to about 90 percent of Massachusetts physicians in the Blue Cross Blue Shield of Massachusetts network by 2012. Previous analyses have found decreases in medical spending on claims and improved quality performance associated with the contract relative to control, with net savings appearing in the fourth year.^{11,12}

Study Data And Methods

PRINCIPAL COMPONENT ANALYSIS We assigned enrollees to subgroups by lower and higher socioeconomic status, using a principal component analysis of socioeconomic and demographic characteristics for each enrollee's area of residence. Characteristics were obtained at the census block group level using the 2010 census and 2011 five-year American Community Survey from the Census Bureau.^{13,14} Census block groups better represent individuals than ZIP codes or census tracts because they comprise smaller and more homogenous populations than ZIP codes or census tracts, both of which are substantially larger geographic units.¹⁵ Five-year estimates from the American Community Survey allow for greater precision than one- or three-year estimates and are preferable when analyzing smaller populations or geographies.¹⁶ The area characteristics included variables such as race, education, income, and employment, which have been linked to quality of care.^{1-6,17,18}

Principal component analysis is widely used in

the biological and social sciences to collapse multidimensional data into fewer dimensions by generating variables that summarize the essential features of the original data.¹⁹ We performed a principal component analysis at the census block group level, identifying three variables whose eigenvalues were above 1 (for details, see online Appendix Exhibit 1).²⁰ Using the first principal component, we grouped enrollees by lower or higher socioeconomic status using the median as the cutoff. In sensitivity analyses, we used alternative cutoffs of the twenty-fifth and seventy-fifth percentiles.

DATA, POPULATION, AND VARIABLES We analyzed data on process measures, outcome measures, and medical spending at the enrollee level. For process measures, data were collected at the enrollee level from 2007 to 2012. For outcome measures, data at the enrollee level were available during the postintervention years (2009–12) only. For medical spending, enrollee-level claims data were available from 2006 to 2012.

We focused on comparisons between subgroups in areas with lower and higher socioeconomic status within the 2009 AQC cohort, which comprised enrollees whose primary care physicians belonged to organizations that joined the AQC in that year. This included 299,285 individuals in the lower-socioeconomic-status subgroup who were continuously enrolled for at least one year and 244,415 individuals in the higher-socioeconomic-status subgroup who were analogously enrolled.

In secondary analyses of process measures and spending, we included enrollees whose primary care physicians belonged to organizations not in the Alternative Quality Contract as a control group, to test whether trends by income group varied outside of the contract. This comparison population included 1,053,089 lower-socioeconomic-status and 650,041 higher-socioeconomic-status Blue Cross Blue Shield of Massachusetts enrollees who were also continuously enrolled for at least one year. In secondary analyses of outcome measures, we used national and New England Healthcare Effectiveness Data and Information Set (HEDIS) average performance scores as an unadjusted comparison benchmark.

Process measures included eighteen ambulatory measures across three domains: chronic disease management, adult preventive care, and pediatric care (for a complete list of the measures, see Appendix Exhibit 2).²⁰ Each measure was applied to enrollees eligible for the measure, and performance was measured as a binary outcome based on whether performance met criteria in a given year. For example, patients with diabetes would satisfy the eye exam measure if they received an eye exam in a given year. In the

AQC, providers would receive a composite measure of quality performance annually, based on the weights assigned to each measure listed in Appendix Exhibit 2.²⁰ The composite performance was then converted into financial rewards based on five “gates” of performance thresholds defined by the percentage of eligible members for whom the measure was met. We analyzed process measures in aggregate as a weighted average and by domain.

The Alternative Quality Contract included five outcome measures: hemoglobin A1c level at or below 9 percent, low-density lipoprotein (LDL) cholesterol level below 100 mg per deciliter, and blood pressure below 140/80 mmHg for patients with diabetes; LDL cholesterol in patients with coronary artery disease; and blood pressure in patients with hypertension. Outcome measures were collected at the enrollee level during post-intervention years for AQC enrollees, which precluded difference-in-differences analysis but enabled adjusted comparisons of postintervention trends. In unadjusted comparisons, we provided average performance at the Blue Cross Blue Shield of Massachusetts network level for the preintervention years and used the national and New England HEDIS average performance for a rough comparison group. Given the confidential nature of outcomes data, these measures had different anonymous enrollee identifiers that prevented cross-linkages with other Blue Cross Blue Shield of Massachusetts claims or quality data. Enrollees were linked to specific provider organizations in the contract via their primary care physician’s affiliation.

Spending was the combination of the insurer payment and enrollee cost sharing. This reflects utilization and negotiated prices between payers and physician organizations. We captured differences in plan benefit design by using plan-level fixed effects in our main analyses. Given that plan-level benefit design might change over time, we also used average enrollee cost sharing at the plan level in a sensitivity analysis.^{11,12} Similar to prior analyses, pharmaceutical spending was excluded from the main analysis because some enrollees had drug benefits carved out of their benefit package, so claims for these services were not available in Blue Cross Blue Shield of Massachusetts claims. Spending was inflation adjusted to 2012 dollars.

STATISTICAL ANALYSIS We used a difference-in-differences framework to isolate changes in process measures and spending associated with the Alternative Quality Contract among the subgroup of lower socioeconomic status relative to changes in the subgroup of higher socioeconomic status.^{21,22} For outcome measures, we tested differences in postcontract trends between the

Qualitative evidence suggests that AQC organizations tended to place an emphasis on quality improvement.

subgroups of lower and higher socioeconomic status.

We used a linear multivariable model that regresses the dependent variable on an indicator of socioeconomic status interacted with postintervention years at the enrollee level. With a large sample size, linear models are often preferable to two-part models and other specifications in estimating the population average, which was the parameter of interest.^{23,24} The base model controlled for age categories, interactions between age and sex, concurrent risk score based on the diagnostic cost group system, secular trends, and plan fixed effects. Regressions with quality as the dependent variable also included fixed effects for each type of quality measure, to identify “within measure” changes associated with socioeconomic status. Standard errors were clustered at the plan level. Given the confidentiality of outcomes data, which did not include plan information, standard errors in outcomes models were clustered at the physician organization level. Results were reported with two-tailed *p* values.

A major threat to the validity of this design is differential preintervention trends between AQC enrollees in areas with lower and higher socioeconomic status. Thus, we tested for differences in preintervention trends between the two subgroups. We also complemented these analyses with a triple-difference approach that included non-AQC enrollees similarly assigned to subgroups of lower and higher socioeconomic status. Because more physicians in Massachusetts joined the AQC over time, a reliable control group of non-AQC Blue Cross Blue Shield of Massachusetts enrollees became less available two years after the contract.¹² Thus, triple-difference analyses were limited to two postintervention years.

LIMITATIONS This study had several limitations. Data for the principal component analysis were census variables at the census block group

Social and environmental factors are recognized to play a larger role than health care in determining the health of populations.

level, instead of characteristics of individual enrollees. Thus, assignment of enrollees to subgroups of lower and higher socioeconomic status using geographic data might involve assignment error. Nevertheless, we used the geography of residence in determining the census block group, consistent with other studies.^{25,26} Moreover, the census block group unit of geography is smaller and more homogenous than the ZIP code, county, or census tract, which improves the accuracy of socioeconomic status assignment.^{27,28}

In addition, because we lacked individual-level outcome measures prior to the Alternative Quality Contract and for non-AQC enrollees, we could not draw strong inferences about outcome measures. However, our aggregate unadjusted analyses suggest no differential trends in improvement by socioeconomic status postintervention, resulting in similarly large improvements relative to national and New England comparisons.

Findings from the AQC might not be representative of global payment models by other payers or similar contracts in other states, as the population, the providers, and the incentives for this payment model might be different from other ACO contexts in important ways.²⁹⁻³¹ For example, the median household income for enrollees in the subgroup of lower socioeconomic status was higher than the median US household income, which is consistent with Massachusetts having one of the highest median incomes relative to other states. Thus, the subgroup of lower socioeconomic status in this study might not be representative of the degree of socioeconomic distress or vulnerability experienced by disadvantaged populations in other states. In sensitivity analyses, we examined comparisons using different cutoffs for defining subgroups of lower and higher socioeconomic status.

In addition, the average cost sharing in the

study population was lower than in typical privately insured populations, which suggests that Blue Cross Blue Shield of Massachusetts plans were more generous, on average.

Our observational design also precludes strong causal inferences about AQC effects, given that entry into the contract was nonrandom and there could be unobserved factors that affected the results.

Lastly, the quality measures we studied do not capture all dimensions of quality that are important to physicians and patients. The process measures were largely primary care oriented, and the outcome measures touched on a small subset of intermediate outcomes of interest. Future developments in quality measures for specialties and in outcome measures would enrich such analyses of quality.

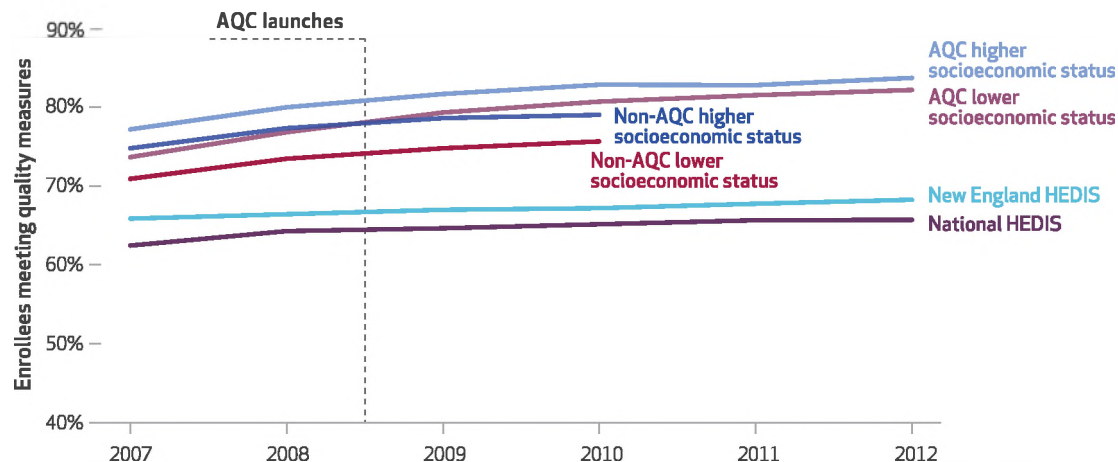
Study Results

POPULATION Enrollees in the 2009 Alternative Quality Contract cohort in areas with lower and higher socioeconomic status were similar in age, sex, diagnostic cost group risk score, and average cost sharing (for details, see Appendix Exhibit 3).²⁰ Enrollees of lower socioeconomic status lived in census block groups that had larger minority populations than did enrollees of higher socioeconomic status (12.6 percent black and 9.6 percent Hispanic, versus 1.6 percent black and 2.4 percent Hispanic), lower levels of education attainment (85.8 percent versus 95.9 percent with at least high school completion), lower median household income (\$58,967 with 9.7 percent of families in poverty, versus \$101,658 with 2.2 percent in poverty), and higher unemployment (9.6 percent versus 6.2 percent). Similar differences were evident among non-AQC enrollees (for details, see Appendix Exhibit 4).²⁰ For summary characteristics of census block groups served by each AQC organization in the 2009 cohort, see Appendix Exhibit 5.²⁰

PROCESS MEASURES Unadjusted aggregate process measures improved more among AQC enrollees in the subgroup of lower socioeconomic status than among enrollees in the higher-status subgroup during the four years, narrowing the difference between these subgroups (Exhibit 1). In adjusted analysis, the lower-socioeconomic-status subgroup in the AQC had a greater improvement in aggregate performance relative to the higher-socioeconomic-status subgroup—on average, 1.2 percentage points per year during the four years ($p < 0.001$) (Exhibit 2). Preintervention trends were not significantly different between the two subgroups (0.1 percentage points per year, $p = 0.45$). Sensitivi-

EXHIBIT 1

Performance on process quality measures among Alternative Quality Contract (AQC) enrollees and comparison groups, by socioeconomic status according to enrollee area of residence, 2007-12



SOURCE Authors' analysis of data from Blue Cross Blue Shield of Massachusetts and the Healthcare Effectiveness Data and Information Set (HEDIS). **NOTES** For an explanation of area socioeconomic status, see the text. Unadjusted aggregate process quality is expressed as a weighted average composite of eighteen process measures across three domains: chronic disease management, adult preventive care, and pediatric care. Each measure was applied to AQC enrollees eligible for the measure, such as hemoglobin A1c measurement for patients with diabetes. Performance was measured as a binary outcome based on whether the measure was satisfied in a given year.

ty analyses were consistent with our main results (for results of the sensitivity analyses, see Appendix Exhibit 6).²⁰

Analyses by domain showed that the differences in improvement were not statistically significant among chronic disease management measures (0.3 percentage points per year in favor of the subgroup of lower socioeconomic status, $p = 0.53$) but were statistically significant for the adult preventive care and pediatric care measures—on average, 1.2 and 1.8 percentage

points per year in favor of the subgroup of lower socioeconomic status, respectively ($p < 0.001$) (Exhibit 2). In secondary analyses involving non-AQC enrollees, the triple-difference model demonstrated qualitatively similar results consistent with Exhibit 1, which suggests that differential trends by socioeconomic status were not driving our findings.

OUTCOME MEASURES Aggregate unadjusted performance on outcome measures demonstrated continuous improvement after the interven-

EXHIBIT 2

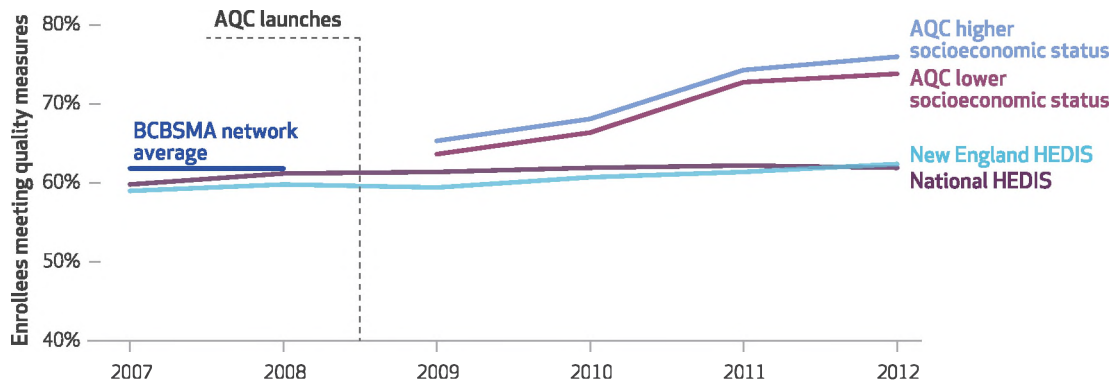
Changes in quality of care and medical spending among Alternative Quality Contract (AQC) enrollees, by socioeconomic status according to enrollee area of residence

	AQC enrollees (2009 cohort)						
	Lower socioeconomic status		Higher socioeconomic status		Difference in differences		
	Pre-AQC	Post-AQC	Pre-AQC	Post-AQC	Unadjusted ^a	Adjusted ^b	p value
Process quality ^b (aggregate)	75.1%	79.7%	78.2%	82.0%	0.8	1.2	<0.001
Chronic disease management	78.8	83.1	79.3	83.4	0.2	0.3	0.530
Adult preventive care	73.9	78.7	76.7	80.8	0.7	1.2	<0.001
Pediatric care	75.5	79.7	81.1	84.2	1.1	1.8	<0.001
Medical spending ^c (per member per quarter)	\$813.32	\$926.74	\$776.91	\$904.81	-\$14.50	-\$5.74	0.430

SOURCE Authors' analysis of data from Blue Cross Blue Shield of Massachusetts. **NOTES** ^aPercentage points. ^bFor quality, pre-AQC refers to 2007-08 and post-AQC refers to 2009-12. The difference-in-differences results represent the average changes in the percentage of eligible enrollees for a measure who met quality performance for the measure from before to after the AQC in the subgroup of lower socioeconomic status as compared with the higher-socioeconomic-status subgroup. Quality measures are measured on an annual basis. ^cFor spending, pre-AQC refers to 2006-08 and post-AQC refers to 2009-12. The difference-in-differences results represent the average change in medical spending on claims per enrollee per quarter from before to after the AQC in the subgroup of lower socioeconomic status as compared with the higher-socioeconomic-status subgroup. Spending is inflation-adjusted to 2012 dollars.

