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Vox

Study: ACA enrollees' costs would spike under Republican plans

Updated by David Cutler, John Bertko, and Topher Spiro | *Feb 24, 2017, 10:10am EST*

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THE BIG IDEA

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When Republicans talk about the supposedly dire effects of Obamacare, they often refer to health care premiums that keep on rising — and many journalists have followed their lead in using premiums as a shorthand for health care costs. But that's a serious mistake. Premium costs are only one component of total consumer costs.

When considering whether proposals to replace the Affordable Care Act are viable or achieve their stated goals, their effects on cost sharing must be taken into account, too. That's the proportion of health care spending by the consumer, as opposed to the insurance company.

Since Republicans haven't agreed on a single replacement health care plan, it's difficult to compare the Affordable Care Act with — well, whatever is to come. But all Republican proposals to replace or repair the ACA share a set of common elements. These elements would dramatically reduce the generosity of insurance, which would, yes, reduce premiums. But they would also increase consumers' out-of-pocket costs, such as deductibles and copays, as well as their financial risk.

The ACA also subsidizes many consumers' premiums through tax credits. The Republican plans would reduce those credits substantially for most people. Finally, the proposals would alter premiums by age, increasing premiums for older people and reducing premiums for younger people.

We're presenting here the first analysis of the net financial impact on Americans of the proposed Republican modifications to health care premiums after tax credits, plus cost sharing. We estimate that the Republican approach would increase the average total cost for an individual covered by the Affordable Care Act by $1,744 per year. The impact would be particularly severe for individuals ages 55 to 64, whose total costs would increase by $6,089 annually.

Although premiums would be lower under the Republican plan, this decrease would be offset by an increase in cost sharing. Once the differences in tax credits are accounted for, the Republican plan would increase total costs for every age group except for those under 25. What's more, families — as opposed to individuals — would see an even larger spike in total consumer costs. For families of every age (as determined by the age of the head of household), total costs would increase.

In this analysis, we use current plans sold through the Affordable Care Act's exchanges as a baseline. We then used the mathematical relationship between premiums and cost sharing to estimate how those plans would change if or when Republicans alter regulations. For the tax credit parameters, we applied the tax credits prescribed in the Empowering Patients First Act legislation, which was sponsored by Secretary of Health and Human Services Tom Price when he was a House member. We assume these parameters would be fairly representative of the Republican approach.

These estimates are average cost increases. Scaling back essential health benefits would raise costs for some individuals by even more. We provide a series of scenarios to demonstrate this aspect of the Republican plans as well.

The Republican proposals share several elements that shift more costs onto consumers

The Affordable Care Act includes three elements that affect the generosity of insurance. First, the ACA requires insurers to cover a minimum share of costs. This minimum "actuarial value" — roughly speaking, the proportion that insurers cover, on average — is set at 60 percent. Second, the ACA provides premium tax credits that are linked to the cost of a plan that covers 70 percent of costs, on average.

Third, the act reduces cost-sharing levels for lower-income individuals whose income falls between 100 percent and 250 percent of the federal poverty level. The combined effect of these elements is that for non-group policies under the ACA, the weighted average share of costs covered by insurers **is about 75 percent**.

All Republican proposals to replace the Affordable Care Act — not just Price's, but **Paul Ryan's and several others**, which vary greatly in their specificity — would remove these elements. The proposals would eliminate the minimum required actuarial value, meaning there would be no guaranteed "floor" on the proportion of costs borne by insurers.

The plans would also eliminate cost-sharing reductions for lower-income individuals and provide flat premium tax credits by age, unrelated to any plan's cost. The combined effect of these changes is that the Republican approach would dramatically reduce the generosity of insurance and sharply increase deductibles and other out-of-pocket costs.

In addition, all Republican proposals would eliminate the requirement that insurers cover 10 essential health benefits. Before the Affordable Care Act, **a**

sizable share of plans did not cover such vital things as prescription drugs, maternity care, mental health care, and pediatric dental and vision care. Without a legal requirement, many insurers would certainly revert to benefit packages that do not include these benefits.

Finally, all Republican proposals would also eliminate or relax the limit on how much insurers can charge older individuals relative to younger people, a practice known as "age rating." The ACA prohibits insurers from charging older people premiums that are more than three times greater than premiums for younger people. Under the Republican plans that have been floated, premiums for older people would rise and those for younger people would fall. Younger Americans would subsidize older Americans to a lesser degree.

How we estimated costs under the Affordable Care Act

To estimate costs under current plans offered on the ACA exchanges, we used data on premiums from the Department of Health and Human Services for silver-level plans — those that cover 70 percent of total costs, on average. Then we applied the ACA's tax credits, using data from the 2015 National Health Interview Survey (NHIS) to estimate enrollment by age and income. (We assumed that everyone in each income range had income in the middle of that range.)

We estimated total costs, and cost sharing, in several steps. First, we estimated what premiums would be without the Affordable Care Act's age bands. (It's necessary to "unlock" premiums by age in order to calculate total costs and cost sharing by age in the next step.) **Based on HHS guidance**, this involves reducing premiums for young adults (ages 18 to 25) by 25 percent on average and increasing premiums for the near elderly (ages 55 to 64) by 25 percent on average.

Second, we used these premiums to estimate total payments to providers and cost sharing. Premiums represent the expected benefit costs that insurers will pay out plus an administrative load (which we assumed to be 20 percent).

Insurer-paid benefit costs are therefore premiums less 20 percent. Because insurer-paid benefit costs represent 70 percent of total costs, using high school math we can solve for total medical costs by dividing insurer-paid benefit costs by 0.70. Using the same NHIS data on enrollment by age and income, we accounted for cost-sharing reductions provided by the ACA.

How we estimated costs under the Republican approach

To model the Republican approach, we looked at common elements of the plans that have been floated (or, in the case of Secretary Price's plan, actually introduced as legislation). We assume that under the Republican approach, the average actuarial value would fall to 50 percent, reflecting the decrease in required coverage. The Republican approach would encourage enrollment in "catastrophic" plans with high deductibles. Under the Affordable Care Act, catastrophic plans available mainly to individuals under age 30 have an actuarial value that is **less than 60 percent**. In addition, the insurance industry pegs the actuarial value of catastrophic ("copper") plans with especially high deductibles **at 50 percent**.

In reality, our assumption of an average actuarial value of 50 percent is conservative —most likely too high. Using the **HHS actuarial value calculator**, removing coverage for prescription drugs, mental health care, and maternity care would reduce actuarial value for the Republican plans to 43 percent. If Republican proposals allow insurers to sell policies across state lines — thereby negating

even state-by-state coverage requirements — it is likely that many plans would not cover these services.

What's more, the general range of premium tax credits contemplated may not be enough for most individuals to afford plans with an actuarial value of 50 percent.

Pushing more costs onto consumers would lead to lower use of both necessary and unnecessary medical services. Based on the RAND Health Insurance Experiment, which examined how people responded to different cost-sharing approaches**, we reduced total costs by 5 percent** to account for this impact. Assuming that insurer-paid costs represent 50 percent of total costs — the plans' actuarial value — we then estimated insurer-paid costs and consumers' out-of-pocket costs. We derived premiums after adding the 20 percent administrative load to insurer-paid costs.

Republicans want to repeal the individual mandate and replace it with a "continuous coverage" requirement, which would guarantee coverage at a rate not reflecting preexisting conditions only for people who stayed on insurance, without gaps. The net impact of this change is uncertain. It would encourage people to stay in the system, but there is no evidence that it would be as effective as the individual mandate at doing so. It might well affect the mix of consumers who enroll in coverage, which would also impact premiums.

In the absence of any policy to replace the individual mandate, the Congressional Budget Office estimates that premiums would increase 20 to 25 percent. A continuous coverage requirement that makes it harder for sicker individuals to enroll in and afford coverage may help mitigate this impact — at the cost of care for the less healthy. But because the impact is uncertain, we conservatively assume that this policy would not cause adverse selection or affect premiums.

Finally, we applied tax credits to premiums under the Republican approach. We used the levels in the **Empowering Patients First Act**, which do not take income into account: $900 for an individual under age 18; $1,200 for an individual age 18 to 35; $2,100 for an individual age 35 to 50; and $3,000 for an individual over age 50.

We found a significant cost increase for consumers under the Republican plans

Table 1 displays the results of our analysis. Compared with the Affordable Care Act, the Republican approach would increase total costs — premium costs plus cost sharing — for the average exchange enrollee by $1,744 per year.

Table 1. Total Annual Costs for Individuals Under the Affordable Care Act and the Republican Approach

	ACA			GOP Approach			
Age range	Premium after tax credit	Cost-sharing	Total cost	Premium after tax credit	Cost-sharing	Total cost	Change in total cost
<18	$1,321	$441	$1,762	$499	$1,166	$1,665	-$97
18-25	$1,409	$437	$1,846	$453	$1,378	$1,831	-$14
26-34	$2,099	$841	$2,939	$1,301	$2,085	$3,386	$447
35-44	$1,949	$855	$2,804	$683	$2,319	$3,002	$198
45-54	$2,233	$1,149	$3,382	$1,660	$3,133	$4,793	$1,412
55-64	$2,207	$1,871	$4,078	$4,182	$5,985	$10,167	$6,089
Weighted average	$1,989	$1,112	$3,101	$1,684	$3,162	$4,846	$1,744

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This change is the net effect of several factors. The Republican approach would increase cost sharing for the average individual buying insurance in the non-group market by $2,050 per year. The trade-off between premiums and median cost sharing would be roughly equivalent on average — but only if the ACA's higher tax

credits and cost-sharing subsidies for low-income individuals are disregarded. When they are brought into the picture, total costs for consumers spike under the Republican plans. So does risk, given that shifting consumers' spending from premiums to out-of-pocket costs raises the likelihood of a stratospheric health care bill.

The impact of the Republican approach would vary significantly by age. The net change in total costs would be negligible for children and young adults 18 to 25. However, the loosening of age rating would substantially increase premiums for the near elderly. For that group, the tax credits would not come close to compensating for this increase. As a result, for individuals ages 55 to 64, total weighted average costs would more than double, rising from $4,078 to $10,167 per year.

To determine the impact of the Republican approach on families, we used National Health Interview Survey data on family composition of exchange enrollees to group individuals into families. For each family type, we added up average costs based on the distribution of the age of each member. To display the results, we grouped families by age of the family head.

Table 2 shows family costs under the Affordable Care Act and the Republican approach. Under the Republican approach, the total weighted average cost for a family would increase by $4,098 per year. The increase in total costs ranges from $881 per year for a family headed by someone between 35 and 44 years old to $9,633 per year for a family headed by someone 55 to 64.

Table 2. Total Annual Costs for Families Under the Affordable Care Act and the Republican Approach

	ACA			GOP Approach			
Age of family	Premium after tax	Cost-	Total	Premium after tax	Cost-	Total	Change in total

head	credit	sharing	cost	credit	sharing	cost	cost
18-25	$4,572	$1,868	$6,440	$2,607	$5,535	$8,143	$1,703
26-34	$5,843	$2,336	$8,179	$3,361	$6,106	$9,467	$1,287
35-44	$5,701	$2,361	$8,062	$2,516	$6,427	$8,943	$881
45-54	$6,196	$2,904	$9,100	$4,169	$8,080	$12,249	$3,149
55-64	$5,053	$3,530	$8,584	$7,259	$10,957	$18,217	$9,633
Weighted average	$5,602	$2,802	$8,404	$4,463	$8,039	$12,502	$4,098

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Once again, our assumptions were very conservative. We assumed zero premium increase from eliminating the individual mandate. We also assumed that most people would enroll in plans with an average actuarial value of 50 percent — although premium tax credits would likely be too small to make these plans affordable. Therefore, the results we present here are likely a lower bound of what the actual cost increases would be under the Republican approach.

Additional cost increases for particular services

Since, under the Republican proposals, many insurance plans would not cover prescription drugs, mental health care, or maternity care, costs for these services would be borne entirely out of pocket by consumers. That would add other cost increases on top of those reported above.

To estimate these additional cost increases, we used data on claims costs for employer-sponsored insurance. Because research suggests that costs for non-group insurance are 10 percent lower than costs for employer-sponsored insurance, we adjusted this data downward by 10 percent. (Exchange plans have narrower networks of care providers, allowing insurers to strike better bargains.) We assumed that consumer-paid costs would increase from 30 percent — with insurance paying the balance — to 100 percent of these adjusted costs.

Table 3 displays additional cost increases for individuals who are enrolled in plans that do not cover selected services, who pay out of pocket for such services. The additional cost increases for these services would range from more than $1,000 up to $8,500 per year. Because our data sources are all at least a few years old, these additional cost increases would likely be even greater.

Table 3. Additional Cost Increases for Selected Services Under the Republican Approach

Service	Year of data	Total costs	10% adjustment	Increase in consumer-paid costs
Drugs for cancer and tumors	2014[1]	$3,099	$2,789	$1,952
Drugs for heart disease	2014[2]	$2,868	$2,581	$1,807
Drugs for lung disease	2014[3]	$1,789	$1,610	$1,127
Drugs for mental illness	2014[4]	$2,550	$2,295	$1,607
Inpatient admission for mental health	2011[5]	$7,842	$7,058	$4,940
Inpatient admission for substance use	2011[6]	$7,230	$6,507	$4,555
Maternity care	2010[7]	$13,494	$12,145	$8,501

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Clearly, using premiums as a proxy for consumer health care costs is a mistake. In judging whether Republican health care plans will be an effective, or even acceptable, replacement, their effects on cost sharing must be taken into account.

Doing so dramatically changes the picture. The Republican plans do reduce premiums — predictably, given how much less coverage consumers would receive. But our analysis shows that the current Republican proposals would

substantially increase total costs on average — not to mention the risks of a financially devastating health care expense.

In short, any discussion that focuses on premiums in isolation hides the true impact of Republican plans to repeal and replace the Affordable Care Act. Consumers' wallets would take a big hit.

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Health Care

Which California Industries would be Most Affected by ACA Repeal and Cuts to Medi-Cal?

Laurel Lucia, Miranda Dietz and Ken Jacobs

February 23, 2017

» Brief

Under the Affordable Care Act (ACA), 3.7 million Californians enrolled in the ACA's Medi-Cal expansion, and another 1.2 million Californians received federal subsidies that make purchasing insurance through Covered California more affordable.1 These coverage gains are at risk if the ACA is repealed. Further cuts to Medi-Cal are also possible if Congress changes how the federal government funds Medicaid by converting it to a block grant program or applying a cap on spending per enrollee. Under such a proposal, federal Medicaid spending could be cut by one-third to one-half over a ten-year period, according to national estimates by the Center on Budget and Policy Priorities.2

Most Californians who rely on these programs are in working families. Eight out of ten Medi-Cal enrollees are in families with at least one worker, according to the Kaiser Family Foundation.3 The majority of those enrolled in Covered California with subsidies are also part of working families.4

In this data brief, we find that California workers who are employed in certain industries, including agriculture and parts of the service industry such as restaurants and retail, disproportionately enroll in ACA coverage, which we define as the Medi-Cal expansion and subsidized coverage through Covered California. Workers in these industries also enroll in the overall Medi-Cal program (including the expansion and all other eligibility categories) at rates higher than the California workforce overall. Not only would workers in these industries be harmed by ACA repeal and federal funding cuts to Medicaid, but firms whose employees lose health insurance may face higher absenteeism and reduced productivity.

Methods

We use 2015 data from the U.S. Census Bureau's American Community Survey (ACS) to estimate California workers' enrollment in certain types of health insurance. Estimates of Medi-Cal enrollment from the ACS are adjusted up by 31% to reflect the percentage by which administrative Medi-Cal enrollment data from the California Department of Health Care Services in July 20165 exceeded the estimated Medi-Cal enrollment reflected in the ACS 2015.

ACA Coverage

We first examine California workers' enrollment in coverage programs of the Affordable Care Act: the Medi-Cal expansion and Covered California with subsidies. (For simplicity we will call this ACA coverage.)

- Medi-Cal expansion enrollment is estimated based on the number of working adults ages 18 through 64 who report having Medi-Cal and who do not have minor children living at home. These "childless adults" comprise the majority of adults enrolled in the ACA Medi-Cal expansion, but some parents at certain income levels are also enrolled in the expansion. Therefore, the Medi-Cal expansion estimates in this brief are low-end estimates.
- Enrollment in Covered California with subsidies is estimated based on the number of working adults ages 18 through 64 who report having private insurance in the individual market and who have income that is at or below 400% of the federal poverty level, making them potentially eligible for Covered California subsidies. This method overestimates the number of enrollees because not all individuals with individual market coverage in this income range receive premium tax credits. Additionally, some purchase coverage directly from an insurer and are not enrolled through Covered California.

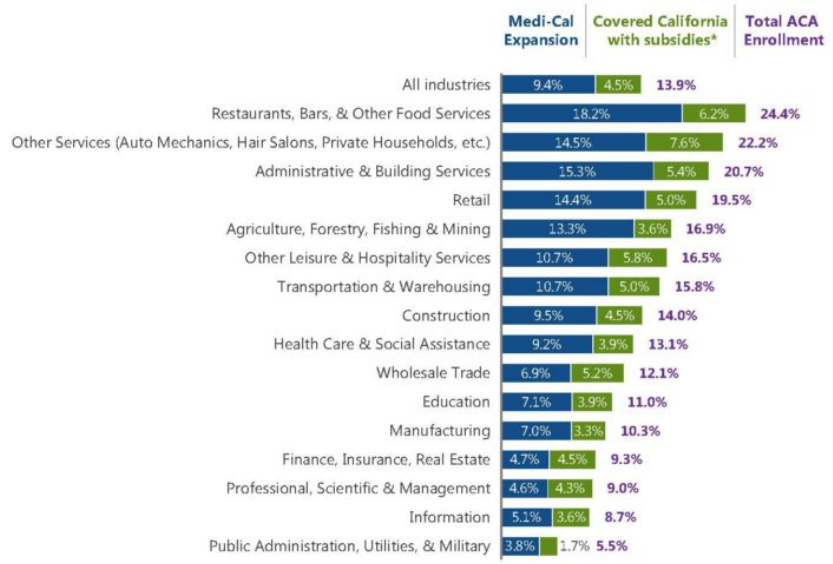
Medi-Cal Coverage

In this analysis we also estimate enrollment in the overall Medi-Cal program, including the expansion plus eligibility categories for parents, individuals with disabilities, and all other aid codes in which adults ages 18-64 are enrolled. Thus, in this analysis there is some overlap in the populations of those receiving ACA coverage and those enrolled in Medi-Cal.

Restaurant, other service industry, and agricultural workers disproportionately rely on ACA coverage

Workers in certain industries in California would be more likely to face loss of insurance under ACA repeal. While 13.9% of California workers ages 18-64 were estimated to be enrolled in the Medi-Cal expansion or Covered California with subsidies in 2015, the enrollment rates for these ACA coverage programs were especially high for restaurant workers (24.4%); retail workers (19.5%); workers in other parts of the service industry like auto repair, hair salons, and private households (22.2%); temporary workers, security guards, and landscapers (20.7%); and workers in agriculture and related industries[6] (16.9%) (Exhibit 1). The estimated number of workers enrolled by industry in 2015 is shown in Appendix Exhibit A.

Exhibit 1: Estimated Percentage of California Workers Ages 18-64 Enrolled in ACA Coverage by Industry, 2015



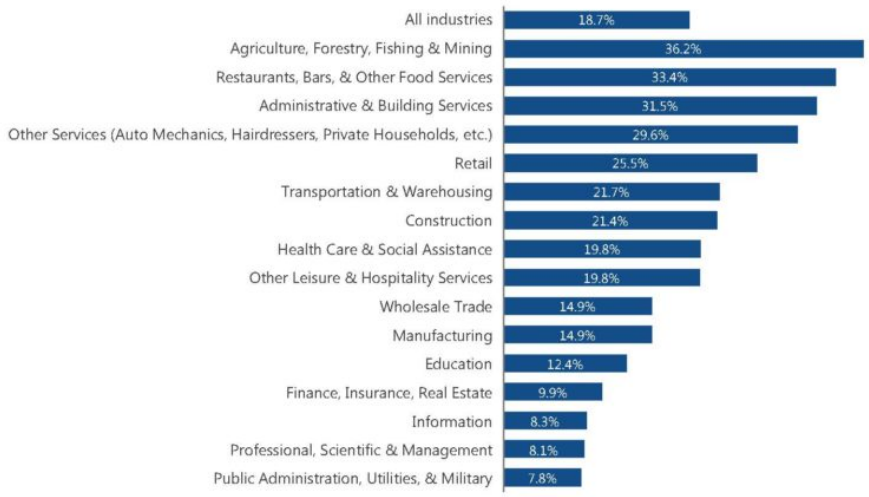
* Potentially enrolled in subsidized insurance through Covered California because reporting individual market coverage and income 139-400% of the Federal Poverty Level
Source: Authors' analysis of American Community Survey 2015; Medi-Cal estimates adjusted to match enrollment total from California Department of Health Care Services (DHCS) in July 2016
Notes: Workers include self-employed; Medi-Cal estimates include restricted-scope aid codes; Medi-Cal expansion estimates include childless adults ages 18-64 without disability

Workers in these industries have higher rates of enrollment in ACA coverage because they are generally less likely than the average worker to be offered or eligible for employer-sponsored insurance,[7] and they are more likely to have family income within the range that makes them eligible for the Medi-Cal expansion or subsidized coverage through Covered California. The Medi-Cal income eligibility threshold for non-disabled adults under age 65 is 138% of the Federal Poverty Level (FPL), or approximately $16,600 for a single individual and $33,900 for a family of four in 2017. Families that are not eligible for Medi-Cal are eligible for subsidies through Covered California if they have income up to 400% FPL, or approximately $48,200 for a single individual and $98,400 for a family of four.

Agricultural, restaurant, and other service industry workers disproportionately rely on Medi-Cal

Nearly one in five (18.7%) workers ages 18-64 in California were estimated to be enrolled in Medi-Cal in 2015, whether they were eligible due to the Medi-Cal expansion under the ACA or were already eligible prior to the law because they were a parent, had a disability, or met some other categorical eligibility criteria. In certain industries, more than one-quarter or one-third of workers were estimated to be enrolled in Medi-Cal: agriculture and related industries (36.2%); restaurant workers (33.4%); temporary workers, security guards, and landscapers (31.5%); workers in other parts of the service industry like auto repair, hair salons, and private households (29.6%); and retail workers (25.5%) (Exhibit 2). The estimated number of workers enrolled by industry in 2015 is shown in Appendix Exhibit A.

Exhibit 2: Estimated Percentage of California Workers Ages 18-64 Enrolled in Medi-Cal by Industry, 2015
Includes all Medi-Cal eligibility categories for non-elderly adults, including the ACA expansion



Source: Authors' analysis of American Community Survey 2015; Medi-Cal estimates adjusted to match enrollment total from DHCS in July 2016
Notes: Workers include self-employed; Includes Medi-Cal restricted-scope aid codes

Workers in these industries are more likely to enroll in Medi-Cal because they are less likely than the average worker to be offered or eligible for employer-sponsored insurance[8] and they are more likely to be low income.

Loss of Health Insurance Could Lead to Increased Worker Absenteeism and Reduced Productivity

If Congress repeals the ACA or makes changes to Medicaid funding that result in cuts to eligibility or benefits, many workers would become uninsured, have less access to healthcare services, or struggle to afford healthcare or insurance. The firms that employ them could also face negative consequences. Research has shown that workers with health insurance are less likely to miss work and miss fewer days of work than those without insurance, even after taking into account underlying differences in health between the two groups.[9] Health issues also affect performance at work. Numerous studies have quantified the economic losses from reduced productivity due to health problems.[10] Few studies have analyzed the direct relationship between workers' access to health insurance and their productivity levels, but one analysis of manufacturing plants found that workers offered health insurance did have greater productivity.[11]

Conclusion

Workers in certain California industries – agriculture and service industries including restaurants, retail, auto repair, hair salons, private households, and building services – would be especially affected by ACA repeal because their rates of combined enrollment in the Medi-Cal expansion and subsidized insurance through Covered California (ranging from 16.9% to 24.4%) are higher than for the state's workforce overall (13.9%). In these same industries, between one-quarter and one-third of workers are enrolled in the overall Medi-Cal program, compared to less than one-fifth of the workforce generally, indicating that potential reductions in eligibility or cuts to benefits resulting from federal policy change would hit workers in these industries harder. Firms that employ these workers could also be harmed by increased absenteeism and reduced productivity due to the health insurance losses.

Endnotes

1. Dietz M, Lucia L, Kominski GF, and Jacobs K. **ACA Repeal in California: Who Stands to Lose?** UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research, December 2016.

2. Park E and Solomon J. **Per Capita Caps or Block Grants would Lead to Large and Growing Cuts in State Medicaid Programs**. Center on Budget and Policy Priorities, June 22, 2016.

3. Kaiser Family Foundation. **State Health Facts: Distribution of the Nonelderly with Medicaid by Family Work Status**, 2015.

4. Data is not available on which Covered California enrollees receiving subsidies are in working families. Using the

Appendix Exhibit A. Estimated Number of California Workers Ages 18-64 Enrolled in ACA Coverage or Medi-Cal by Industry, 2015

	Workforce Total	Enrollment			
		Medi-Cal	Medi-Cal Expansion	Covered California with subsidies*	Total ACA Enrollment
Administrative & Building Services	937,000	295,000	143,000	51,000	194,000
Agriculture, Forestry, Fishing & Mining	503,000	182,000	67,000	18,000	85,000
Construction	1,175,000	252,000	112,000	53,000	165,000
Education	1,560,000	193,000	110,000	61,000	171,000
Finance, Insurance, Real Estate	1,077,000	107,000	51,000	49,000	100,000
Health Care & Social Assistance	2,225,000	441,000	204,000	87,000	291,000
Information	552,000	46,000	28,000	20,000	48,000
Manufacturing	1,736,000	259,000	121,000	58,000	179,000
Other Leisure & Hospitality Services	729,000	144,000	78,000	42,000	120,000
Other Services (Auto Mechanics, Hair Salons, Private Households, etc.)	957,000	283,000	139,000	73,000	212,000
Professional, Scientific & Management	1,518,000	123,000	70,000	66,000	136,000
Public Administration, Utilities, & Military	1,064,000	83,000	40,000	18,000	58,000
Restaurants, Bars, & Other Food Services	1,287,000	430,000	234,000	80,000	314,000
Retail	2,061,000	526,000	297,000	104,000	401,000
Transportation & Warehousing	774,000	168,000	83,000	39,000	122,000
Wholesale Trade	536,000	80,000	37,000	28,000	65,000
All industries	17,754,000	3,317,000	1,671,000	796,000	2,467,000

* Potentially enrolled in subsidized insurance through Covered California because reporting individual market coverage and income 139-400% of the Federal Poverty Level
Source: Authors' analysis of American Community Survey 2015; Medi-Cal estimates adjusted to match enrollment total from DHCS in July 2016
Notes: Workers include self-employed; Medi-Cal estimates include restricted-scope aid codes; Medi-Cal expansion estimates include childless adults ages 18-64 without disability

methods described in this brief, we estimate that 796,000 California working adults were enrolled in individual market insurance and had income in the range that made them potentially eligible for premium subsidies (Appendix Exhibit A), out of approximately 1.2 million individuals enrolled in subsidized insurance through Covered California in 2015 (Covered California, **Active Member Profile**, June 2015). An unknown share of the approximately 400,000 remaining enrollees may have working spouses or parents. These estimates suggest that at least the majority of enrollees are in working families, though the precise percentage remains unknown.

5. California Department of Health Care Services, Research and Analytic Studies Division, **Medi-Cal Monthly Enrollment Fast Facts**, July 2016.

6. The estimated enrollment rates for agricultural workers in this brief reflect our best estimates using the U.S. Census Bureau's American Community Survey. However, past research has shown that the U.S. Census undercounts farmworker households, especially immigrant farmworker households. (Kissam E, **A Summary Review of Research Relevant to Housing Units Missing from the Census Bureau's Master Address File (MAF)**, WKF Giving Fund, October 3, 2016.) Therefore, the total size of the agricultural workforce presented in this brief is likely an underestimate. Assuming that farmworkers who are not counted in the survey are more likely to lack eligibility for full-scope Medi-Cal benefits or Covered California due to immigration status, the number of agricultural workers utilizing these programs in this brief may be underestimated, while the share of agricultural workers utilizing the programs might be overestimated.

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BROOKINGS

Report

How has Obamacare impacted state health care marketplaces?

Michael Morrisey, Richard P. Nathan, Alice M. Rivlin, and Mark Hall Thursday, February 9, 2017

The Affordable Care Act (ACA) changed the nature of competition among health plans by creating regulated insurance exchanges, introducing new insurance industry regulations, and providing premium and cost-sharing reduction subsidies. Through these reforms, the law aimed to increase access to and the value of insurance coverage while lowering costs. To better understand the law's implementation and its effect on competition, researchers with the ACA Implementation Research Network interviewed key marketplace stakeholders to analyze why carriers chose to enter or exit markets, how provider networks were built, and how state regulatory decisions affected the landscape.

As Congress and the new Administration deliberate on what's next for the law, the Network presents their analyses of competition in California, Florida, Michigan, North Carolina, and Texas (PDFs). A summary report (PDF) of the general findings, authored by Texas A&M Professor Michael Morrisey, Brookings Senior Fellow Alice Rivlin, ACA Network Lead Richard P. Nathan, and Mark A. Hall, Brookings Nonresident Senior Fellow, is intended to generate hypotheses for further testing across state marketplaces and to identify individual idiosyncrasies within the states that provide context for national- and state-level reforms.

STATE HIGHLIGHTS

1. In **California** (PDF), Micah Weinberg and Patrick Kallerman of the Bay Area Council Economic Institute report that the state's uninsured population was cut in half between 2014 and 2017, and many stakeholders attributed this to both the state's

active purchasing model—including aggressively negotiating with insurers over premiums— and their active navigator program—which succeeded in increasing enrollments for individuals between 100 and 200 percent of the federal poverty level.

2. In **Florida** (PDF), Patricia Born of Florida State University noted that respondents in the state see the marketplace as being largely successful, particularly in population-dense areas, and highlighted the positive impact navigators and other consumer-assistance efforts appear to have had in many parts of the state, despite legislation making navigator licensure more difficult.

3. In **North Carolina** (PDF), the participation of Aetna and UnitedHealthcare provided a strong start for the state marketplace. However, Mark A. Hall and Katherine Booth of Wake Forest University report that both insurers withdrew due to higher-than-expected claim costs and the state's lack of Medicaid expansion. Additionally, the decision of the federal government to refuse to permit a merger between Aetna and Humana likely contributed to Aetna's decision to pull out, leaving Blue Cross as the dominant insurer in the state.

4. In **Michigan** (PDF), Megan Foster Friedman, Josh Fangmeier, Nancy Baum and Marianne Udow-Phillips at the Center for Healthcare Research & Transformation report that the success of regional insurers over national insurers, particularly Medicaid managed care organizations, is believed to have contributed to the general success of competition in Michigan compared to other states.

5. In **Texas** (PDF), Michael Morrisey and Tiffany Radcliff of Texas A&M University found that the marketplace "unraveled rather dramatically," when insurers left the marketplace due to higher-than-expected claims and losses from poor risk

adjustment procedures, leaving even major urban areas like Houston with only three insurers.

CONCLUSION

While the results of this five-state study may not be applicable across the country, the authors emphasize a few key lessons for further consideration when crafting a potential replacement plan or changes to the law:

1. **Health insurance markets are local** and depend on the ability of insurers to create competitively priced plans. While this is often more difficult in rural locations, metropolitan areas also see variation in competition.

2. **Higher-than-expected claims costs caused concern** for insurers initially, as they lacked information on the amount of health care service utilization to expect from exchange enrollees. It remains to be seen whether the trend will continue or if recent market adjustments reflect a "one-time correction."

3. **Insurer networks have narrowed,** which potentially provides greater opportunity for insurers to negotiate lower prices by assuring a greater volume of patients to a more limited number of providers. The number of preferred provider organization (PPO) exchange plans has also been decreasing, as these plans had disproportionate enrollment of people with pre-existing conditions and are generally less able to negotiate low prices from providers.

4. **Both hospital and provider competition are vital for competitive markets**, with population and the number of physician groups and health systems playing a role in cost competition.

ACA **SPOTLIGHT**

LAST UPDATED- FEBRUARY 2017:

Potential Impact of ACA Repeal on California: Premi Tax Credits

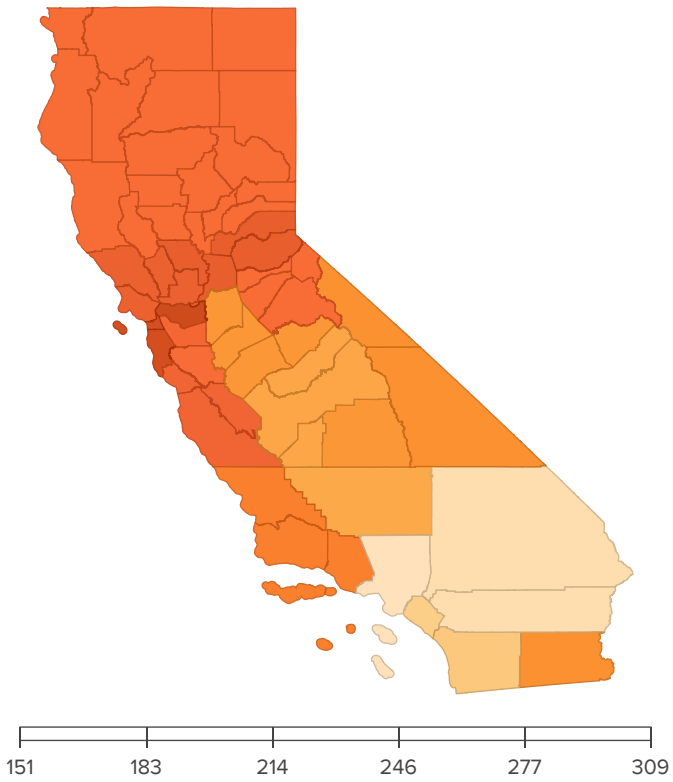
If premium tax credits were eliminated, how much would premium costs increase for those with Covered Californi health insurance?

SEE A SIMILAR ANALYSIS FOR STATES WITH HEALTHCARE.GOV PLANS.

VIEW ▶ Gross increase in premium cost without PTC ($) | FOR ▶ 27 YEAR OLD AT 150% FPL | SEE RESULT

Gross Increase in Monthly Health Insurance Cost Without a Premium Tax Credit (PTC) by County

For a Single 27 Year Old Earning $17,820 Annually/at 150% of the Federal Poverty Level (FPL)



Overview

Health insurance plans offered through Covered California, California's Affordable Care Act (ACA) Marketplace, charge enrollees a monthly premium. Lower-income enrollees may qualify for a premium tax credit (PTC) to subsidize a plan's premium costs and decrease the amount the enrollee pays each month.

As of January 2017, there is no change to the ACA and PTCs are available to those who qualify. However, the US Congress is considering legislation to significantly alter the ACA, including the possible elimination of PTCs. This installment of the ACA Spotlight illustrates what the increases in enrollees' premium costs would be for Covered California plans if PTCs were eliminated based on the 2017 premiums.

For example in Alameda County, for a 27 year old earning $17,820 annually and enrolled in the second-lowest cost silver plan, he or she could see the monthly premium cost go up to $340 per month without a PTC, a 467% increase from the $60 per month the enrollee would pay with a PTC. This would increase the enrollee's share of annual income paid toward premium costs from 4% to 23%, nearly a quarter of his or her annual earnings. To see the effects on premium costs for other counties, ages, and income levels, use the drop-down menus at the top.

Background

Methodology

Additional Resources

ASPE RESEARCH BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

Did Consumers Respond to Changes in Gross Premiums or to Changes in Premiums Net of Tax Credits When Making Health Plan Choices in the 2016 ACA Marketplaces?

January 18, 2017

The Affordable Care Act established the Health Insurance Marketplaces (Marketplaces) to provide consumers with choices of affordable health plans offered in a competitive insurance market. HealthCare.gov and state-run Marketplaces offer detailed information about each health insurance plan sold in an area, including the premiums, deductibles, other out-of-pocket costs, provider network, and more. Consumers can obtain information regarding their expected premium after tax credits by inputting their age, income, family size, geographic location, and smoking status when shopping.

Previous modeling by ASPE assumed that consumers make their plan choices based on their expected premiums net of tax credits.[i] However, as there is much public reporting each year – especially in the media – regarding premium growth that does not take into account the countervailing effect of premium tax credits, it is conceivable that increases in gross premiums could have an effect on consumers' plan choices.

To explore whether consumers responded to changes in net or gross premiums when making health plan choices in the 2016 ACA Marketplaces, we conducted two sets of analyses, one based on comparing counties and one based on comparing individuals.

In the county-level analysis, we conduct a statistical analysis comparing plan switching rates across counties by changes in average enrollment-weighted gross premiums between 2015 and 2016 and by changes in benchmark premiums between 2015 and 2016. The logic behind the county-level analysis is that, in counties in which average gross premiums increased yet benchmark premiums kept pace, most consumers likely saw little change in their premiums net of tax credits. Thus, if consumers are responding only to net premiums when making plan choices, it should not matter, in these counties, whether gross premiums increased by a large or small degree. However, if consumers are responding to increases in gross premiums when making plan decisions, we likely would see more consumers switching plans in counties when gross premiums increase regardless of whether benchmark premiums kept pace.

[i] For example, see DeLeire and Marks, "Consumer Decisions Regarding Health Plan Choices, in the 2014 and 2015 Marketplaces" ASPE Research Brief, October 28, 2015.

In our individual-level analysis, we conduct a statistical analysis examining whether consumers were more likely to switch plans in 2016 when their gross premium increased, or when their net premium increased.

Key Findings

- Comparing counties, we find:
  - A substantially greater fraction of Marketplace enrollees switched plans in 2016 when average premiums increased but benchmark premiums did not keep pace than if premiums did not change.
    - For example, we estimate that a $50 increase in average premiums with no change in benchmark premiums would lead to a 9.8 percentage point increase in the switching rate (a 37% increase).
  - When average premiums increased but benchmark premiums increased by the same amount, the fraction of Marketplace enrollees that switched plans in 2016 increased by a small amount, consistent with the fact that only a small percentage of enrollees are not eligible for premium tax credits.
    - For example, we estimate that a $50 increase in both average premiums and benchmark premiums led to a 3 percentage point increase (11%) in the switching rate.
  - These results suggest that consumers primarily respond to net premiums, rather than to gross premiums, when making plan selections in 2016.
- Examining consumer decisions at the individual-level, we find:
  - Consumers were much more likely to switch plans when the net premium of their 2015 plan increased (e.g., when that plan's premium increases by more than the benchmark premium), but were not more likely to switch plans when the gross premium of their 2015 increased but the net premium did not.
    - For example, we estimate that, if both net premiums and gross premiums increased by $50, the fraction of enrollees switching plans in 2016 increased 7.4 percentage points (34%). However, if gross premiums increased by $50 but net premiums did not change, there was no increase in the fraction of enrollees switching plans.
  - These results also suggest that consumers only responded to net premiums, and did not respond to gross premiums, when making plan selections in 2016.

I. CONSUMER RESPONSIVENESS TO CHANGES IN AVERAGE AND BENCHMARK PREMIUMS AT THE COUNTY LEVEL

A. Motivation

Counties experienced large variation in their rates of premium growth – both growth in average premiums and benchmark premiums – between 2015 and 2016. Because of the way in which tax credits are calculated, consumers who are eligible for premium tax credits (roughly 85% of Marketplace enrollees in 2015), experience no increase in premiums net of tax credits if benchmark premiums increase by the same amount as their plan's premium. (For the purposes of this analysis, we hold consumers' age, family composition, and income constant.) Thus, we would expect to see little difference in consumer behavior across counties in which average premiums and benchmark premiums

increased by the same amount, if consumers responded to premiums net of tax credits when making plan decisions. However, if consumers respond to average premiums without taking into account tax credits, we would see greater responsiveness (in terms of plan switching) among consumers in counties in which average premiums increased substantially regardless of whether benchmark premiums kept pace.

B. Approach

To conduct this analysis, we calculate the enrollment-weighted average age 21 Marketplace premium in each county in 2015 and 2016 using enrollment and premium data from CMS on states using the HealthCare.gov platform in both 2015 and 2016. We also calculate the benchmark premium in each county in each year. Finally, we calculate the county-level switching rate as the fraction of individuals in a county that purchased Marketplace coverage in both 2015 and 2016 who selected a different plan in 2016 than in 2015.[ii]

Table 1 reports the average and standard deviation of these premiums in each year as well as of the switching rate in 2016.

Table 1
County-Level Summary Statistics

	Mean	Standard Deviation
Fraction of 2015 Enrollees that Switched Plans in 2016	0.215	0.132
Average Age 21 2015 Premium	$217.85	$27.47
Average Age 21 2016 Premium	$236.32	$35.86
Difference	$18.44	$19.48
Percent Difference	8.1%	7.9%
2015 Age 21 Benchmark Premium	$217.83	$30.59
2016 Age 21 Benchmark Premium	$229.59	$39.67
Difference	$16.41	$24.04
Percent Difference	7.2%	10.4%
N	2,597	

Source: CMS enrollment and premium information from states using the HealthCare.gov platform in 2015 and 2016.

Notes: Statistics are weighted by total Marketplace enrollment at the county-level.

[ii] For consumers whose 2015 plan is no longer available in 2016, we do not consider them to have switched plans if they select the "cross-walked" plan.

We conduct a statistical analysis in which we related the county-level switching rate to the 2015 to 2016 changes in the county-level average premium and the county-specific benchmark premium using linear regression. We estimate two specifications, one in which the change in premiums are measured in dollars, and one in which the change in premiums are measured in percentage terms. The results of this statistical analysis are reported in Appendix Table 1.

C. Findings

The county-level switching rate was highly sensitive to changes in average premiums and was sensitive only to a small degree to changes in average premiums net of changes in benchmark premiums in 2016, based on the results of our statistical model.

This result is illustrated in Table 2 and in Figure 1. In both, we report the estimated increase in the county-level switching rate in response to a $50 increase in both the average and benchmark premium and the estimated increase in the switching rate in response to a $50 increase in the average premium with no change in the benchmark premium.[iii] In the case in which average premiums increase and benchmark premiums keep pace, most consumers would not see much of a change in their premiums net of tax credits. However, in the case in which average premiums increase but benchmark premiums do not change, all consumers would see their premiums increase as tax credits would not change from their previous-year levels.

In 2016, the average county-level switching rate was 21.5%. The results show that the switching rate was substantially higher – 9.8 percentage points higher – in counties in which average premiums increased by $50 but benchmark premiums did not change. By contrast, the switching rate was only slightly higher – 3.0 percentage points higher – in counties in which both average and benchmark premiums increased by $50. This finding is consistent with the fact that only a small percentage of Marketplace consumers were not eligible for tax credits in 2015 and 2016.

Table 2

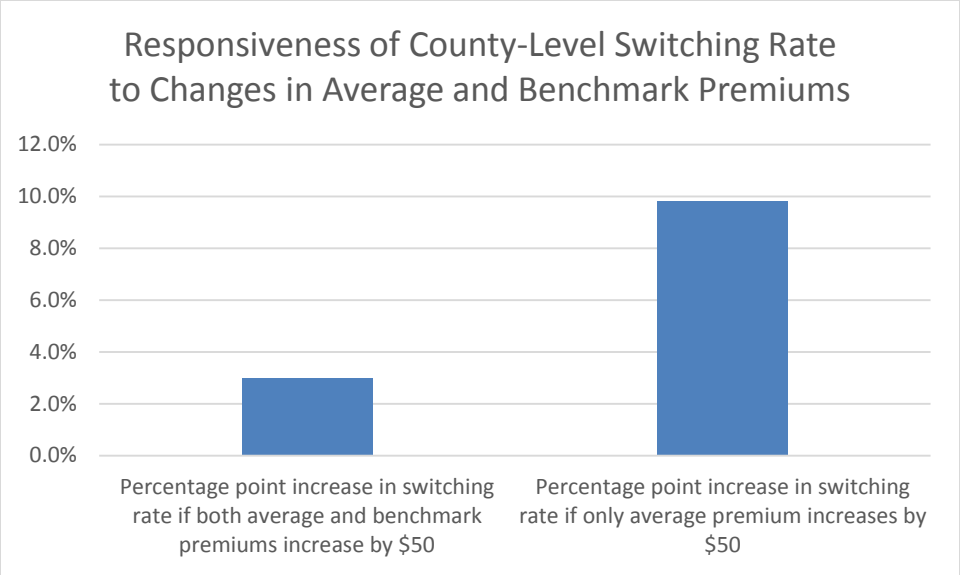
Estimated Responsiveness of the County-Level Switching Rate to Changes in the Average and Benchmark Premiums

Percentage point increase in switching rate if both average and benchmark premiums increase by $50	3.0%
Percentage point increase in switching rate if only average premium increases by $50	9.8%
Average County-Level Switching Rate	21.5%

Source: CMS enrollment and premium information from states using the HealthCare.gov platform in 2015 and 2016.
Notes: Based on a linear regression weighted by county-level Marketplace enrollment. Model results reported in Appendix Table1.

[iii] These estimates are based on the specification, reported in Appendix Table 1, in which we measure changes in premiums in levels. We prefer this specification because premiums net of tax credits are designed to remain constant only if benchmark premiums increase by the same amount, in dollar terms, as the increase in premiums.

Figure 1



The findings presented in Table 2 and in Figure 1 are consistent with consumers being sensitive to the net premium rather than to the gross premium when making health plan choices in 2016.

II. CONSUMER RESPONSIVENESS TO CHANGES IN NET AND GROSS PREMIUMS AT THE INDIVIDUAL LEVEL

A. Motivation

Consumers also experienced large variation in how much the gross premium of their 2015 plan increased in 2016 and in how much the premium, net of tax credits, of their 2015 selected plan increased in 2016. In this section, we explore whether consumers are sensitive to changes in their net premium or to changes in their gross premium when making Marketplace plan choice decisions.

Consumers who were enrolled in Marketplace plans in 2015 could have seen these premiums change to varying degrees in 2016. Moreover, they also could have seen changes in their net premiums depending, in addition, upon how their benchmark premium changed between 2015 and 2016. 2016 premium tax credits also could change if the consumer's family income or family size changed.

Because of the same underlying variation across areas in premiums and benchmark premiums discussed in the previous section, there was a great deal of variation across consumers in terms of how gross and net premiums changed between 2015 and 2016. We use this variation to determine whether consumers respond to changes in their gross premium or to changes in their net premium when making 2016 plan choices.

B. Approach

To conduct the individual-level analysis, we restrict the population to 2016 Marketplace enrollees who were also enrolled in 2015. For each of these consumers, we determine both the gross premium and the premium net of any advanced premium tax credits of the plan selected in 2015. We also determine the 2016 gross premium of the plan the consumer selected in 2015. The difference in gross premiums, for a consumer, between 2015 and 2016 is calculated as the difference between the 2015 and 2016 premium

of the plan selected in 2015. We calculate the 2016 net premium of the plan the consumer selected in 2015 as the 2016 gross premium of that plan less the amount of APTC the consumer was eligible for in 2016. The difference in net premium between 2015 and 2016 is calculated as the difference between the 2015 and 2016 net premiums of the plan selected in 2015. Finally, we determine that a consumer switched plans between 2015 and 2016 if the plan selected in 2016 is different from the plan selected in 2015.[iv]

Table 3 reports the average and standard deviation of premiums in each year and of the individual level switching rate in 2016.

Table 3
Individual-Level Summary Statistics

	Individuals	
	Mean	Standard Deviation
Fraction of 2015 Enrollees that Switched Plans in 2016	0.215	0.169
2015 Gross Premium	$351.91	$181.70
2016 Gross Premium of 2015 Selected Plan	$409.67	$211.55
Difference	$57.77	$60.89
Percent Difference	15.3%	14.4%
2015 Net Premium	$139.51	$141.96
2016 Net Premium	$179.26	$161.79
Difference	$39.74	85.5
Percent Difference	33.2%	70.2%
N	9,862,592	

Source: CMS enrollment and premium information from states using the HealthCare.gov platform in 2015 and 2016.

One could determine whether consumers respond to changes in gross or net premiums by estimating linear regressions of the probability of switching plans in 2016 where the change in the net premium of the 2015 selected plan and the change in the gross premium of the 2015 selected plan are the independent variables. However, this approach is complicated by the fact that the change in the net premium between 2015 and 2016 likely is endogenous. This endogeneity could arises because changes in income or changes in family size should have a direct effect on whether a consumer changes plans above and beyond any indirect effects through how these changes affect premium tax credits. As a result, we use a method that deals with this issue.

To estimate the effect of changes in the consumer's net premium on plan choice decisions, we use an instrumental variables approach. We first construct a "simulated" 2016 net premium of the consumer's

[iv] For consumers whose 2015 plan is no longer available in 2016, we do not consider them to have switched plans if they select the "cross-walked" plan.

2015 selected plan as the 2016 gross premium less the consumer's 2015 APTC, which is unaffected by changes in the consumer's income or family size between 2015 and 2016. At the same time, there is substantial stability across plan years in terms of APTCs. We then use the change between the 2015 net premium and the 2016 "simulated" net premium as an instrument for the change in the net premium between 2015 and 2016 in our analysis.[v] The results of this statistical analysis are reported in Appendix Table 2. As in the county-level analysis, we report the results of two specifications: one in which the difference in premiums is measured in levels and one in which this difference is measured in percentage terms.

C. Findings

The likelihood that consumers switched plans in 2016 was highly sensitive to changes in net premiums and was not sensitive to changes in gross premiums, based on the results of our statistical model.

This result is illustrated in Table 4 and in Figure 2. In both, we first report the estimated percent increase in the individual-level switching rate in response to a $50 increase in the gross premium with the net premium not increasing at all (which could occur, for example, if the benchmark premium increased by the same amount as the consumer's 2015 premium). Second, we report the estimated change in the individual-level switching rate in response to a $50 increase in both the gross and net premium (which could occur, for example, if the consumer's 2015 premium increased but the benchmark premium did not change).[vi]

In 2016, the average individual-level switching rate was 21.5%. The results show that the switching rate was substantially higher – 7.4 percentage points higher – among individuals whose net premiums increased by $50. By contrast, the results show that the switching rate was not higher among individuals whose gross premiums increased but whose net premiums did not change.

Table 4

Estimated Responsiveness of the County-Level Switching Rate to Changes in the Average and Benchmark Premiums

Percentage point increase in switching rate if gross premium increases by $50 but net premium does not change	-3.2%
Percentage point increase in switching rate if gross and net premiums both increase by $50	7.4%
Average Individual-Level Switching Rate	21.5%

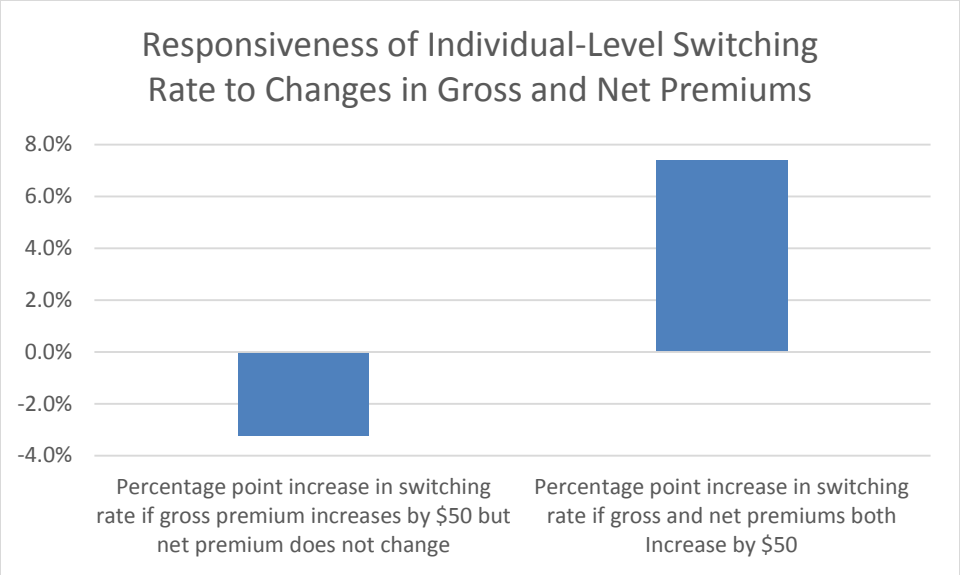
Source: CMS enrollment and premium information from states using the HealthCare.gov platform in 2015 and 2016.

Notes: Estimated by instrumental variables. Robust standard errors clustered at the rating area level are reported in parentheses.

[v] The coefficient from the "first-stage" regression of simulated change in net premiums on the change in net premiums is 1.002 with a standard error of 0.001. The coefficient from the "first-stage" regression of the percent change in simulated net premiums on the percent change in net premiums is 0.138 with a standard error of 0.005.

[vi] These estimates are based on the specification, reported in Appendix Table 2, in which we measure changes in premiums in levels. We once again prefer this specification because premiums net of tax credits are designed to remain constant only if benchmark premiums increase by the same amount, in dollar terms, as the increase in premiums.

Figure 2



The findings presented in Table 4 and in Figure 2, once again, are consistent with consumers being sensitive to the net premium rather than to the gross premium when making health plan choices in 2016.

III. CONCLUSIONS

In this brief, we examine whether there is evidence that consumers responded to gross premiums, rather than to net premiums, when making plan choice decisions in 2016. We find little evidence to support the idea that consumers responded to changes in gross premiums during the 2016 open enrollment period.

In 2017, the increases in average premiums were substantial in many parts of the country and tended to be much larger than in 2016.[vii] However, because benchmark premiums increased substantially as well, we expect that most consumers will see little change in their premiums net of tax credits. The findings presented in this brief suggest that consumers will respond to the change in their net premium, not to changes in the premium without taking into account tax credits.

[vii] "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace" ASPE Research Brief, October 24, 2016.

Appendix Tables

Appendix Table 1

Effect of Changes in Average and Benchmark Premiums on County-Level Switching Rates

	Level Differences	Percent Differences
Difference in Average Premium, 2015 to 2016	0.0020	0.4418
	(0.0005)	(0.1097)
Difference in Benchmark Premium, 2015 to 2016	-0.0014	-0.2654
	(0.0004)	(0.0898)
Constant	0.2648	0.2621
	(0.0063)	(0.0067)
N	2,597	2,597

Source: CMS enrollment and premium information from states using the HealthCare.gov platform in 2015 and 2016.

Notes: Estimated by linear regression weighted by county-level Marketplace enrollment. Robust standard errors are reported in parentheses.

Appendix Table 2

Effect of Changes in Gross and Net Premiums on Individual-Level Switching Rates

	Level Differences	Percent Differences
Difference in Gross Premium, 2015 to 2016	-0.0006	0.1276
	(0.0005)	(0.0285)
Difference in Net Premium, 2015 to 2016	0.0021	0.0554
	(0.0007)	(0.0092)
Constant	0.2102	0.2191
	(0.0059)	(0.0062)
N	9,862,592	9,862,592

Source: CMS enrollment and premium information from states using the HealthCare.gov platform in 2015 and 2016.
Notes: Estimated by linear regression weighted by county-level Marketplace enrollment. Robust standard errors are reported in parentheses.

Congressional Budget Office

JANUARY 2017

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.

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Pre-ACA Market Practices Provide Lessons for ACA Replacement Approaches

Gary Claxton, Larry Levitt, and Karen Pollitz

Significant changes to the Affordable Care Act (ACA) are being considered by lawmakers who have been critical of its general approach to providing coverage and to some of its key provisions. An important area where changes will be considered has to do with how people with health problems would be able to gain and keep access to coverage and how much they may have to pay for it. People's health is dynamic. At any given time, an estimated 27% of non-elderly adults have health conditions that would make them ineligible for coverage under traditional non-group underwriting standards that existed prior to the ACA. Over their lifetimes, everyone is at risk of having these periods, some short and some that last for the rest of their lives.

One of the biggest changes that the ACA made to the non-group insurance market was to eliminate consideration by insurers of a person's health or health history in enrollment and rating decisions. This assured that people who had or who developed health problems would have the same plan choices and pay the same premiums as others, essentially pooling their expected costs together to determine the premiums that all would pay.

Proposals for replacing the ACA such as Rep. Tom Price's Empowering Patients First Act and Speaker Paul Ryan's "A Better Way" policy paper would repeal these insurance market rules, moving back towards pre-ACA standards where insurers generally had more leeway to use individual health in enrollment and rating for non-group coverage.[1] Under these proposals, people without pre-existing conditions would generally be able to purchase coverage anytime from private insurers. For people with health problems, several approaches have been proposed: (1) requiring insurers to accept people transitioning from previous coverage without a gap ("continuously covered"); (2) allowing insurers to charge higher premiums (within limits) to people with pre-existing conditions who have had a gap in coverage; and (3) establishing high-risk pools, which are public programs that provide coverage to people declined by private insurers.

The idea of assuring access to coverage for people with health problems is a popular one, but doing so is a challenge within a market framework where insurers have considerable flexibility over enrollment, rating and benefits. People with health conditions have much higher expected health costs than people without them (Table 1 illustrates average costs of individuals with and without "deniable" health conditions). Insurers naturally will decline applicants with health issues and will adjust rates for new and existing enrollees to reflect their health when they can. Assuring access for people with pre-existing conditions with limits on their premiums means that someone has to pay the difference between their premiums and their costs. For people enrolling in high-risk pools, some ACA replacement proposals provide for federal grants to states, though the amounts may not be sufficient. For people gaining access through continuous coverage provisions, these costs

would likely be paid by pooling their costs with (i.e., charging more to) other enrollees. Maintaining this pooling is difficult, however, when insurers have significant flexibility over rates and benefits. Experience from the pre-ACA market shows how insurers were able to use a variety of strategies to charge higher premiums to people with health problems, even when those problems began after the person enrolled in their plan. These practices can make getting or keeping coverage unaffordable.