EXHIBIT 3

Performance on outcome quality measures among Alternative Quality Contract (AQC) enrollees and comparison groups, by socioeconomic status according to enrollee area of residence, 2007-12



SOURCE Authors' analysis of data from Blue Cross Blue Shield of Massachusetts (BCBSMA) and the Healthcare Effectiveness Data and Information Set (HEDIS). **NOTES** Unadjusted aggregate outcome quality includes five measures: hemoglobin A1c level ≤ 9 percent, low-density lipoprotein (LDL) cholesterol level < 100 mg per deciliter, and blood pressure $< 140/80$ mmHg for patients with diabetes; LDL cholesterol in patients with coronary artery disease, blood pressure $< 140/80$ mmHg for patients with hypertension. Given that 2007 and 2008 were preintervention years, data were collected at the BCBSMA network level and performance was not separable by socioeconomic status for AQC enrollees.

tion among AQC enrollees in areas with both lower and higher socioeconomic status (Exhibit 3). Unadjusted performance for lower-socioeconomic-status enrollees improved from 63.6 percent in 2009 to 73.8 percent in 2012 (a 10.2-percentage-point change), while that for higher-socioeconomic-status enrollees improved from 65.3 percent to 76.0 percent (a 10.7-percentage-point change). In adjusted analysis, average improvement in outcome measures was not statistically different between lower-socioeconomic-status and higher-socioeconomic-status subgroups across the four post-AQC years (-0.11 percentage point per year, $p = 0.82$). Sensitivity analyses supported our results (see Appendix Exhibit 7).²⁰

In secondary analyses, the slope of improvement in outcome measures was comparably greater for AQC enrollees of both lower and higher socioeconomic status compared to national and New England HEDIS averages (Exhibit 3). This comparison is limited because HEDIS performance was not disaggregated by socioeconomic status, but it offers a sense of AQC performance across socioeconomic status subgroups relative to HEDIS.

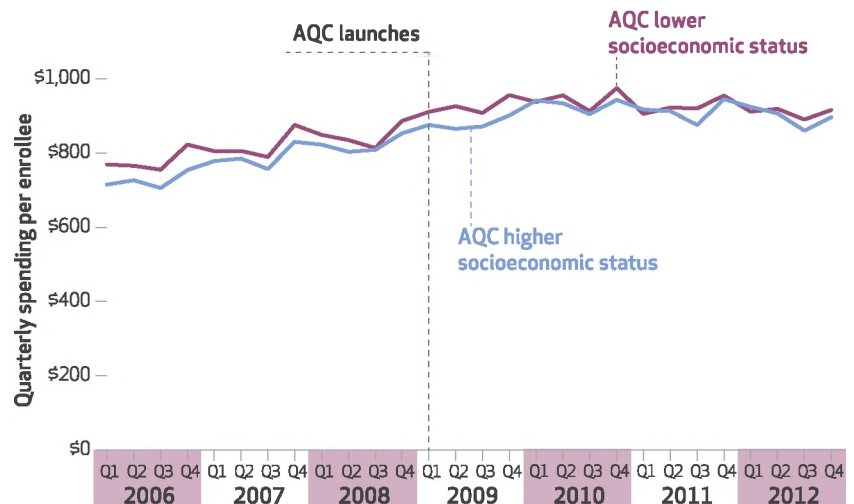
SPENDING Average unadjusted medical spending on claims was higher among AQC enrollees of lower socioeconomic status than among those of higher socioeconomic status nearly throughout the study period, and both subgroups saw slower growth in spending after the intervention (Exhibit 4).

In adjusted analyses, AQC enrollees of lower socioeconomic status had similar changes in

spending as did their higher-socioeconomic-status peers during the first four years of the contract, but the difference was not statistically significant ($-\$5.74$ per enrollee per quarter, $p = 0.43$) (Exhibit 2). Preintervention trends in spending between these two subgroups were also not significantly different ($-\$3.06$ difference, $p = 0.52$) (data not shown). Sensitivity an-

EXHIBIT 4

Quarterly medical spending among Alternative Quality Contract (AQC) enrollees, by socioeconomic status according to enrollee area of residence, 2006-12



SOURCE Authors' analysis of data from Blue Cross Blue Shield of Massachusetts. **NOTES** Unadjusted aggregate medical spending per enrollee per quarter as obtained through medical claims, representing the sum of the amount paid by the payer and the amount paid through enrollee cost sharing. Spending is inflation-adjusted to 2012 dollars.

analyses were broadly consistent with these findings, although a more restrictive definition of lower socioeconomic status produced a small but statistically significant difference in spending (see Appendix Exhibit 8).²⁰ The triple-difference model also demonstrated qualitatively similar results.

Discussion

Improvements in process measures were generally greater among Alternative Quality Contract enrollees in areas with lower socioeconomic status than among those in higher-socioeconomic-status areas during the AQC's first four years. This finding was robust to secondary analyses and sensitivity analyses, including those that used Blue Cross Blue Shield of Massachusetts enrollees who were not in the AQC as controls. The lack of preintervention and control data for outcome measures at the individual level precluded as thorough of an analysis for outcomes. Nevertheless, our adjusted analysis of outcomes postintervention shows comparable trends between subgroups of lower and higher socioeconomic status, and both subgroups outperformed national and New England HEDIS averages. Meanwhile, spending trends were similar between the subgroups. Overall, these findings suggest a likely narrowing of disparities in process quality under the AQC without significant differences in spending along the socioeconomic status dimension.

The fact that disparities between enrollees in areas with lower and higher socioeconomic status narrowed among process measures but not for outcome measures, despite larger improvements for both subgroups in outcome measures, could reflect a weak relationship between process and outcome measures. For example, monitoring hemoglobin A1c for patients with diabetes (process measure) might not translate into lower hemoglobin A1c levels (outcome measure). Moreover, most process measures, such as cancer screening, do not have a corollary in the outcome measure domain (for example, cancer-specific survival rates), and improvements in outcomes may take longer to manifest. In general, improvement in outcome measures is considered more complex and challenging because it requires patient adherence and changes in health behaviors, which are less under the direct influence of providers than process measures are. The fact that outcomes improved substantially for AQC enrollees of both lower and higher socioeconomic status is meaningful.

Furthermore, quality measures in the AQC exhibited different trends in improvement when compared to national and New England HEDIS

These results suggest that in its early years, the AQC likely contributed to a narrowing of disparities in some dimensions of quality.

averages. Process measures improved slowly across the postintervention years, potentially reflecting the increased difficulty of further improvement at higher baseline levels of performance. Meanwhile, outcome measures improved more quickly and in a sustained fashion. This difference could be explained by lower baseline performance for outcome measures as compared with process measures, rendering outcome measures less susceptible to a ceiling effect by which improvement is increasingly difficult from higher levels of performance. This ceiling effect may have analogously contributed to greater improvements in process quality attained by enrollees of lower socioeconomic status, who began with lower performance levels than those of their peers in higher-socioeconomic-status areas. The fact that outcome measures were triple-weighted toward determining incentive payments in the AQC, whereas process measures were largely single-weighted, might have also contributed to the difference. Gains in the intermediate outcomes of hemoglobin A1c, LDL, and blood pressure reflect improved control of major chronic illnesses including hypertension, diabetes, and risk factors for coronary artery disease and stroke—an encouraging sign relative to regional and national averages.

The sizable incentives for quality under the AQC might have played an important role in the greater gains among enrollees of lower socioeconomic status compared to their peers in higher-socioeconomic-status areas. In 2009–10, physician organizations could earn up to 10 percent of their risk-adjusted budgets in bonus payments for quality performance—an amount substantially larger than the 2.3 percent average bonus for quality performance in prior pay-for-performance contracts.¹⁰ Since 2011, rewards for quality were determined as a per member per month amount to equalize payments

across physician organizations for a given level of performance, but they nevertheless remained substantial.³² For population-based payment models elsewhere in the country, the Alternative Quality Contract could provide an example of the potential of large quality incentives to improve quality without exacerbating disparities. Indeed, even in a relatively higher-average-income population overall, differences in quality still narrowed under the AQC.

Qualitative evidence suggests that AQC organizations tended to place an emphasis on quality improvement, partly because bonuses were large and could be allocated freely by the organization internally.³³ Additional discussions from Blue Cross Blue Shield of Massachusetts collaborations with AQC providers and best-practice sharing forums suggest that providers serving areas with lower socioeconomic status developed strategies for patient engagement, in many cases adopting new staffing models to enable more customized outreach to improve access and achieve quality goals for patients. For patients, receiving more frequent communication regarding preventive care may help compliance with recommended services. Moreover, the size of the Blue Cross Blue Shield of Massachusetts enrollee population could help facilitate positive peer- or neighborhood-level effects on health, given that populations with similar socioeco-

nom and demographic characteristics tend to cluster geographically.^{34,35} Ultimately, social and environmental factors are recognized to play a larger role than health care in determining the health of populations. This suggests that efforts to reduce disparities in poverty, education, and related factors would be an important complement to interventions in the health care system.^{36,37}

Conclusion

During the first four years of the Alternative Quality Contract in Massachusetts, improvements in quality of care for enrollees in areas with lower socioeconomic status were comparable or greater than those in areas with higher socioeconomic status, without statistically significant differences in spending trends. These results suggest that in its early years, the AQC likely contributed to a narrowing of disparities in some dimensions of quality, notably as reflected by process measures in the contract. Moreover, our results suggest that in a population-based global budget model, sufficiently large quality incentives with an overall adequate budget could be important factors in giving physician organizations the financial resources necessary to intensify efforts toward improving quality of care for disadvantaged populations. ■

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The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation

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In-Brief

On December 7, 2016, we released estimates of the coverage and cost impacts of a partial repeal of the Affordable Care Act (ACA) through the budget reconciliation process. If partial repeal is modeled on the reconciliation bill passed by Congress in January 2016 and vetoed by President Obama, it would eliminate the Medicaid expansion, the individual and employer mandates, and the Marketplace premium tax credits and cost-sharing reductions, but the ACA's insurance market reforms (e.g., guaranteed issue, modified community rating, essential health benefit requirements, prohibitions on pre-existing condition exclusions) would remain. We estimated that an additional 29.8 million people would become uninsured because of the anticipated reconciliation bill. In this brief, we examine the financial impact of partial ACA repeal on health care providers: hospitals, physicians, other services, prescription drugs.

We find that spending by insurers (public and private) and households on health care delivered to the nonelderly population would be \$145.8 billion lower in 2019 and \$1.7 trillion lower between 2019 and 2028 as a result of reconciliation. Spending by these sources on hospital care would be \$59.1 billion lower in 2019 and \$596.4 billion lower between 2019 and 2028. Care provided in physician offices, other services, and prescription drugs – would be \$86.8 billion lower in 2019 and \$1.1 trillion lower between 2019 and 2028.

The newly uninsured would seek \$88.0 billion in additional uncompensated care in 2019 (not included in spending figures above), \$24.6 billion of that amount from hospitals. From 2019 to 2028, the newly uninsured would seek \$1.1 trillion in additional uncompensated care, including \$296.1 billion in hospital care. Even if this additional uncompensated care is provided to the uninsured, a large body of research has linked uninsurance to reduced receipt of health care, increased financial stress, and worse health outcomes.

Federal funding for uncompensated care would increase very little under a reconciliation bill similar to that passed in January 2016. The ACA's Medicaid Disproportionate Share Hospital (DSH) cuts never materialized, and our estimates assume that they would never have been implemented. We estimate that Medicare DSH funding would rise by \$35.0 billion from 2019 to 2028 because a component of the DSH allocation formula increases with the number of uninsured. The 2016 reconciliation bill did not allocate additional funds beyond the automatic increase, and so far Congress has not signaled an intent to pay for the higher level of uncompensated care. The \$35.0 billion increase in federal uncompensated care funding over 10 years would offer scant relief against the projected \$1.1 trillion increase in uncompensated care services under an anticipated reconciliation bill. Budget constraints will limit how much state and local governments can contribute; the additional costs would require a sixfold increase in their spending on uncompensated care if they were to finance it all.

Thus, the additional financial burden of uncompensated care is likely to fall hardest on health care providers. Partial ACA repeal could lead to a fourfold increase in the amount of uncompensated care providers finance themselves compared to current levels. As a result there would likely be a substantial increase in unmet health care need for the uninsured.

Introduction

Congress passed a reconciliation bill repealing substantial portions of the Affordable Care Act (ACA) in January 2016; the bill was vetoed by President Obama.¹ Congress is now poised to pass a similar bill in early 2017.^{2,3} The vetoed bill did not contain policies intended to replace the ACA, presumably because a consensus did not exist on what form such an alternative should take. It is unlikely that supporters of ACA repeal will have agreed on an alternative before voting on repeal. In the absence of agreement on an alternative to the ACA, Congress is likely to delay the repeal of most, if not all, provisions in the bill for two or three years, giving legislators time to develop an alternative set of policies. This was the approach taken by Congress last year. We recently analyzed the coverage and health care spending implications of this approach.⁴

Building on the previous analysis, this brief provides additional detail on the decreases in health care spending and increases in uncompensated care sought that would result from an estimated 29.8 million increase in the uninsured. We estimate how the reductions in health care spending and increases in uncompensated care would be distributed across different types of health care services: hospital care, office-based physician care, prescription drugs, and other services.

Significant coverage losses would result from repeal of the Medicaid expansion, elimination of financial assistance for purchase of private nongroup insurance through the Marketplaces, repeal of the individual mandate, and the unraveling of the private nongroup insurance market (as explained in our recent brief). The coverage losses would in turn decrease revenues for providers of all types. Providers' variable costs would also decrease, but their fixed costs would not. In this analysis, we estimate revenue changes but not cost changes.