Table 1: Average Health Costs for Non Elderly Adults With and Without Deniable Health Conditions, by Age Range, 2014

Age Range	Average Costs	
	With Deniable Condition	Without Deniable Condition
18-34	$5,190	$1,809
35-44	$6,371	$2,279
45-54	$10,195	$2,657
55-64	$11,537	$4,641
18-64	$8,853	$2,527

Source: Kaiser Family Foundation analysis of data from the Medical Expenditure Panel Survey.

The discussion below focuses on some of the issues faced by people with health issues in the pre-ACA non-group insurance market. These pre-ACA insurance practices highlight some of the challenges in providing access and stable coverage for people and some of the issues that any ACA replacement plan will need to address. Many ACA replacement proposals have not yet been developed in sufficient detail to fully deal with these questions, or in some cases may defer them to the states.

We start by briefly summarizing key differences between the ACA and pre-ACA insurance market rules for non-group coverage that affect access and continuity of coverage. We then focus on pre-ACA access and continuity issues for three different groups: (1) people transitioning from employer coverage or Medicaid to the non-group market; (2) people with non-group coverage who develop a health problem; and (3) people who are uninsured (are not considered to have continuous coverage) who want to buy non-group coverage. After that, we discuss how medical underwriting and rating practices can segment a risk pool, initially and over time, and challenges that this poses for assuring continuous coverage. We end by reviewing some of the policy choices for addressing the challenges that have been raised.

Non-Group Insurance Market Practices Before the ACA

The ACA significantly simplified the rules for health insurance enrollment, rating and benefits in the non-group market. Generally, benefits are the same for all policies offered in a state, with four levels of cost sharing (bronze, silver, gold, and platinum). Insurers cannot consider a person's health at enrollment or in determining their premium. People can enroll in any plan during an annual open enrollment period or other times under special circumstances (called special enrollment periods), such as the loss of prior coverage.

The ACA was a substantial departure from prior insurance practices in most states, where insurers had far more flexibility over enrollment, rating and benefits. State laws and practice varied -- for example, a few states required insurers to accept all applicants and prohibited rating variation based on health, similar to the ACA -- but this was not the norm. In most states, insurers were permitted to consider health in their enrollment and rating decisions. Some of the more important differences between ACA and pre-ACA market rules are described here. Their implications for providing access to coverage and assuring continuous and stable coverage are discussed in the next sections.

1) **Medical Screening of Applicants.** The first and most obvious difference is that insurers could ask applicants about their health and generally could deny coverage to people with health problems. They also could choose to accept the applicant at a higher premium, and, in many states, could accept the applicant but limit the terms of the coverage to exclude benefits related to a specified health condition (for example, an insurer could exclude benefits related to asthma). Underwriting decisions could vary with the type and level of coverage sought: an insurer could deny enrollment in a policy with a lower deductible to an applicant with a relatively minor condition, such as acne, but might accept them in a higher deductible plan or in a plan without drug coverage.

   As will be discussed in the next section, the Health Insurance Portability and Accountability Act (HIPAA) provided access to coverage for people with at least 18 months of prior coverage, if the most immediate prior coverage was in a group health plan (generally a plan offered pursuant to employment by a public or private employer, but not Medicaid or Medicare). Insurers were required to accept these applicants (called "HIPAA-eligible" individuals) without a pre-existing condition exclusion, but generally could charge them much higher rates than other applicants. States could specify an alternative coverage mechanism for HIPAA-eligible applicants; 38 states specified an alternative, with most specifying a state high-risk pool. HIPAA-eligible individuals without health problems could choose to apply for medically-underwritten non-group policies, but doing so made them subject to preexisting condition exclusion provisions (see Medical Underwriting and Pre-existing Condition Exclusion Provisions box below).

2) **Multiple Rating Classes for Similar People in the Same Policy.** Another difference is that premiums for people of the same age from the same place could be quite different for the same policy. Except for a differential for smoking, people of the same age from the same place face the same (unsubsidized) premium for the same plan under the ACA. Prior to the ACA, there were many rate classifications. For example, there could be a rate for new applicants who have no health conditions, there could be several "substandard" rate tiers for people with health problems, there could be different rates for people based on how long they have had the policy (durational rating, described more below, which means that a newly issued 40 year old would pay a lower rate than a 40 year old who bought the same policy two years prior), there could be different rates based on how the policy was purchased (through an agent, directly from the insurer, through a trade group), the person's occupation, and others. Also, from year to year, the rates in each class could change by different percentages, increasing the differences for similar people in different rating classes.

3) **Rating by Policy or Block.** A third difference relates to how premiums are established for different policies offered by an insurer in a state. Under the ACA, where all policies cover the same essential health benefits, an average expected cost is estimated for all projected enrollees across all of an insurer's non-group products in a state, and premiums for particular policies are determined on the objective differences (i.e., cost sharing and provider network) from the average cost. In contrast, prior to the ACA, premiums were established for each policy (or a group of policies, sometimes called a block) based on the expected claims costs for the people expected to be enrolled in that policy or block, projected over current and future years. Importantly, the experience of each policy or block is developed independent of the costs or results expected in other policies or blocks, which means that two policies that are almost the same could have very different premiums associated with them based on the anticipated costs of who is projected to be enrolled (and who has actually enrolled). As discussed more below, a policy or block of policies no longer for sale to new people (called a closed policy or block) would likely have much higher premiums for the same benefits than a policy currently available to new enrollees.[2]

4) **Broad Variation in Benefits Across Policies.** Another difference is that there was significant variation in the benefits covered by pre-ACA policies, including options that excluded entire classes of benefits such as prescription drugs or mental health. Under the ACA, all policies cover the same essential health benefits, with variations largely relating to cost sharing and network. Pre-ACA policies sometimes had annual or lifetime limits on specific or total benefits: for example, a policy might limit prescription benefits to $500 per year. Most states specified some benefits that needed to be covered or at least offered to applicants by insurers.

5) **Limited Ability to Switch Among Non-Group Plans.** A fifth difference relates the ability of a person with non-group coverage to switch policies without re-submitting to medical underwriting. Before the ACA, people who were accepted into a non-group policy were not necessarily able to switch into new non-group policies, at renewal or otherwise, either from their current insurer or from others, without passing medical underwriting. Insurers sometimes offered people the ability to elect different policies at renewal (usually the ability to take a policy with higher cost sharing to moderate a rate increase), but they were not required to do so and did not have to allow current policyholders to move to different policies.

Medical Underwriting and Pre-Existing Condition Exclusion Provisions

Prior to the ACA, insurers often used the health of individual enrollees in making decisions about their coverage. **Medical underwriting** is the process by which an insurer acquires information about the health of applicants for coverage and uses the information to make decisions about whether to offer coverage, what coverage to offer, and what premium to charge. Applicants for non-group coverage generally were required to answer a long series of questions about their health and health history, and often were required to provide authorization for the insurer to obtain their medical records. In the non-group market, insurers generally were permitted to use the information to decline the application, accept the applicant for a reduced scope of coverage, or accept the applicant at a higher premium.

A **pre-existing condition exclusion provision** is a contract term that permits an insurer to exclude coverage for benefits sought by an enrollee during a defined period after the coverage begins (for example, twelve months) if the insurer can show that the claim relates to a condition that existed before the policy was issued. State laws varied in defining pre-existing conditions for non-group coverage; for example, in how far an insurer could look back to detect the condition, or in whether the condition must have been actually treated or whether a reasonable person would have sought treatment. This exclusion allowed insurers to exclude benefits for pre-existing conditions that were not necessarily detected during the medical underwriting process.

While there are many other differences between ACA and pre-ACA non-group market rules (e.g., permitted cost sharing, limits on age rating), these have the most implications for providing access to and continuous coverage for people with health problems. Most fundamentally, medical screening divides people by health at initial enrollment, and the inability to switch policies can trap people who develop health problems into much more expensive coverage. The potential implications of this are discussed below.

Issues Raised by Pre-ACA Non-Group Market Rules for Access to Coverage and Continuous Coverage

To examine the issues raised by these pre-ACA market rules, we look at three different groups of people:

1) People transitioning from existing coverage and applying for non-group coverage
2) People with non-group coverage who develop health problems
3) People without recent prior coverage applying for non-group coverage

People Transitioning From Existing Coverage to Non-group Coverage

Assuring access to non-group coverage for people who maintain continuous coverage has been a priority for proponents of changing the ACA. One of the attributes of the ACA is that people who lose eligibility for coverage can obtain replacement coverage in the non-group market on the same terms as others covered in the market, without consideration of their health.

A large number of people who lose their coverage might want or need access to non-group coverage. Looking at the 2012 through 2013 period (the 24 months immediately prior to the ACA coverage expansion), about 32 million people with coverage lost it and became uninsured for some period. People without health problems leaving previous coverage generally could purchase underwritten policies in the market. Some, but not all, people with health problems who had previous coverage could qualify for designated non-group policies without regard to their health.

As noted above, prior to the ACA, federal law provided guaranteed access to non-group coverage for people with at least 18 prior months of continuous coverage if their most recent prior coverage was an employer plan and if they did not have a gap in coverage of more than 63 days. These HIPAA-eligible individuals qualified for specified policies (most often, coverage in a state high-risk pool, but sometimes designated plans offered by non-group insurers), with no pre-existing condition exclusion. Their premiums were almost always much higher than the rates charged to applicants who could pass medical underwriting.

The HIPAA non-group market provisions were perceived generally to have fairly limited effect, primarily because the coverage made available could be expensive. Several factors limited HIPAA's effectiveness in assuring access to non-group coverage:

1) Eligibility. The guaranteed access and waiver of pre-existing condition exclusion provisions were available only to a limited group of people: those whose most recent previous coverage was involuntarily terminated and employment-based. Limiting the option to people leaving employer group plans left out people coming from public coverage such as Medicaid or who lost a prior non-group plan because they moved out of area served by their insurer. A few states expanded the requirement to include other types of coverage, but it was not the general rule. The provisions also left out people who wanted to switch plans within the non-group market, for example, because of network changes in their existing plan or if it had become unaffordable (discussed below).

2) Cost. Federal HIPAA portability provisions also did not limit the premiums that could be charged for the specified plans available to HIPAA-eligible people. Most states used a high-risk pool to serve HIPAA-eligible people, where premiums typically ranged from 125% to 200% of the estimated standard premiums for non-group coverage. With a couple exceptions, income-based subsidies were not available in high-risk pools, making it quite difficult for people with modest incomes. In states where insurers were required to make private policies available to HIPAA-eligible individuals, insurers often were able to charge much higher premiums to HIPAA-eligible individuals with health problems; for example, insurers could develop separate rating classes for HIPPA-eligible individuals who could meeting medical underwriting standards and those would could not. A few states limited the additional premium that could be charged to HIPAA-eligible individuals who could not pass medical underwriting.

   In addition, HIPAA only extended guaranteed availability to people after they had exhausted their eligibility for continuation coverage under COBRA or under state continuation laws. Continuation coverage can be expensive: COBRA premiums are 102% of the full cost of the employer plan for at least 18 months. Affording COBRA can be difficult for people who lost their job and may not have new work.

The requirement to exhaust continuation coverage and the relatively high premiums served to limit the number of people who could afford to take advantage of the guaranteed availability opportunity under HIPAA. As discussed below, people who could pass medical underwriting could save these expenses and enroll in lower-cost plans, but they would not get the full benefits of having continuous coverage.

3) Combining Guaranteed Access and Waiver of Pre-Existing Condition Exclusion in the Same Provision. The law provided for guaranteed access to coverage and the waiver of pre-existing condition exclusion provisions only in specified policies, which tended to be quite expensive. HIPAA-eligible individuals who were healthy and could pass medical underwriting could get a non-group policy for much less than the policies offered generally to HIPAA-eligible people, but in choosing the cheaper policy they sometimes exposed themselves to a new pre-existing condition exclusion period, despite the fact that they had at least 18 months of continuous coverage. Many people may not even have understood that they were making this tradeoff.

A different kind of issue facing people leaving employer group coverage or Medicaid who wanted to maintain continuous coverage were the limits on benefits in many non-group policies. One of the significant changes in non-group coverage under the ACA was the establishment of a fairly comprehensive essential health benefit package. In particular, pre-ACA non-group policies had significant limits on mental health benefits (mental health parity requirements, which applied to employer-group plans for employers with more than 50 employees, did not apply to non-group coverage), and, unless required by states, typically excluded coverage for many policies, and also did not cover costs associated with pregnancy or routine delivery. Some state high-risk pools, which were the only options for HIPAA-eligible individuals with health problems, had tight limits on coverage for prescriptions.[3],[4]

Prior to the ACA, non-group coverage was decidedly less comprehensive than employer group coverage. Substantial shares of non-group enrollees did not have coverage for routine maternity, substance abuse or mental health services, and it was not uncommon for policies to have relatively low annual benefit limits for prescription drugs or mental health services. Even though insurers were able to medically screen applicants in most instances, they still imposed significant limits on benefits where there is a greater chance of purchasers selecting coverage based on the need for particular services. Unlike the group market, where employers select levels of benefits for all their employees, insurers are wary of non-group purchasers who are willing to pay the relatively high cost for more comprehensive benefits. These benefit limits, along with the rating issues discussed in the next section, meant that the non-group market was not a good long-term coverage option for many people, including those who wanted to start a family or who developed mental health problems.

People Enrolled in Non-Group Coverage Who Develop Health Problems

Another aspect of maintaining continuous coverage is being able to keep the coverage you obtain on a reasonable basis. Prior to the ACA, non-group coverage generally was guaranteed renewable, which meant that enrollees had the right to renew their coverage (with certain limited exceptions) by paying their premiums. Insurers also generally were not permitted to vary renewal premiums based on an enrollee's individual health or claims. Insurers, however, through selectively closing policies or blocks of business to new enrollees and

through certain rating approaches, were able to access higher premiums than enrollees who developed health problems after they enrolled. As discussed above, people with non-group coverage generally were not able to switch carriers or move to a new policy (in an open block of business) unless they could pass medical screening. As a result, they could find themselves essentially locked into policies with escalating premiums that could be difficult to afford.

This can happen several ways. The medical underwriting process allows insurers to protect themselves from adverse selection (see The Issue of Adverse Selection box below), but it also produces complicated dynamics that can segment risk by health even after people in good health have been accepted into coverage. Medically screening new applicants, and declining applicants who are unhealthy, produces a group of healthy new enrollees whose expected claims costs over the short term could be meaningfully below the costs for an average mix of people. Prior to the ACA, the expected low costs for these enrollees would be reinforced because the group also would generally be subject to a pre-existing condition exclusion provision for the first year that eliminated coverage for claims for pre-existing health conditions not uncovered during the medical underwriting process. Over time, however, some of the group of enrollees would develop health problems, and the average costs of the group would grow each year; by year three or four after their enrollment the expected costs for the group would roughly equal the expected costs for an average mix of people. This is sometimes referred to as "underwriting wearing off." An insurer, at any given time, will have a group of recently underwritten enrollees, with relatively low expected costs, and other groups enrolled for varying lengths of time, with the tendency for those enrolled longer to have worse average health. If an insurer closed these older products to new enrollees – and allowed healthy enrollees in them to sign up for new, medically-underwritten products – premiums for existing enrollees would escalate over time, and those with medical conditions would essentially be trapped into paying those higher premiums because they could not switch to other coverage.

The Issue of Adverse Selection

Prior to the ACA, insurers used medical underwriting in the non-group market to protect themselves and their policyholders from adverse selection. Unlike coverage offered to large employer groups, where insurers anticipate getting a mix of better and worse health risks when they accept a new group, non-group coverage is sold person-by-person. While virtually everyone wants to have health insurance, people with high or ongoing health needs are more likely to sign up at any given price, a tendency referred to as adverse selection. Adverse selection occurs not only in the decision of whether or not to purchase coverage, but also in decisions about how much coverage to get (people in poorer health tend to want more comprehensive benefits and less cost sharing) and in decisions about whether or not to keep coverage (people in better health are more likely to drop coverage or move to less coverage in the face of premium increases). The relatively high cost of health insurance makes adverse selection more acute (premiums can be a large portion of a monthly budget, so there is a tendency for healthier people to forgo coverage if they do not think they will need it). This is particularly an issue in the non-group market where enrollees pay the full premiums.

There are several ways insurers can reflect these differences in their rating and enrollment practice rates, and this a place where problems can occur for people who develop health problems after enrollment. One option is for insurers to combine the new and existing enrollees in blocks of business that are being actively marketed (called "open" here), so that low expected costs of new enrollees can help offset the higher costs of enrollees who have been covered longer. As long as there is a reasonable stream of people entering and leaving the block, premiums can remain reasonably spread over the entire group. Insurers also can pool the expected total claims of each durational group of enrollees over their average expected length of enrollment. This requires charging new and early-duration enrollees for more than their expected costs during their early years, setting aside a portion of the premium (i.e., creating a reserve) that can be used to offset the higher costs for those who keep their policies for longer periods.

Some insurers, however, may not want to pool the lower costs of new entrants with the higher costs of longer-term enrollees. For example, insurers with larger and older blocks of business may find that they cannot compete well for new enrollees against insurers without as much existing business, because those insurers would have a higher proportion of new healthy enrollees and could have lower rates for new business, particularly if the new carrier is not reserving for the effects of underwriting wearing off. An insurer also might develop a new group of policies based on a new approach (for example, a policy where it shares risk with an Accountable Care Organization (ACO) network) where it does not want to pool experience with its existing policies in determining rates. An insurer also may want to increase its market share by being more competitive for new enrollees, which it might do by setting the premiums for new enrollees closer to their expected first year costs.

Insurers that want to reduce the pooling of newer and longer-term enrollees have several ways to do so. One is to use the duration of enrollment as an explicit rating factor. Insurers using durational rating can set initial rates relatively low for new enrollees, but will need to raise them relatively rapidly each year (on top of

increases for rising health costs generally) for these enrollees to reflect their higher expected claims at later durations. Another option is for an insurer to stop selling policies in blocks of business to new enrollees, directing them to new policies in a new block of business without any existing enrollees. Because premiums are set based on the expected costs for specific policies or blocks of business, premiums for the new policies do not need to reflect the costs of the existing enrollees in the closed block, and future premiums for the closed block will reflect only relatively higher average costs of the existing enrollees.

Both of these practices end up harming enrollees who develop health problems. Enrollees facing the relatively higher premiums under durational rating or in a closed block will look for lower cost alternatives. Healthier enrollees who can pass medical screening will move to lower cost policies (essentially starting over as new entrants), while people with health problems who cannot move will have to stay and pay the higher premiums being charged. The new round of higher premiums will cause more of the healthier enrollees to leave, resulting in higher expected costs for those remaining and higher premiums, a cycle that will continue until most enrollees have left the block.

People without recent prior coverage applying for non-group coverage

There was a substantial number of people without health insurance prior to the ACA, many of whom had been without coverage for long periods of time.[5] The primary reason people went without coverage was its cost, although in some cases people were unable to qualify for coverage due to their health.[6] The two factors sometimes worked together; many states had high-risk pools or similar options for people with health problems who were denied non-group coverage, but the high premiums and other limitations could make these options difficult for people to afford and the pools had fairly low enrollment.

High-risk pools are being discussed as an important part of ACA replacement proposals. About 227,000 people were enrolled in 35 state high-risk pools at the end of 2011, including HIPAA-eligible individuals, which was equal to just over 2% of non-group market enrollment nationally.[7] A few states with relatively lower premiums, such as Maryland, Wisconsin, Minnesota, and Oregon, covered somewhat higher shares of their people.[8] Enrollment in state high-risk pools tapered off with the opening of the federal Pre-Existing Condition Insurance Pool, created and funded under the ACA, which served many of the people who previously would have been covered in the state pools.

State high-risk pools varied in terms of benefits, premiums, and funding.[9] As noted above, in many states the high-risk pool served as the state-designated mechanism to cover HIPPA-eligible individuals. There were a few common themes: premiums generally were calculated as a percentage of estimated standard premiums in the non-group market (typically 125% to 200% of standard premiums); coverage for pre-existing conditions was limited for a period after enrollment; pools generally offered several benefit options, most states had lifetime benefit limits and a few had annual limits; premiums did not cover the cost of benefits, with the difference subsidized by state and federal payments (a few states had dedicated revenue sources) or assessments on insurers.

A combination of factors limited the attractiveness of pre-ACA state high-risk pools. The relatively high premiums made coverage difficult to afford for people with low or modest incomes, and only a couple of states had subsidies for lower-income enrollees. In addition, pools generally had pre-existing condition exclusion

periods for enrollees who were not HIPAA-eligible individuals, which means that people were required to pay for coverage that would not cover the illnesses that had made them eligible for the high-risk pool in the first place for six months to a year or more (depending on the state). A few state pools also had annual limits on some or all benefits, and the majority had lifetime benefit limits. Given the populations served, these limits could affect those with high cost chronic conditions, such as the ongoing need for expensive prescriptions.

A few states addressed access for people with health problems by requiring all insurers (or in some cases, one or more designated insurers) to accept applicants even if they were in poor health. Premiums in these states tended to be much higher than premiums in states that permitted medical underwriting, which limited participation in non-group coverage significantly and made coverage even more difficult to afford for people with modest incomes.

Discussion

There were many aspects of the pre-ACA non-group market that made it difficult for people with health problems to get and keep non-group coverage. Any proposal for replacing the ACA will have to determine which, if any, of these previous insurance practices will once again be permitted. Medical screening was the most obvious barrier, combined with high premium costs for people who were HIPAA-eligible. Even people who purchased coverage when they were healthy sometimes were unable to keep it because certain rating approaches could cause their premiums to spiral. Returning to a less structured, less regulated non-group market raises questions about how people with health problems will be treated in terms of access to and cost of coverage. Health insurance underwriting and rating is complex, and reviewing how the pre-ACA market operated provides information about the types of issues that people with health problems may confront if the ACA market structure is replaced.

Endnotes

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Health Care Use And Spending Patterns Vary By Wage Level In Employer-Sponsored Plans

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ABSTRACT **Employees face an increasing financial burden for health services as health care costs increase relative to earnings. Yet little is known about health care utilization patterns relative to employee wages. To better understand this association and the resulting implications, we examined patterns of health care use and spending by wage category during 2014 among 42,936 employees of four self-insured employers enrolled in a private health insurance exchange. When demographics and other characteristics were controlled for, employees in the lowest-wage group had half the usage of preventive care (19 percent versus 38 percent), nearly twice the hospital admission rate (31 individuals per 1,000 versus 17 per 1,000), more than four times the rate of avoidable admissions (4.3 individuals per 1,000 versus 0.9 per 1,000), and more than three times the rate of emergency department visits (370 individuals per 1,000 versus 120 per 1,000) relative to top-wage-group earners. Annual total health care spending per patient was highest in both the lowest-wage ($4,835) and highest-wage ($5,074) categories relative to the middle two wage groups ($3,952 and $3,987, respectively). These findings provide new insights about wage-associated variations in health care use and spending in employer-sponsored plans. For policy makers, these findings can inform employer benefit design strategies and research priorities, to encourage effective use of health care services.**

As health care cost trends have continued to exceed the general inflation rate, employers have intensified their efforts to contain costs by limiting wage increases and shifting a portion of the health care cost burden to workers enrolled in their benefits. Employer-offered health insurance plans usually provide equal coverage to all workers.[1] However, commercial plans and employers rarely analyze health care use or spending by employee wage level, leaving companies and consultants largely unaware of potential differences in utilization patterns across wage bands.

The rising cost of care—and employers' responses to the increase—has created circumstances in which some workers might avoid or delay health care services despite having coverage. High-deductible health plans (HDHPs) now cover nearly 30 percent of the workforce and are growing in popularity among employers to manage expenses and promote employees' knowledgeable use of health care services.[1,2] These plans represent a sizable portion of the cost shift to employees. While the plans might appear attractive to low-wage earners by virtue of their more affordable premiums, they might also create substantial financial barriers to health care for the low-wage employees because of the significant out-of-pocket expenses they face until

their deductibles are met.[3,4]

The financial challenges are compounded for low-wage workers because of the higher prevalence of unhealthy lifestyle behaviors and chronic conditions among them compared to higher-wage workers.[5] The higher prevalence, in turn, increases their need for and cost of health care.[6] Additionally, low-wage workers are more likely to be paid hourly and to have fewer paid days off to seek medical care, potentially resulting in decreased earnings. Furthermore, low-wage workers face more challenges in seeking care, including such social determinants of health as transportation; access to providers; and affordable, stable housing.[7] These challenges may shift attention away from health and toward other personal priorities,[8] placing low-wage workers at a disadvantage in both accessing and paying for health care.

The purpose of this analysis is to describe how health care use and spending patterns vary across wage levels in a population of employees enrolled in a commercial, self-insured private exchange offering. We performed comparisons between wage levels, adjusting for differences in benefits and employees' demographic and health-status attributes.

Study Data And Methods

DATA AND SAMPLE This study examined the 2014 health care use patterns of 42,936 active employees working at least thirty hours per week who were enrolled in health insurance coverage for the entire twelve months of 2014 through a self-insured private health insurance exchange (RightOpt from Xerox Human Resource Services), and for whom wage data were available. The RightOpt private exchange is administratively managed as a portfolio of integrated health plan offerings using a "quilted network" strategy, where each of the nation's Metropolitan Statistical Areas is served by a single plan with the greatest negotiated discounts, thereby lowering employer costs. Most private exchanges offer benefits enrollees an array of health plan–sponsored benefit options from which to select. The RightOpt exchange offering also includes a portfolio of comprehensively integrated services, including medical and pharmacy benefits, well-being programs, an employee assistance program, consumer decision support tools, and health care navigation support services. Benefit design options include preferred provider organization (PPO) plans and HDHPs with health savings account or health reimbursement arrangement options. The primary client market for the private exchange is represented by self-insured US employers with 3,000 or more benefits-eligible[9] employees.

Relative to public exchanges, private exchanges are operated by commercial entities and marketed to employers as an alternative to direct employer contracting with health plans for benefits. While individuals can enroll in a public exchange offering (with the potential for an income-related subsidy), only benefits-eligible employees can enroll in a private exchange, with subsidies, if any, determined by the employer.

Four employers were included in the analysis, each with a nationally distributed workforce. Because of exchange and employer confidentiality concerns, no additional details are available.

The exchange data warehouse, managed by Truven Health Analytics, serves as a platform for aggregation of deidentified, individually attributable data from exchange vendor partners, which permits detailed analysis and reporting of exchange offerings' effectiveness, employer-specific results, as well as vendor performance. Specifically, the data warehouse combines health care claims, health assessment and biometrics testing values, benefit eligibility and wage information, along with other health-related data sources as noted above and not included in this analysis. Claims data include actual (reimbursed) payment amounts and health plan and employee spending.

During open enrollment, eligible employees were provided with a choice among up to five different HDHP and PPO plans, with a range of different actuarial values. Employee resources for informed plan selection were based primarily on prior-year claims costs and enrollees' financial priorities. The HDHP options had higher deductible amounts and lower premium payments, some of which included employer-provided funding of health reimbursement arrangements or health savings accounts. One employer included a three-tier subsidy for benefit premiums of up to $400 per enrollee per year based on wage bands. Employers included in this analysis did not offer a worksite clinic.

WAGE COHORT AND CLINICAL DATA DEFINITIONS Midyear employee wage data were used as a basis for allocating employees into quartiles: $30,000 or less, $30,001–$44,000, $44,001–$70,000, and $70,001 or more. The lowest quartile was further divided into two groups ($24,000 or less, $24,001–$30,000) to enable better understanding of differences in health care use at lower wage levels.

We examined the association of wage category and use of specific types of health care services, including emergency department use, avoidable emergency department use, inpatient admissions, ambulatory care–sensitive hospital admis-

sions (hospitalizations that may be avoided through use of effective outpatient care),[10] and preventive office visits. We also assessed compliance rates among eligible individuals in each wage category with US Preventive Services Task Force recommendations for colon, breast, and cervical cancer screening.

The methodology for calculating annual preventive screening compliance is based on calendar-year data and not modified to extrapolate values for tests offered at a less than annual frequency, which provides a partial explanation of why the observed values are not closer to 100 percent.

STATISTICAL ANALYSIS We regressed each utilization measure on wage group indicators and covariates: age and sex categories (ages 18–34, female; 35–44, female; 45–54, female; 55–64, female; and similar categories for males), ZIP code–based median household income from the American Community Survey ($62,000 or less, $62,001–$82,000, $82,001–$105,000, $105,001 or more), geographic census region (Northeast, North Central, South, and West), first-year-of-employment indicator (versus longer tenure), health plan contract type (individual, individual plus spouse, individual plus child, or family), net deductible (less employer contribution) as a percentage of annual wages, comorbid condition prevalence (Charlson Comorbidity Index and Psychiatric Diagnostic Groupings), and an indicator variable for each employer represented in the database. Continuous outcomes were modeled using generalized linear models, and binary outcomes were modeled using logistic regression. Utilization and spending measures in each wage category were compared to the highest ($70,001 or more) category, adjusting for multiple comparisons. A description of the detailed statistical methodology is provided in the online Appendix.[11]

LIMITATIONS This study had several limitations. First, the study population included self-insured employers that had adopted a private exchange benefits offering, so it might not be generalizable to all employers. Similarly, the study population consisted of active employees and might not reflect the experience of dependents. Our study population demographics were also different from those of the 2014 Medical Expenditure Panel Survey Household Component data of privately insured individuals,[12] with a similar sex ratio but a higher mean age and significantly greater geographic representation of employees in the South relative to the West. Population-level health profiles and access to health care vary across the United States, so our findings might not be representative of populations with different distribution.

Low-wage workers have been particularly affected by employers' health care cost containment efforts.

Second, the study design separated employees on the basis of their individual wages and did not account for other contributions to household income. We also appreciated that wages might be a reflection of other individual characteristics such as literacy, education, and other factors. While it is possible that combined household income might well result in shifts between wage categories for some employees, our analysis included adjustment for health plan enrollment category (single, employee plus spouse, employee plus family, and so forth) in an attempt to mitigate this concern. We also controlled for ZIP code–level median household income in an effort to account for earnings from other household members. From a practical perspective, employee wage is a readily accessible measure that employers, other stakeholders, and researchers might be able to incorporate in future data analysis as a proxy for household income.

Third, while benefit plan options within the RightOpt exchange were generally limited to four plans for each employer, the available options differed somewhat between employers in terms of actuarial value, while providing a consistent set of supplemental enrollee services. We therefore attempted to control for plan design using the net deductible amount corresponding to the plan choice by each enrollee in our statistical modeling.

Fourth, we did not control for variation across wage categories in employee education level, health literacy, or health care consumerism engagement. We appreciate the interdependency of these factors in association with educational and wage status and their impact on patterns of health care use. Further research in this area is needed.

Lastly, we performed a one-year, cross-sectional analysis, so direction and causality between variables cannot be determined. The findings should be interpreted with caution as they occur within the context of plan selection by employees, since plan selection might occur differentially across employee characteristics. In an effort to

address this issue, we performed a number of sensitivity analyses with plans and included a wide variety of observable characteristics, with robust results, as detailed in the Appendix.[11] Future study of similar associations without the presence of plan selection would help further isolate the association between wages and utilization. No inferences can be made about the longitudinal implications of wage-based health care utilization patterns or changes in health status.

Study Results

CHARACTERISTICS OF EMPLOYEES Low-wage workers were younger, more likely female, and less likely to live in the northeastern United States in comparison to higher-wage earners. Annualized mean wages for each of the five categories were $19,030, $26,974, $36,388, $54,739, and $111,555, respectively. These earnings levels correlated well with ZIP code–imputed household median income estimates. Low-wage earners were more than twice as likely to be in their first year of employment and also 40 percent less likely to be a part of the salaried workforce. These individuals were also more than twice as likely to enroll in an employee-only benefit plan option (see Appendix Exhibit 1).[11]

Low-wage workers had comparatively greater health and financial challenges than high-wage workers. Adjusted for age, sex, and other covariates, low-wage workers had a higher chronic physical illness and psychiatric illness burden (data not shown). Regarding health benefits spending, net of employer contribution, deductible amounts represented 10 percent of total wages in the lowest-wage category. In contrast, in the highest-wage category, insurance deductible amounts were less than 1 percent of wages.

HEALTH CARE USE Exhibit 1 shows medical and prescription drug use from claims data following adjustment for demographic and health variables. The proportion of employees who received any medical or prescription service went progressively higher as the wage level increased. Workers in the highest wage group were significantly more likely to have filed a medical or prescription claim during 2014 relative to all lower-wage categories ($p < 0.0001$). Additionally, the proportion of individuals filing claims for medical or prescription drug services or both increases in direct association with wage category.

PATTERNS OF MEDICAL SERVICES USE Exhibit 2 illustrates health care use for common service categories, such as emergency department visits; avoidable emergency department visits; inpatient admissions; and days' supply of prescriptions, defined as the overall number of daily chronic medication doses in an individual's possession during the year. Use of emergency department services was highest among the low-wage group and was significantly lower in the higher-wage categories ($p < 0.007$ for all wage categories relative to the highest wage group). Following adjustment for confounding variables, low-wage earners had an emergency department utilization rate more than three times greater than their higher-earning counterparts. No significant difference was observed across wage categories in the frequency of avoidable emergency department visits, representing the subset of such visits for which care could also have been provided in an ambulatory care setting (data not shown).

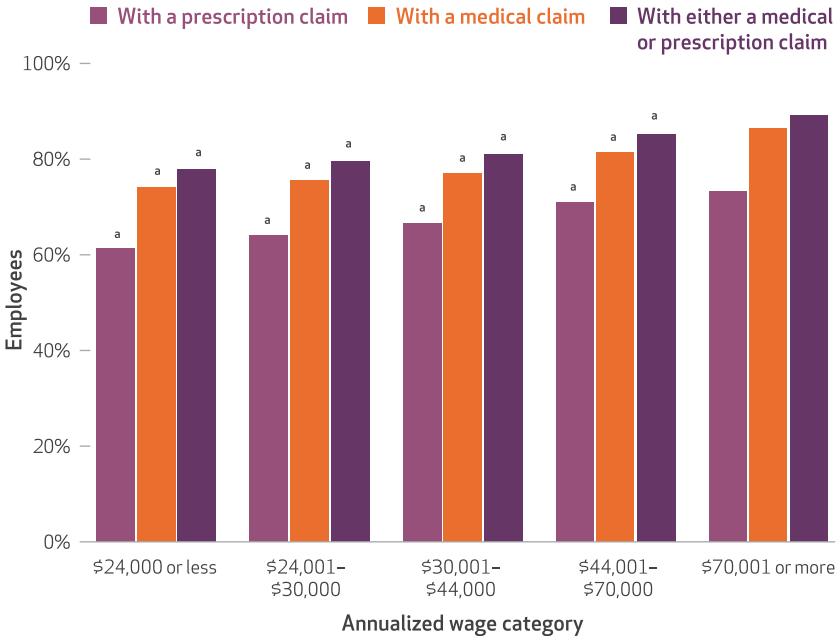
Adjusted hospitalization rates were lowest (17 per 1,000 employees) in the highest wage category, reaching a peak at 31 per 1,000 (72 percent higher) and 33 per 1,000 (94 percent higher) among those earning between $24,001 and $30,000, and $24,000 or less, respectively ($p < 0.0002$ for two lowest wage categories relative to the highest wage group) (see Appendix Exhibit 3).[11] Avoidable or ambulatory care–sensitive hospitalization rates (shown as avoidable admissions in Exhibit 2) followed a similar pattern across wage categories, at 0.9 per 1,000 employees in the highest wage categories, with highest values of 3.8 per 1,000 in the $24,001–$30,000 wage category, and 4.3 per 1,000 in the $24,000 or less wage category ($p < 0.0026$ for two lowest wage categories relative to the highest wage group). Prescription days' supply (see the Appendix)[11] also followed the same pattern, with more consistent prescription medication refills for high-wage earners resulting in cumulatively greater medication dose availability during the analysis period ($p < 0.0001$ for the three lowest wage categories relative to the highest wage group).

PREVENTIVE CARE SERVICES UTILIZATION RATES Use of preventive care office visits and cancer screening rates among individuals eligible based on US Preventive Services Task Force guidelines are shown in Exhibit 3. Following adjustment for covariates, use of preventive care visits and recommended cancer screenings was highest in the top-wage group and directly associated with increasing wage category. Comparing lowest to highest wage categories, preventive care visits were 50 percent lower; breast cancer, cervical cancer, and colon cancer screening rates were 42 percent, 39 percent, and 35 percent lower, respectively ($p < 0.0001$ for the bottom three wage categories relative to the highest wage group).

HEALTH CARE SPENDING PATTERNS The total allowed amount of medical spending per person

EXHIBIT 1

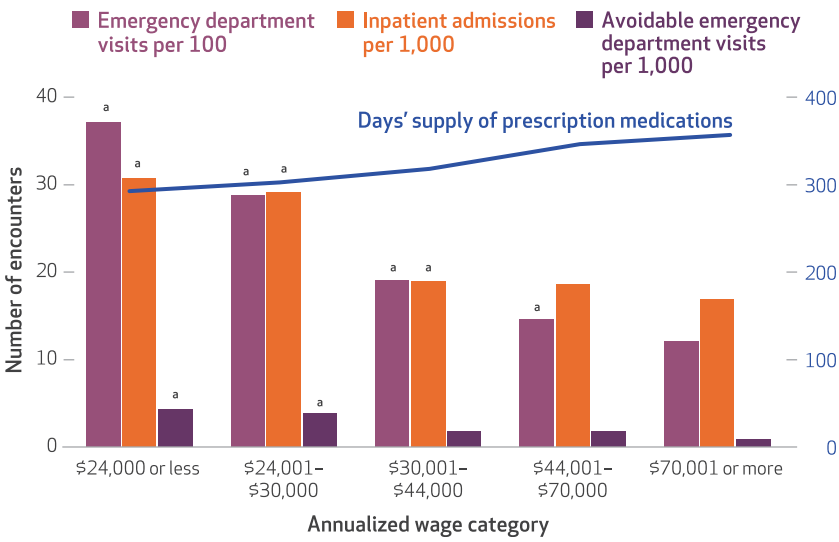
Employees' medical and prescription drug use, by wage category



SOURCE Authors' analysis of employee-only claims data from the 2014 Xerox RightOpt private exchange database. **NOTES** Predicted values adjusting for all covariates. Appendix Exhibit 2 displays confidence intervals for all values (see Note 11 in text). [a]Significance denotes the difference between the four lower wage categories and the category of $70,001 or more ($p < 0.0001$).

EXHIBIT 2

Employees' health care use patterns, by wage category



SOURCE Authors' analysis of employee-only claims data from the 2014 Xerox RightOpt private exchange database. **NOTES** Predicted values adjusting for all covariates. For a definition of "days' supply of prescription medications," see the text. In each of the three types of health care use, the number is per 100 or 1,000 employees in each respective age group. Appendix Exhibit 3 displays confidence intervals for all values (see Note 11 in text). [a]Significance denotes the difference between the four lower wage categories and the category of $70,001 or more ($p < 0.0125$).

for individuals in each respective wage category and total allowed amount per patient for only individuals filing claims exhibited a pattern in which costs were highest at the ends of the wage distribution and lower in the mid-wage range. Employees in the highest wage category had the greatest spending amount, followed by employees in the lowest wage category. Mid-level wage groups had the lowest spending of all groups (Exhibit 4).

Specifically, outpatient medical and drug spending drove high overall expenditures in the highest wage category, and hospitalization and emergency department costs were responsible for greater expenditures within the lower wage categories (Appendix Exhibit 5).[11]

Discussion

According to 2016 census data, 28.8 percent of adult civilian workers with employer-sponsored insurance earn less than $30,000 per year, with an additional 13.8 percent earning between $30,001 and $40,000 per year.[13] In 2016 workers with health insurance had an annual deductible averaging $1,478 and an average annual premium of $1,129 per year.[1] In total, this equates to a lower-wage worker allocating more than 8.5 percent ($2,600 per $30,000) of pretax earnings for health care. In our study population with high-deductible plan options, the lowest-wage workers might pay as much as 21 percent of their pretax income for premiums and deductibles before reaching their deductible limit.

Low-wage workers have been particularly affected by employers' health care cost containment efforts. Cost shifting in benefit design has resulted in a 67 percent increase in deductibles since 2010, which is six times more than the rise in workers' wages (10 percent) and general inflation (9 percent).[1] Perhaps related, financial challenges are now the most prevalent source of employee stress—ahead of work issues, family concerns, and personal health.[8]

Many studies have compared health use or spending across income, wealth, or wage distribution.[3,14,15] To our knowledge, however, a detailed examination of the association between wage status and health care utilization patterns in an employed, commercially self-insured population has not been previously reported. This study of private exchange enrollees provides direct evidence that the health care delivery system is used differently by subpopulations along the continuum of wage categories, particularly at the extremes.

Despite the comparatively higher health care spending as a percentage of wages borne by low-wage workers, they did not appear to be savvy

consumers of appropriate care.[16] Rather, their utilization patterns reflected a more reactive approach to health care, perhaps as a result of either necessity or choice, which led to substantially greater emergency department use and fewer preventive visits, along with a significantly greater number of ambulatory care–sensitive hospitalizations, relative to their higher-paid counterparts. In contrast, higher-wage earners had higher health care utilization rates for nearly all outpatient categories, coupled with comparatively lower hospitalization rates. With their greater use of preventive and outpatient services, these individuals appeared to be addressing health concerns before they became serious, therefore avoiding either emergency department or inpatient care.

The higher spending amounts associated with the high-wage-earning employees appear to result from greater use of outpatient services and prescription medications. These findings might well be a consequence of greater availability of discretionary funds for health care expenditures that Samuel Dickman and colleagues described as "income-based receipt of medical care."[15] These data reflect patterns of greater resource consumption where resource limitations do not exist.[17] These observations are consistent with behavior by higher-wage earners who treat health services as an investment by placing greater emphasis on consuming health services that are likely to produce health benefits in the future.

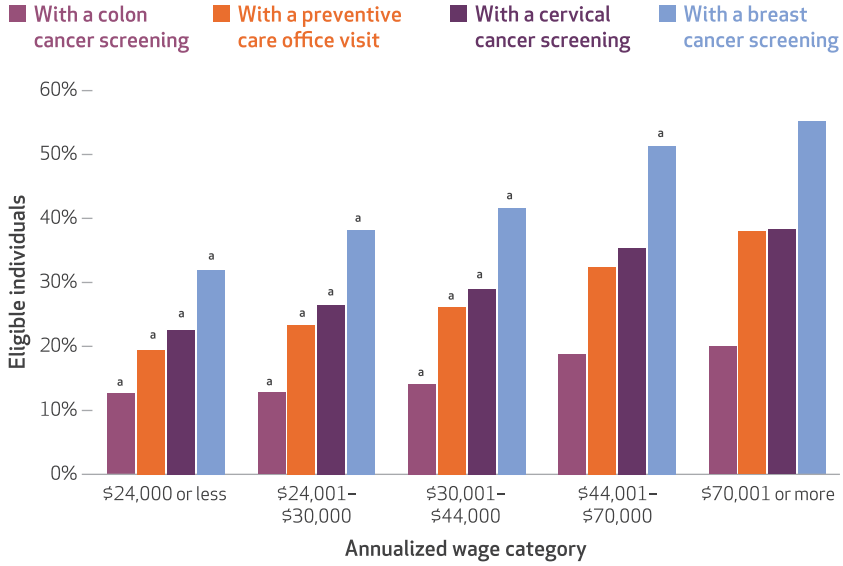
Our findings raise additional questions and challenges. For example, the more reactive and seemingly inefficient health care utilization patterns among low-wage workers could be a consequence of financial limitations,[14] other social determinants of health,[18] cultural beliefs, habitual behaviors, health literacy, health care consumerism, inflexible work hours, lack of paid time away from work for health care, or a combination of these.[19] These data also raise the question as to how optimal care delivery can be defined. Does the lowest point of the observed distribution of health care spending by wage category in Exhibit 4 reflect optimal care, with low-wage earners being inefficient in their utilization patterns, while their high-wage counterparts are overusing ambulatory care services to negligible clinical benefit beyond peace of mind?

What is clear is that after adjustment for observable differences in employee characteristics, employees in different wage categories use health care services in different ways. Accordingly, different solutions might be needed to address the issues within the different wage subgroups. Whether these are tailored to wage, geographic location, generational affiliation, or other demographic categories, the approach needs to be relevant to the consumer.

Because the relationship between low wages and inefficient use of health care services is almost certainly more complex than a simple fi-

EXHIBIT 3

Employees' preventive care services use patterns, by wage category



SOURCE Authors' analysis of employee-only claims data from the 2014 Xerox RightOpt private exchange database. **NOTES** Predicted values adjusting for all covariates. Appendix Exhibit 4 displays confidence intervals for all values (see Note 11 in text). [a]Significance denotes the difference between the four lower wage categories and the category of $70,001 or more ($p < 0.0001$).

EXHIBIT 4

Employees' health care spending patterns, by wage category

SOURCE Authors' analysis of employee-only claims data from the 2014 Xerox RightOpt private exchange database. **NOTES** Predicted values adjusting for all covariates. Appendix Exhibit 5 displays confidence intervals for all values (see Note 11 in text). [a]Significance denotes the difference between the four lower wage categories and the category of $70,001 or more ($p < 0.0125$).

nancial cause and effect, successful efforts to improve prevention and reduce emergency department use will necessarily extend beyond cost subsidies and coverage design. As an example, to address barriers to both availability and convenience of primary care, employers can consider offering on-site clinics. There is evidence that access to clinics at the worksite reduces emergency department use by low-wage, hourly workers.[20] Additionally, there are effective examples of proactive education programs for patients that lead to more appropriate use of services.[21]

Assuming that decreased utilization by low-wage workers reflects, in part, their financial constraints, solutions are not simple. It is unrealistic to call for higher wages and lower insurance costs for low-wage workers because most companies face budget limitations. Presuming no new funds, one potential solution would have employers shift benefit costs from low-wage workers to their higher-paid colleagues, effectively decreasing the overall compensation value of this latter group. However, this reallocation approach hasn't appeared to attract employer interest, likely because of the potential negative impact on job satisfaction and retention among higher-wage workers.

For employers believing that health is an essential component of human capital and that healthy workers—including low-wage workers—provide a competitive advantage, these results reveal a new concern. If employees with chronic conditions postpone or forgo appropriate treatment, they might negatively affect productivity through illness-related impairment or absence.

In an effort to mitigate the health care spending burden among low-wage workers, some employers have implemented wage-based premiums or deductibles, in effect subsidizing their lower-wage employees.[1] This can reduce financial barriers to appropriate care seeking but necessarily adds or shifts costs elsewhere in the employer's budget. To our knowledge, the impact of such initiatives has not been formally evaluated, leaving employers without clearly defined strategies to lessen the disproportionate cost burden on low-wage workers.

At a policy level, these findings should build awareness and prompt discussion about potential disparities created by existing health benefit designs. This issue is becoming increasingly important as more employers move to plan designs with higher deductibles or coinsurance to maintain premiums or contain premium growth. Based on our analysis, current benefit design strategies do not appear to be effective in engaging lower-wage workers in their own health care and might actually be creating access barriers to high-value services.

We appreciate that wages are correlated with many other individual characteristics, including educational attainment, health literacy, and lifestyle behaviors, which might also influence medical care use and spending outcomes but which are not captured in this model. It is admittedly difficult to determine whether the observed differences represent an income or price effect versus differing preferences for care in low versus high wage categories. Given evidence of low-wage workers' preferences for emergency and hospital-based care, changes in plan design or financial support might not reduce those care-seeking patterns as intended.[22] Further research can help determine what represents the most effective policy lever for improved health care use within low wage groups.

Other possible interventions to address low-wage workers' needs include evidence-based care for chronic conditions as a predeductible covered service through legislation[23] or benefit design.[24] Such approaches would increase access for workers at all wage levels, although with the risk of increasing near-term benefit expenditures. Alternatively, a shift in employer health-related incentive strategies to disproportionately reward low-wage workers might also promote more appropriate use of health care services. Lastly, the use of wage-based deductibles may help reduce the out-of-pocket spending burden for low-wage workers.

Conclusion

Our analysis has provided insight into the relationship between wage category and health care use and spending among commercially insured workers. For plan sponsors, health plans, benefit consultants, and policy makers, these data have substantial implications regarding benefit design and health care cost trend management. We hope that the results from our analysis prompt further investigation, ultimately leading to more thoughtful employer support for low-wage workers' health. Equipped with a greater awareness and understanding, policy makers and other stakeholders can develop more strategic benefit design and communication approaches to ensure that the goals of appropriate health care use and improved health status are attainable for all members of the workforce. ■

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By John A. Graves and Sayeh S. Nikpay

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

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

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The health insurance reforms brought about by the Affordable Care Act (ACA) have resulted in an estimated twenty million people obtaining insurance.[1] These coverage gains, according to the National Health Insurance Survey, contributed to a decline in the uninsurance rate from 16.0 percent (48.6 million people) in 2010 to 9.1 percent (28.4 million) by early 2016—the lowest recorded rate in the United States.[2]

As the focus of policy makers now turns to the ultimate fate of the ACA, it will be important to understand the precise channels through which these coverage changes occurred. For example, survey evidence suggests that one-third of enrollees in the ACA's state-based health insurance Marketplaces were previously uninsured.[3–5] However, the uninsurance rate could also decline if Medicaid retention rates improved or if people transitioning from employer-sponsored insurance obtained Marketplace coverage or Medicaid in lieu of becoming uninsured.

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

This study's primary objectives were to provide

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

Study Data And Methods

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

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

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

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

STATISTICAL ANALYSIS Our statistical approach focused on two quantities of interest: first, the probability of transition from the initial coverage source (for example, employer-sponsored insurance) to a different coverage source (for example, nongroup coverage) within a given time frame (for example, within twelve months); and second, the change in that transition probability over time (for example, 2012–13 versus 2013–14).[8,9]

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

Transition rates were estimated nonparametrically using a Kaplan-Meier-based multistate model that accounted for right-censoring that might occur because of temporary or permanent attrition from the survey or the end of the sur-

vey.[10–14] Separate models were fitted for each baseline insurance category (employer-sponsored insurance—own, employer-sponsored insurance—dependent, nongroup, public, and uninsured) and each MEPS panel (2011–12, 2012–13, and 2013–14). The use of nonparametric methods and analyses stratified by population group and MEPS panel ensured that our analysis relied entirely on patterns observed in the raw data instead of on restrictive proportional hazards or proportional odds modeling assumptions.[9] We converted the transition rates estimated by the multistate models to transition probabilities using the nonparametric Aalen–Johansen estimator.[13,14]

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

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

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

While both of the above approaches would understate the total number of insurance transitions in the population, our multistate approach understated transitions only among individuals with more than one transition during a twenty-four-month period. This is particularly important to highlight because of the one-time nongroup plan cancellations at the end of 2013.[15] These cancellations occurred as issuers discontinued plans that were not compliant with the ACA's essential health benefits requirements or as issuers otherwise consolidated their plan offerings in advance of the state Marketplaces beginning in 2014. For these individuals, we observed only the first coverage type they received after the plan cancellation. The impact of these cancellations on our overall transition estimates was small, however, because another limitation of our data was the relatively small number of individuals ($n = 539$) who began with nongroup coverage.

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

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

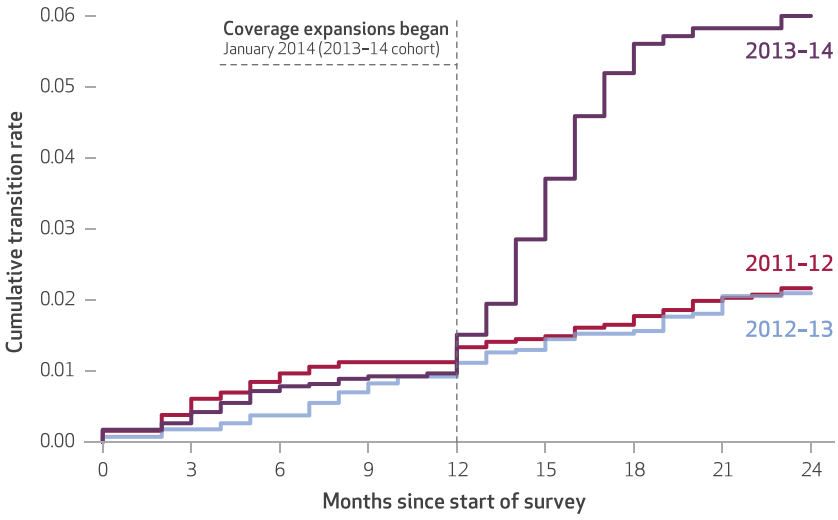
Finally, because the MEPS public data do not contain state identifiers, we were unable to assess differences across states or state groups based on Medicaid expansion status. The impact on the ACA's coverage provisions on transitions likely varied with state Marketplace outreach efforts, Medicaid expansion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

Study Results

Exhibit 1 plots cumulative transition rates in each month since the start of the survey for transitions from uninsured status to obtaining nongroup coverage. Separate lines are shown for the

EXHIBIT 1

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



SOURCE Authors' analysis of 2011–14 MEPS data. **NOTES** Plot shows cumulative transition hazard rates for each MEPS panel. Higher numbers indicate that transitions occurred more frequently. $N = 11{,}046$ uninsured adults.

three MEPS panels; thus, the lines compare how transitions from uninsured status to nongroup coverage evolved during three distinct twenty-four-month periods: 2011–12, 2012–13, and 2013-14. For a given month (for example, month 12), higher values indicate that these transitions occurred more frequently in the population during that time period.

Exhibit 1 also shows that the rate of transitioning from uninsured to nongroup coverage was stable during the time periods leading up to 2014. That is, the lines for the 2011–12 and 2012–13 panels overlap, indicating that the rate at which uninsured adults transitioned to nongroup insurance policies was nearly identical from January 2011 to December 2012 as compared to a similar twenty-four-month period between January 2012 and December 2013. In addition, the plotted line for the 2013–14 panel overlaps with the earlier panels for the first twelve months—again indicating that the transition rates were similar from January 2013 to December 2013 to what they were in the first twelve months in the earlier years.

Beginning in month 13 for individuals in the 2013–14 MEPS cohort, we found an abrupt and sustained increase in transitions from uninsured status to nongroup coverage. This increase in insurance transitions at month 13 coincided with the launch of the ACA's insurance Marketplaces and subsidies for the purchase of Marketplace coverage in January 2014. Additional plots showing transitions for other coverage types are in Appendix Figures 2–6.[7]

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

The left-hand section of Exhibit 2 shows the twenty-four-month transition probabilities for 2012–13. For example, it shows that 59.4 percent of uninsured adults experienced no transitions and remained uninsured, while 16.0 percent ob-

EXHIBIT 2

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

	Transitioning to:									
	2012–13					2013–14				
Transitioning from:	ESI—own	ESI—dependent	Nongroup	Public	Uninsured	ESI—own	ESI—dependent	Nongroup	Public	Uninsured
ESI—own	81.6%	2.9%	1.0%	1.8%	12.6%	81.0%	3.7%	1.7%	1.6%	11.9%
ESI—dependent	9.1	77.4	1.1	1.8	10.7	9.9	77.6	1.1	2.1	9.3
Nongroup	10.8	8.0	69.4	1.9	9.9	16.9	7.6	59.5	2.5	13.6
Public	3.5	3.6	0.7	66.1	26.1	4.6	1.9	1.0	69.3	23.1
Uninsured	16.0	7.5	2.7	14.5	59.4	18.4	7.4	5.8	19.3	49.1

SOURCE Authors' analyses of 2011–14 Medical Expenditure Panel Survey data. **NOTES** Each panel shows the probability that a US adult retained his or her original insurance type or transitioned to another insurance type during a twenty-four-month period. ESI is employer-sponsored insurance. Sample sizes: ESI—own, 11,088; ESI—dependent, 5,300; nongroup, 539; public, 5,221; and uninsured, 11,046.

tained employer-sponsored insurance coverage as the primary policyholder and 2.7 percent enrolled in a nongroup plan.

The right-hand section of Exhibit 2 shows the same transition probabilities for 2013–14. Recall that in Exhibit 1 we found that the coverage transition rates from uninsured to nongroup insured were similar during the first twelve months when comparing the 2011–12, 2012–13, and 2013–14 panels. Thus, the differences in coverage transition probabilities for uninsured to nongroup insured in Exhibit 2 stemmed from changes in transition rates that occurred starting in January 2014. Here, we found that the probability that an uninsured person remained without coverage for twenty-four months was 49.1 percent in 2013–14—a decline of 10.3 percentage points from 59.4 percent in 2012–13.

Exhibit 3 reports the change in probabilities between the two panels of Exhibit 2. We found that uninsured adults (24.7 percent of the baseline sample; see Exhibit 1) were 3.1 percent more likely to enroll in a nongroup (Marketplace) plan by the end of 2014 relative to the 2012–13 period ($p < 0.01$). Again, this estimate simply quantifies, in terms of a probability change, the difference in the cumulative transition rates observed at twenty-four months.

Exhibit 3 shows clearly that the first year of the ACA's coverage reforms was associated with large reductions in the probability of remaining uninsured among adults who lacked insurance at baseline. In addition to a higher likelihood of obtaining nongroup coverage, these adults also had a higher probability of obtaining employer-sponsored insurance (2.4 percent) or enrolling in Medicaid (4.8 percent).

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

Exhibit 3 also shows that adults with employ-

EXHIBIT 3

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

SOURCE Authors' analyses of Medical Expenditure Panel Survey data. **NOTES** Plot shows the change in the twenty-four-month probability of retaining the original coverage type or transitioning to another insurance type from 2012–13 to 2013–14. ESI is employer-sponsored insurance. Sample sizes are in the Notes to Exhibit 2.

er-sponsored insurance saw surprisingly little change in their probability of becoming uninsured in 2014. Moreover, the probability of switching from employer-sponsored insurance to nongroup coverage increased by less than 1 percent between 2013 and 2014. The change in transitions to public coverage is small and statistically insignificant, which suggests that, on average, few of those who qualified for both employer-sponsored insurance and Medicaid dropped employer-sponsored insurance coverage for public coverage.