Uninsured people use less medical care than they would if they had health insurance.⁵ Recent studies found that uninsured parents and children were much more likely to report delaying health care

because of costs, having trouble paying medical bills, and having greater unmet health care needs, compared with those with health coverage.^{6,7} These studies also found that the uninsured were much less likely to have seen a doctor or dentist over the past 12 months. But though overall use of care declines when people become uninsured and unmet health care needs increase, many uninsured people do use some health care. This care is financed in different ways: some is paid for directly by the uninsured, some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital [DSH] programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid DSH, funding for public hospitals), and some is delivered as free or reduced-price care by providers (e.g., hospitals, physicians, pharmaceutical companies). We assume that newly uninsured people would contribute to the costs of their own care consistent with the patterns of spending by uninsured people with similar characteristics and health needs in recent years. Health care delivered to the uninsured that is not paid for by the uninsured people themselves is referred to as uncompensated care.

In general, uncompensated care funding (e.g., from federal, state, and local governments or health care providers) does not increase automatically with the number of uninsured. The exception is federal funding under the Medicare DSH program, which would increase modestly—no higher than 2013 levels—if the number of uninsured people increased significantly. Such an increase in federal funding would be very small, however, relative to the increase in uncompensated care sought by the additional 29.8 million uninsured. It is unclear whether funding from federal, state, and local governments or from providers would increase to meet the larger amount of uncompensated care expected to be sought by the newly uninsured. As a result, we estimate the amount of care that the newly uninsured would *seek*, not the value of the uncompensated care they would actually *receive*. The amount of uncompensated care that uninsured people would seek is estimated based

on the observed use of uncompensated care by the uninsured in recent years, taking individual characteristics and health statuses into account.

Key Findings

- As a direct effect of the projected increase in the uninsured under the anticipated reconciliation bill, spending by insurers (public and private) and households on health care delivered to the nonelderly would be \$145.8 billion lower in 2019 and \$1.7 trillion lower between 2019 and 2028.
- In 2019, spending by insurers (public and private) and households on hospital care would be \$59.1 billion lower, spending on physician care would be \$20.0 billion lower, spending on other services would be \$34.7 billion lower, and spending on prescription drugs would be \$32.1 billion lower under the anticipated reconciliation bill than under the ACA. From 2019 to 2028, insurer and household spending would be \$596.4 billion, \$217.7 billion, \$416.4 billion, and \$428.6 billion lower for hospitals, physicians, other services,⁸ and prescription drugs, respectively.
- We estimate that the 29.8 million additional uninsured under the reconciliation bill would seek an additional \$88.0 billion in uncompensated care in 2019—\$24.6 billion in hospital care, \$11.9 billion in physician office-based care, \$33.6 billion in other services, and \$18.0 billion in prescription drugs.
- We estimate that from 2019 to 2028 the uninsured would seek an additional \$1.1 trillion in uncompensated care, including an additional \$296.1 billion in hospital care, \$147.0 billion in physician care, \$406.1 billion in other services, and \$217.6 billion in prescription drugs.
- Federal funding for uncompensated care would increase no more than \$3.2 billion in 2019 and no more than \$35.0 billion from 2019 to 2028. This automatic increase in federal funding would compensate for less than 4 percent of the increase in uncompensated care sought by the newly uninsured. There is no clear source of funding for the remainder. If federal, state, and local governments do not allocate more funding for this care, the financial burden would fall on health care

providers. Large increases in unmet need for the uninsured are likely because the additional costs would require a fourfold increase in provider funding of uncompensated care from current levels.

A recent report commissioned by the American Hospital Association and the Federation of American Hospitals also examined the impact of ACA repeal on hospitals, estimating that net hospital revenue would be reduced by \$165.8 billion from 2018 to 2026, assuming restoration of Medicaid DSH payments.⁹ Our analysis is broader, including revenue for nonhospital providers, highlighting the increase in uncompensated care sought by those who would lose health coverage, and accounting for uncertainty in the provision and financing of that care. We do not estimate provider costs or net revenue, so our estimates are not directly comparable to those in the industry study. Additional information on differences between the two reports is given at the end of this analysis.

Results

In this brief, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the reduction in spending on health care services by insurers and households and the increase in uncompensated care that would result from partial repeal of the Affordable Care Act (ACA). These estimates are made separately for hospitals, physicians, prescription drugs, and other services (including health care services delivered by providers other than hospitals and office-based physicians and additional services such as dental care, home health care, and other medical equipment). Health care spending on behalf of the uninsured is estimated by the source of funding: the uninsured themselves versus spending by federal, state, and local governments and health care providers on behalf of the uninsured. Methodological detail is provided at the end of this brief.

We estimate that if the ACA is partially repealed through a budget reconciliation

bill similar to the one passed by Congress in January 2016, the number of uninsured people in 2019 would be more than double that under the ACA, increasing from 28.9 million to 58.7 million (table 1).⁴ This coverage loss is larger than the estimated coverage gains stemming from the ACA because partial repeal of this type would unravel the private nongroup insurance market. This unraveling would be caused by three forces: the elimination of financial assistance allowing lower-income, typically healthy nongroup enrollees to afford coverage; the elimination of the individual mandate's incentives for healthier individuals to purchase and retain insurance; and the retention of requirements for insurers to sell coverage to all would-be purchasers without discrimination by health status. The resulting decrease in coverage among many healthy enrollees would lead to an upward spiral in premiums and a downward spiral in coverage in these markets. These changes would be both dramatic and swift.

Table 1. Health Insurance Coverage Distribution of the Nonelderly under the ACA and the Anticipated Reconciliation Bill, 2019

	ACA (current law)		Reconciliation Bill		Difference (thousands)
	People (millions)	Share of US total	People (millions)	Share of US total	
<i>Insured</i>	245.4	89%	215.6	79%	-29.8
Employer	149.0	54%	149.8	55%	0.9
Nongroup (eligible for tax credit)	9.3	3%	0.0	0%	-9.3
Nongroup (other)	10.0	4%	1.6	1%	-8.4
Medicaid/CHIP	68.6	25%	55.6	20%	-12.9
Other (including Medicare)	8.6	3%	8.6	3%	0.0
<i>Uninsured</i>	28.9	11%	58.7	21%	29.8
Total	274.3	100%	274.3	100%	0.0

Source: Urban Institute analysis using HIPSM 2016.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Columns may not sum to totals because of rounding.

Health Care Spending and Uncompensated Care Sought by Provider Type, 2019

With fewer people insured, total spending on health care services would decrease. Our estimate of insurer (public and private) and household spending on health care for the nonelderly includes the following:

- Federal government spending on health care services (but not administrative costs) for Medicaid enrollees
- State government spending on health care services (but not administrative costs) for Medicaid enrollees
- Households' direct, out-of-pocket spending on health care services
- Payments by private insurers for health care claims incurred by enrollees (e.g., coverage through group and nongroup insurance policies, the latter including coverage sold inside or outside Marketplaces)

This definition of spending is different from the narrow definition of government health care spending used in our earlier analysis. Previously, we assessed the ACA's effect on federal and state spending on Medicaid (including claims and administrative costs) and Marketplace financial assistance (premium tax credits and cost-sharing reductions).

We estimate that if the ACA remained in place, about \$1.7 trillion would be spent by insurers (public and private) and households on health care for the nonelderly in 2019 (table 2). Under the anticipated reconciliation bill, health

care spending by these payers would be \$145.8 billion lower, for a total of \$1.6 trillion. About \$59.1 billion less would be spent on services provided by hospitals, \$20.0 billion less on services provided by office-based physicians, \$34.7 billion less on other health care services, and \$32.1 billion less on prescription drugs.

Appendix table 1 provides these details by state. For example, in California, health care spending by these payers would be \$17.1 billion lower in 2019, with \$6.8 billion less spent on hospital care, \$2.4 billion less spent on care delivered in physician offices, \$4.2 billion less spent on other services, and \$3.8 billion less spent on prescription drugs.

Coverage losses from partial ACA repeal have another important consequence for health care providers: an increase in the amount of uncompensated care sought by the uninsured, with no obvious source of funding.¹⁰ Only one component of uncompensated care funding would automatically increase with the number of uninsured: federal funding through the Medicare DSH program, which would increase to 2013 levels. We estimate that this increase in federal funding would be \$3.2 billion in 2019 and \$35.0 billion from 2019 to 2028, whereas the increase in uncompensated care sought would be \$88.0 billion in 2019 and \$1.1 trillion from 2019 to 2028. This automatic increase in federal funding would therefore compensate for less than 4 percent of the total increase in uncompensated care

sought by the newly uninsured, and it would accrue exclusively to hospitals.¹¹

We estimate that under the ACA, \$19.8 billion of uncompensated care would be unfunded by government programs and delivered to the uninsured by health care providers in 2019 (figure 1). State and local governments would fund \$14.1 billion in uncompensated care, and federal government programs would fund an additional \$22.6 billion.

Under the ACA, an estimated \$56.6 billion in uncompensated care would be provided to the uninsured in 2019 (table 3). The uncompensated care would be distributed as follows: \$16.4 billion in services provided by hospitals, \$7.1 billion in services provided by physician offices, \$21.8 billion in other services, and \$11.3 billion in prescription drugs.

As the number of uninsured would increase markedly under the anticipated reconciliation bill, so too would the total amount of uncompensated care sought by uninsured people. We estimate that the uninsured would seek \$144.6 billion in uncompensated care in 2019 under the anticipated reconciliation bill—an additional \$88.0 billion in care beyond the amount estimated under the ACA. Because government funding would not automatically increase to cover the amount of uncompensated care sought, \$84.8 billion of this additional \$88.0 billion would be “unfunded” uncompensated care.

Table 2. Health Care Spending by Insurers (Public and Private) and Households on the Nonelderly, with the ACA and Under the Anticipated Reconciliation Bill, 2019
Billions of dollars

	Total health care spending	Hospitals	Physician practices	Other services	Prescription drugs
Under the ACA	\$1,728.9	\$639.4	\$270.8	\$421.8	\$396.9
Under anticipated reconciliation bill	\$1,583.1	\$580.3	\$250.8	\$387.2	\$364.8
Difference	-\$145.8	-\$59.1	-\$20.0	-\$34.7	-\$32.1

Source: Urban Institute analysis using HIPSMS 2016.

Note: Health care spending includes insurance claims paid by private insurers and Medicaid and household out-of-pocket spending by the insured and the uninsured.

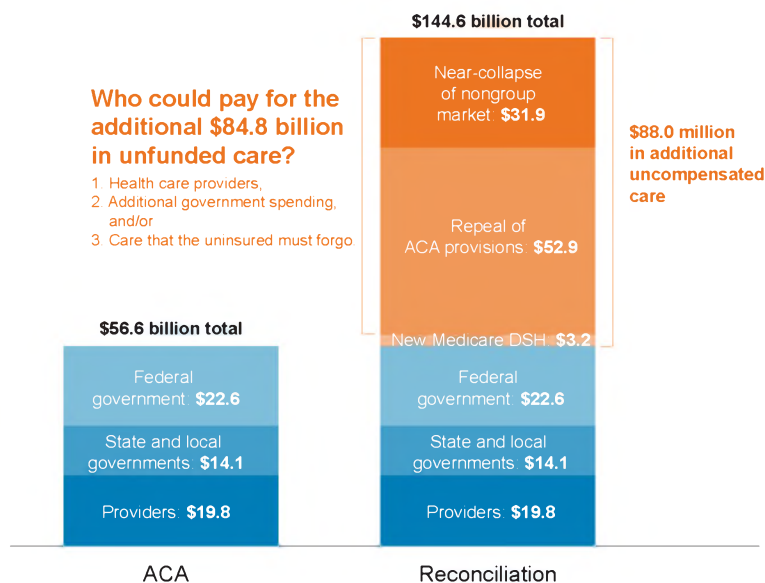
Table 3. Uncompensated Care Sought under the ACA and the Anticipated Reconciliation Bill, 2019
Billions of dollars

	Total health care spending	Hospitals	Physician practices	Other services	Prescription drugs
Under the ACA	\$56.6	\$16.4	\$7.1	\$21.8	\$11.3
Under anticipated reconciliation bill	\$144.6	\$41.0	\$19.0	\$55.4	\$29.3
Difference	\$88.0	\$24.6	\$11.9	\$33.6	\$18.0

Source: Urban Institute analysis using HIPSIM 2016.

Note: This table includes uncompensated care funded by federal, state, or local governments, and health care providers.

Figure 1. Uncompensated Care in 2019, With and Without the ACA Billions of dollars



Source: The Urban Institute. HIPSIM 2016. These estimates originally appeared in Table 5 of Blumberg, Buettgens, and Holahan, *Implications of partial Repeal of the ACA through Reconciliation*.

Of the additional \$88.0 billion in uncompensated care that would be sought under the anticipated reconciliation bill in 2019, about \$24.6 billion would be attributable to care sought in hospitals, \$11.9 billion to care sought in physician offices, \$33.6 billion to other services, and \$18.0 billion to prescription drugs. Appendix table 2 shows this distribution at the state level.

It is not at all clear whether the federal government would increase funding for uncompensated care beyond the \$3.2 billion automatic increase in Medicare DSH funding in 2019; whether state or local governments would increase their

financing of uncompensated care at all; or whether any level of government would increase funding sufficiently to compensate for the increase in care sought by the newly uninsured. The increase in Medicare DSH funding would cover less than 4 percent of the increase in uncompensated care sought. Medicaid DSH and supplemental payments support uncompensated care, but these payments are not scheduled to increase (the ACA's Medicaid DSH cuts never materialized, and our estimates assume that they would never have been implemented). Both funding sources vary greatly across states, providing substantial relief in some and much

less in others. If federal, state, and local governments do not allocate additional funding, the cost of financing the estimated increase in uncompensated care sought would be more than four times the cost of uncompensated care expected to be financed by providers under the ACA. Given the large expected increase, it is unlikely that providers could internalize these costs while remaining financially viable. Without additional government spending, the reconciliation bill would lead to bigger financial losses for providers and even larger increases in unmet health care needs among the uninsured.

Health Care Spending and Uncompensated Care Sought by Provider Type, 2019–2028

Table 4 provides 2019–2028 estimates of health care spending funded by insurers (public and private), and households that parallel the 2019 estimates in table 2. We estimate that if the ACA remains in place through 2028, about \$21.1 trillion would be spent on health care for the nonelderly from 2019 to 2028 (table 4). If, however, the anticipated reconciliation bill is passed, health care spending over that period would be \$19.5 trillion, \$1.7 trillion lower than under the ACA (table 4, figure 2). About \$596.4 billion less would be spent on services provided by hospitals, \$217.7 billion less on services provided by office-based physicians, \$416.4 billion less on services provided in other facilities, and \$428.6 billion less on prescription drugs. Appendix table 3 shows this distribution at the state level.