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

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

Our results in Exhibit 2 set the stage for understanding the dynamics of insurance transitions by age group. Exhibit 2 findings indicate a higher likelihood of gaining nongroup coverage among those who were uninsured. We also found no evidence of change in the probability of obtaining nongroup coverage or becoming uninsured among those with employer-sponsored insurance. This suggests that the availability of subsidized Marketplace coverage might not have attracted individuals previously covered through their employer. Conversely, we found a 10-percentage-point decline in the probability that someone with nongroup coverage in 2013 maintained that plan into 2014.

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

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

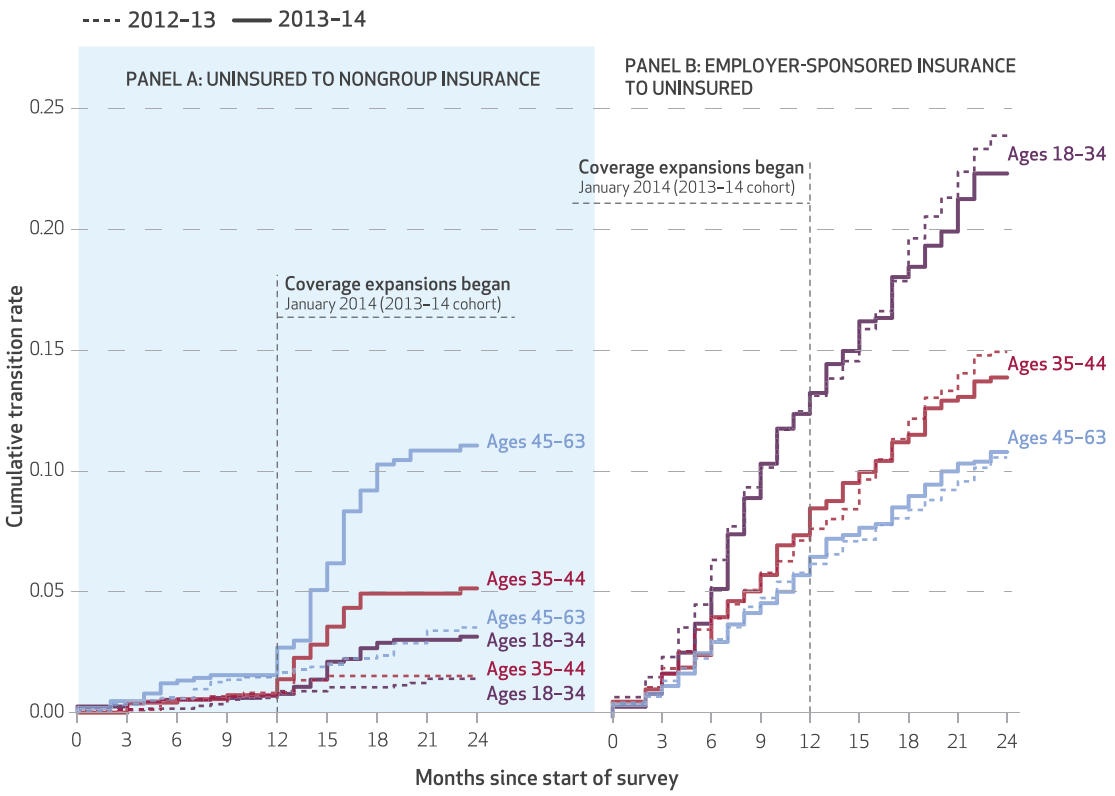
Discussion

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

Our study can provide answers to several important questions facing policy makers as they debate the future of the ACA. For example, state-level debates about whether to expand Medicaid have focused on the question of whether the expansion would lead to crowd-out of private insurance. Here, our results add to existing estimates suggesting little crowd-out overall.[17] Crowd-out could manifest in two ways: People who are currently covered by private insurance

EXHIBIT 4

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



SOURCE Authors' analysis of 2011–14 Medical Expenditure Panel Survey (MEPS) data. **NOTES** Plot shows cumulative transition hazard rates for each MEPS panel. Higher numbers indicate that transitions occurred more frequently. ESI is employer-sponsored insurance. Sample sizes are in the Notes to Exhibit 2.

but also become eligible for Medicaid might drop private for public coverage; alternatively, those who are currently uninsured might choose to obtain public coverage instead of private coverage. Our results show little evidence that either form of crowd-out occurred after 2014.

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

A third question is whether the ACA would destabilize the nongroup market, as low enrollment combined with higher demand among sick people would result in adverse selection.[20] Similar to those of another recent study,[4] our results show that nongroup enrollment rates among the previously uninsured were concentrated among older adults—validating a claim made often by Marketplace insurers.[21] This is notable considering that young adults constituted the largest fraction of the uninsured population at baseline (see Appendix Table 1).[7]

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

Leading into the open enrollment period for 2014, outreach efforts were understandably focused on identifying and enrolling those who were already uninsured. Much less attention was paid to an estimated ten million people (annually) who become eligible for a special enrollment period when they lose insurance because their work or family circumstances change.[22] Our findings are consistent with this figure and show further that those who lost employer-

sponsored insurance were disproportionately younger—precisely the demographic that policy makers and issuers need to keep risk pools stable and Marketplace premiums low. Yet, at least in 2014, the large population of young adults transitioning off employer-sponsored insurance was missed by insurers in the state insurance Marketplaces.

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

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

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

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

Conclusion

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

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THE CENTURY FOUNDATION

COMMENTARY HEALTH CARE

1 in 10 Americans Could Lose Access to Marketplace Plans

FEBRUARY 03, 2017

The new administration and Congress have set down a path to repeal the Affordable Care Act (ACA) through a reconciliation bill with a delayed effective date, and then to subsequently replace it with yet-to-be-determined policies at a future date. A similar "repeal and delay" bill was vetoed by President Obama last year. The Congressional Budget Office (CBO) recently estimated the impact such legislation would have on premiums and access to plans in the Health Insurance Marketplaces (Marketplaces). In a previous Century Foundation post, we translated CBO's projected premium increases into dollar amounts and found that repeal-and-delay could add roughly $725 to $900 to the 2018 average annual premiums for young adults.

Today, we analyzed another one of CBO's conclusions on the legislation: that "roughly 10 percent of the population would be living in an area that had no insurer participating" in the first year after enactment, which could be 2018. In 2017, zero percent of Americans had no insurer participating in their Marketplaces.

While the decision by insurers whether or not to offer coverage in a particular county is multi-facted, the map below lays out—in our view—one of the more likely scenarios under repeal and delay for 2018. The map identifies the counties that are most at risk of a complete loss of competition—those counties where only one insurer currently participates. The cumulative population of these at-risk counties represents slightly less than 20 percent of the total U.S. population. The High Risk counties, which have the lowest number of potential customers among all at-risk counties, correspond to the 10 percent of the population projected by CBO to lose total access to Marketplace coverage. The Vulnerable counties also only have one insurer, but have a larger customer base, making them less likely to lose all insurer participation in the first year, all else equal.

While this analysis depicts only one possible scenario under either "repeal and delay" or administrative actions to undermine the same policies, it is clear that, no matter how you distribute the effects, a loss of access to Marketplace coverage for 10 percent of Americans cannot be written off. And with these access to coverage loss numbers projected by CBO to grow to 50 or even 75 percent of the population with the repeal of financial assistance, the "repeal and delay" approach ultimately fails to meet the promise of more coverage by the president and members of Congress.

COVER PHOTO: MATTHEW PERKINS, OLD BOURKE HOSPITAL BED, FEBRUARY 11, 2016.

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ISSUE BRIEF
FEBRUARY 2017

The COMMONWEALTH FUND

How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016

Sara R. Collins, Munira Z. Gunja, Michelle M. Doty, and Sophie Beutel

ABSTRACT

Issue: Since 2001, long before the passage of the Affordable Care Act (ACA), the Commonwealth Fund Biennial Health Insurance Survey has examined health coverage and consumers' experiences buying insurance and using health care. **Goals:** To examine long-term trends and to make comparisons before and after passage of health reform. **Methods:** Analysis of the Commonwealth Fund Biennial Health Insurance Survey, 2016. **Findings and Conclusions:** There have been dramatic improvements in people's ability to buy health plans on their own following the passage of the ACA. For adults with family incomes less than $48,500, uninsured rates dropped about 17 percentage points below their 2010 peak. Lower-income whites, blacks, and Latinos have experienced drops this large, though Latinos are uninsured at higher rates. Among working-age adults who had shopped for plans in the individual market and ACA marketplaces over the prior three years, the percentage who reported it was very difficult to find affordable plans fell by nearly half from 2010, prior to the ACA reforms, to 2016. Coverage gains are helping working-age Americans get the care they need: the number of adults who reported problems getting needed health care and filling prescriptions because of costs fell from a high of 80 million in 2012 to an estimated 63 million in 2016.

BACKGROUND

Prior to the passage of the Affordable Care Act, the individual insurance market was a notoriously difficult place for consumers without employer-based health benefits to purchase insurance. It also was challenging for insurers to sell insurance without incurring large losses. As a result, insurers went to great lengths to exclude people with even mild health problems. In 2010, the Commonwealth Fund Biennial Health Insurance Survey found that more than one-third of people who tried to purchase health insurance in the individual market in the previous three years—an estimated 9 million people—had been turned down, charged a higher price, or had a condition excluded from their health plan.[1]

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By January 2016, near the end of the ACA's fourth open-enrollment period, things had changed. The size of the individual market has nearly doubled since 2010.[2] As a result of changes that have made purchasing and affording coverage easier—and with consumer protections such as bans against insurers charging people more or denying coverage because of preexisting conditions—nearly 9 million people have signed up for a plan through HealthCare.gov, the federal marketplace website.[3] This does not include enrollment in 11 states plus the District of Columbia that operate their own marketplaces. An additional 7 million are estimated to have purchased coverage in the individual market outside the marketplaces, where insurers must comply with the same regulations as the ACA.[4] Further, more than 16 million people have enrolled in Medicaid and the Children's Health Insurance Program.[5] All told, more than 30 million people are currently insured as a result of the ACA's insurance subsidies, expanded Medicaid eligibility, state and federal outreach efforts, and market regulations.

Members of Congress and the Trump administration are currently pursuing repeal of certain provisions of the ACA. In this time of uncertainty, the Commonwealth Fund Biennial Health Insurance Survey, fielded nearly every other year since 2001, examines long-term trends in the stability of insurance coverage, consumers' experiences buying coverage, cost-barriers to timely health care, and problems paying medical bills. The current survey was conducted from July 12 to November 20, 2016, by Princeton Survey Research Associates International, with 4,186 adults ages 19 to 64 (see How This Study Was Conducted for more information).

SURVEY FINDINGS

Number of Uninsured Continues to Fall Across All Demographic Groups

The number of uninsured U.S. adults ages 19 to 64 declined to 23 million, or 12 percent of the population, in July to November 2016 from a high of 37 million, or 20 percent, in 2010 (Exhibit 1,

Exhibit 1

The Number of Uninsured Adults Dropped to 23 Million in 2016, Down from 37 Million in 2010

Adults ages 19–64	2001	2003	2005	2010	2012	2014	2016
Uninsured now	15% 24 million	17% 30 million	18% 32 million	20% 37 million	19% 36 million	16% 29 million	12% 23 million
Insured now, had a gap	9% 15 million	9% 16 million	9% 16 million	8% 15 million	10% 19 million	13% 23 million	10% 18 million
Continuously insured	76% 123 million	74% 127 million	72% 125 million	72% 132 million	70% 129 million	72% 131 million	78% 147 million

Notes: "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, 2014, 2016).

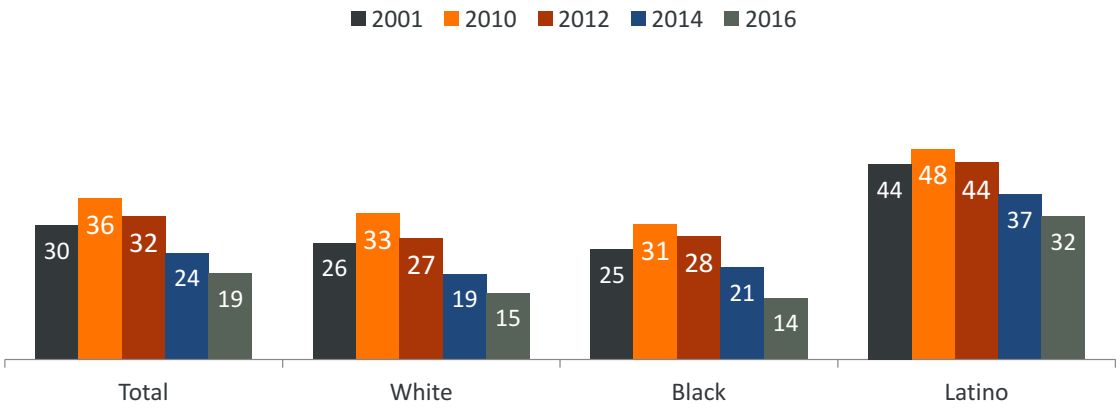
Table 1).[6,7] An estimated 18 million adults, or 10 percent, were insured at the time of the survey but had gaps in their insurance coverage in the past 12 months—about the same as in years prior to the ACA. About 147 million adults, or 78 percent, were insured continuously in 2016, up from a low of 70 percent, or 129 million, in 2012.

There have been broad coverage gains since passage of the law in 2010 across racial and ethnic groups, age ranges, and income. People with low and moderate incomes have experienced particularly dramatic gains. For adults with family incomes less than $48,500, the uninsured rates are now about 17 percentage points below their 2010 peak and 10 percentage points below 2001 levels (Exhibit 2). Whites, blacks, and Latinos in lower-income households have experienced drops this large. For lower-income Latinos, while the drops have been similar, they are uninsured at higher rates than whites and blacks. This is because Latinos had higher rates of uninsurance than other groups prior to the ACA, some states that have not expanded eligibility for Medicaid have large Latino populations, and undocumented immigrants are not allowed to enroll in the law's coverage expansions.[8] Young adults ages 19 to 34 have made the largest gains of any age group since 2010 (Exhibit 3).

Exhibit 2

People with Family Incomes Less Than $48,500 Have Uninsured Rates More than 10 Percentage Points Below 2001 Levels

Percent of adults ages 19–64 who are uninsured an earn less tha 200% FPL

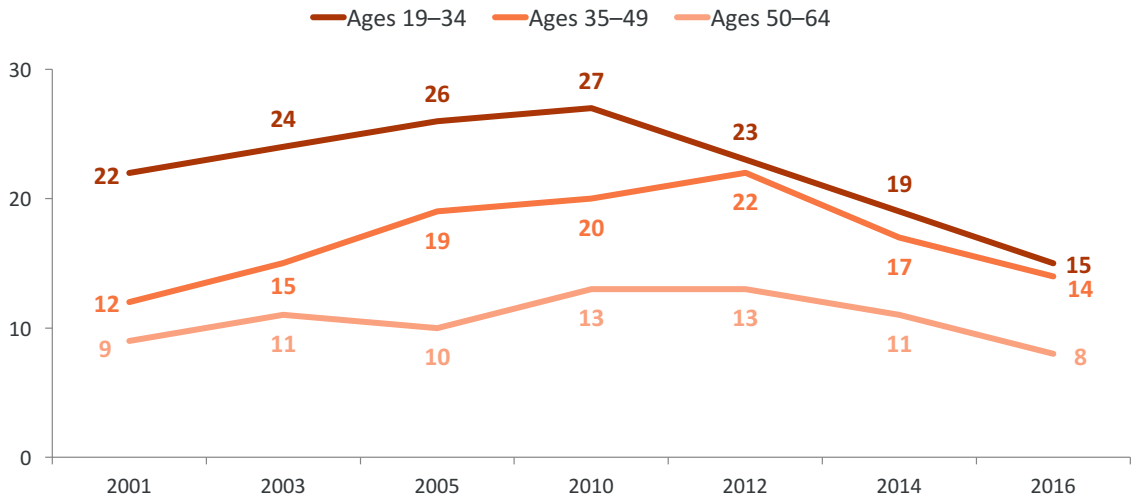


Notes: FPL refers to federal poverty level. Income levels are for a family of four in 2015. Rates are for those uninsured at the time of the survey.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016).

Exhibit 3

Young Adults Have Made the Greatest Gains in Coverage of Any Age Group Since 2010

Percent of adults ages 19–64 who are uninsured



Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, 2014, 2016).

Individual Market Reforms and Subsidies Have Made Buying Insurance Easier

Prior to the ACA, people without job-based health benefits had few affordable options. Because public insurance programs like Medicaid and the Children's Health Insurance Program were available in most states only to children, pregnant women, and parents with very low incomes, people without job-based insurance were limited to purchasing coverage in the individual market and paying full premiums. States set their own rules for their markets; in most, people were charged premiums that reflected their health, gender, and age. They could be denied coverage because of a preexisting condition or have conditions excluded from their plan.[9] Once insured, they could face annual and lifetime limits on what plans would pay and could have a policy cancelled retroactively (i.e., "rescinded") if they developed a health problem.

One of the primary goals of the ACA was to reform the individual insurance market so that anyone without employer health benefits, regardless of their health status, could find and afford a plan that provided coverage at least as comprehensive as an employer plan. Under the ACA, insurers in the individual market now must offer a plan to all who apply, cannot charge people more based on health or gender, are limited in how much more they can charge an older person relative to someone younger, and are restricted from imposing lifetime or annual benefit limits and rescissions. To help consumers choose plans, all must be sold at four tiers of coverage that vary only by premium and cost-sharing amounts. The benefit package stays the same and must cover an essential set of services. Finally, people with incomes between $24,000 and $97,000 for a family of four are eligible for premium tax credits that reduce their share of premium costs.

These changes have made a dramatic difference. In 2010, an estimated 26 million people said they either had a plan or tried to buy a health plan in the individual market over the prior three years (Exhibit 4).[10] In 2016, 44 million tried to purchase coverage either through the marketplaces

Exhibit 4

The ACA's Individual Market Reforms and Subsidies Have Made It Easier for People to Buy Health Plans on Their Own

	Total		Health problem**		<200% FPL		200%+ FPL	
	2010	2016	2010	2016	2010	2016	2010	2016
Adults ages 19–64 with individual coverage* or who tried to buy it in past three years who:	**26 million**	**44 million**						
Found it very difficult or impossible to find affordable coverage	60%	34%	70%	42%	64%	35%	54%	32%
Found it very difficult or impossible to find coverage they needed	43%	25%	53%	31%	49%	26%	35%	23%
Has individual coverage* or ended up buying a health insurance plan^	46% **12 million**	66% **29 million**	36%	60%	34%	63%	57%	71%

Note: FPL refers to federal poverty level. * Bought in the past three years. ** Respondent rated their health status as fair or poor, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol. ^ Among those who ever tried buying health insurance on their own in the past three years.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010 and 2016).

or directly from an insurance company. In 2010, fewer than half (46%) of people who tried to buy a plan on their own, or 12 million people, ended up purchasing one. By 2016, two-thirds (66%), or 29 million people, ended up purchasing a health plan in the preceding three years.[11]

In 2010, 60 percent of adults who had a plan or tried to buy a plan on their own in the individual market found it very difficult or impossible to find one they could afford (Exhibit 4). By 2016, that percentage had fallen to about one-third (34%) of people. Among people with health problems, the share of those reporting difficulties finding an affordable plan dropped from 70 percent in 2010 to 42 percent in 2016. Among those with incomes less than 200 percent of poverty, the percentage who had trouble finding a plan they could afford dropped from nearly two-thirds (64%) in 2010 to one-third (35%) in 2016. Adults with higher incomes also found it easier to find an affordable plan in 2016 compared to 2010.

The law's requirements for comprehensive health plans, along with bans on preexisting condition exclusions, appear to have made a significant difference in people's ability to find plans that fit their health care needs. In 2010, 43 percent of people buying plans on their own said they found it very difficult or impossible to find a plan with coverage they needed; by 2016, the share had fallen to one-quarter (25%) (Exhibit 4). Among those with health problems, the share who reported difficulty finding a plan that met their needs fell from 53 percent in 2010 to 31 percent in 2016.

Fewer Adults Reported Cost-Related Problems Getting Needed Care

Expanded insurance coverage also is helping people get the care they need. The number of adults who did not get needed care in the past 12 months because of cost declined from a high of 80 million in 2012, or 43 percent of those surveyed, to 63 million, or 34 percent, in 2016 (Exhibit 5, Table 2). This is the lowest rate of cost-related access problems reported by adults since this measure was added to the survey in 2003.

Exhibit 5

Fewer Adults Report Not Getting Needed Care Because of Cost

	2003	2005	2010	2012	2014	2016
Percent of adults ages 19–64 who reported any of the following cost-related access problems in the past year: • *Had medical problem but did not visit doctor or clinic* • *Did not fill a prescription* • *Skipped recommended test, treatment, or follow-up* • *Did not get needed specialist care*	**37%** 63 million	**37%** 64 million	**41%** 75 million	**43%** 80 million	**36%** 66 million	**34%** 63 million

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016).

There were declines in all four cost-related access problems asked about in the survey. The percentage of adults who said that because of cost they had not gone to the doctor when they were sick fell from 29 percent in 2012 to 20 percent in 2016; the percentage of those who said they had not filled a prescription because of cost dropped from 27 percent in 2012 to 19 percent in 2016; the share who said they skipped a recommended test, treatment, or follow-up visit because of cost fell from 27 percent to 18 percent; and the share who said they had not gotten needed care from a specialist fell from 20 percent to 13 percent (Table 2).

These population-wide declines in cost-related problems getting care are consistent with other recent federal surveys and reflect nationwide gains in insurance coverage.[12] Fewer people are facing the full cost of their health care. We also found declines in cost-related problems getting care among the uninsured (Exhibit 6, Table 3), possibly explained by improved economic conditions as well as a significant shift in the demographic composition of the uninsured in the wake of the ACA's coverage expansions.[13]

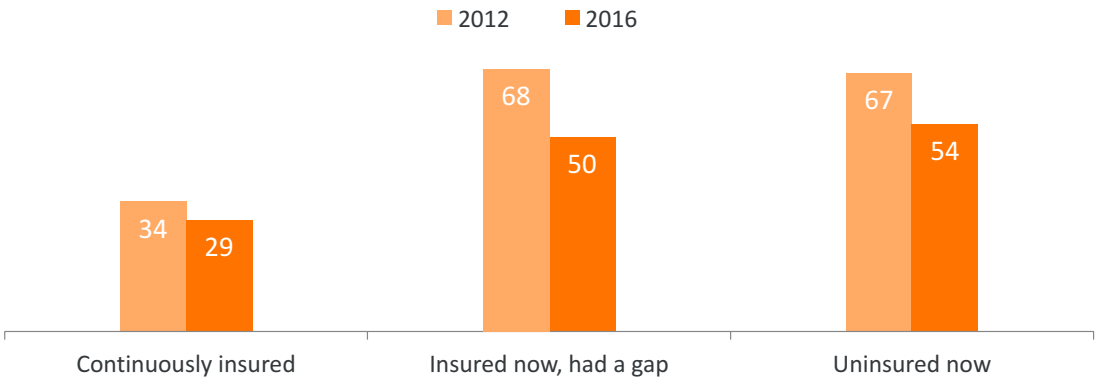
Still, as in past surveys, uninsured adults reported cost-related access problems at nearly two times the rate of those insured all year (Exhibit 6). In addition, cost-related access problems among people who had experienced gaps in coverage in the prior year were almost as high as those who were uninsured at the time of the survey.

While there have been modest declines in cost-related access problems among insured adults, rates remain high: three of 10 adults (29%) who had coverage for the full year reported not getting care because of cost. People with individual market coverage continue to report cost-related access problems at higher rates than those with employer coverage (45% vs. 28%) (Table 3).

Exhibit 6

Uninsured Adults and Those with Coverage Gaps Reported Cost-Related Access Problems at Higher Rates Than Did Those Continuously Insured

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



Notes: * Includes any of the following because of cost: did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic. "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2012 and 2016).

Fewer Adults Have Problems Paying Medical Bills

There has been modest but significant improvement in the percentage of adults who report medically related financial difficulties. In 2012, 75 million people, or 41 percent of those surveyed, said they had problems paying their medical bills in the past 12 months or were paying off medical debt. In 2016, this figure was 70 million, or 37 percent (Exhibit 7, Table 2).[14]

From 2012 to 2016, among the four areas of medical bill problems asked about in the survey, there was significant improvement among people's ability to pay their bills and fewer reports of calls

Exhibit 7

Fewer Adults Reported Medical Bill Problems in 2016 Than in 2012

	2005	2010	2012	2014	2016
Percent of adults ages 19–64 who reported any of following bill or medical debt problems in the past year: • *Had problems paying or unable to pay medical bills* • *Contacted by a collection agency for unpaid medical bills* • *Had to change way of life to pay bills* • *Medical bills being paid off over time*	**34%** 58 million	**40%** 73 million	**41%** 75 million	**35%** 64 million	**37%** 70 million

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016).

from collection agencies about unpaid bills. The percentage of adults who said they had problems paying or were unable able to pay their bills fell from 30 percent to 23 percent (Table 2). The percentage who reported they had been contacted by a collection agency about unpaid medical bills fell from 18 percent to 14 percent.

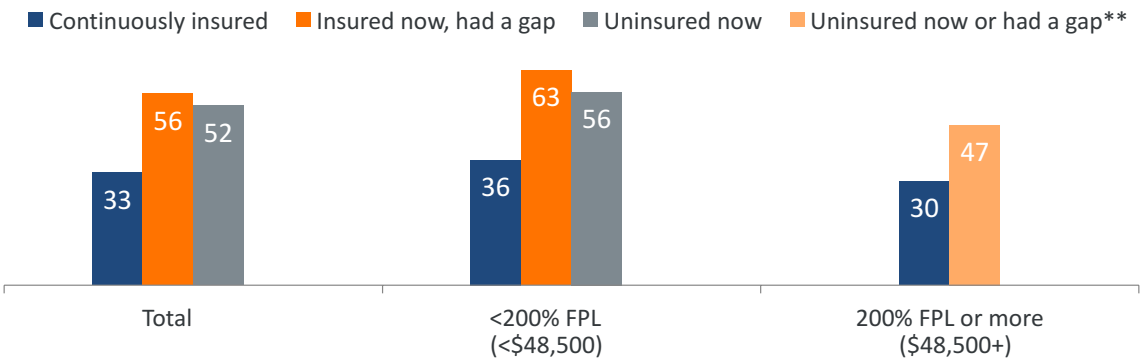
But there has been no improvement in the share of people who are paying off medical debt over time. Nearly a quarter (24%) of adults, or an estimated 46 million people, reported they had medical bills they were paying off over time, nearly the same as in 2012 (Table 2).

Lacking health insurance for even part of the year is associated with a much higher risk of medical bill problems, particularly among people with low incomes. Nearly two-thirds (63%) of adults with incomes of less than 200 percent of poverty who had experienced a gap in their insurance coverage in 2016 reported difficulties paying medical bills or were in medical debt compared to just over a third (36%) of people in that income group who had been insured continuously (Exhibit 8). Still, these rates are high even for insured adults.

Exhibit 8

Uninsured Adults and Those with Coverage Gaps Reported Medical Bill Problems at Higher Rates Than Did Those Continuously Insured, 2016

*Percent of adults ages 19–64 who had medical bill problems or accrued medical debt**



Notes: * Includes any of the following: had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt. ** Sample size too small to separate by "Insured now, had a gap" and "Uninsured now." "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date. FPL refers to federal poverty level. Income levels are for a family of four in 2015.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

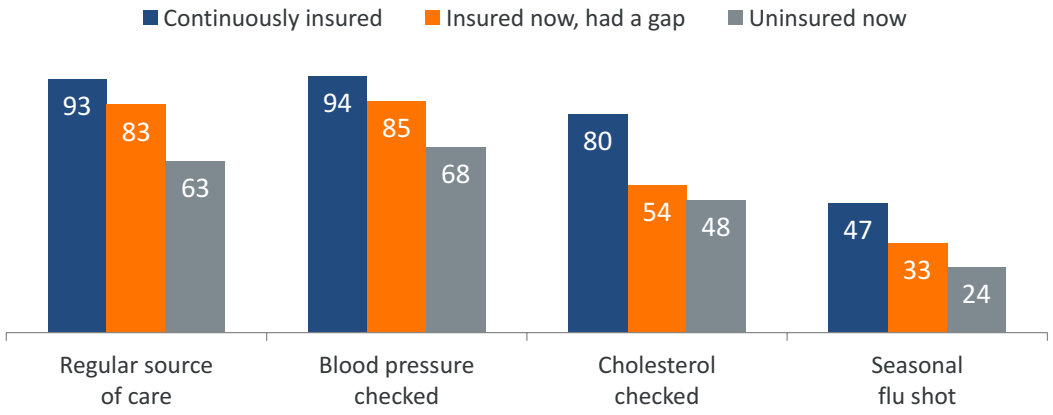
Insurance Status Makes Marked Difference in Adults' Rates of Having a Regular Doctor and Getting Preventive Care

Having health insurance coverage paves the way for people to have a regular doctor and get timely medical care. In the survey, continuously insured adults are more likely than those who were uninsured to have a regular source of care and to report receiving timely preventive care tests and cancer screenings (Exhibits 9 and 10, Table 3). Even gaps in health insurance is associated with disruptions in recommended care. For example, 72 percent of women ages 40–64 who had been insured continuously had received a mammogram in the past two years, compared to 55 percent of those who had a coverage gap and only 40 percent of those who were uninsured at the time of the survey.