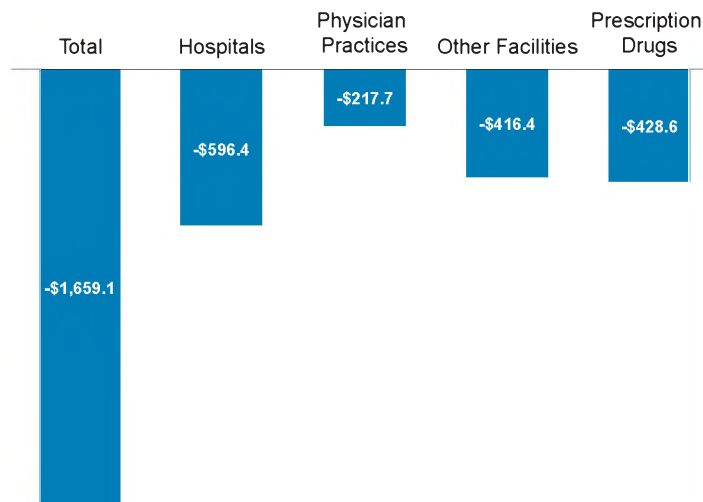
Table 4. Health Care Spending by Insurers (Public and Private) and Households on the Nonelderly, under the ACA and the Anticipated Reconciliation Bill, 2019–28
Billions of dollars

	Total health care spending	Hospitals	Physician practices	Other services	Prescription drugs
Under the ACA	\$21,134.4	\$7,783.7	\$3,263.9	\$5,172.8	\$4,914.0
Under anticipated reconciliation bill	\$19,475.3	\$7,187.3	\$3,046.2	\$4,756.4	\$4,485.4
Difference	-\$1,659.1	-\$596.4	-\$217.7	-\$416.4	-\$428.6

Source: Urban Institute analysis using HIPSMS 2016.

Note: Health care spending includes insurance claims (public and private) and household out-of-pocket spending by the insured and the uninsured.

Figure 2. Impact of Partial ACA Repeal on Health Care Spending by Insurers (Public and Private) and Households, 2019–28
Billions of dollars



Source: Urban Institute analysis using HIPSMS 2016.

Note: Health care spending includes claims paid by public and private insurers and out-of-pocket spending by both insured and uninsured households.

Table 5 provides 2019–2028 estimates of uncompensated care that parallel the 2019 estimates in table 3. We estimate that under the ACA, \$656.0 billion in uncompensated care would be provided to the uninsured from 2019 to 2028 (figure 3, table 5). Of this amount, \$190.0 billion would be spent on services provided in hospitals, \$82.7 billion on services provided in physician offices, \$252.8 billion on other services, and \$130.4 billion on prescription drugs.

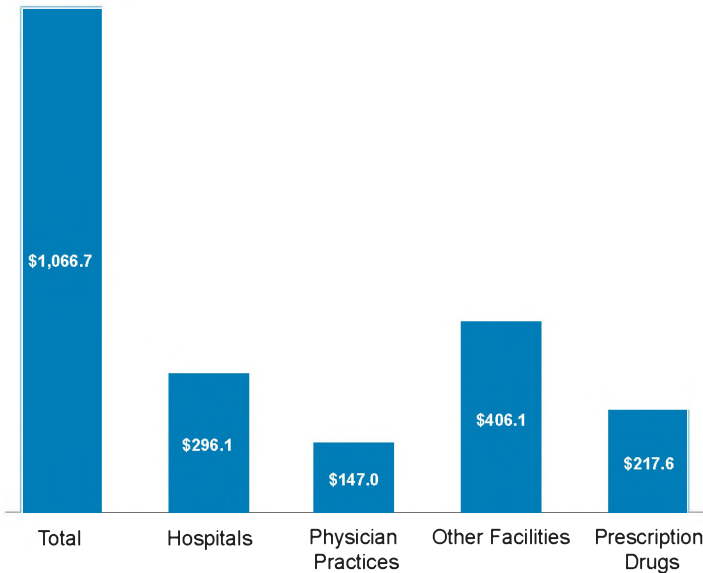
Table 5. Uncompensated Care Sought under the ACA and the Anticipated Reconciliation Bill, 2019–28 Billions of dollars

	Total health care spending	Hospitals	Physician practices	Other services	Prescription drugs
Under the ACA	\$656.0	\$190.0	\$82.7	\$252.8	\$130.4
Under anticipated reconciliation bill	\$1,722.7	\$486.1	\$229.6	\$658.9	\$348.0
Difference	\$1,066.7	\$296.1	\$147.0	\$406.1	\$217.6

Source: Urban Institute analysis using HIPSMS 2016.

Note: This table excludes uncompensated care funded by federal, state, or local governments.

Figure 3. Additional Uncompensated Care Sought As Result of Partial ACA Repeal, 2019–28 Billions of dollars



Source: Urban Institute analysis using HIPSMS 2016.

Note: Uncompensated care is funded by a mix of federal, state, and local government programs and care delivered by health care providers without outside funding. Federal funding for uncompensated care would automatically increase by \$35.0 billion over the 2019–28 period under reconciliation, less than 4% of the increase in uncompensated care that would be sought by the newly uninsured.

Under the anticipated reconciliation bill, an additional \$1.1 trillion in uncompensated care would be sought, for a total of \$1.7 trillion from 2019 to 2028. Of the \$1.1 trillion increase in care sought, \$296.1 billion would be in hospital services, \$147.0 billion in physician office services, \$406.1 billion in other services, and \$217.6 billion in prescription drugs. State-specific breakdowns of these figures are provided in appendix table 4.

A reconciliation bill similar to that passed in 2016 would increase federal funding

for uncompensated care by \$35.0 billion from 2019 to 2028, covering only a small fraction of the \$1.1 trillion increase in uncompensated care that would be sought by the newly uninsured. Federal funding for providers serving the uninsured could increase if legislative action is taken, but this is currently not anticipated. States and localities could also increase funding. If funds were increased but not commensurate with the increase in the uninsured, financial pressures on providers would increase substantially, and unmet medical needs

among the uninsured would climb as well. The large projected increases in uncompensated care sought, relative to current support provided by governments and health care providers, suggests that these payers could not absorb much of the additional need.

How Does the Recent Hospital Industry Analysis Compare to the Urban Institute Analysis?

A recent report commissioned by the American Hospital Association and the Federation of American Hospitals also examined the impact of ACA repeal on hospitals.⁹ They estimated that repeal would have substantial adverse effects on hospital finances, but their study differs notably from ours in methods, assumptions, and focus. In particular, they estimate that net hospital revenue would be reduced by \$165.8 billion from 2018 to 2026, assuming restoration of Medicaid DSH payments.

There are several important differences between our analysis and the hospital industry study. First, their study focused on hospital finances and net revenue, including detailed analyses of hospital payment provisions under the ACA and what may happen under repeal. Our analysis is broader, including revenue for nonhospital providers, highlighting the increased demand for uncompensated care from those who would lose their health coverage, and accounting for uncertainty about how much of that demand would be met. We do not estimate provider costs or net revenue.

Second, the industry analysis assumed that ACA repeal would bring coverage back to 2013 levels. However, we estimate that the number of uninsured would be significantly higher than that in 2013 because Senate budget reconciliation rules permit the elimination of the individual mandate and financial assistance for Marketplace coverage but not repeal of the nongroup insurance market reforms (e.g., guaranteed issue, modified community premium rating, prohibitions on pre-existing condition exclusions, and requirements that all plans cover essential benefits). As a result, the nongroup market would largely collapse. Moreover, health care cost growth would lead to a gradual erosion of private insurance coverage over time; this trend has been observed for decades. Without the ACA, losses in private coverage would coincide with gradual increases in the uninsured and in Medicaid enrollment.

Third, we follow the MEPS-HC categorization of health care costs into hospital, physician, prescription drugs, and other services. The MEPS-HC levels of spending and categorization may not entirely agree with the industry's approach to measuring hospital care.

Discussion

We estimate that a reconciliation bill like that passed by Congress in January 2016 would increase the number of uninsured by 29.8 million people in 2019. Fewer insured people means lower spending on health care services; lower spending on health care services means lower revenue for health care providers and fewer services rendered. We estimate that from 2019 to 2028, insurers (public and private) and households would spend \$1.7 trillion less on health care services for the nonelderly under the anticipated reconciliation bill than under the ACA. Of that total, spending on hospitals would be \$596.4 billion lower, spending on services provided in physician offices would be \$217.7 billion lower, spending on other services would be \$416.4 billion lower, and spending on prescription drugs would be \$428.6 billion lower than under the ACA.

The January 2016 reconciliation bill would have restored the ACA's cuts to federal Medicare DSH payments totaling \$22 billion between 2014 and 2019 (\$3.7 billion per year on average). Though this would have eliminated the federal Medicaid DSH cuts included in the ACA, those cuts had already been delayed and have yet to be implemented. This analysis assumes that the Medicaid DSH cuts would never have been implemented under the ACA. Even so, the increase in federal funding with restoration of the Medicare DSH cuts would only fund \$3.2 billion of the \$88.0 billion increase in uncompensated care that would be sought in 2019. Because Congress is likely to seek cuts in federal spending, it is unclear if additional funds for uncompensated care would be forthcoming. State and local governments may be able to increase funding for uncompensated care modestly, but they also face difficult budget constraints. The expected increase in uncompensated care sought under reconciliation is more than four times the value of current uncompensated care financed by providers, so providers probably could not absorb the costs and remain financially viable. Their provision of free and reduced-price care would surely increase to some extent, but the amount of unmet need for health care services would also increase considerably without a substantial increase in federal funding to support it.

Methods

The results in this brief are based on our earlier report estimating the coverage and cost implications of partial ACA repeal through budget reconciliation.⁴ In this brief, we separate each individual's health care spending into four categories: hospital expenditures (including inpatient, outpatient, and emergency room care), physician expenditures, expenditures on prescription drugs, and all other spending for insurance-covered services (including health care services delivered by providers other than hospitals and office-based physicians and additional services such as dental care, home health care, and other medical equipment).

The estimation of health care costs for individuals with various types of insurance and the estimation of uncompensated care

are basic features of the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). Health care spending data used in HIPSM come from the Medical Expenditure Panel Survey-Household Component (MEPS-HC) as well as other sources. Details are available in the HIPSM methodology documentation.¹² We estimate total health care spending for each person represented in HIPSM for each possible health insurance status; these estimates of spending control for a broad array of sociodemographic variables and health statuses. Using the MEPS-HC, we then compute the share of individual health expenditures attributable to each type of care (hospital, office-based physician, prescription drugs, other) by individual characteristics: health insurance coverage, age, gender, income, and health status. The percentage splits of spending across provider types are then imputed to the individuals represented in HIPSM.

The MEPS-HC separates the amount spent on care by the uninsured themselves, so we are able to estimate how much health care spending for each type of service on behalf of the uninsured is self-paid and how much is attributable to uncompensated care. Uncompensated care is care delivered to uninsured people that is financed by government programs or is contributed by the health care providers themselves as free care. A recent study found that in 2013, people uninsured for a full year paid for an average of 30 percent of the care they received; the other 70 percent of health care spending on their behalf was attributable to uncompensated care.¹³ Our analysis for this study found consistent results, with 31 percent of care provided to the uninsured financed directly by the uninsured themselves and 69 percent financed by federal, state, or local governments or by providers.

We predict the amount of uncompensated care that each newly uninsured person would seek, controlling for age, gender, income, health status, and other sociodemographic characteristics. The prediction model is estimated using 2013 MEPS-HC data, where the dependent variable is the value of uncompensated care received by each uninsured person

that year.¹⁴ We use this estimated equation to predict the value of uncompensated health care services that each insured individual *would seek* if he or she were to become uninsured. As explained in the results, current patterns of use of uncompensated care may not persist if, for example, large increases in the number of uninsured are not met by commensurate increases in government funding or in provider contributions of free or reduced-price care. As a result, we refer to the estimated amounts of care based on recent patterns of use of uncompensated care as the value of the care the newly uninsured *would seek*, not the value of the uncompensated care they would actually *receive*. Levels of uncompensated care sought are inflated by per capita growth

in health care expenditures to 2019 and beyond.

Uncompensated care is currently funded in a number of ways:

- Medicaid disproportionate share hospital (DSH) and upper payment limit programs
- Medicare DSH payments
- The Veterans Health Administration
- Other federal programs
- State and local government programs
- Private programs, such as the patient assistance programs that provide free or reduced-cost prescription drugs to qualifying individuals
- Charity care and bad debt absorbed by health care providers

Coughlin and colleagues estimated that about 39 percent of uncompensated care in 2013 was funded by the federal government through programs such as Medicaid and Medicare DSH payments, 24 percent was funded by state and local governments, and 37 percent was funded by health care providers.¹³ Aside from the restoration of federal Medicare DSH funding cuts, we do not make assumptions about the source of funding for increased uncompensated care under an anticipated reconciliation bill, since it is unclear how willing or able the different levels of government and the providers would be to increase funding for such care in the future.

Appendix

Appendix Table 1. Health Care Spending by Insurers (Public and Private) and Households on the Nonelderly in 2019 by State, Under the ACA and the Anticipated Reconciliation Bill (Millions \$)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
National	1,728,947	639,409	270,767	421,838	396,933	1,583,100	580,317	250,798	387,179	364,807	-145,847	-59,092	-19,969	-34,660	-32,125
Expansion States	1,101,757	406,232	171,001	270,568	253,955	1,011,667	370,664	159,316	248,158	233,529	-90,090	-35,568	-11,685	-22,410	-20,426
AK	5,289	1,946	826	1,326	1,192	4,895	1,790	766	1,232	1,107	-394	-155	-60	-93	-85
AZ	36,507	13,658	5,490	8,908	8,450	32,496	12,066	5,016	7,897	7,516	-4,011	-1,592	-474	-1,011	-934
AR	14,280	5,309	2,226	3,444	3,301	13,144	4,809	2,080	3,181	3,074	-1,137	-500	-146	-263	-228
CA	196,962	72,135	31,353	48,447	45,027	179,848	65,349	29,002	44,229	41,269	-17,115	-6,787	-2,351	-4,218	-3,758
CO	27,382	9,936	4,277	6,831	6,339	24,136	8,667	3,853	6,015	5,601	-3,246	-1,269	-424	-815	-738
CT	26,145	9,478	4,131	6,508	6,029	24,762	8,961	3,941	6,155	5,706	-1,383	-517	-190	-353	-323
DE	5,644	2,078	874	1,385	1,306	5,363	1,969	836	1,318	1,241	-281	-109	-39	-67	-65
DC	4,423	1,630	662	1,101	1,031	4,303	1,591	647	1,064	1,001	-121	-40	-14	-37	-30
HI	8,050	3,040	1,259	1,922	1,829	7,562	2,848	1,198	1,804	1,712	-488	-193	-61	-118	-116
IL	71,872	26,460	11,327	17,700	16,385	66,732	24,382	10,678	16,453	15,219	-5,140	-2,078	-649	-1,247	-1,167
IN	36,086	13,390	5,658	8,682	8,356	33,642	12,397	5,325	8,104	7,817	-2,443	-993	-333	-578	-539
IA	16,346	5,953	2,597	4,040	3,756	15,604	5,641	2,496	3,866	3,601	-742	-312	-101	-174	-155
KY	25,995	9,694	3,912	6,328	6,061	21,766	7,995	3,412	5,276	5,083	-4,230	-1,699	-500	-1,053	-978
LA	23,751	8,862	3,596	5,768	5,525	20,952	7,741	3,256	5,068	4,888	-2,798	-1,121	-340	-700	-637
MD	36,204	13,254	5,745	9,020	8,185	33,537	12,237	5,400	8,334	7,566	-2,667	-1,017	-345	-686	-619
MA	48,373	17,639	7,683	12,007	11,045	46,158	16,804	7,380	11,440	10,535	-2,215	-835	-304	-566	-510
MI	54,403	20,370	8,324	13,079	12,631	50,200	18,685	7,783	12,044	11,688	-4,203	-1,685	-541	-1,035	-943
MN	32,806	11,971	5,080	8,184	7,571	31,426	11,429	4,890	7,840	7,266	-1,379	-541	-190	-343	-304
MT	5,636	2,111	857	1,366	1,301	4,664	1,722	740	1,125	1,077	-972	-390	-117	-241	-224
NV	14,767	5,454	2,327	3,557	3,429	12,821	4,686	2,069	3,084	2,982	-1,945	-768	-258	-473	-446
NH	9,154	3,359	1,466	2,244	2,084	8,615	3,147	1,395	2,113	1,961	-538	-212	-71	-131	-124
NJ	49,357	17,754	7,614	12,447	11,543	43,321	15,436	6,850	10,916	10,118	-6,035	-2,317	-763	-1,530	-1,424
NM	13,641	5,087	2,046	3,391	3,117	11,116	4,142	1,736	2,712	2,527	-2,524	-945	-310	-679	-590
NY	115,282	42,878	17,155	28,430	26,818	110,171	40,869	16,444	27,180	25,679	-5,110	-2,010	-712	-1,250	-1,139
ND	3,705	1,343	592	922	848	3,365	1,203	545	843	774	-341	-140	-47	-80	-74
OH	66,997	24,957	10,279	16,194	15,568	61,968	22,950	9,664	14,939	14,415	-5,029	-2,006	-615	-1,255	-1,153
OR	23,869	8,882	3,628	5,848	5,511	20,538	7,603	3,229	4,987	4,718	-3,332	-1,279	-399	-861	-793
PA	65,552	24,181	10,160	15,971	15,240	61,603	22,599	9,607	15,036	14,361	-3,949	-1,581	-554	-936	-879
RI	8,006	3,018	1,235	1,941	1,812	7,247	2,738	1,139	1,735	1,634	-758	-280	-95	-205	-177

Appendix Table 1 (continued)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
VT	4,755	1,750	738	1,168	1,099	4,566	1,677	713	1,120	1,056	-189	-73	-25	-48	-43
WA	40,221	14,779	6,333	9,936	9,173	36,041	13,132	5,817	8,875	8,217	-4,180	-1,648	-516	-1,061	-956
WV	10,296	3,877	1,551	2,473	2,395	9,101	3,400	1,410	2,172	2,120	-1,195	-477	-141	-301	-275
Non-Expansion States	627,190	233,177	99,766	151,270	142,977	571,434	209,653	91,482	139,020	131,278	-55,757	-23,524	-8,284	-12,249	-11,699
AL	22,391	8,275	3,621	5,403	5,091	20,899	7,619	3,400	5,080	4,800	-1,491	-656	-221	-323	-291
FL	95,920	35,791	15,004	22,819	22,307	84,311	30,891	13,283	20,314	19,822	-11,609	-4,899	-1,721	-2,505	-2,485
GA	51,789	19,316	8,276	12,437	11,761	46,735	17,165	7,533	11,332	10,704	-5,054	-2,150	-742	-1,105	-1,056
ID	8,391	3,180	1,299	2,008	1,905	7,626	2,844	1,183	1,846	1,753	-765	-336	-115	-162	-152
KS	14,211	5,246	2,294	3,458	3,214	13,362	4,872	2,169	3,276	3,045	-849	-374	-125	-181	-169
ME	8,774	3,241	1,376	2,113	2,044	8,217	3,013	1,290	1,992	1,923	-556	-229	-86	-121	-121
MS	14,627	5,556	2,267	3,454	3,350	13,365	5,013	2,086	3,178	3,087	-1,262	-543	-181	-276	-263
MO	34,128	12,762	5,375	8,146	7,845	31,354	11,604	4,962	7,529	7,258	-2,774	-1,157	-413	-617	-587
NE	9,564	3,497	1,553	2,341	2,173	8,950	3,237	1,456	2,207	2,049	-615	-260	-97	-134	-124
NC	56,774	21,264	8,903	13,621	12,987	50,024	18,460	7,926	12,115	11,523	-6,750	-2,804	-976	-1,506	-1,464
OK	19,247	7,196	3,029	4,620	4,401	18,118	6,709	2,862	4,372	4,175	-1,129	-488	-167	-248	-226
SC	23,895	8,961	3,758	5,681	5,496	22,271	8,270	3,508	5,330	5,164	-1,625	-691	-250	-351	-332
SD	4,434	1,639	702	1,088	1,004	4,151	1,522	659	1,022	948	-283	-118	-43	-65	-57
TN	34,246	12,862	5,323	8,206	7,856	31,246	11,645	4,911	7,482	7,208	-3,000	-1,218	-412	-724	-647
TX	135,557	50,380	21,883	32,919	30,374	123,963	45,447	20,126	30,401	27,989	-11,594	-4,933	-1,757	-2,518	-2,385
UT	13,890	5,078	2,253	3,496	3,062	12,980	4,693	2,113	3,293	2,881	-910	-385	-140	-203	-182
VA	44,389	16,190	7,281	10,911	10,007	41,194	14,856	6,791	10,210	9,337	-3,194	-1,334	-490	-701	-670
WI	31,775	11,601	5,060	7,758	7,356	29,798	10,778	4,765	7,319	6,936	-1,977	-823	-296	-438	-420
WY	3,189	1,141	509	795	744	2,870	1,014	458	722	676	-319	-127	-51	-73	-68

Source: Urban Institute analysis, HIPSM 2016.

Note: Includes insurance claims (via Medicaid and private insurance policies) and household out-of-pocket health spending by the insured and the uninsured.

Other services includes: health care services delivered by providers other than hospitals and office-based physicians and additional services, such as dental care, home health care, and other medical equipment.

Appendix Table 2. Uncompensated Care Sought by the Uninsured, 2019, Under the ACA and the Anticipated Reconciliation Bill (Millions \$)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
National	56,564	16,379	7,103	21,808	11,274	144,607	40,977	18,997	55,380	29,254	88,043	24,598	11,894	33,572	17,980
Expansion States	29,497	8,408	3,726	11,492	5,871	85,033	24,107	11,207	32,624	17,095	55,536	15,699	7,481	21,132	11,224
AK	319	95	40	118	65	468	135	61	176	96	149	40	21	58	30
AZ	1,692	470	222	678	321	3,449	963	456	1,348	682	1,757	492	234	670	361
AR	665	180	74	276	135	1,741	487	205	696	352	1,076	307	131	420	217
CA	5,979	1,660	779	2,342	1,199	18,066	4,973	2,416	7,016	3,662	12,087	3,313	1,637	4,674	2,463
CO	1,119	280	136	476	227	3,098	789	410	1,259	641	1,979	510	273	783	414
CT	442	119	61	178	84	1,616	426	227	654	308	1,175	307	167	477	224
DE	119	31	15	52	21	331	81	41	146	63	212	50	26	93	42
DC	78	27	13	25	14	181	52	29	64	35	102	25	16	40	21
HI	138	38	21	53	25	345	96	51	133	65	208	58	29	80	40
IL	2,029	600	249	774	405	6,319	1,872	838	2,323	1,285	4,290	1,272	589	1,549	880
IN	1,189	375	151	434	229	3,129	1,021	390	1,127	592	1,940	646	239	693	363
IA	345	99	39	144	63	1,197	339	160	464	234	851	239	120	320	171
KY	578	166	67	231	114	1,916	580	240	726	370	1,338	414	173	494	257
LA	837	241	106	328	163	2,428	723	310	913	482	1,591	483	204	585	319
MD	668	188	88	265	127	2,011	579	264	777	392	1,343	391	175	512	265
MA	361	107	43	140	71	1,716	491	242	655	327	1,355	384	200	515	256
MI	1,427	414	159	571	284	4,457	1,272	532	1,767	887	3,030	858	373	1,196	604
MN	931	258	104	380	190	2,970	805	374	1,181	610	2,039	548	270	801	420
MT	319	85	40	133	61	800	225	103	316	156	481	140	63	183	95
NV	577	162	74	229	111	1,581	441	208	621	311	1,005	279	134	392	200
NH	131	38	17	49	28	524	146	66	210	102	393	109	49	161	74
NJ	1,078	306	145	405	222	3,286	914	451	1,258	663	2,208	608	306	853	441
NM	350	97	46	135	71	954	272	127	362	194	604	174	81	226	123
NY	2,719	818	360	1,003	538	6,291	1,825	855	2,361	1,250	3,572	1,007	495	1,358	712
ND	83	25	10	33	14	371	102	53	141	74	288	77	43	107	60
OH	1,400	404	176	533	287	4,118	1,223	554	1,505	836	2,718	819	378	972	549
OR	605	177	76	232	120	2,060	605	274	770	411	1,455	428	198	538	291
PA	1,671	504	210	634	323	4,192	1,220	556	1,571	845	2,521	715	346	937	522
RI	79	22	10	33	14	340	88	46	137	68	261	67	36	104	54
VT	102	26	12	42	22	308	77	39	122	69	206	51	27	81	47

Appendix Table 2 (continued)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
WA	1,200	322	150	474	254	4,004	1,076	532	1,546	850	2,804	753	382	1,073	596
WV	267	72	33	93	69	767	207	96	279	185	500	135	64	186	115
Non-Expansion States	27,067	7,971	3,377	10,316	5,403	59,574	16,870	7,789	22,756	12,158	32,508	8,899	4,413	12,440	6,756
Alabama	880	275	102	317	186	1,930	556	238	715	421	1,050	282	136	398	235
Florida	5,004	1,409	635	1,953	1,007	11,453	3,103	1,464	4,556	2,330	6,450	1,694	829	2,603	1,323
Georgia	2,278	675	293	861	449	4,774	1,353	634	1,812	975	2,497	678	342	951	526
Idaho	428	131	55	159	84	981	266	139	371	204	552	135	84	212	121
Kansas	624	212	79	221	113	1,549	504	207	550	288	924	292	128	329	175
Maine	229	63	28	91	47	704	198	83	280	143	475	135	54	189	96
Mississippi	858	261	98	314	185	1,608	480	197	589	342	751	219	99	275	158
Missouri	1,388	402	162	552	271	3,319	914	428	1,296	681	1,932	512	266	744	410
Nebraska	348	95	40	147	65	920	247	129	363	181	572	152	89	215	116
North Carolina	1,713	530	214	635	334	4,562	1,348	624	1,675	915	2,849	818	410	1,039	581
Oklahoma	1,432	441	182	534	275	2,462	748	328	908	478	1,030	306	147	374	203
South Carolina	1,034	313	126	383	213	1,937	564	248	728	396	902	252	122	345	183
South Dakota	193	57	24	73	38	453	132	59	171	91	260	75	35	97	52
Tennessee	1,273	380	155	470	268	2,709	780	351	1,002	576	1,436	400	196	532	308
Texas	5,829	1,737	756	2,206	1,130	11,712	3,389	1,545	4,445	2,333	5,883	1,652	789	2,239	1,203
Utah	747	203	94	295	155	1,569	441	210	600	318	822	238	116	305	163
Virginia	1,857	519	221	732	384	4,255	1,107	552	1,678	917	2,398	589	331	946	533
Wisconsin	761	212	90	299	159	2,336	645	308	889	495	1,575	433	217	590	336
Wyoming	191	57	21	73	40	340	94	45	129	73	149	37	23	57	33

Source: Urban Institute analysis, HIPSMS 2016.

Note: This table includes uncompensated care funded by federal, state, or local governments, and health care providers. Federal funding for uncompensated care would automatically increase by \$3.2 billion in 2019 under reconciliation, less than 4% of the increase in uncompensated care that would be sought by the newly uninsured.

Other services includes: health care services delivered by providers other than hospitals and office-based physicians and additional services, such as dental care, home health care, and other medical equipment.

Appendix Table 3. Health Care Spending by Insurers (Public and Private) and Households on the Nonelderly 2019-2028 by State, Under the ACA and the Anticipated Reconciliation Bill (Millions \$)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
National	21,134,414	7,783,738	3,263,926	5,172,756	4,913,994	19,475,296	7,187,318	3,046,200	4,756,389	4,485,389	-1,659,118	-596,419	-217,727	-416,367	-428,605
Expansion States	13,527,113	4,988,901	2,066,293	3,327,934	3,143,985	12,369,686	4,564,907	1,919,781	3,028,723	2,856,275	-1,157,427	-423,994	-146,512	-299,211	-287,710
AK	66,369	24,398	10,205	16,728	15,037	62,321	22,990	9,632	15,721	13,978	-4,047	-1,408	-573	-1,007	-1,059
AZ	486,831	182,660	71,788	118,937	113,447	428,548	160,293	65,093	104,071	99,091	-58,283	-22,366	-6,695	-14,866	-14,356
AR	178,277	66,202	27,509	43,103	41,464	163,327	60,203	25,618	39,524	37,982	-14,951	-5,999	-1,891	-3,579	-3,482
CA	2,355,330	856,913	370,565	581,492	546,360	2,168,642	792,855	345,820	531,795	498,172	-186,689	-64,058	-24,745	-49,697	-48,189
CO	348,517	126,846	53,573	87,047	81,052	301,811	108,994	47,551	75,166	70,100	-46,706	-17,852	-6,022	-11,881	-10,952
CT	313,043	113,684	48,648	77,949	72,763	295,210	107,731	46,219	73,213	68,046	-17,834	-5,953	-2,430	-4,735	-4,716
DE	70,536	26,011	10,748	17,338	16,439	66,458	24,547	10,199	16,369	15,343	-4,078	-1,464	-549	-970	-1,095
DC	58,896	21,572	8,622	14,729	13,973	56,778	20,837	8,378	14,119	13,444	-2,118	-734	-245	-611	-528
HI	98,276	37,138	15,198	23,559	22,380	91,463	34,540	14,378	21,872	20,673	-6,812	-2,598	-821	-1,687	-1,707
IL	875,525	322,225	136,072	216,141	201,088	810,293	297,669	128,038	199,719	184,867	-65,232	-24,555	-8,034	-16,422	-16,220
IN	439,216	163,469	67,819	105,473	102,455	407,861	151,546	63,681	97,902	94,733	-31,354	-11,923	-4,138	-7,571	-7,723
IA	198,659	72,586	31,117	49,192	45,765	189,071	68,982	29,815	46,797	43,478	-9,588	-3,604	-1,302	-2,395	-2,287
KY	325,183	121,500	48,135	79,375	76,173	266,066	98,437	41,195	64,382	62,052	-59,117	-23,063	-6,940	-14,993	-14,121
LA	292,463	109,128	43,518	71,177	68,640	256,011	95,164	39,228	61,891	59,728	-36,452	-13,964	-4,291	-9,285	-8,912
MD	450,080	164,755	70,450	112,642	102,233	415,894	152,683	66,161	103,471	93,579	-34,185	-12,071	-4,289	-9,171	-8,654
MA	575,790	209,787	90,041	143,294	132,669	555,395	203,678	87,400	137,211	127,107	-20,395	-6,109	-2,641	-6,083	-5,562
MI	644,522	241,448	97,006	155,268	150,799	593,857	222,962	90,705	142,137	138,052	-50,665	-18,486	-6,301	-13,131	-12,747
MN	416,492	152,888	63,251	103,757	96,596	397,003	145,562	60,594	98,680	92,167	-19,490	-7,326	-2,657	-5,077	-4,430
MT	71,259	26,762	10,674	17,294	16,529	57,670	21,493	9,051	13,897	13,228	-13,589	-5,268	-1,623	-3,397	-3,301
NV	192,471	70,903	30,012	46,382	45,175	165,094	60,716	26,442	39,520	38,416	-27,377	-10,187	-3,570	-6,862	-6,758
NH	105,960	38,738	16,795	26,137	24,290	100,168	36,712	16,058	24,632	22,767	-5,792	-2,027	-737	-1,505	-1,523
NJ	605,292	218,211	91,728	152,677	142,677	522,658	187,974	81,373	131,314	121,997	-82,634	-30,237	-10,355	-21,363	-20,680
NM	179,877	67,030	26,671	44,979	41,197	143,033	53,462	22,154	35,044	32,373	-36,844	-13,568	-4,518	-9,935	-8,823
NY	1,454,420	542,489	212,205	358,709	341,017	1,389,795	519,288	203,251	342,178	325,078	-64,625	-23,201	-8,953	-16,531	-15,939
ND	44,398	16,106	6,994	11,061	10,238	40,341	14,566	6,438	10,078	9,259	-4,058	-1,540	-555	-983	-979
OH	805,987	301,507	121,512	194,699	188,270	738,131	275,722	113,361	177,458	171,591	-67,857	-25,786	-8,151	-17,241	-16,679
OR	299,237	111,189	44,669	73,645	69,734	251,710	93,726	39,015	61,090	57,879	-47,527	-17,463	-5,654	-12,555	-11,856
PA	798,290	295,276	121,754	194,544	186,715	749,910	277,862	115,145	182,458	174,446	-48,379	-17,414	-6,609	-12,087	-12,269
RI	98,664	37,327	14,966	23,891	22,480	87,892	33,519	13,604	20,972	19,796	-10,771	-3,807	-1,361	-2,919	-2,684