Exhibit 9

Uninsured Adults Are Less Likely to Have a Regular Source of Care or Receive Preventive Care, 2016

Percent of adults ages 19–64



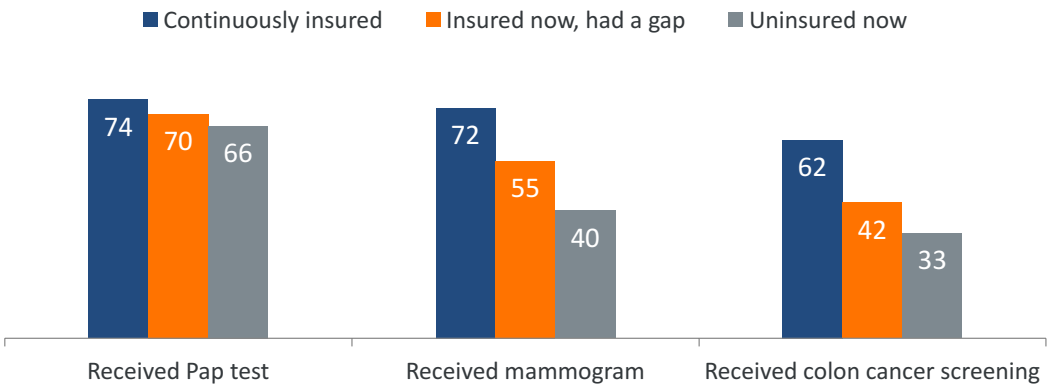
Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey. Respondents were asked if they: had their blood pressure checked within the past two years (in past year if has hypertension or high blood pressure); had their cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); and had their seasonal flu shot within the past 12 months.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Exhibit 10

Uninsured Adults Are Less Likely to Receive Cancer Screenings, 2016

Percent of adults ages 19–64



Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey. Respondents were asked if they: received a Pap test within the past three years for females ages 21–64, received a mammogram within the past two years for females ages 40–64, and received a colon cancer screening within the past five years for adults ages 50–64.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

CONCLUSION

This analysis indicates the Affordable Care Act has increased health insurance coverage for U.S. adults of all races, ages, and income groups. These coverage gains are allowing working-age adults to get the health care they need. In contrast, Americans who still lack health insurance are less likely to go to the doctor when they need to or get preventive care and cancer screenings. Even a gap in coverage is often associated with a lower likelihood that someone will get timely health care.

The Commonwealth Fund Biennial Health Insurance Survey highlights the strong growth in the use of the individual market by Americans since the ACA market reforms and subsidies went into effect in 2014. The market has evolved from being a place where mostly healthy people and those with sufficient income could buy plans to one where all are offered comprehensive plans, regardless of factors like gender or health status, with income-based financial assistance to offset costs for those eligible.

The survey does expose areas of weakness in the law and in U.S. health insurance coverage generally, including that offered by employers. The rates of people who cite problems affording plans in the individual market or finding plans that meet their needs have improved but remain high. These problems could be remedied by improving the generosity of marketplace subsidies as well as ongoing efforts to help people understand and compare health plans. Nearly 23 million working-age adults remained uninsured in 2016. To cover more people, all states could move to expand their Medicaid programs and increase outreach efforts to those potentially eligible. Immigration reform and lifting restrictions on ACA eligibility for undocumented immigrants could help lower uninsured rates among Latinos. Finally, rates of cost-related problems getting needed care and medical bill problems remain high even among insured people in all coverage types. Reducing deductibles and other cost-sharing in all private plans would help alleviate health care cost burdens for U.S. families whose incomes have barely kept pace with growth in medical costs.[15] Repealing the Affordable Care Act's insurance subsidies and Medicaid expansion without an effective replacement plan will only exacerbate these weaknesses in the marketplaces and leave problems in employer-based plans unaddressed.

HOW THIS STUDY WAS CONDUCTED

The Commonwealth Fund Biennial Health Insurance Survey, 2016, was conducted by Princeton Survey Research Associates International from July 12 to November 20, 2016. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 6,005 adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial samples was used to reach people. In all, 2,402 interviews were conducted with respondents on landline telephones and 3,603 interviews were conducted on cellular phones, including 2,262 with respondents who live in households with no landline telephone access.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,186). Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2016 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 187.4 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 14 percent response rate and the cellular phone component achieved a 10 percent response rate.

We also report estimates from the 2001, 2003, 2005, 2010, 2012, and 2014 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2016, except the 2001, 2003, and 2005 surveys did not include a cellular phone random-digit dial sample. In 2001, the survey was conducted from April 27 through July 29, 2001, and included 2,829 adults ages 19 to 64; in 2003, the survey was conducted from September 3, 2003, through January 4, 2004, and included 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; and in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64.

NOTES

1 S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (The Commonwealth Fund, March 2011).

2 The number of people ages 19 to 64 with individual coverage climbed from an estimated 11.4 million people in 2010 to 22.7 million in 2015; analysis of the Current Population Survey by Sherry Glied and Ougni Chakraborty for The Commonwealth Fund.

3 Centers for Medicare and Medicaid Services, *Biweekly Enrollment Snapshot: Weeks 10 and 11, Jan. 1–Jan. 14, 2017,* News release (CMS, Jan. 18, 2017).

4 Office of the Assistant Secretary for Planning and Evaluation, *About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies,* ASPE Data Point, (ASPE, Oct. 4, 2016).

5 Centers for Medicare and Medicaid Services, *Medicaid and CHIP November 2016 Application, Eligibility, and Enrollment Data* (CMS, Jan. 18, 2017). This includes people eligible for both expanded eligibility for coverage under the ACA and the existing Medicaid and CHIP programs.

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

7 These estimates are in the range of those found in other recent surveys. The federal government and a number of private organizations including The Commonwealth Fund have used different surveys and methodologies aimed at measuring the change in insurance coverage as a result of the coverage expansions under the Affordable Care Act. Most recently, the Center for Disease Control's National Health Interview Survey found that in the first six months of 2016, 8.9 percent of the U.S. population, or 28.4 million people, and 12.4 percent of adults ages 18 to 64, or 24.4 million people, were uninsured (https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201611.pdf). Data from the U.S. Census Bureau's Current Population Survey (CPS) showed that 12.6 percent of adults ages 19 to 64, or 24.3 million people, were uninsured in 2015 (http://www.census.gov/library/publications/2016/demo/p60-257.html; analysis of 2015 Current Population Survey by Sherry Glied and Ougni Chakraborty of New York University for The Commonwealth Fund). The Commonwealth Fund reported in May 2016 using its ACA Tracking Survey that the uninsured rate among adults ages 19 to 64 had declined from 19.9 percent in July–September 2013 to 12.7 percent in February–April 2016, or an estimated 24 million people (http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction).

8 The survey finds that low-income Latinos born outside the United States are uninsured at significantly higher rates (42 percent) than are Latinos born in the United States (15 percent). This distinction should only be viewed as a loose approximation of immigration status.

9 M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* (The Commonwealth Fund, July 2009); K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (Russell Sage Foundation, 2006); S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (The Commonwealth Fund, Oct. 2007); N. C. Turnbull and N. M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market—Findings from a Study of Seven States* (The Commonwealth Fund, Feb. 2005).

[10] S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (The Commonwealth Fund, March 2011).

[11] Of this group, some people who shopped for plans in the marketplaces may have ended up enrolling in Medicaid. By the time of the survey in 2016, of this group 15 percent had a Medicaid plan, 30 percent were enrolled in an employer plan, and 43 percent had a plan through the individual market.

[12] 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, Dec. 2016); and B. W. Ward, T. C. Clarke, and J. S. Schiller, *Early Release of Selected Estimates Based on Data from the January–June 2016 National Health Interview Survey* (National Center for Health Statistics, Nov. 2016).

[13] In particular, Latinos make up a significantly greater share of the uninsured in 2016 than they did in 2010 (31% vs. 42%) (data not shown). As a group, Latinos report less use of health care overall than do whites (M. M. Doty, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*, The Commonwealth Fund, Feb. 2003). In addition, uninsured Latinos have consistently reported significantly lower rates of cost-related problems getting needed care than whites over the duration of the survey (data not shown).

[14] While this is slightly higher than the rate in 2014, the change is not statistically significant.

[15] 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* (The Commonwealth Fund, Oct. 2016).

Table 1

Insurance Status by Demographics, 2016 (base: adults ages 19–64)

	Total (19–64)	Continuously insured	Insured now, had a gap	Uninsured now	Uninsured now or had a gap
Total (millions)	187.4	147.0	17.9	22.6	40.4
Percent distribution	100%	78%	10%	12%	22%
Unweighted n	*4,186*	*3,268*	*398*	*520*	*918*
Age					
19–34	34	71	14	15	29
35–49	30	78	9	14	22
50–64	36	86	6	8	14
Race/Ethnicity					
Non-Hispanic White	59	85	7	7	15
Black	13	75	14	12	25
Latino	18	58	15	28	43
Asian/Pacific Islander	4	90	5	4	10
Other/Mixed	5	77	7	16	23
Poverty status					
Below 133% poverty	30	65	13	21	35
133%–249% poverty	18	74	13	14	26
250%–399% poverty	19	83	11	6	17
400% poverty or more	26	95	3	3	5
Below 200% poverty	45	68	13	19	32
200% poverty or more	48	89	7	4	11
Fair/Poor health status, or any chronic condition*	45	77	10	13	23
Adult work status					
Full-time	54	82	8	9	18
Part-time	13	70	14	16	30
Not currently employed	33	76	10	15	24
Employer size**					
1–19 employees	24	67	9	24	33
20–49 employees	10	70	16	14	30
50–99 employees	7	75	14	12	25
100 or more employees	56	89	7	4	11

Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date.

* Reported at least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

** Base: full- and part-time employed adults ages 19–64.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Table 2

Cost-Related Access Problems and Medical Bill Problems by Year (base: adults ages 19–64)

	Percent						Estimated millions					
	2003	**2005**	**2010**	**2012**	**2014**	**2016**	**2003**	**2005**	**2010**	**2012**	**2014**	**2016**
Total (adults ages 19–64)	100%	100%	100%	100%	100%	100%	172.0	172.5	183.6	183.9	182.8	187.4
Access problems in past year												
Went without needed care in past year because of costs:												
Did not fill prescription	23	25	26	27	19	19	39	43	48	50	35	36
Skipped recommended test, treatment, or follow-up	19	20	25	27	19	18	32	34	47	49	35	34
Had a medical problem, did not visit doctor or clinic	22	24	26	29	23	20	38	41	49	53	42	37
Did not get needed specialist care	13	17	18	20	13	13	22	30	34	37	23	25
At least one of four access problems because of cost	37	37	41	43	36	34	63	64	75	80	66	63
Delayed or did not get dental care	27	–	38	39	32	31	46	–	69	72	58	57
Medical bill problems in past year												
Had problems paying or unable to pay medical bills:	23	23	29	30	23	23	40	39	53	55	43	43
Contacted by collection agency	21	21	23	22	20	21	35	36	42	41	37	38
Contacted by collection agency for unpaid medical bills	–	13	16	18	15	14	–	22	30	32	27	25
Contacted by collection agency because of billing mistake	–	7	5	4	4	5	–	11	9	7	8	9
Had to change way of life to pay bills	15	14	17	16	14	14	26	24	31	29	26	26
*Any bill problem**	–	28	34	34	29	29	–	48	62	63	53	53
Medical bills/debt being paid off over time	–	21	24	26	22	24	–	37	44	48	40	46
*Any bill problem or medical debt**	–	34	40	41	35	37	–	58	73	75	64	70

– Question was not asked in that year.

* Does not include adults who reported being contacted by a collection agency because of a billing mistake.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016).

Table 3

Cost-Related Access Problems and Preventive Care by Insurance Continuity, Insurance Type, and Poverty Level (base: adults ages 19–64)

		Insurance status				Insurance type*				Federal poverty level			
	Total 19–64	Continuously Insured	Insured now, had a gap	Uninsured now	Uninsured now or had a gap	Employer	Individual**	Medicaid	Medicare (under age 65, disabled)	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	187.4	147.0	17.9	22.6	40.4	102.0	18.3	21.1	13.3	56.6	34.4	35.0	47.9
Percent distribution	100%	78%	10%	12%	22%	54%	10%	11%	7%	30%	18%	19%	26%
Unweighted n	*4,186*	*3,268*	*398*	*520*	*918*	*2,158*	*415*	*515*	*381*	*1,302*	*758*	*739*	*1,084*
Access problems in past year													
Went without needed care in past year because of costs:													
Did not fill prescription	19	16	30	31	31	15	27	19	25	24	26	19	10
Skipped recommended test, treatment, or follow-up	18	15	24	37	31	15	24	10	20	20	21	18	13
Had a medical problem, did not visit doctor or clinic	20	15	29	41	36	16	25	16	19	23	27	22	10
Did not get needed specialist care	13	10	21	30	26	10	20	8	16	17	16	12	8
At least one of four access problems because of cost	34	29	50	54	52	28	45	31	39	38	44	34	22
Delayed or did not get dental care	31	25	48	52	51	25	36	31	31	37	40	33	16
Preventive care													
Regular source of care	88	93	83	63	72	92	91	90	96	83	89	90	93
Blood pressure checked in past 2 years¥	90	94	85	68	75	94	90	88	94	83	87	93	96
Dental exam in past year	60	67	40	34	36	73	57	42	46	47	50	63	83
Received mammogram in past 2 years (females ages 40–64)	68	72	55	40	47	73	69	66	64	59	63	69	76
Received Pap test in past 3 years (females ages 21–64)	73	74	70	66	68	79	68	71	54	65	72	79	82
Received colon cancer screening in past 5 years (ages 50–64)	58	62	42	33	37	63	56	52	56	48	58	55	68
Cholesterol checked in past 5 years¥¥	74	80	54	48	51	82	73	65	79	63	70	78	87
Seasonal flu shot in past 12 months	43	47	33	24	28	48	35	44	52	38	39	44	50
Access problems for people with health conditions													
Unweighted n	*2,199*	*1,753*	*210*	*236*	*446*	*1,030*	*205*	*307*	*315*	*764*	*425*	*380*	*497*
Stayed overnight in a hospital or visited the emergency room because of [this/any of these] problem[s]^	20	18	29	23	26	14	21	23	35	26	17	19	11
Skipped doses or did not fill a prescription for medications for the health condition(s)^...?	19	14	28	41	35	13	18	17	24	24	24	18	8

Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date.

* Insurance type at time of survey for those who had insurance.

** "Individual" includes adults who are enrolled in either marketplace plans or purchased directly off the marketplace.

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

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

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

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Table 4

Medical Bill Problems, by Insurance Continuity, Insurance Type, and Poverty Level (base: adults ages 19–64)

		Insurance status				Insurance type*				Federal poverty level			
	Total 19–64	Continuously Insured	Insured now, had a gap	Uninsured now	Uninsured now or had a gap	Employer	Individual**	Medicaid	Medicare (under age 65, disabled)	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	187.4	147.0	17.9	22.6	40.4	102.0	18.3	21.1	13.3	56.6	34.4	35.0	47.9
Percent distribution	100%	78%	10%	12%	22%	54%	10%	11%	7%	30%	18%	19%	26%
Unweighted n	*4,186*	*3,268*	*398*	*520*	*918*	*2,158*	*415*	*515*	*381*	*1,302*	*758*	*739*	*1,084*
Medical bill problems in past year													
Had problems paying or unable to pay medical bills	23	18	41	39	40	18	23	25	37	30	31	26	6
Contacted by collection agency for unpaid medical bills	14	11	23	24	24	10	9	17	27	19	21	12	4
Had to change way of life to pay bills	14	11	22	25	24	11	17	10	20	17	19	13	6
Any bill problem	29	23	49	46	47	23	30	31	46	36	39	31	11
Medical bills/debt being paid off over time	24	23	35	24	29	26	27	16	35	25	31	29	19
Any bill problem or medical debt	37	33	56	52	54	33	41	34	55	43	48	39	23
Base: Any medical debt													
How much are the medical bills that are being paid off over time?													
Less than $2,000	41	42	34	41	37	41	37	38	48	43	36	40	44
$2,000 to less than $4,000	24	23	25	23	24	23	30	25	22	22	31	21	21
$4,000 to less than $8,000	15	15	18	14	16	17	11	14	10	13	13	20	19
$8,000 to less than $10,000	5	5	11	3	8	4	4	8	11	6	8	4	5
$10,000 or more	12	12	9	17	13	11	16	12	8	13	10	13	12
Was this for care received in past year or earlier?													
Past year	50	50	48	48	48	51	60	—	43	44	48	49	56
Earlier year	43	42	46	47	46	40	39	—	49	51	47	40	33
Both	7	7	6	5	6	9	1	—	4	3	5	11	12
Were these bills for someone who was insured at the time the care was provided or was the person uninsured then?													
Insured at time care was provided	67	82	44	26	34	84	85	50	65	50	68	80	91
Uninsured at time care was provided	27	13	48	69	59	11	13	42	30	44	27	15	5

Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey; "Uninsured now or had a gap" refers to adults who were uninsured at any point during the year before the survey field date or on the survey field date.

* Insurance type at time of survey for those who had insurance.

** "Individual" includes adults who are enrolled in either marketplace plans or purchased directly off the marketplace.

— Sample size less than 100.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

About the Authors

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

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The COMMONWEALTH FUND

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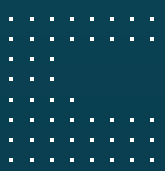
ACA Implementation—Monitoring and Tracking

Recent Evidence on the ACA and Employment: Has the ACA Been a Job Killer? 2016 Update

February 2017

By Bowen Garrett, Robert Kaestner, Anuj Gangopadhyaya



Robert Wood Johnson Foundatio

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

IN BRIEF

The potential effect of the Affordable Care Act (ACA) on the labor market has been controversial since the law was enacted, and remains so today, in the light of current proposals for ACA repeal. Because the ACA defines a full-time worker as one working 30 hours or more per week, employers subject to the employer mandate may reduce or avoid penalties by keeping workers' hours below the 30-hour threshold, thereby increasing the amount of involuntary part-time employment. The ACA's Medicaid expansions and income-based marketplace subsidies may provide incentives for some workers to voluntarily reduce their work hours or drop out of the labor market altogether. In this brief, we provide updated estimates through 2016 of the ACA's effects on employment, the usual number of hours worked per week among workers, and part-time employment. Our main findings are as follows:

- We find no evidence to support claims that the ACA has been a job killer. Through 2016, the ACA had little to no adverse effect on employment and usual hours worked per week. For both measures, levels in 2014, 2015, and 2016 are statistically identical to our projections based on patterns existing before 2014, the year the major provisions of the ACA went into effect. Our conclusion applies to the full sample of nonelderly persons and to subgroups of nonelderly persons based on gender and educational attainment.
- Levels of part-time work (29 or fewer hours per week) have fallen since 2014, but remain at somewhat higher levels than would be expected given recent declines in the unemployment rate and overall economic improvement. In 2016, the ratio of part-time employment to population was 9.2 percent, 0.56 percentage points (6 percent) higher than our prediction based on pre-2014 patterns. The higher-than-expected rate of part-time work is driven by increases in voluntary part-time work. In 2016, voluntary part-time work was 0.80 percentage points (10 percent) higher than predicted. Involuntary part-time work was 0.33 percentage points (17 percent) lower than predicted.
- The findings for voluntary and involuntary part-time work suggest that the ACA did not lead to widespread cutbacks in workers' hours by employers attempting to avoid employer mandate penalties (i.e., a reduction in labor demand). Instead, the evidence suggests that the ACA is associated with a reduction in the number of hours workers chose to work. Most would view an ACA-induced decrease in labor demand as a negative unintended consequence of the ACA. On the other hand, a voluntary decrease in labor supply in response to the ACA is consistent with an improvement in a person's welfare, although it may cause a decrease in *measured* economic activity.
- Three years after implementation of the ACA's major provisions, the policy seems to have increased health insurance coverage for 20 million Americans with little or no adverse effects on employment.

INTRODUCTION

The potential effect of the Affordable Care Act (ACA) on the labor market has been controversial since the law was enacted, and remains so today, in the light of current proposals for ACA repeal.[1,2] In this brief, we provide updated estimates of the ACA's effects on employment, the usual number of hours worked per week among workers, and part-time employment.

As we have noted in previous briefs, the ACA contains several provisions that could affect labor market outcomes: the mandate requiring large employers to offer health insurance coverage to their full-time workers or face a penalty, the expansion of Medicaid benefits to low-income adults, and the provision of subsidies (in the form of tax credits) in the health insurance marketplaces.[3] Because the ACA defines a full-time worker as one working 30 hours or more per week, employers subject to the employer mandate may reduce or avoid penalties by keeping workers' hours below the 30-hour threshold, thereby increasing the amount of part-time employment. Similarly, the Medicaid expansions and income-based marketplace subsidies provide incentives for some workers, particularly low-wage workers, to reduce labor effort by reducing the number of hours worked or dropping out of the labor market altogether. Like other public programs that tie benefits to income, the ACA may have unintended consequences on employment.[4]

The Congressional Budget Office predicted that the ACA would reduce the total number of hours worked in the economy by 1.5 to 2.0 percent from 2017 to 2024, and it attributed most of this effect to a decline in labor supply rather than labor demand.[5] The CBO's predictions about labor market effects are an important part of its dynamic scoring of the ACA's budgetary cost, though it acknowledged substantial uncertainty about its estimates. In its 2015 analysis of the budgetary effects of repealing the ACA, the CBO estimated that repeal would *increase* the federal budget deficit by $353 billion over the next 10 years, but this estimate did not account for the macroeconomic effects of the ACA that are largely driven by a labor supply response. When the CBO included potential labor market responses as well as other macroeconomic effects, they estimated that repeal would increase the deficit by only $137 billion.[6] Thus, while much of the focus on the ACA has been on health insurance coverage, the labor market consequences of the ACA are also important. This brief continues our monitoring of those consequences.

When we examined the evidence available as of early last year, we concluded that the ACA had little, if any, adverse effect on employment.[7] In this brief, we update these estimates using data through 2016. We provide estimates of the ACA's effects on employment, the usual number of hours worked per week among workers, and part-time employment. First, we examine the ACA's overall effects by assessing whether labor market outcomes in 2014, 2015, and 2016 differ from what we would predict based on pre-2014 trends. We do this for all nonelderly adults, and separately for men and women by educational attainment. We then provide additional analysis on whether the ACA has affected part-time work, one area for which prior evidence has not been uniform. Finally, we discuss our findings within the broader context of ACA employment effects.

We use data from the monthly files of the Current Population Survey (CPS) from January 2000 through December 2016. We limit our analysis to nonelderly adults (ages 18 to 64). We examine three labor market outcomes: employment at the time of the survey, usual number of hours worked per week among those who are employed, and part-time employment (measured as those who report working fewer than 30 hours per week). We further investigate the type of part-time work by dividing part-time status into voluntary part-time work—those who worked 0 to 29 hours in the previous week and who report working part-time for "noneconomic reasons"—and involuntary part-time work—those who worked 0 to 29 hours in the previous week for "economic reasons" including slack work or inability to find full-time work.[8] Our analysis focuses on changes in the time trend of each outcome and, specifically, changes since the ACA was implemented in 2014. To isolate the effect of the ACA from other factors affecting labor market outcomes, we use regression methods to generate a counterfactual (predicted) outcome in the years after 2013. Deviations of actual labor market outcomes from their predicted values in 2014 may indicate effects of the ACA, but such deviations may also result from "unexpected" changes in the labor market independent of the ACA (i.e., economic changes that are not predicted by our regression model). See the appendix for additional information on our methodological approach.

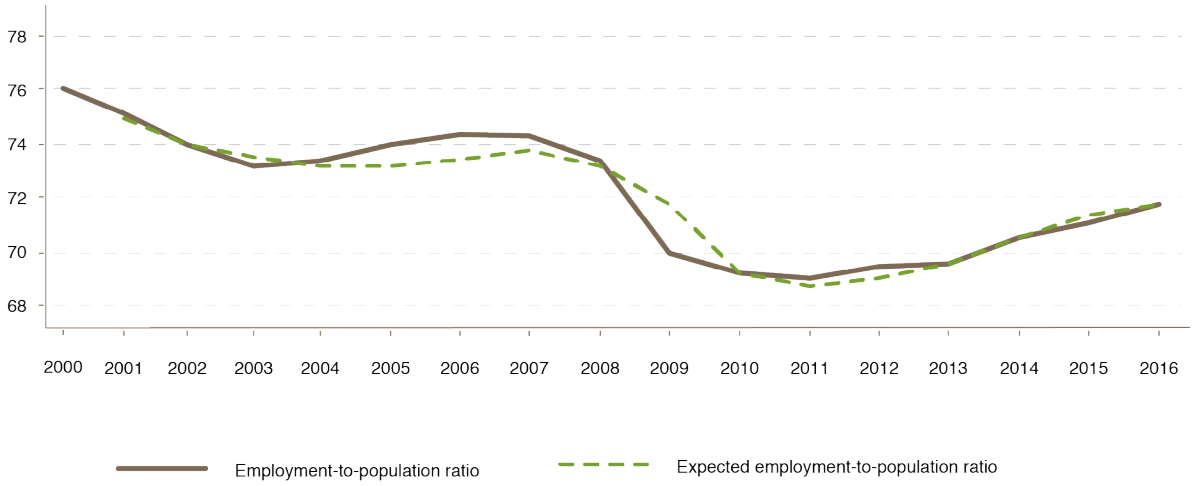
MAIN FINDINGS

In Figures 1 through 3, we show the trend in each employment measure and its predicted value from 2000 to 2016. Table 1 (left panel) reports the difference between actual and predicted levels for each labor market outcome measure for 2014 to 2016 among nonelderly adults.

Figure 1 shows the trend in the employment-to-population ratio among nonelderly adults by year. This ratio declined from 76 percent to 70 percent between 2000 and 2013, although the decline was not continuous. Notably, between 2004 and 2008, the employment-to-population ratio was relatively constant at 74 percent and was preceded by a modest decline. A relatively sharp decline between 2008 and 2011 corresponds roughly with the Great Recession and its aftermath. Since 2011, the employment-to-population ratio has increased steadily, although it has not returned to its pre-recession level.

Also shown in Figure 1 is the expected employment-to-population ratio by year, which is derived from a regression model (see equation 1 in Appendix). The expected employment-to-population ratio tracks the actual ratio very well in every year except 2009, when the actual employment rate fell precipitously because of the Great Recession. The 2014 to 2016 values of the expected employment-to-population ratio are forecasts—they are predicted by the regression model. A comparison of the actual and predicted employment-to-population ratios in 2014, 2015, and 2016 reveals virtually no statistically or economically meaningful difference. In 2016, the actual and expected employment-to-population ratios were both 71.8 percent, indicating no overall effect on employment associated with the ACA.

Figure 1. Employment-to-Population Ratio



Source: Authors' analysis of Current Population Survey data from 2000 to 2016.

Notes: Employment-to-population ratio is computed for the nonelderly adult population. Expected rates are from a regression using the previous year's employment-to-population ratio, current opposite age and opposite gender unemployment rate, previous year's unemployment rates, state, year, age, sex, race and ethnicity, education, marital status, and number of children as predictors. See appendix for details of the regression specification.

We also estimated the ACA's impact on employment by gender and education status. Earlier research has shown the labor supply of women to be more responsive to changes in work incentives than that of men, so we expect women and men to respond differently to the ACA.[9] Though the ACA's provisions apply to large parts of the economy and a large share of the U.S. population, low-income workers may be particularly affected because they are more likely to be eligible for subsidies in the health insurance marketplaces or Medicaid and are more likely to lack health insurance. Therefore, overall findings for the entire U.S. population of nonelderly adults may obscure effects of the ACA on this arguably more affected group. To assess this possibility, we further stratify our analysis by education status. Education status is strongly related to income but not directly affected by the ACA. If the ACA affected employment, it would also have a direct effect on income, and stratifying the sample on the basis of income would lead to biased estimates.

Table 1 indicates that the differences in actual and predicted employment-to-population ratios differ by gender and education status. For men with a high school education or less, the actual employment-to-population ratio, around 70 to 71 percent, exceeds its expected level by 0.4 to 0.9 percentage points depending on the year, but none of the differences between actual and expected values are statistically significant. For men with more than a high school education, the actual employment-to-population ratio after 2013 is slightly lower than expected (0.2 to 0.4 percentage points lower, depending on the year), but again, these differences are not statistically significant. For women, the results are similar. Among women with a high school education or less, actual employment is higher than predicted, but not by a statistically significant amount. For women with more than a high school education, no economically meaningful differences exist between actual and predicted employment. In sum, we see no evidence of an ACA effect on employment overall, and the small differences we see by gender and education status are not statistically significant. In fact, we observe some *higher*-than-expected rates of employment among men and women with a high school education or less, though these are small (less than 1 percentage point higher).