Appendix Table 3 (continued)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
VT	55,700	20,398	8,521	13,784	12,997	53,840	19,904	8,258	13,251	12,428	-1,859	-494	-263	-532	-570
WA	497,031	182,841	77,064	122,940	114,186	435,237	159,569	69,387	107,035	99,245	-61,794	-23,272	-7,677	-15,905	-14,941
WV	124,521	46,914	18,464	29,994	29,148	108,198	40,719	16,540	25,759	25,180	-16,323	-6,196	-1,924	-4,235	-3,968
Non-Expansion States	7,607,301	2,794,837	1,197,633	1,844,822	1,770,009	7,105,609	2,622,411	1,126,418	1,727,666	1,629,114	-501,691	-172,425	-71,215	-117,156	-140,895
AL	264,363	96,221	42,551	64,317	61,273	250,463	91,393	40,586	61,116	57,368	-13,900	-4,828	-1,965	-3,201	-3,906
FL	1,131,583	412,566	174,687	271,668	272,662	1,038,052	382,404	161,581	250,097	243,971	-93,531	-30,162	-13,106	-21,572	-28,691
GA	638,338	235,055	100,984	153,951	148,348	589,982	217,741	94,261	142,992	134,988	-48,356	-17,315	-6,722	-10,959	-13,361
ID	105,373	39,701	16,068	25,267	24,337	96,698	36,359	14,815	23,399	22,126	-8,675	-3,342	-1,253	-1,868	-2,211
KS	168,996	62,031	27,046	41,290	38,629	160,467	58,854	25,825	39,378	36,410	-8,529	-3,177	-1,222	-1,911	-2,219
ME	99,838	36,435	15,411	24,236	23,756	95,411	35,139	14,771	23,150	22,351	-4,428	-1,297	-640	-1,086	-1,405
MS	175,227	66,035	26,832	41,592	40,768	163,424	61,625	25,235	38,902	37,661	-11,803	-4,410	-1,597	-2,690	-3,106
MO	407,623	150,819	63,440	97,767	95,597	382,082	142,274	59,753	91,690	88,365	-25,541	-8,544	-3,688	-6,077	-7,232
NE	112,693	40,683	18,143	27,782	26,085	107,565	39,168	17,313	26,465	24,619	-5,128	-1,515	-829	-1,317	-1,466
NC	690,424	255,307	107,006	166,643	161,468	626,308	232,609	98,325	151,533	143,841	-64,116	-22,698	-8,681	-15,111	-17,627
OK	234,960	87,163	36,639	56,663	54,494	225,744	84,020	35,333	54,527	51,864	-9,216	-3,143	-1,306	-2,136	-2,630
SC	284,050	105,197	44,197	67,956	66,700	272,965	101,726	42,577	65,425	63,237	-11,085	-3,470	-1,620	-2,532	-3,463
SD	54,498	20,160	8,517	13,402	12,419	51,490	19,058	8,066	12,691	11,675	-3,008	-1,102	-451	-711	-744
TN	425,962	159,140	65,373	102,404	99,045	389,781	146,230	60,579	93,220	89,752	-36,181	-12,910	-4,794	-9,184	-9,293
TX	1,693,764	623,560	271,201	412,794	386,209	1,592,834	587,818	256,401	389,839	358,776	-100,930	-35,743	-14,799	-22,955	-27,434
UT	178,415	64,787	28,535	45,024	40,070	168,290	61,060	27,010	42,653	37,566	-10,125	-3,727	-1,525	-2,370	-2,504
VA	532,457	191,874	86,806	131,912	121,866	507,447	184,052	83,075	125,806	114,514	-25,009	-7,822	-3,730	-6,106	-7,352
WI	371,303	134,875	58,312	90,778	87,338	352,746	128,910	55,566	86,209	82,061	-18,557	-5,965	-2,746	-4,569	-5,277
WY	37,432	13,228	5,886	9,377	8,942	33,861	11,972	5,346	8,574	7,968	-3,572	-1,256	-540	-802	-974

Source: Urban Institute analysis, HIPS 2016.

Note: Includes insurance claims (via Medicaid and private insurance policies) and household out-of-pocket health spending by the insured and the uninsured.

Other services includes: health care services delivered by providers other than hospitals and office-based physicians and additional services, such as dental care, home health care, and other medical equipment.

Appendix Table 4. Uncompensated Care Sought by the Uninsured, 2019-2028 by State, Under the ACA and the Anticipated Reconciliation Bill (Millions \$)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
National	655,979	190,031	82,686	252,829	130,434	1,722,656	486,145	229,636	658,888	347,987	1,066,677	296,114	146,950	406,059	217,554
Expansion States	339,888	96,894	43,113	132,407	67,474	1,016,095	286,968	136,282	388,701	204,144	676,208	190,074	93,169	256,294	136,671
AK	3,693	1,107	457	1,372	756	5,399	1,540	712	2,053	1,094	1,707	433	255	681	338
AZ	20,213	5,652	2,660	8,090	3,810	41,432	11,604	5,531	16,146	8,151	21,219	5,952	2,871	8,055	4,341
AR	7,489	2,046	839	3,084	1,520	20,280	5,711	2,441	8,037	4,092	12,791	3,665	1,602	4,952	2,572
CA	68,157	18,951	8,897	26,667	13,643	208,295	57,011	28,269	80,607	42,409	140,138	38,060	19,371	53,940	28,766
CO	12,932	3,226	1,592	5,483	2,631	38,215	9,683	5,082	15,515	7,934	25,283	6,457	3,490	10,032	5,303
CT	5,088	1,406	693	2,036	953	19,963	5,283	2,858	8,133	3,689	14,875	3,877	2,165	6,096	2,737
DE	1,345	353	169	588	235	4,155	1,079	525	1,745	805	2,809	727	355	1,157	570
DC	810	275	128	256	152	2,518	688	381	955	495	1,708	413	253	699	343
HI	1,580	436	248	610	286	4,337	1,139	617	1,708	873	2,757	703	369	1,098	587
IL	23,186	6,835	2,871	8,848	4,631	77,732	22,751	10,503	28,613	15,865	54,547	15,916	7,632	19,765	11,233
IN	13,831	4,367	1,764	5,047	2,653	36,984	11,932	4,705	13,308	7,039	23,154	7,565	2,942	8,260	4,386
IA	4,150	1,203	492	1,702	754	14,764	4,162	2,038	5,661	2,902	10,614	2,960	1,547	3,959	2,148
KY	6,627	1,905	771	2,649	1,302	22,240	6,730	2,796	8,477	4,237	15,613	4,825	2,025	5,828	2,935
LA	9,331	2,681	1,184	3,651	1,816	26,893	7,986	3,459	10,097	5,350	17,562	5,305	2,275	6,446	3,535
MD	7,944	2,256	1,056	3,133	1,499	23,926	6,875	3,173	9,259	4,620	15,982	4,619	2,117	6,126	3,121
MA	4,182	1,248	496	1,619	819	21,317	6,088	3,030	8,201	3,998	17,135	4,841	2,534	6,582	3,178
MI	15,763	4,581	1,771	6,286	3,126	51,168	14,565	6,318	20,084	10,201	35,405	9,984	4,547	13,799	7,075
MN	10,491	2,904	1,184	4,274	2,129	35,030	9,714	4,430	13,761	7,126	24,539	6,810	3,246	9,487	4,997
MT	3,731	996	477	1,530	727	8,848	2,502	1,163	3,450	1,733	5,117	1,505	686	1,920	1,005
NV	7,123	1,999	932	2,826	1,366	20,129	5,542	2,690	7,870	4,027	13,006	3,543	1,758	5,044	2,661
NH	1,489	425	196	554	314	6,292	1,715	819	2,491	1,267	4,802	1,290	623	1,937	953
NJ	12,447	3,535	1,684	4,687	2,541	41,417	11,586	5,805	15,717	8,309	28,970	8,051	4,121	11,030	5,768
NM	4,002	1,108	527	1,556	811	10,632	3,012	1,423	4,031	2,166	6,630	1,905	896	2,475	1,355
NY	31,125	9,345	4,132	11,496	6,152	78,548	22,648	10,854	29,550	15,497	47,423	13,303	6,721	18,054	9,345
ND	984	289	122	396	177	4,874	1,344	715	1,845	970	3,890	1,055	593	1,449	793
OH	15,862	4,588	2,007	6,032	3,235	51,291	15,201	7,178	18,517	10,396	35,429	10,613	5,171	12,485	7,161
OR	8,575	2,475	996	3,420	1,683	23,736	6,930	3,189	8,913	4,703	15,161	4,455	2,192	5,494	3,020
PA	18,769	5,651	2,375	7,119	3,624	51,727	14,816	7,000	19,466	10,445	32,958	9,166	4,625	12,347	6,821
RI	903	242	116	379	167	3,720	968	512	1,494	746	2,817	726	396	1,115	579
VT	1,081	276	132	440	232	3,506	881	456	1,380	789	2,426	604	324	940	557

Appendix Table 4 (continued)

State	ACA					ACA Repealed Through Reconciliation					Difference				
	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs	Total Health Care Spending	Hospitals	Physician Practices	Other Services	Prescription Drugs
WA	14,142	3,769	1,806	5,571	2,995	48,091	12,924	6,512	18,472	10,182	33,949	9,155	4,706	12,901	7,187
WV	2,841	764	338	1,004	735	8,635	2,358	1,097	3,145	2,035	5,794	1,594	759	2,142	1,300
Non-Expansion States	316,091	93,136	39,573	120,422	62,960	706,561	199,176	93,355	270,187	143,843	390,469	106,040	53,782	149,765	80,883
AL	10,031	3,129	1,170	3,614	2,118	21,822	6,215	2,723	8,103	4,780	11,791	3,086	1,553	4,489	2,662
FL	57,506	16,254	7,307	22,358	11,587	132,560	35,668	16,985	53,018	26,889	75,053	19,414	9,678	30,660	15,301
GA	27,680	8,210	3,559	10,484	5,427	57,766	16,258	7,670	22,092	11,746	30,086	8,048	4,111	11,608	6,319
ID	5,024	1,543	648	1,859	974	11,471	3,120	1,625	4,340	2,386	6,446	1,577	977	2,481	1,412
KS	7,231	2,427	918	2,570	1,316	18,470	5,904	2,483	6,631	3,452	11,239	3,477	1,565	4,060	2,136
ME	2,472	685	303	978	507	7,477	2,106	935	2,887	1,549	5,004	1,421	632	1,909	1,042
MS	9,543	2,909	1,096	3,492	2,045	18,147	5,377	2,260	6,657	3,854	8,604	2,467	1,164	3,164	1,809
MO	15,812	4,579	1,863	6,285	3,084	40,281	11,047	5,217	15,796	8,220	24,469	6,468	3,354	9,511	5,136
NE	4,076	1,124	484	1,710	758	11,161	3,110	1,620	4,269	2,162	7,085	1,986	1,136	2,560	1,404
NC	20,357	6,308	2,558	7,530	3,961	55,399	16,274	7,769	20,191	11,164	35,041	9,966	5,211	12,662	7,203
OK	16,398	5,047	2,099	6,116	3,136	28,730	8,781	3,936	10,485	5,528	12,331	3,734	1,837	4,369	2,392
SC	11,919	3,608	1,459	4,410	2,442	21,984	6,419	2,840	8,261	4,464	10,065	2,811	1,381	3,851	2,022
SD	2,241	666	282	845	447	5,630	1,582	771	2,128	1,148	3,389	916	489	1,283	700
TN	14,759	4,403	1,817	5,445	3,095	31,441	9,023	4,125	11,684	6,609	16,682	4,620	2,308	6,239	3,514
TX	68,576	20,395	8,890	25,987	13,305	138,246	39,849	18,319	52,503	27,575	69,669	19,454	9,429	26,516	14,270
UT	9,386	2,528	1,191	3,707	1,960	21,418	5,881	2,927	8,225	4,384	12,031	3,353	1,736	4,518	2,424
VA	21,998	6,186	2,627	8,695	4,489	50,710	13,239	6,673	19,995	10,803	28,713	7,052	4,046	11,300	6,314
WI	8,844	2,472	1,048	3,488	1,836	28,316	7,788	3,801	10,753	5,974	19,472	5,316	2,752	7,265	4,138
WY	2,237	663	252	850	472	5,534	1,535	675	2,170	1,154	3,297	872	423	1,320	683

Source: Urban Institute analysis, HIPS M 2016.

Note: This table includes uncompensated care funded by federal, state, or local governments, and health care providers. Federal funding for uncompensated care would automatically increase by \$35.0 billion over the 2019-28 period under reconciliation, less than 4% of the increase in uncompensated care that would be sought by the newly uninsured.

Other services includes: health care services delivered by providers other than hospitals and office-based physicians and additional services, such as dental care, home health care, and other medical equipment.

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- 8 Other services include health care services delivered by providers other than hospitals and office-based physicians and additional services such as dental care, home health care, and other medical equipment.
- 9 Dobson A, DaVanzo J, Haught R, Luu P. Estimating the Impact of Repealing the Affordable Care Act on Hospitals. Vienna, VA: Dobson DaVanzo & Associates; 2016.
- 10 Our earlier analysis of the effects of the anticipated reconciliation bill erroneously ignored the automatic increase in federal Medicare DSH funding, restoring the cuts in the ACA. The ACA's Medicaid DSH cuts have never been implemented; we assume that they are restored permanently and held constant and that Congress has no interest in increasing them. States could increase their use of Medicaid supplemental payments to fund uncompensated care, but under the anticipated reconciliation bill, fewer patients would be eligible for these payments. Other sources of federal funding for uncompensated care could increase, but any increases are likely to be modest given the new administration's commitment to budget cuts.
- 11 The increase in uncompensated care and the decrease in spending on care by insurers and households should not be added together to obtain a total effect on providers. When direct spending on care decreases and less care is provided, the variable costs incurred by those providers decrease as well. We are unable to estimate the decrease in costs that providers would experience as they deliver reduced levels of health care to those becoming uninsured under the reconciliation bill.
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Repealing Federal Health Reform: Economic and Employment Consequences for States

Tags: [Affordable Care Act \(/publications/issue-briefs#f:tagsfacet=\[Affordable Care Act\]\)](#)

January 5, 2017

Authors

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Abstract

[\(/interactives-and-data/maps-and-data/the-impact-of-aca-repeal-on-employment\)](#)**Issue:** The incoming Trump administration and Republicans in Congress are seeking to repeal the Affordable Care Act (ACA), likely beginning with the law's insurance premium tax credits and expansion of Medicaid eligibility. Research shows that

the loss of these two provisions would lead to a doubling of the number of uninsured, higher uncompensated care costs for providers, and higher taxes for low-income Americans. **Goal:** To determine the state-by-state effect of repeal on employment and economic activity. **Methods:** A multistate economic forecasting model (PI+ from Regional Economic Models, Inc.) was used to quantify for each state the effects of the federal spending cuts. **Findings and Conclusions:** Repeal results in a \$140 billion loss in federal funding for health care in 2019, leading to the loss of 2.6 million jobs (mostly in the private sector) that year across all states. A third of lost jobs are in health care, with the majority in other industries. If replacement policies are not in place, there will be a cumulative \$1.5 trillion loss in gross state products and a \$2.6 trillion reduction in business output from 2019 to 2023. States and health care providers will be particularly hard hit by the funding cuts.

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INTRODUCTION

President-elect Donald Trump and Republican leaders of Congress seek to repeal and replace the Affordable Care Act (ACA)—also known as Obamacare—in 2017. A likely strategy is to repeal two key elements of the health reform law: the insurance premium tax credits and the expansion of Medicaid eligibility. A bill passed by Congress in 2015 (H.R. 3762) sought to do just that beginning in 2018—with no replacement plan—but it was vetoed by President Obama. The new Congress could pass a repeal bill in early 2017 but not develop a replacement bill until later.¹

Recent analyses show canceling the ACA's tax credits and Medicaid expansion would double the number of uninsured Americans.^{2,3} As millions lose their insurance, hospitals and other providers would see their uncompensated medical care costs soar by \$1.1 trillion from 2019 to 2028, and they would experience major revenue losses as well.

But repeal could also have much broader economic repercussions. Our analysis examines the potential economic and employment effects of repealing the ACA's tax credits and Medicaid expansion, without a replacement plan, for every state and the District of Columbia. We estimate changes in:

- employment—the number of jobs lost in health care, construction, and other sectors of the economy
- economic activity, such as state gross product (the state equivalent of national gross domestic product) and business output
- state and local tax revenues.

POLICY BACKGROUND

Although the ACA dramatically lowered the number of uninsured,^{4,5} Republican leaders believe that the law is harmful and are committed to its repeal.⁶ A plausible scenario is that, in 2017, Congress passes a budget resolution requiring the repeal of key ACA provisions. This would be accomplished through a reconciliation bill that could be passed by simple majorities in the House of Representatives and the Senate—the strategy used to pass H.R. 3762 in 2015. Numerous Republican replacement policies have been suggested, though a consensus has yet to emerge.⁷ Thus, Congress may pass repeal in early 2017, with implementation delayed for a couple of years, but replacement policies are likely to be developed much later.

Because plans for replacement are unresolved, we focus on the repeal of federal premium tax credits and Medicaid expansion. Key elements of the current policies are:

- **Federal premium tax credits.** These help those with low to moderate incomes (100 percent to 400 percent of poverty) who purchase Qualified Health Plans in the health insurance marketplaces. Most are provided as advance premium tax credits paid directly to the insurance plans, so consumers pay only the difference between their tax credits and actual plan premiums. The tax credit varies with income, with higher credits for those with the lowest incomes.
- **Federal payments to states for expanding Medicaid eligibility.** These aid individuals newly eligible for Medicaid under the ACA: nonelderly adults with incomes below 138 percent of the federal poverty level. Because the Supreme Court ruled in 2012 that states cannot be required to expand eligibility, 31 states and the District of Columbia have expanded Medicaid while 19 states have not. The federal government covers nearly all the costs of covering newly eligible adults through 2016, with matching rates declining to 90 percent by 2020.⁸

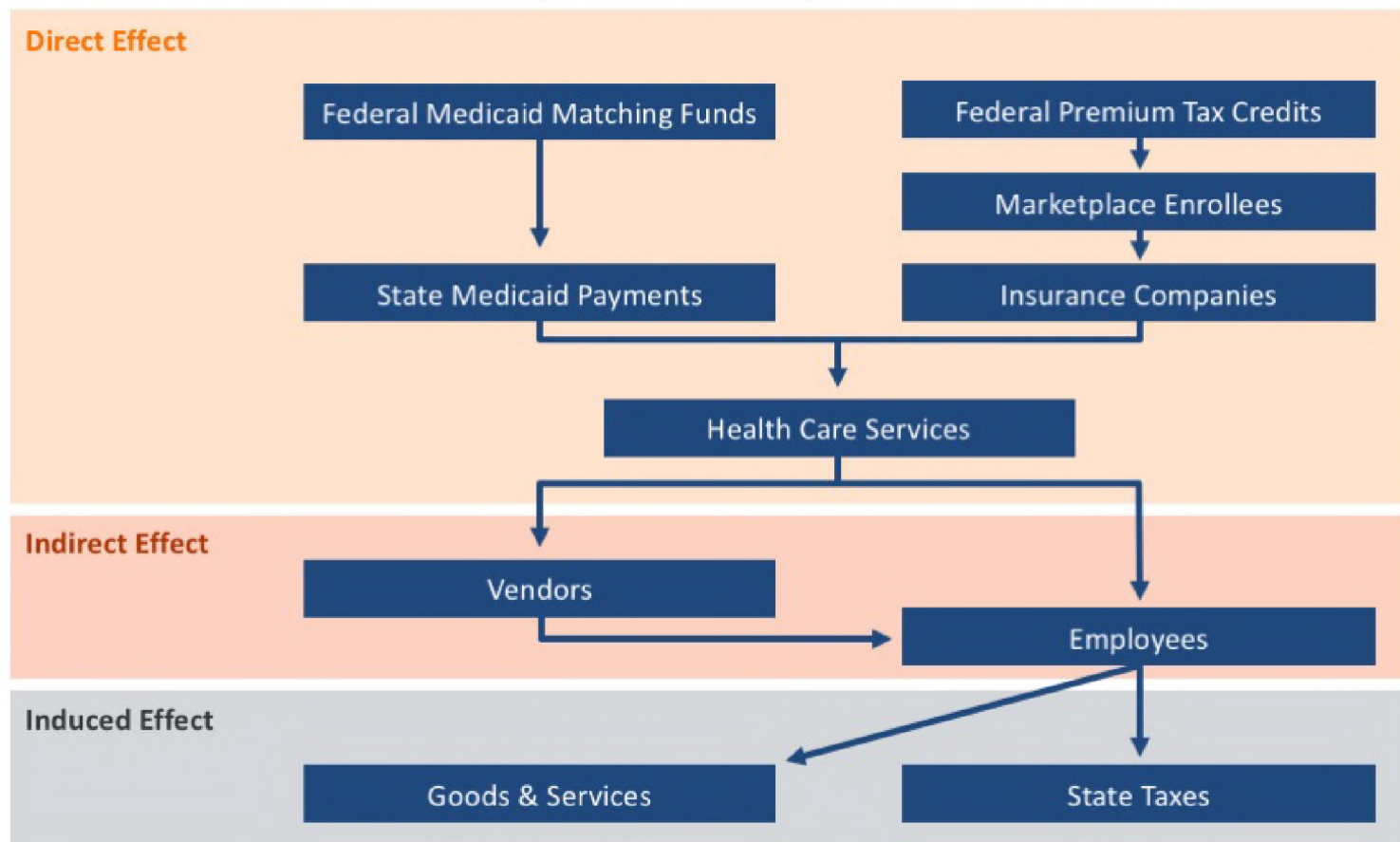
HOW FEDERAL HEALTH FUNDING STIMULATES JOBS AND STATE ECONOMIES

Health care will comprise almost one-fifth (18.5%) of the nation's economy by 2019.⁹ As such, major changes to health care will reverberate across other parts of the economy.

These economic consequences can be projected by analyzing how funding flows from the federal government to states, consumers, and businesses. As illustrated in Exhibit 1, federal tax credits first flow to health insurers. Most of the money, aside from carriers' overhead, flows to hospitals, clinics, pharmacies, and other providers. Similarly, federal funding supports state Medicaid programs, which pay health care providers. These are the *direct effects* of federal funding.

Exhibit 1

How Federal Health Funding Flows Through State Economies



Most of the revenue earned by health care providers is used to hire and pay staff and to purchase goods and services, like clinic space or medical equipment. In turn, those vendors pay their employees and buy additional goods and services. This is the *indirect effect* of federal funding.

The *induced effect* is manifested as workers use their incomes to pay for food, mortgages, rent, transportation, and other goods and services, which provides income to other businesses.

Federal funding thus initiates an economic cycle that ripples throughout the economy, both within and across state borders. The gains from this cycle also generate additional state and local tax revenues. When federal funds are cut, the results play out in the other direction, triggering losses in employment, economic activity, and state and local revenues.

To conduct our analysis of repeal's potential impact, we first projected the level of federal funding for tax credits and state Medicaid expansions that would be cut through repeal. A multistate economic model (PI+ from Regional Economic Models, Inc.) quantified the effects for each state. (See "[Summary of Study Methods \(###summary\)](#)" below. Detailed methods and data sources are available in the full version of this analysis, *The Economic and Employment Consequences of Repealing Federal Health Reform: A 50 State Analysis*, available at https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Repealing_Federal_Health_Reform.pdf (https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Repealing_Federal_Health_Reform.pdf).

It is important to note that other health policy changes, or even changes to tax policy, could modify our projections. We focus on these two repeal policies alone because it is not yet clear what additional policy changes might be advanced.

FINDINGS ABOUT POTENTIAL EFFECTS

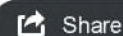
As seen in Exhibit 2, repeal results in a \$140 billion cut in federal funding for health care in 2019. This in turn leads to about 2.6 million jobs lost that year, rising to nearly 3 million by 2021. A third of these lost jobs are in health care, but the majority is in other industries such as construction, real estate, retail trade, and finance. Nearly all are private-sector jobs.

Exhibit 2

Repeal of Both Premium Tax Credits and Medicaid Expansion: Potential National Impact

	2019	2020	2021	2022	2023	Total 2019-23
Federal Funding Cut (billions of \$)	-\$139.5	-\$150.0	-\$161.5	-\$172.0	-\$184.0	-\$807.0
TOTAL EMPLOYMENT LOST (thousands of jobs)	-2,599	-2,854	-2,978	-2,924	-2,857	N/A
Private Employment:	-2,535	-2,754	-2,857	-2,796	-2,727	N/A
> Health Care	-912	-942	-974	-984	-1,003	N/A
> Construction & Real Estate	-292	-385	-410	-383	-340	N/A
> Retail Trade	-261	-275	-282	-275	-268	N/A
> Finance & Insurance	-159	-165	-168	-163	-159	N/A
> All Other Private	-912	-988	-1,023	-991	-957	N/A
Public Employment	-63	-100	-120	-128	-130	N/A
Business Output Lost (billions of \$)	-\$440.5	-\$502.7	-\$542.7	-\$551.6	-\$555.3	-\$2,592.7
Gross State Product Lost (billions of \$)	-\$255.9	-\$292.1	-\$316.2	-\$322.6	-\$326.1	-\$1,512.8
State & Local Taxes Lost (billions of \$)	-\$8.2	-\$9.3	-\$10.1	-\$10.3	-\$10.4	-\$48.4

Source: George Washington University analyses.



If replacement policies are not in position, state economic losses will rise. From 2019 to 2023, there will be a cumulative \$1.5 trillion loss in gross state products and a \$2.6 trillion reduction in business output (combined transactions at the production, wholesale, and retail levels).

State and local tax revenues also will fall during this period, dropping by \$48 billion. State and local governments could be faced with declining revenues, and safety-net health care providers would see their uncompensated care costs rise sharply as millions of people lose their insurance.

The effects are similar but smaller when the two repeal elements are considered separately. Exhibit 3 shows that tax credit repeal cuts federal funding by \$341 billion from 2019 to 2023. This leads to 1.1 million fewer jobs in 2019 alone. Gross state products shrink by \$623 billion over five years and state and local tax revenues fall by \$21 billion.

Exhibit 3 Repeal of Premium Tax Credits Only: Potential National Impact

	2019	2020	2021	2022	2023	Total 2019-23
Federal Funding Cut (billions of \$)	-\$61.0	-\$65.0	-\$68.8	-\$71.8	-\$74.8	-\$341.3
TOTAL EMPLOYMENT LOST (thousands of jobs)	-1,105	-1,202	-1,232	-1,184	-1,121	N/A
Private Employment:	-1,077	-1,159	-1,181	-1,130	-1,068	N/A
> Health Care	-369	-377	-382	-377	-373	N/A
> Construction & Real Estate	-125	-164	-172	-157	-134	N/A
> Retail Trade	-109	-114	-115	-109	-103	N/A
> Finance & Insurance	-88	-91	-91	-88	-85	N/A
> All Other Private	-386	-414	-421	-399	-373	N/A
Public Employment	-27	-43	-51	-53	-53	N/A
Business Output Lost (billions of \$)	-\$188.4	-\$212.5	-\$225.2	-\$224.0	-\$218.6	-\$1,068.7
Gross State Product Lost (billions of \$)	-\$109.3	-\$123.4	-\$131.1	-\$130.9	-\$128.3	-\$623.0
State & Local Taxes Lost (billions of \$)	-\$3.7	-\$4.1	-\$4.4	-\$4.4	-\$4.3	-\$20.9

Source: George Washington University analyses.