Table 1. Estimates of Actual and Expected Labor Market Outcomes, by Gender and Education Level

		All			Men					
					High School Education or Less			More than High School Education		
	Year	Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Employment-to-Population Ratio (%)	2014	70.53	70.45	0.07	69.57	68.67	0.91	81.08	81.25	-0.18
	2015	71.06	71.35	-0.29	70.04	69.67	0.37	81.83	82.24	-0.41
	2016	71.80	71.82	-0.02	70.76	70.05	0.71	82.48	82.86	-0.37
Hours worked per week if employed	2014	38.79	38.82	-0.03	40.52	40.24	0.28	41.79	41.65	0.14
	2015	38.88	38.92	-0.04	40.49	40.33	0.17	41.87	41.76	0.11
	2016	38.89	39.03	-0.14	40.40	40.38	0.02	41.77	41.83	-0.05
Part-Time Employment-to-Population Ratio (%) (based on usual hours worked per week)	2014	9.45	9.14	0.31	6.29	6.32	-0.03	6.78	6.89	-0.11
	2015	9.22	8.86	0.37	6.22	6.12	0.09	6.44	6.62	-0.17
	2016	9.19	8.63	0.56**	6.22	6.03	0.19	6.50	6.39	0.11
Part Time Employment-to-Population Ratio (%) (based on hours worked in prior week)	2014	10.50	10.04	0.46**	7.79	7.71	0.08	8.06	8.05	0.01
	2015	10.23	9.79	0.44**	7.63	7.60	0.03	7.61	7.79	-0.18
	2016	10.08	9.59	0.49**	7.53	7.53	0.00	7.64	7.60	0.04

		All			Women					
					High School Education or Less			More than High School Education		
	Year	Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Employment-to-Population Ratio (%)	2014	70.53	70.45	0.07	53.78	53.20	0.58	71.68	71.72	-0.04
	2015	71.06	71.35	-0.29	53.68	53.24	0.44	72.26	72.25	0.01
	2016	71.80	71.82	-0.02	54.45	53.45	1.01	72.78	72.57	0.21
Hours worked per week if employed	2014	38.79	38.82	-0.03	35.23	35.42	-0.19	36.86	36.93	-0.07
	2015	38.88	38.92	-0.04	35.37	35.54	-0.17	36.99	37.09	-0.10
	2016	38.89	39.03	-0.14	35.50	35.67	-0.16	37.07	37.22	-0.16
Part-Time Employment-to-Population Ratio (%) (based on usual hours worked per week)	2014	9.45	9.14	0.31	11.24	10.63	0.61	12.80	12.43	0.37
	2015	9.22	8.86	0.37	10.98	10.43	0.56	12.57	12.05	0.52
	2016	9.19	8.63	0.56**	11.05	10.25	0.80**	12.37	11.66	0.71**
Part Time Employment-to-Population Ratio (%) (based on hours worked in prior week)	2014	10.50	10.04	0.46**	11.94	11.13	0.82**	13.55	13.09	0.47
	2015	10.23	9.79	0.44**	11.64	10.89	0.76**	13.38	12.72	0.66**
	2016	10.08	9.59	0.49**	11.47	10.68	0.79**	13.05	12.36	0.69**

Source: Authors' analysis of Current Population Survey data from 2000 to 2016

Notes: Part-time employment is defined as working fewer than 30 hours per week. Expected labor market outcomes are based on regression models using data through 2013. See text for specification of regression models. ** p-value < .05

In Figure 2, we present trends in workers' actual and expected number of usual hours worked per week. The time series pattern for this outcome mirrors the employment-to-population ratio, showing an overall decline from 2000 to 2016 with a period of relative stability during the mid-2000s, although in this case the decline in average hours occurs somewhat earlier in 2007. As with other outcomes, the expected trend is a very good fit for the actual trend: the two lines are virtually identical. After 2014, the actual number of usual hours worked per week is virtually the same as the predicted number of usual hours worked per week. In Table 1, the difference of -0.14 hours for 2016 is not statistically significant and translates to a 0.36 percent reduction in hours worked. Table 1 further indicates that the estimates are virtually identical when stratifying the main analysis by gender and education status.

Because of the employer mandate and the 30-hour threshold used to define full-time employees, one major concern about the ACA was its potential effect on part-time work. The ACA required employers with 50 or more full-time equivalent employees to offer qualifying health benefits or face a penalty. This penalty went into effect at the start of 2015 for employers with 100 or more full-time equivalent employees (after being delayed one year). The penalty was further delayed until 2016 for employers with 50 to 99 full-time employees. Workers were designated full-time employees by averaging their past hours over a "look-back" period of 3 to 12 months; as a result, the employer mandate provision may have affected employer behavior in 2014 or even earlier, and many observers have suggested as much.[10]

Figure 3 provides some evidence on this issue, showing the trend in actual and predicted part-time (less than 30 hours per week) employment by year. Since reaching a peak in 2010 in the wake of the Great Recession, the actual ratio of part-time employment to population has trended downward, falling from 9.8 percent in 2010 to 9.18 percent in 2016. The predicted trend tracks the actual trend very well in the years before 2014. In 2014, the actual amount of part-time work was 9.5 percent, exceeding the predicted amount by 0.31 percentage points. In 2016, the difference was 0.56 percentage points and was statistically significant (leftmost panel of Table 1).

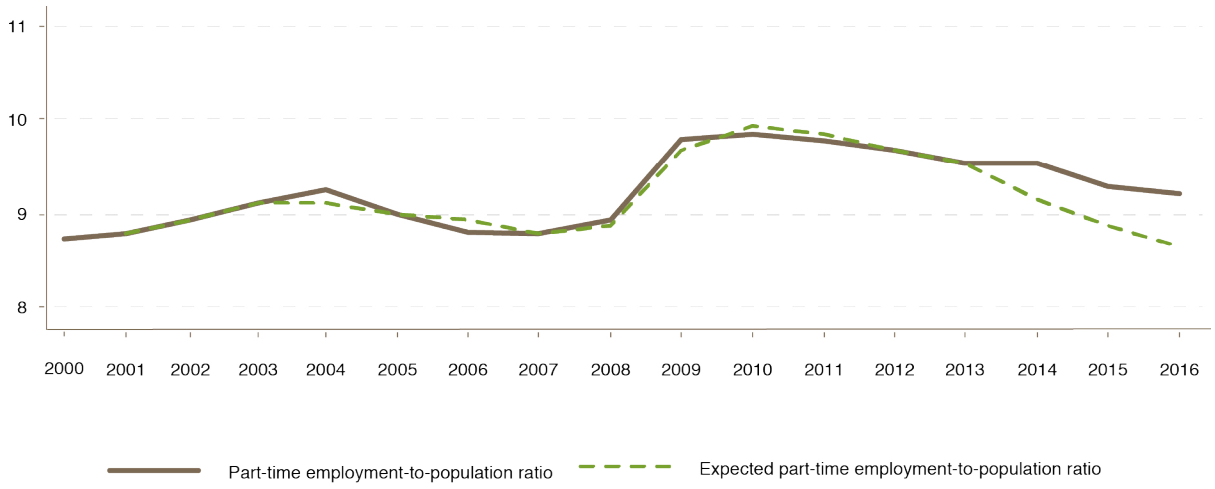
Figure 2. Usual Hours Worked per Week

Source: Authors' analysis of Current Population Survey data from 2000 to 2016.

Notes: Usual hours worked per week is computed for employed nonelderly adults. Expected hours are from a regression using the previous year's usual hours worked per week, current opposite age and opposite gender unemployment rate, previous year's unemployment rates, state, year, age, sex, race and ethnicity, education, marital status, and number of children as predictors. See appendix for details of the regression specification.

The higher-than-expected part-time employment observed in the full sample masks differences by gender; specifically it was concentrated among women, as there was no significant difference between the actual and expected rate of part-time employment for men in either education group. Among women, the actual rate of part-time employment was higher than predicted and the 2016 differences were statistically significant. Specifically, the actual rate of part-time employment was 0.80 and 0.71 percentage points (7 percent and 6 percent) higher for women with lower and higher levels of education, respectively. We also examined an alternative measure of part-time work based on hours worked in the last week. As can be observed in Table 1, the results with respect to part-time employment are very similar whether we define part-time status using usual hours worked per week or the hours worked in the last week.

Figure 3. Part-Time Employment-to-Population Ratio



Source: Authors' analysis of Current Population Survey data from 2000 to 2016.

Notes: Part-time employment-to-population ratio is computed for nonelderly adults. Part-time employment is defined as usually working fewer than 30 hours per week. Expected rates are from a regression using the previous year's part-time employment-to-population ratio, current opposite age and opposite gender unemployment rate, previous year's unemployment rates, state, year, age, sex, race and ethnicity, education, marital status, and number of children as predictors. See appendix for details of the regression specification.

Overall, the evidence presented in Figures 1 through 3 and in Table 1 indicates that, even up to three years following the implementation of the ACA's main provisions, employment measures were more or less as expected at this point in the business cycle. For two of the three outcomes—employment-to-population ratio and usual hours worked per week—the actual value was not statistically different from the expected value, and observed differences were small and not economically meaningful. However, part-time work has not fallen by as much as expected since 2013 despite an overall downtrend, suggesting a potential link between the ACA provisions and part-time work. Part-time employment was higher than expected in 2014 and 2015; the gap was more pronounced in 2016, but not by enough to significantly affect employees' average hours worked per week. The gap in part-time work is more pronounced in 2015 and 2016. This finding was due to the experiences of women who have higher rates of part-time work and traditionally have less consistent attachment to the labor force than men. In short, though we find no evidence that the ACA had a significant impact on overall employment and hours worked per week, we do find some evidence that the ACA increased part-time work among women in the first years of its implementation.

What explains higher-than-expected part-time work since 2013?

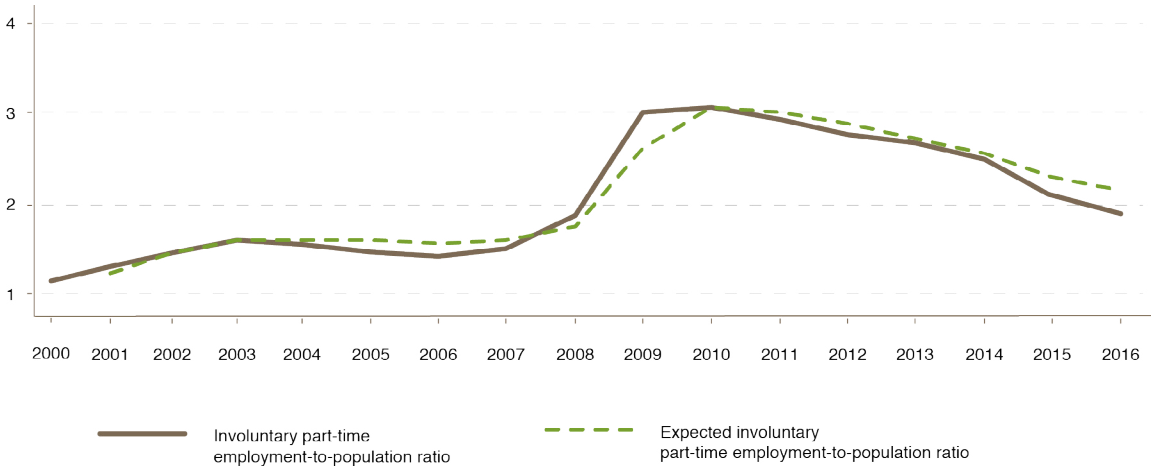
The emergence of a gap between actual and expected levels of part-time work in 2014, continuing into 2015 and 2016, coincides with the implementation of the ACA's major coverage provisions. In this section, we examine whether higher-than-expected part-time work among women represents a shift in labor supply or labor demand. If the employer mandate reduced labor demand by causing employers to reduce worker hours to avoid a penalty, we would expect to see an increase in involuntary part-time work. If, on the other hand, the availability of subsidized health insurance coverage outside of full-time employment provided an opportunity for some workers to cut back their hours, then we would expect to see an increase in voluntary part-time work.

In Figures 4 and 5 and in Table 2, we examine trends in involuntary and voluntary part-time work (defined as working 0 to 29 hours in the previous week). Again, we estimate regression models to generate expected values (as shown in equation 1 in Appendix). Reasons for voluntary or involuntary part-time status in the CPS are classified with respect to reported hours worked in the previous week, not usual hours per week. For this analysis, we measure part-time status on the basis of hours worked last week and separate those working part-time by this measure based on whether they worked part-time voluntarily or involuntarily.

Figure 4 shows the trend in involuntary part-time work. Among nonelderly adults, the rate of involuntary part-time work was 1.1 percent in 2000 and varied within a narrow band until 2007. Involuntary part-time work then increased from 1.4 percent in 2007 to a peak of 3.0 percent in 2010 following the Great Recession. Since 2010, the rate of involuntary part-time work has fallen steadily. Expected involuntary part-time work tracks with actual part-time work very well in the pre-2014 period. Post-2014, the actual values of involuntary part-time

employment are somewhat below their expected values. In 2016, the actual rate of part-time work was 1.89 percent, compared with an expected rate of 2.22 percent. The small differences between actual and expected involuntary part-time work in the left panel of Table 2 are statistically significant in 2015 and 2016 (-0.25 and -0.33 percentage points, respectively). Accordingly, the higher-than-expected level of part-time work overall does not appear to be driven by employer demand for labor (i.e., because of the ACA's employer mandate).

Figure 4. Involuntary Part-Time Employment-to-Population Ratio



Source: Authors' analysis of Current Population Survey data from 2000 to 2016.

Notes: Involuntary part-time employment-to-population ratio is computed for nonelderly adults. Involuntary part-time employment is defined as working fewer than 30 hours in the last week and working part-time for economic reasons. Expected rates are from a regression using the previous year's involuntary part-time employment-to-population ratio, current opposite age and opposite gender unemployment rate, previous year's unemployment rates, state, year, age, sex, race and ethnicity, education, marital status, and number of children as predictors. See appendix for details of the regression specification.

Figure 5 shows the trend in voluntary part-time work. The ratio of voluntary part-time work to population declined from 8.8 percent in 2000 to 7.7 percent in 2013. Over that period, the decline was fairly steady and showed little cyclical movement with steeply increasing unemployment rates from 2007 to 2010. From 2000 to 2013, expected voluntary part-time work tracks the actual value very well. From 2013 to 2014, the actual rate of voluntary part-time work increased markedly to 8.1 percent, while the expected value continued to decline with the earlier trend, creating a gap of 0.53 percentage points (Table 2, left panel). The gap between actual and expected voluntary part-time work expanded through 2015 (0.67 percentage points) and 2016 (0.80 percentage points). The gap was statistically significant in each of the three years. Thus, the higher-than-expected level of part-time work seen in Figure 2 is almost entirely explained by an increase in voluntary part-time work relative to what would be expected based on past trends. This suggests that if the ACA led to an increase in part-time work, it did so by reducing labor supply. That is, the availability of subsidized coverage through health insurance marketplaces or Medicaid may have led to voluntary decisions by employees to work fewer hours.

The results for the combined sample of both genders and both education groups obscure some important heterogeneity. When the sample is stratified by gender and education, the increase in voluntary part-time employment associated with the ACA is particularly large for women, although the increase in voluntary part-time employment for men with a high school education or less was also significant (Table 2). In 2016, the actual rate of voluntary part-time employment for women is approximately 1 percentage point (10 percent) higher than expected for both education groups. Analogous results for men are approximately half the size. Figures in Table 2 also indicate that men's rate of involuntary part-time employment for 2014 through 2016 was lower than expected. In 2016, actual rate of involuntary part-time work for men with a high school education was 0.72 percentage points less than the expected rate of 3.2 percent (23 percent less). Rates of involuntary part-time work were also lower than expected for men with more than a high school education. For women with more than a high school education, actual involuntary part-time work was significantly lower than expected levels only in 2015 and 2016. In absolute terms, the lower-than-expected rate of involuntary employment is smaller than the higher-than-expected rate of voluntary part-time work. In sum, the increase in part-time employment associated with the ACA has been driven largely by an increase in voluntary unemployment, particularly for women. The increase in voluntary part-time employment for men was smaller than that for women and was offset by a decrease in involuntary part-time employment, making the total change in part-time employment associated with the ACA small and statistically insignificant.

Table 2. Estimates of Actual and Expected Part-time Work, Involuntary Part-time Work, and Voluntary Part-time Work, by Gender and Education Level

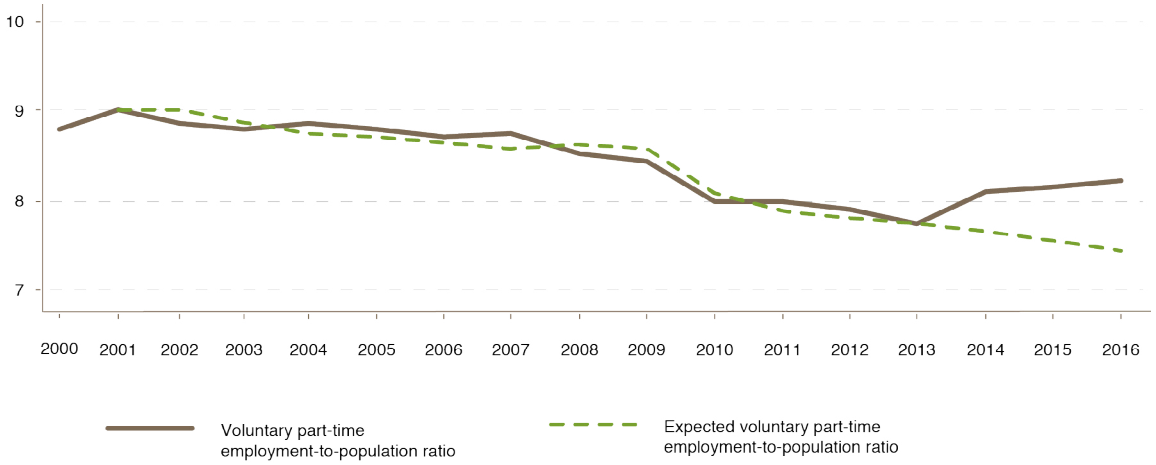
		All			Men					
					High School Education or Less			More than High School Education		
	Year	Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Involuntary Part-Time Employment-to-Population Ratio (%)	2014	2.39	2.47	-0.08	3.04	3.25	-0.20	1.79	2.01	-0.22**
	2015	2.07	2.32	-0.25**	2.72	3.22	-0.50**	1.50	1.89	-0.40**
	2016	1.89	2.22	-0.33**	2.48	3.20	-0.72**	1.43	1.85	-0.41**
Voluntary Part Time Employment-to-Population Ratio (%)	2014	8.11	7.58	0.53**	4.75	4.46	0.29**	6.27	6.05	0.22
	2015	8.16	7.49	0.67**	4.91	4.45	0.46**	6.11	5.92	0.19
	2016	8.19	7.40	0.80**	5.05	4.45	0.60**	6.21	5.77	0.44**

		All			Women					
					High School Education or Less			More than High School Education		
	Year	Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Involuntary Part-Time Employment-to-Population Ratio (%)	2014	2.39	2.47	-0.08	3.11	3.00	0.11	2.08	2.16	-0.08
	2015	2.07	2.32	-0.25**	2.77	2.77	0.00	1.75	2.00	-0.25**
	2016	1.89	2.22	-0.33**	2.46	2.59	-0.14	1.60	1.90	-0.31**
Voluntary Part Time Employment-to-Population Ratio (%)	2014	8.11	7.58	0.53**	8.83	8.13	0.70**	11.48	10.95	0.53
	2015	8.16	7.49	0.67**	8.88	8.12	0.76**	11.57	10.61	0.96**
	2016	8.19	7.40	0.80**	9.02	8.09	0.93**	11.45	10.47	0.98**

Source: Authors' analysis of Current Population Survey data from 2000 to 2016.

Notes: Part-time status (working fewer than 30 hours per week) is based on hours worked last week. Expected labor market outcomes are based on regression models using data through 2013. See appendix for details of regression models. ** p-value < .05

Figure 5. Voluntary Part-Time Employment-to-Population Ratio



Source: Authors' analysis of Current Population Survey data from 2000 to 2016.

Notes: Voluntary part-time employment-to-population ratio is computed for nonelderly adults. Voluntary part-time employment is defined as working fewer than 30 hours in the last week and working part-time for noneconomic reasons. Expected rates are from a regression using the previous year's voluntary part-time employment-to-population ratio, current opposite age and opposite gender unemployment rate, previous year's unemployment rates, state, year, age, sex, race and ethnicity, education, marital status, and number of children as predictors. See appendix for details of the regression specification.

DISCUSSION

Based on data through 2016—three years after implementation of the ACA's major coverage provisions—we find no evidence that the ACA has been a job killer. We find no statistically significant adverse impact on employment rates or total hours worked in the economy. Even when we focus on nonelderly adults with a high school education or less, who are more likely to be affected by the ACA, we see no effects on employment or average hours worked per week. Policymakers should consider this lack of a detectable economy-wide employment effect alongside the substantial health coverage gains (20 million newly insured Americans) made under the ACA.[11,12]

The CBO's assumption that the ACA would reduce the number of hours worked by 1.5 to 2.0 percent from 2017 to 2024 was a key input to their dynamic scoring of repeal legislation. In its 2015 analysis of the budgetary effects of repealing the ACA (without replacement legislation), the CBO estimated that repealing the ACA would increase the federal budget deficit by $353 billion over the next 10 years if there were no labor market effects or other macroeconomic repercussions of repeal. If there were labor market effects the increase in the deficit would be considerably smaller. The evidence we presented suggest that there are few labor market effects of the ACA, which suggest repeal would increase the federal deficit by a larger amount.[6,13] Three years after implementation of the ACA's main provisions and two years after the phased-in implementation of the ACA's employer mandate, we see little if any evidence that the ACA adversely affected the labor market. But the labor market effects of the ACA may still be playing out, whether because of delayed implementation of the employer mandate or because of lagged labor supply responses by individuals.

Although we found no effect on employment or hours worked per week, we do find evidence that the level of part-time work has fallen since 2013 by less than the value expected in the context of recovery from the Great Recession and falling rates of unemployment. In 2016, the share of nonelderly adults working part-time was about half a percentage point higher than expected based on pre-2014 patterns. Since 2013, the level of involuntary part-time work is slightly lower than expected. The relatively slow decline in overall part-time work since 2013 appears to be driven almost entirely by a shift in labor supply choices by workers and not by labor demand, and to be largely concentrated among women. Our findings are therefore inconsistent with employers reducing workers' hours to avoid penalties under the ACA's employer mandate. Indeed, if anything we find lower-than-expected involuntary part-time employment. Instead, we find that the relative increase in part-time work is composed entirely of a higher-than-expected level of voluntary part-time work.

Whether the ACA caused the elevated level of voluntary part-time work since 2014 is unclear. The subsidized coverage available under the ACA could lead some workers to cut back their hours because of an income effect or because of the availability of coverage outside of full-time employment. However, we would expect such an effect to apply more strongly to workers with a high school education or less; people in this group tend to have lower incomes and are more likely to be eligible for subsidized coverage. Instead, we find nearly equivalent effects for those with a high school education or less and those with more than a high school education. However, the higher-than-expected rate of voluntary part-time employment was concentrated among women. Rates of part-time work for women, including relatively educated women, are higher than for men, and research shows that women's labor supply remains more responsive to work incentives than men's.[9] Therefore, women (including those with higher educational attainment) may be more likely to adjust their employment in response to ACA incentives.

Our findings for part-time work are consistent with some earlier studies and differ substantially from others. Using data through June 2015, Moriya, Selden, and Simon found that the ACA had little effect on part-time work overall and did not increase involuntary part-time work from 2012 to 2015 in firms with 50 or more employees, after adjusting for unemployment rate changes.[14] Mathur, Slavov, and Strain found a shift toward part-time work from 25 to 29 hours per week, but the shift was not more pronounced among workers expected to be more affected by the employer mandate.[15] The Center for Economic and Policy Research highlighted an increase in voluntary part-time work starting in 2014, breaking the past trend.[16] The findings of two recent working papers contrast with the findings presented here. Even and MacPherson used CPS data up to 2014 and compared trends in part-time work across industries and occupations expected to be more or less affected by the employer mandate using a difference-in-differences approach; the authors concluded that around 1 million workers shifted to involuntary part-time status as a result of the ACA.[17] Dillender, Heinrich, and Houseman constructed a comparison group using Hawaii, which already had an employer mandate that was stricter than the ACA's, and concluded that the ACA increased involuntary part-time work by a half-million workers in the retail, accommodations, and food service sectors.[18] Although a detailed review is beyond the scope of this brief,

we believe a closer look at modeling assumptions is needed in studies that claim to find a causal link between the ACA and involuntary part-time work.[19]

Though this brief examines potential overall effects of the ACA, a number of earlier studies have investigated the specific impacts of the ACA's Medicaid expansions on labor supply.[3,20–22] Despite finding substantial increases in Medicaid coverage and corresponding decreases in uninsured rates following the expansions, these studies have consistently found little to no evidence of reductions in hours worked attributable to Medicaid expansion. This suggests that if the ACA caused the increase we observed in voluntary part-time work, a mechanism other than the Medicaid expansions may be at work. Marketplace subsidies for low-income people may play a role. Also, the availability of non-employment-based coverage without restrictions on pre-existing conditions may have reduced job lock and allowed individuals to work their preferred number of hours per week.

In sum, we find no evidence to support claims that the ACA has been a job killer. We see little to no overall effects on employment or work hours, as some have predicted. We find no evidence that the employer mandate caused employers to reduce worker hours below 30 per week against the workers' wishes. We do find an increase in voluntary part-time work above expected levels, which may be attributable to the ACA. Voluntary shifts to part-time work in response to newly available health insurance, possibly driven by subsidies, should enhance the welfare of the people affected. Our findings are consistent with the CBO's determination that the main effects of the ACA on employment would work primarily through labor supply, not labor demand. However, although the CBO predicted that the ACA would reduce the total number of hours worked by at least 1.5 percent by 2017, our evidence suggests a much smaller, or even, no effect of the ACA on labor supply. Based on this evidence, after three years of implementation of the ACA's major provisions, it appears that the ACA has increased health insurance coverage for 20 million Americans with little or no adverse effects on employment.

APPENDIX

Methodological Approach

We use data from the monthly files of the Current Population Survey (CPS) from January 2000 through December 2016. The CPS is the federal government's main source of information about employment and the U.S. labor force. We limit the sample to nonelderly adults (ages 18 to 64). The CPS monthly files provide approximately 900,000 to 1 million observations per year and information on the demographic characteristics, labor market status, and state of residence of people in our sample. Because analyses using all nonelderly adults may obscure effects on the most-affected subgroups, we also conduct analyses for samples stratified by gender and educational attainment. Adults with a high school degree or less are more likely to have lower incomes and therefore are more likely to be affected by the ACA's Medicaid expansions or subsidies for marketplace coverage.

We examine three labor market measures: employment at the time of the survey, usual number of hours worked per week among those who are employed, and part-time employment (measured as those who report working fewer than 30 hours per week). We further investigate the type of part-time work by dividing part-time status into voluntary part-time work (measured as those who worked 0 to 29 hours in the previous week and who report working part-time for "noneconomic reasons") and involuntary part-time work (measured as those who worked 0 to 29 hours in the previous week for "economic reasons"). We report average values for each labor market outcome from 2000 to 2016 to show recent changes within the context of the longer-term trend, spanning a period that contains two recessions and two subsequent economic recoveries.

Our analysis focuses on changes in the trend of each outcome and, specifically, whether there was a distinct change in that trend in 2014, when the ACA was implemented. A noticeable change in the trend from 2014 to 2016 is evidence of the ACA's impact. However, changes in the trends of the employment outcomes after 2014 may be caused by changes in other determinants of labor supply and labor demand. Most notably, the labor market has been slowly recovering since the unemployment rate reached a peak of 10 percent in October 2009 during the Great Recession. Accordingly, employment and hours worked have generally been increasing since 2010 for reasons unrelated to the ACA.

To isolate the effect of the ACA from other factors that affect labor market outcomes, we use regression methods to generate a counterfactual (predicted) outcome for the years after 2013.