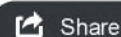


Exhibit 4 shows how canceling states' Medicaid expansions lowers federal funding by \$466 billion from 2019 to 2023. This leads to 1.5 million fewer people with jobs in 2019. Moreover, gross state products shrink by nearly \$900 billion and state and local tax revenues drop by \$29 billion.

The majority of these losses occur in the states that have expanded Medicaid (31, plus the District of Columbia), with nearly 1.2 million jobs lost in 2019. However, the 19 states that have not expanded Medicaid also experience major setbacks: collectively, they lose about 338,000 jobs in 2019, even though they do not receive the direct federal matching funds for Medicaid expansion.

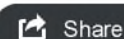
Exhibit 4 Repeal of Medicaid Expansion Only: Potential National Impact

ALL STATES COMBINED	2019	2020	2021	2022	2023	Total 2019-23
Federal Funding Cut (billions of \$)	-\$78.5	-\$85.0	-\$92.8	-\$100.3	-\$109.3	-\$465.8
Total Employment Lost (thousands of jobs):	-1,495	-1,653	-1,748	-1,744	-1,739	N/A
> Health Care	-543	-566	-592	-608	-631	N/A
> All Other	-952	-1,088	-1,155	-1,136	-1,108	N/A
Business Output Lost (billions of \$)	-\$252.4	-\$290.4	-\$317.9	-\$328.2	-\$337.3	-\$1,526.1
Gross State Product Lost (billions of \$)	-\$146.7	-\$168.8	-\$185.3	-\$192.0	-\$198.1	-\$891.0
State & Local Taxes Lost (billions of \$)	-\$4.7	-\$5.4	-\$6.0	-\$6.2	-\$6.4	-\$28.7

31 STATES & DC EXPANDING MEDICAID	2019	2020	2021	2022	2023	Total 2019-23
Federal Funding Cut (billions of \$)	-\$78.5	-\$85.0	-\$92.8	-\$100.3	-\$109.3	-\$465.8
Total Employment Lost (thousands of jobs):	-1,158	-1,277	-1,354	-1,361	-1,369	N/A
> Health Care	-451	-470	-492	-506	-527	N/A
> All Other	-707	-808	-862	-855	-842	N/A
Business Output Lost (billions of \$)	-\$195.0	-\$223.9	-\$245.7	-\$255.5	-\$264.8	-\$1,185.0
Gross State Product Lost (billions of \$)	-\$114.0	-\$130.9	-\$144.1	-\$150.4	-\$156.5	-\$695.8
State & Local Taxes Lost (billions of \$)	-\$3.8	-\$4.3	-\$4.7	-\$5.0	-\$5.2	-\$22.9

19 STATES NOT EXPANDING MEDICAID	2019	2020	2021	2022	2023	Total 2019-23
Federal Funding Cut (billions of \$)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total Employment Lost (thousands of jobs):	-338	-376	-394	-383	-369	N/A
> Health Care	-86	-90	-93	-95	-97	N/A
> All Other	-251	-287	-301	-288	-272	N/A
Business Output Lost (billions of \$)	-\$53.2	-\$61.8	-\$67.1	-\$67.6	-\$67.4	-\$317.1
Gross State Product Lost (billions of \$)	-\$32.7	-\$37.9	-\$41.2	-\$41.7	-\$41.7	-\$195.2
State & Local Taxes Lost (billions of \$)	-\$1.0	-\$1.1	-\$1.2	-\$1.2	-\$1.2	-\$5.8

Source: George Washington University analyses.



For example, although Utah has not expanded Medicaid, federal repeal causes the state to lose nearly 9,000 jobs in 2019 (Exhibit 5). Medicaid expansion in other states—like nearby Colorado, Arizona, Nevada, New Mexico, and California—spurs economic growth in those states. But because businesses and individuals there also buy goods and services from Utah firms, Utah’s economy benefits, too. Ending Medicaid expansion therefore creates losses for Utah and other nonexpanding states.

Data for eight selected states, five of which have expanded Medicaid and three of which have not, are shown in Exhibit 5. In the five expansion states, the majority of lost jobs and economic activity are caused by Medicaid expansion repeal. In the other three states, the majority of losses are caused by tax credit repeal. Nonetheless, all eight states experience serious losses when tax credits and

Medicaid expansions disappear. Appendix Tables A1 to A4 ([click here \(~/media/754502ecfd0742e699174c223bcc80e9.ashx\)](~/media/754502ecfd0742e699174c223bcc80e9.ashx)), summarize results for every state.

Exhibit 5 Summary of Potential Consequences for Eight Selected States

REPEAL OF TAX CREDITS & MEDICAID EXPANSION	Arizona*	Florida	Maine	New York*	Ohio*	Pennsylvania*	Utah	West Virginia*
Federal Funding Cut, 2019-23 (billions of \$)	-\$6.8	-\$54.4	-\$2.7	-\$15.5	-\$34.9	-\$36.9	-\$3.4	-\$7.2
Employment Lost in 2019								
Total Employment Lost (thousands of jobs):	-33.9	-181.0	-13.1	-130.7	-126.3	-137.2	-18.6	-16.5
> Health Care	-10.5	-64.2	-5.0	-47.7	-49.7	-57.0	-4.9	-7.2
> All Other	-23.4	-116.8	-8.1	-83.0	-76.6	-80.2	-13.7	-9.3
Economic Activity Lost, 2019-23								
Business Output Lost (billions of \$)	-\$29.11	-\$146.46	-\$12.09	-\$154.11	-\$119.52	-\$128.93	-\$17.18	-\$15.97
Gross State Product Lost (billions of \$)	-\$17.67	-\$90.42	-\$6.88	-\$89.67	-\$69.52	-\$76.47	-\$10.07	-\$9.12
State & Local Taxes Lost (billions of \$)	-\$0.53	-\$3.03	-\$0.27	-\$3.55	-\$2.20	-\$2.42	-\$0.31	-\$0.35

REPEAL OF TAX CREDITS ONLY	Arizona*	Florida	Maine	New York*	Ohio*	Pennsylvania*	Utah	West Virginia*
Federal Funding Cut, 2019-23 (billions of \$)	-\$3.6	-\$54.4	-\$2.7	-\$2.7	-\$5.4	-\$9.9	-\$3.4	-\$1.4
Employment Lost in 2019								
Total Employment Lost (thousands of jobs):	-13.7	-140.3	-7.0	-44.5	-38.7	-46.5	-9.8	-5.9
> Health Care	-4.3	-52.7	-2.7	-13.4	-13.1	-16.7	-3.0	-2.4
> All Other	-9.4	-87.6	-4.3	-31.1	-25.6	-29.9	-6.8	-3.5

Economic Activity Lost, 2019-23								
Business Output Lost (billions of \$)	-\$11.24	-\$115.47	-\$6.25	-\$54.03	-\$37.26	-\$44.80	-\$8.53	-\$5.78
Gross State Product Lost (billions of \$)	-\$6.84	-\$71.08	-\$3.64	-\$30.59	-\$21.32	-\$26.16	-\$5.07	-\$3.26
State & Local Taxes Lost (billions of \$)	-\$0.21	-\$2.38	-\$0.14	-\$1.21	-\$0.67	-\$0.83	-\$0.16	-\$0.12

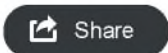
REPEAL OF MEDICAID EXPANSION ONLY	Arizona*	Florida	Maine	New York*	Ohio*	Pennsylvania*	Utah	West Virginia*
Federal Funding Cut, 2019-23 (billions of \$)	-\$3.2	\$0.0	\$0.0	-\$12.8	-\$29.5	-\$26.9	\$0.0	-\$5.8

Employment Lost in 2019								
Total Employment Lost (thousands of jobs):	-20.3	-40.8	-6.0	-86.3	-87.6	-90.7	-8.8	-10.6
> Health Care	-6.3	-11.5	-2.2	-34.4	-36.5	-40.3	-1.9	-4.7
> All Other	-14.0	-29.3	-3.8	-51.9	-51.1	-50.4	-7.0	-5.9

Economic Activity Lost, 2019-23								
Business Output Lost (billions of \$)	-\$17.90	-\$31.05	-\$5.87	-\$100.27	-\$82.29	-\$84.18	-\$8.67	-\$10.19
Gross State Product Lost (billions of \$)	-\$10.84	-\$19.38	-\$3.26	-\$59.19	-\$48.22	-\$50.34	-\$5.01	-\$5.86
State & Local Taxes Lost (billions of \$)	-\$0.33	-\$0.65	-\$0.13	-\$2.34	-\$1.52	-\$1.59	-\$0.16	-\$0.22

* States expanding Medicaid.

Source: George Washington University analyses.



DISCUSSION

Repeal of key parts of the Affordable Care Act would lead to major cuts in federal assistance for health care, thereby triggering major losses in employment and serious economic dislocations in all states. These losses would not be limited to hospitals, clinics, and patients; they would have widespread repercussions for businesses and workers as well, affecting multiple sectors of each state's economy. Because economic benefits and losses flow across state lines, even states that did not expand Medicaid would experience losses if Medicaid expansions were canceled.

These findings are noteworthy in part because of the common (and debunked) concern that Obamacare has been a "job killer."¹⁰ (##10) Evidence shows that job growth has been robust since the ACA was implemented and the economy has thrived.¹¹ (##11)

The economic burdens for states and health care providers will be particularly detrimental. Because they serve so many uninsured and Medicaid patients, safety-net facilities such as hospitals and community health centers could be especially hard hit. Recent studies demonstrate that Medicaid expansions are associated with lower uncompensated care burdens for hospitals and with increased capacity at nonprofit community health centers, signaling the adverse consequences of reversing them.^{12,13} (##12) In the end, states could be forced to choose between cutting vital services and raising tax rates.

An important question post-repeal will be what policies might replace existing ones. Some conservatives have recommended the broader use of health insurance tax deductions, in lieu of tax credits, whether for all health coverage or specifically for tax-advantaged health savings accounts (HSAs).¹⁴ (##14) While tax deductions can lower costs for higher-income individuals, who have higher marginal tax rates and already are mostly insured, they offer little help to people with low or moderate incomes, who are far more likely to lose their insurance and access to health care if premium tax credits and Medicaid expansions disappear.

Analyses by the RAND Corporation found that the broader tax deductions recommended by the Trump team during the presidential campaign would increase federal costs, with little gain in insurance coverage.¹⁵ (##15) Any savings would primarily help those with higher incomes. The ACA's reforms, on the other hand, target assistance to low- and moderate-income families, who use the savings to meet basic needs like housing, food, and transportation. Moreover, such spending creates greater economic stimulus than tax deductions that disproportionately benefit wealthier individuals, who are likely to shift more money into savings, which is less stimulative.

Another key question is whether additional states would be able to expand their Medicaid programs prior to repeal. Some of these states might be more interested in doing so under a Republican administration if they believe they would have more flexibility in designing their expansion. A related question is whether federal funding for expansion would be continued after repeal goes into effect. Speaker of the House Paul Ryan has proposed converting Medicaid into a block grant that would provide more limited funding to states in the future.¹⁶ (##16) Presumably, states' federal block-grant funding levels would be based on federal payments for a baseline period. Would Medicaid expansion funds be included in state baselines under block grants so that states could continue to offer expanded coverage in the future? Such an approach could limit some of the economic damage, but current plans in Congress are not clear.

Recent analyses have indicated that ACA repeal could double the number of uninsured Americans, reduce access to health services, and increase burdens for health care facilities.^{17,18} (##17) This analysis demonstrates that the consequences could extend well beyond the health care system, triggering major reductions in employment and substantial losses in state economic activity and reduced state and local revenues. And these repercussions are likely to reverberate across all states and most sectors of the economy.

Summary of Study Methods

To project federal funding losses for every state and the District of Columbia, we used the most recent data from the U.S. Department of Health and Human Services to estimate baseline 2016 federal expenditures for premium tax credits and federal Medicaid expansion funding. Federal funding losses from calendar years 2019 to 2023 were based on Congressional Budget Office (CBO) baseline projections.^{19 (#/19)} To be conservative, we did not include projections related to the Affordable Care Act's marketplace cost-sharing reductions or the potential loss of coverage for those already eligible for Medicaid.

State- and year-specific federal funding losses were input into the PI+ (version 2.0) economic forecasting model, developed by Regional Economic Models, Inc.^{20 (#/20)} PI+ is a dynamic structural equation model that projects state-level economic and employment forecasts. The model includes elements of input-output, general economic equilibrium, econometric, and economic geography methodologies. The estimated effects are based on differences between a baseline model (control forecast) and models assuming policy changes—in this case, the loss of premium tax credits or federal Medicaid expansion funding. The multiregion model accounts for the flow of funds and goods both within and across states. Most health care is local; patients generally use clinics, hospitals, and pharmacies near their home, but health care income eventually translates into purchases of diverse goods and services, so that funds originating in one state eventually flow across state lines into the interstate economy. We estimate state-level changes in the following measures by calendar year:

1. **Employment:** Number of full- or part-time jobs that could be added or lost in each state, including private health care, construction, real estate, retail, finance, and insurance jobs and public-sector employment.
2. **Business output:** Equivalent to the sum of all transactions at production, wholesale, and retail levels in a state.
3. **Gross state product (GSP):** Net value added within a state. It is the state-level analogue to the gross domestic product for the nation.
4. **State and local tax revenue:** State and local income, sales, and other taxes.

Business output, GSP, and state and local tax revenues are measured in current (nominal) dollars for their respective calendar years.

Study Limitations

All projections entail uncertainty. The health care market and the general economy are ever changing. We focus solely on the effects of revoking premium tax credits and Medicaid expansions. If cancellation dates for tax credits or Medicaid expansion are shifted up or down by one year, results should be similar but moved forward or backward in time.

Given current legislative uncertainties, we are unable to account for potential Affordable Care Act replacement policies or other economic policy changes. A recent analysis of the economic effects in California assumed changes in health-related taxes and reached conclusions that were consistent with the national analyses reported here.^{21 (#/21)} In an analysis like this, an important question is whether the federal funding that is cut would be used for another purpose; this is also unclear. CBO estimated that H.R. 3762 could have reduced the federal deficit,^{22 (#/22)} but alternative uses for these savings were not specified. It did not appear that the federal savings would be rechanneled to help states or support health care. Updated analyses may be possible in the future. The study also did not explicitly model the effects of other provisions that might be considered, such as elimination of some taxes and penalties. However, the California study suggests that the effect of these changes on employment would be modest.

A complete description of this study's methods and data sources is available in the full version of this analysis, *The Economic and Employment Consequences of Repealing Federal Health Reform: A 50 State Analysis*, available at

https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Repealing_Federal_Health_Reform.pdf
(https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Repealing_Federal_Health_Reform.pdf).

Notes

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