Predicted values of an outcome are constructed from estimates of the following regression model:

$$(1)\ Y_{agjt} = \alpha_0 + \alpha_1 Y_{j(t-1)} + \alpha_2 UNEMPLOYED_{a'g'jt} + \alpha_3 UNEMPLOYED_{agj(t-1)} + \alpha_4 TIME + \beta_j + X'_{agjt}\Gamma + \varepsilon_{agjt}$$

In equation 1, the dependent variable Y is one of the four measures of labor market outcomes for individuals belonging to age group *a*, gender *g*, state *j*, and in year *t*. The first three explanatory variables are, in order, the previous year's mean value of the outcome measured at the state-year level, the current year's unemployment rate of the opposite gender and opposite age group (noted as *a' and g'*) measured at the state-year level, and the previous year's mean value of own-gender and own–age group unemployment rate measured at the state-year level. Though it is important for our model to incorporate information on the current year's business cycle through changes in the unemployment rate, the "own-group" unemployment rate is mechanically related to the labor outcomes measured and could introduce bias in our estimates. To break this mechanical link while retaining business cycle information from the current period, we instead use the current unemployment rate of the group of individuals of the opposite gender and age group. For example, we match the current unemployment rates of men ages 18 to 44 and women ages 45 to 64 (and vice versa) to break the mechanical relationship between the outcome measure and the unemployment rate, while retaining much of the ability of unemployment rates to predict other labor market outcome measures. We also include a linear time trend, TIME, state fixed effects β_j, and a set of individual level covariates X: age-by-gender dummy variables, race and ethnicity dummy variables, education and marital status dummy variables, and the number of own children.[23]

We estimate equation 1 using data up to 2013 only. Thus, the predicted values for 2014 to 2016 are forecasts based on known values of demographic and unemployment measures in each year. For 2015 and 2016, the forecast replaces the previous year's actual mean outcome explanatory variable with the model-predicted estimate of the previous year's mean outcome. We selected this specification over others we considered (e.g., specifications without the previous year's average value of the dependent variable, without

unemployment rates, or with only the contemporaneous unemployment rate) using a best fit criterion (AIC), or how well the models' predictions fit actual data for 2000 to 2013. Though deviations of actual levels of labor market outcomes from their predicted values in 2014 may indicate effects of the ACA, such deviations may also result from "unexpected" changes in the labor market that are independent of the ACA (i.e., economic changes that are not predicted by the regression model represented in equation 1). To speed computation, we collapse the individual-level CPS data to the state * age group * gender * education group * year-level before model estimation.

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- The Affordable Care Act, 2010 (PDF (http://files.kff.org/attachment/Summary-of-the-Affordable-Care-Act))
- Rep. Tom Price's Empowering Patients First Act, 2015 (PDF (http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Rep-Tom-P
- House Speaker Paul Ryan's A Better Way: Our Vision for a More Confident America, 2016 (PDF (http://files.kff.org/attachment/Proposals-to-F Care-Act-Speaker-Paul-Ryan))
- Sen. Bill Cassidy's Patient Freedom Act, 2017 (PDF (http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Senator-Bill-Cassidy))
- Sen. Rand Paul's Obamacare Replacement Act, 2017 (PDF (http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Senator-Ran
- House Discussion Draft, February 10, 2017 (PDF (http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-House-Disc

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ACA SUMMARY Current Law	AMERICAN HEALTH CARE ACT	ADD A PLAN
Date Introduced ()		
March 23, 2010	March 6, 2017	
Overall approach ()		
• **Require most U.S. citizens and legal residents to have health insurance.** • **Create state-based health insurance exchanges** through which individuals and small businesses can compare plans, apply for financial assistance, purchase coverage. • **Provide refundable premium tax credits**, based on income and cost of coverage, for individuals/families with income between 100-400% of the federal poverty level. • **Impose new insurance market regulations,** including requiring guaranteed issue of all non-group health plans during annual open enrollment and special enrollment periods; limiting rating variation to 4 factors: age (3 to 1 ratio), geographic rating area, family composition, and tobacco use (1.5 to 1 ratio); prohibiting pre-existing condition exclusion periods; prohibiting lifetime and annual limits on coverage; and extending dependent coverage to age 26. • **Require ten essential health benefits be covered** by all individual and small group health insurance • **Require plans to provide no-cost preventive benefits and limit annual cost-sharing.** • **Expand Medicaid** to 138% of the federal poverty level at state option and require a single, streamlined application for tax credits, Medicaid, and CHIP. • **Extend CHIP funding to 2015** and increase the match rate by 23 percentage points up to 100%. • **Close the Medicare Part D doughnut hole** and enhance coverage of preventive benefits in Medicare. • **Reduce Medicare spending** by reducing payments for Medicare Advantage plans, hospitals, and other providers. • **Establish the Independent Payment Advisory Board and the Center for Medicare and Medicaid Innovation (CMMI).**	• **Repeal ACA mandates (2016), standards for health plan actuarial values (2020), and, premium and cost sharing subsidies (2020).** • **Modify ACA premium tax credits for 2018-2019** to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges and to catastrophic policies. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age. Eligibility for new tax credits phases out at income levels between $75,000 and $115,000 • **Retain private market rules,** including requirement to guarantee issue coverage, prohibition on discriminatory premiums and pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios. • **Retain health insurance marketplaces, annual Open Enrollment periods (OE),** and special enrollment periods (SEPs). • **Impose late enrollment penalty for people who don't stay continuously covered.** • **Establish State Innovation Grants and Stability Program** with federal funding of $100 billion over 9 years. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes. In states that don't successfully apply for grants, funds will be used for reinsurance program • **Repeal funding for Prevention and Public Health Fund** at the end of Fiscal Year 2018 and rescind any unobligated funds remaining at the end of FY2018. Provide supplemental funding for community health centers of $422 million for FY 2017 • **Encourage use of Health Savings Accounts** by increasing annual tax free contribution limit and through other changes • **Eliminate enhanced FMAP for Medicaid expansion as of January 1, 2020 except for those enrolled as of December 31, 2019 who do not have a break in eligibility of more than 1 month**	

	• **Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year** • **No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings** • **Repeal Medicare HI tax increase and other ACA revenue provisions** • **Prohibit federal Medicaid funding for Planned Parenthood clinics**	

- **Individual mandate ()**
- **Premium subsidies to individuals ()**
- **Cost sharing subsidies to individuals ()**
- **Individual health insurance market rules ()**
- **Benefit design ()**
- **Women's health ()**
- **Health savings accounts (HSAs) ()**
- **High-risk pools ()**
- **Selling insurance across state lines ()**
- **Exchanges/Insurance through associations ()**
- **Dependent coverage to age 26 ()**
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January 2017 | Issue Brief

Current Flexibility in Medicaid: An Overview of Federal Standards and State Options

Samantha Artiga, Elizabeth Hinton, Robin Rudowitz and MaryBeth Musumeci

Key Takeaways

This brief provides an overview of current federal standards and state options in Medicaid to help inform upcoming debates about increasing state flexibility in the program as part of efforts to restructure Medicaid financing.

- Today, states operate their Medicaid programs within federal standards and a wide range of state options in exchange for federal matching funds that are provided with no limit.
- Each state Medicaid program is unique, reflecting states' use of existing flexibility and waiver authority to design their programs to meet their specific needs and priorities.
- As proposals to restructure Medicaid financing develop, it will be important to examine what additional flexibilities they would provide to states and what standards, accountability and enrollee protections would remain for states to access federal funds.

Executive Summary

The Trump Administration and Republican leaders in Congress have called for fundamental changes in Medicaid financing that would limit federal financing for Medicaid through a block grant or per capita cap. Such changes may be tied to offers of increased flexibility to states to manage their programs within a more limited financing structure. Which federal standards would remain in place and what increased flexibility might be provided to states would have significant implications. To help inform discussion around increased flexibility, this brief provides an overview of current federal standards and state options in Medicaid and how states have responded to these options in four key areas: eligibility, benefits, premiums and cost sharing, and provider payments and delivery systems.

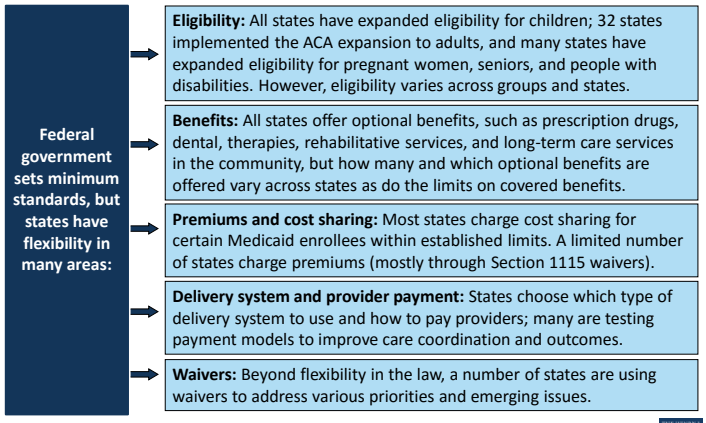
Today, states operate their program within federal standards and a wide range of state options in exchange for federal matching funds that are provided with no limit. Medicaid is jointly financed by the federal government and states, with the federal government providing federal matching funds for allowable state Medicaid spending on an open-ended basis. In exchange for the federal funds, states must meet federal standards that reflect the program's role covering a low-income population with limited resources and often complex health needs. The federal standards largely focus on requiring states to cover certain core groups, such as poor children and pregnant women, as well as certain core benefits. However, states can choose to cover additional groups and benefits and have wide latitude over many aspects of the program, particularly how they pay providers and structure their delivery systems. Moreover, states can use Section 1115 waiver

authority to vary from the federal standards and state options to address different priorities and emerging issues.

Each state Medicaid program is unique, reflecting states' use of existing program flexibility and waiver authority to design their programs to meet their specific needs and priorities. The programs vary widely in terms of who is eligible, what benefits are covered, what premiums and cost sharing are charged, and how providers are paid and care is delivered (Figure 1). Over time, many states have expanded Medicaid to reach a greater share of their low-income population through both targeted and broad expansions. States also have used program flexibility to continually evolve and transform how they pay for and deliver care. Further, during economic downturns, states have used options to cut provider rates and restrict benefits to control Medicaid spending.

Figure 1

State Responses to Program Options in Medicaid



As proposals to restructure federal Medicaid financing develop, it will be important to examine what additional flexibilities they would provide to states and what standards, accountability and enrollee protections would remain for states to access federal funds. As noted, states have broad flexibility over many aspects of their programs and can gain increased flexibility under Section 1115 waiver authority. What additional flexibilities would be provided beyond these options under such proposals would have implications for states, enrollees, and providers. What federal standards would remain in place will affect the extent of accountability for the federal investment in the program and the scope of nationwide protections available for enrollees. Additionally, how such proposals would address existing program variation in establishing base levels for the caps will be key, including variation as a result of 32 states, including DC, adopting the ACA expansion. Setting the caps based on current spending could lock historical state choices and program variation in place potentially rewarding states with higher historic spending and creating "winners" or "losers" across states.

Introduction

Medicaid is jointly financed by the federal government and states. The federal government provides matching dollars to states for allowable spending on Medicaid on an open-ended basis.[1] In exchange for the significant federal investment in the program, states design and administer their programs within a set of federal standards and broad state options defined by law that reflects the program's role covering a low-income population with limited resources and often complex health needs. Beyond these options, federal law also authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid requirements and to provide federal Medicaid funding for options not otherwise allowed under law for approaches the Secretary determines promote the objectives of the program.

The Trump Administration and Republican leaders in Congress have called for fundamental changes in Medicaid financing that would limit federal financing for Medicaid through a block grant or per capita cap. Such changes may be tied to offers of increased flexibility to states to manage their programs within a more limited financing structure. Which federal standards would remain in place and what increased flexibility might be provided to states would have significant implications. To help inform discussion around increased flexibility, this brief presents an overview of current federal standards and state options within Medicaid in four areas: eligibility, benefits, premiums and cost sharing, and provider payments and delivery systems.

The Upcoming Debate around Flexibility

President Trump and other Republican leaders have called for providing states with increased flexibility in how they operate their Medicaid programs. In December, Republican Leaders in the House of Representatives and Republican Members of the Senate Finance Committee sent letters to Governors and Insurance Commissioners to request information about health care reforms including a focus on Medicaid. In January, Republican Chairmen from the Senate Finance Committee and House Energy and Commerce Committee sent a letter to the Medicaid and CHIP Payment and Access Commission (MACPAC) requesting detailed information on Medicaid optional benefits and populations covered in each state to inform debate around controlling Medicaid spending. Previous analysis conducted prior to the ACA showed that 60% of total Medicaid spending is for optional eligibility groups and optional services for all groups and that some of the sickest enrollees fall into optional groups and many optional benefits, such as prescription drugs, are integral to comprehensive coverage. The share of spending that goes toward optional groups and benefits has likely increased since this analysis was completed, as states have gained additional program options since that time.

Calls for increased Medicaid flexibility are not new, and the minimum standards and options have evolved over time through federal legislation. For example, the Deficit Reduction Act of 2005 added more options for states to charge premiums and cost-sharing as well as increased flexibility around benefits. More recently, the Affordable Care Act (ACA) and the Supreme Court ruling on its constitutionality in 2012 provided new program flexibility around eligibility as well as for delivery system reform and new options for states to deliver community-based long-term care. Moreover, before the most recent Congressional letters, there were earlier efforts to expand state flexibility including the plan offered by Senator Hatch and Representative Upton in 2013 and the Republican Governors Public Policy Committee report in 2011 as part of block grant proposal debates. At the state level, trends over time show that states have used flexibility with the Medicaid program to different degrees. However, many states have used options to cover a greater share of

their low-income population through targeted and broad expansions. States have also used available flexibility to continually evolve and transform how they how they pay for and deliver care. Further, during economic downturns, states have used options to cut provider rates and restrict benefits to control Medicaid spending.

Upcoming proposals for increased flexibility are anticipated to emerge within the context of reducing and capping federal spending by restructuring Medicaid financing to a block grant or per capita cap. However, previous analysis suggests that increased flexibility may only provide limited gains in program efficiencies, and that states would need to reduce enrollment or benefits to achieve large reductions in federal spending. For example, prior analyses examining block grant proposals released by House Republicans in 2011 and 2012 showed that even if states were able to limit per enrollee spending growth, the magnitude of the federal spending reductions would result in enrollment cuts of 42% to 50% accounting for the repeal of the ACA or 25% to 35% due to the block grant cuts; the analysis also showed reductions in reimbursement for providers including hospitals and nursing homes. Congressional Budget Office analysis from 2011 also noted that the large reduction in federal payments under the House Budget Plan would likely require states to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more in state funds than would be the case under current law. Moreover, the wide variation in spending across state programs resulting from current flexibility in the program creates challenges to establishing a block grant or per capita cap. Setting the caps based on current spending could lock historical state choices and program variation in place potentially rewarding states with higher historic spending creating "winners" or "losers" across states.

Minimum Standards and State Options

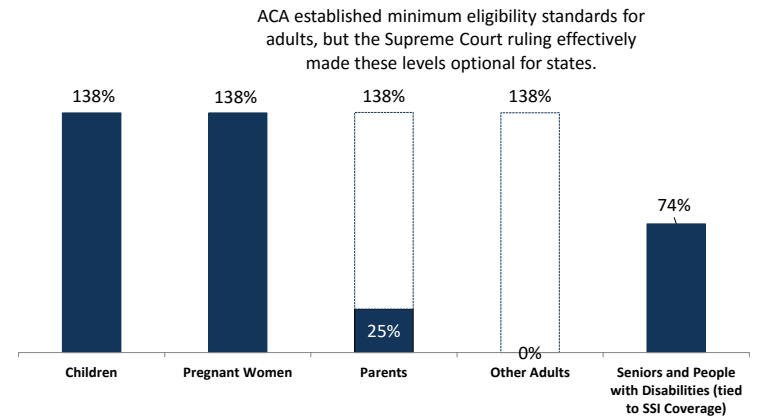
Eligibility

Minimum Standards

Minimum eligibility standards for pregnant women and children have expanded over time. At the Medicaid program's outset in 1965, the minimum coverage groups were closely tied to welfare and included low-income families, seniors, and individuals with disabilities who were receiving cash assistance. Over time, the minimum coverage standards have expanded, particularly for children and pregnant women, largely following state adoption of options to expand coverage for these groups. Reflecting these expansions, prior to the ACA, states were required to cover children under age six and pregnant women with family incomes up to 133% FPL and older children with family incomes up to 100% FPL. The ACA built on these previous expansions by extending the 133% FPL minimum to older children. It also includes a five percentage point of income disregard that effectively raises the minimum to 138% FPL (Figure 2).[2] As a result of this change, some states moved older children from separate CHIP programs to Medicaid. The ACA also established a

Figure 2

Minimum Eligibility Standards by Group



NOTE: Parent minimums vary across states; median minimum shown. 138% FPL is $16,394 for an individual and $27,821 for a family of three in 2016.

maintenance of effort provision under which states must keep eligibility levels for children at least as high as they were when the ACA was enacted in 2010, until 2019.

Prior to the ACA, many low-income adults were excluded from Medicaid. Prior to the ACA, minimum eligibility standards for parents remained very low and there was no minimum or option to cover other low-income adults without dependent children. The ACA also expanded the 138% FPL minimum to adults, making many parents and other adults newly eligible for coverage.[3] Although this expansion was enacted as a nationwide standard, the 2012 Supreme Court ruling on the ACA's constitutionality effectively made the expansion to adults a state option.

The ACA did not change minimum eligibility standards for seniors and people with disabilities. States generally must cover seniors and people with disabilities receiving Supplemental Security Income (SSI)[4] benefits (equivalent to 74% FPL, or about $8,800 per year for an individual, in 2017).[5] States also must offer Medicare Savings Programs through which low-income Medicare beneficiaries with incomes generally below 135% FPL (or about $16,000 per year for an individual in 2016) receive Medicaid assistance with some or all of their Medicare premiums, deductibles, and other cost-sharing requirements (these "partial dual eligible" beneficiaries do not receive Medicaid benefits). Medicare has high out-of-pocket costs, and through the Medicare Savings Programs, Medicaid helps make Medicare affordable for those with the lowest incomes.[6]

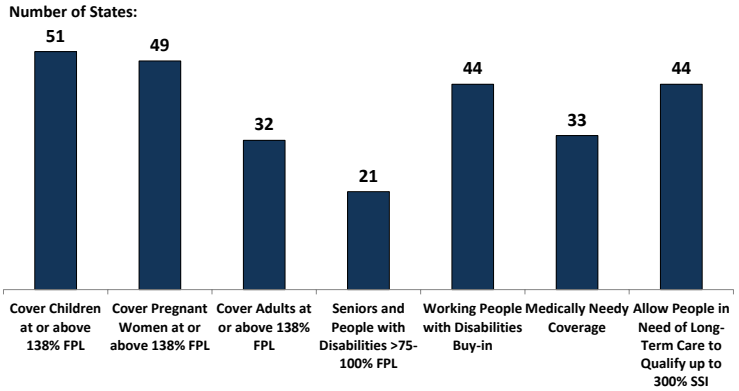
State Options

Before the ACA, states could expand eligibility beyond the minimum levels for children, pregnant women, parents, seniors, and individuals with disabilities and receive federal Medicaid matching funds. The creation of the Children's Health Insurance Program (CHIP) in 1997 provided states additional options and enhanced federal funding to expand coverage for children. However, prior to the ACA, there was no option for states to cover low-income adults who did not fit into one of these categories, regardless of their income. As such, states could not receive federal funds to cover these adults, unless they received a waiver of federal rules and found offsetting savings to fund their coverage. As a result of the ACA expansion, states can now cover low-income adults up to 138% FPL and receive enhanced federal matching funds for this coverage. States also can choose to cover children, pregnant women, and other adults beyond the ACA's 138% FPL minimum and receive federal funds for this coverage at their regular matching rate.

All states have taken up options to expand eligibility for children and many have expanded eligibility for pregnant women and other adults. As of January 2017, all states expanded eligibility for children above the 138% FPL minimum with 49 states setting eligibility for children at 200% FPL or higher through Medicaid and CHIP. Forty-nine states cover pregnant women above the federal minimum with 32 states setting eligibility at 200% FPL or higher (Figure 3). A total of 32 states, including DC, have taken up the ACA option to expand Medicaid to low-income adults with incomes up to 138% FPL, and three states

Figure 3

State Take up of Options to Expand Eligibility



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2017 and the Kaiser Commission on Medicaid and the Uninsured Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2015.

extend coverage to parents and/or other adults at higher incomes. However, in the 19 states that have not expanded, eligibility limits for parents remain very low, with a median of 44% FPL, and other adults are not eligible regardless of income in all but one of these states.

All states have expanded coverage for seniors and people with disabilities, with most states electing multiple coverage options. As of 2015, 21 states have increased eligibility for seniors and individuals with disabilities above the SSI level up to a federal maximum of 100% FPL; states also may apply an asset limit to this pathway, and all but one do. Nearly all states offer an eligibility pathway for children with significant disabilities living at home without regard to parental income who would be Medicaid-eligible if institutionalized.[7] Thirty-three states chose to offer medically needy coverage, which enables people with high medical bills to spend down to a state-set eligibility standard.[8] Forty-four states allow working individuals with disabilities with income above eligibility limits to buy into Medicaid, and five states offer a buy-in for children with significant disabilities with household income up to 300% FPL ($60,480 per year for a family of 3 in 2016).

States also can expand access to coverage for individuals with long-term care needs. In addition to the age and disability-related eligibility pathways above, states can offer Medicaid to people who need institutional or community-based long-term care with incomes up to 300% of SSI ($26,388 per year for an individual in 2016). States also set the asset limits to qualify for long-term care services. As of 2015, 44 states allowed people in need of nursing facility care to qualify for Medicaid with income up to 300% of SSI, and nearly all of these states use the same expanded financial eligibility standard for people receiving long-term care in the community. Moreover, states can expand Medicaid functional eligibility criteria to cover people with functional needs that do not yet meet an institutional level of care through the Section 1915 (i) state plan option. This option allows enrollees to remain in their homes and helps prevent the need for more intensive and costly services in the future. As of 2015, 17 states elected the Section 1915 (i) option to provide home and community based services (HCBS) to people at risk of future institutionalization.[9] States have most frequently targeted this option to adults and children with significant mental health needs and people with intellectual or developmental disabilities.

Benefits

Minimum Standards

Federal standards outline minimum benefits for states to cover through their state Medicaid benefit package (Figure 4). For children, the minimum Medicaid benefit package offers access to all necessary services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which includes regular screenings, vision, dental, and hearing services and any other medically necessary care. For adults, minimum benefits include services such as those provided by physicians and hospitals. The ACA added some new minimum

Figure 4

Minimum and Optional Medicaid Benefits

Minimum Benefits	Selected Optional Benefits
• Physician services	• Prescription drugs
• Laboratory and x-ray services	• Clinic services
• Inpatient hospital services	• Dental services
• Outpatient hospital services	• Physical, occupational, and speech therapy
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	• Other diagnostic, screening, preventive, and rehabilitative services
• Family planning	• Prosthetic devices, dentures, eyeglasses
• Rural and federally-qualified health center (FQHC) services	• Intermediate care facilities for intellectual and developmental disabilities (ICF/IDD) services
• Nurse midwife services	• Inpatient psychiatric care for individuals under 21
• Nursing facility (NF) services for individuals 21 or over	• Home health care services (for those not entitled for NF care)
• Home health care services for individuals entitled to nursing facility care	• Personal care services with option to self direct
• Smoking cessation services for pregnant women	• Health home services to individuals with chronic conditions
• Free-standing birth center services	• Community First Choice attendant care services
	• Case management
	• Hospice services

benefits including smoking cessation services for pregnant women and free-standing birth center services. Although states must cover these minimum benefits, they determine the amount, duration, and scope of this coverage. Other services that are important for comprehensive care, such as prescription drugs, are not included in the minimum benefit package for adults.

Federal minimum long-term care benefits include nursing facility services and home health services for those who qualify for nursing facility services. There is no minimum standard for states to provide coverage for home and community-based care beyond the home health benefit in the Medicaid program. However, under the 1999 Supreme Court decision, *Olmstead v. L.C.,* the Justices ruled that, under the Americans with Disabilities Act (ADA), institutionalizing a person with a disability who can benefit from and wants to live in the community is illegal discrimination.

State Options

Reflecting the diverse health needs of enrollees, there is a broad range of optional benefits that states may choose to cover and for which they may receive federal matching funds. Many of these optional benefits include long-term care services and supports that are not typically included in private insurance plans. For both minimum and optional benefits, states determine the amount, duration, and scope of covered benefits (e.g., the number of covered visits), subject to the requirement that coverage of the benefit be sufficient to achieve its purpose. All states offer at least some optional benefits, including prescription drugs, but how many and which optional benefits are offered vary across states as do the limits on covered benefits. The ACA created a new optional health home benefit to provide coordinated care to individuals with chronic conditions; states can receive a 90% federal match for the first two years that they offer this benefit.[10] In 2016, 21 states (including DC) had at least one Medicaid health home program in place.

States can choose to provide a range of optional HCBS.[11] Some of these include personal care services, offered by 32 states in 2013, and Community First Choice (CFC) attendant care services and supports, offered by eight states as of 2016. CFC is a new option added by the ACA that offers enhanced federal matching funds. In recent years, states also have been adding services such as supportive housing and supported employment to help people with disabilities function independently in the community. States also have the option to allow beneficiaries to self-direct their services by selecting and dismissing workers and/or allocating dollars within their service budgets. States have used the Medicaid HCBS options to shift the balance of long-term care spending away from institutions and toward community-based care. The share of Medicaid LTSS spending devoted to HCBS increased from 18% in 1995 to 53% in 2014.[12] These options have also helped states meet their *Olmstead* obligations under the ADA by providing services that help people with disabilities live independently in the community.

States may provide some groups with "alternative benefit plans" (formerly called "benchmark benefit packages") instead of the traditional state Medicaid benefit package. This option was established in the Deficit Reduction Act of 2005 (DRA), which also newly allowed states to vary the benefits provided by coverage group or geographic area within the state.[13] States can choose to base their alternative benefit plans on the standard Blue Cross Blue Shield (BCBS) preferred provider plan under the Federal Employees Health Benefits Plan (FEHBP), a state employee plan, the state's largest commercial health maintenance organization (HMO), or other Secretary-approved coverage.[14] Very few states have used this DRA option for benefits. The ACA requires that

states provide expansion adults with an alternative benefit plan, but nearly all states have aligned their expansion adult benefit package with the benefit package provided to other enrollees for ease of administration and to provide equitable coverage across populations.

States also may use Medicaid funds as premium assistance to purchase private insurance rather than providing direct coverage. Medicaid premium assistance programs must be cost-effective and provide wraparound coverage so that enrollees have access to the same benefits and cost sharing protections as they would under traditional Medicaid coverage. Most states operate a premium assistance program, but enrollment in these programs is relatively low.[15] This low enrollment reflects the limited availability of employer-sponsored coverage among the low-income population. More recently, Arkansas and New Hampshire are using the Medicaid premium assistance option to purchase Marketplace coverage for their ACA expansion adults.[16]

Premiums and Cost Sharing

Minimum Standards

Federal standards exempt certain groups and services from premium and cost sharing charges to prevent cost barriers to coverage and care for the lowest income Medicaid enrollees. States may not charge premiums to Medicaid enrollees with incomes below 150% FPL. States cannot charge cost-sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in alternative benefit plans in Medicaid. In addition, children with incomes below the minimum eligibility standard generally cannot be charged cost-sharing.

State Options

States may charge premiums and cost sharing for certain Medicaid enrollees within established limits. The DRA gave states new options to charge premiums and cost sharing, which vary by group, income, and service.[17] States may charge premiums for enrollees with incomes above 150% FPL. States also may charge cost sharing, but allowable charges vary by income (Table 1). Regardless of income, aggregate out-of-pocket costs for an individual may not exceed 5% of family income. The DRA also allowed states to make premiums and cost sharing enforceable for certain enrollees, meaning that individuals over 150% FPL can be disenrolled from coverage due to unpaid premiums, and a state can allow providers to deny care (other than emergency services) to those above poverty, unless an individual makes a required copayment at the point of service.[18]

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs Preferred Non-Preferred	 $4 $8	 $4 $8	 $4 20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled through mandatory eligibility pathways, emergency services, family planning services, pregnancy-related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning Oct. 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Premium and cost sharing charges in Medicaid vary across states and eligibility groups. As of January 2017, four states charge premiums and three states charge cost sharing for children in Medicaid. (A larger number of states charge children premiums or enrollment fees and cost sharing in CHIP because the program covers children with relatively higher incomes and has different premium and cost sharing rules.) Among adults, 39 states charge parents cost-sharing in Medicaid, and 23 of the 32 states that have expanded Medicaid charge cost-sharing for expansion adults. Cost sharing amounts for adults are generally nominal, reflecting the low incomes of adults covered by Medicaid. Similarly, because eligibility levels for parents and other adults are generally at or below 138% FPL, most states do not charge premiums for adults. However, six states (Arizona, Arkansas, Indiana, Iowa, Michigan, and Montana) have received Section 1115 waiver approval to charge premiums or monthly contributions that are not otherwise allowed for their Medicaid expansion adults; these amounts are generally 2% of income, equivalent to what beneficiaries from 100-138% FPL would incur if they enrolled in Marketplace coverage.

Provider Payments and Delivery Systems

Minimum Standards

States have latitude to determine provider payments so long as the payments are consistent with efficiency, economy, quality and access and safeguard against unnecessary utilization. Within these broad guidelines, provider payments must be sufficient to ensure Medicaid beneficiaries with access to care that is equal to others in the same geographic area, and payments to managed care organizations must be actuarially sound.[19] There are additional requirements that vary by provider type. For institutional providers such as hospitals and nursing facilities, states must publish payment methodologies for public review and comment and payments are subject to upper payment limits. States must pay federally qualified health centers and rural health clinics based on a prospective payment system that relies on costs in a base year, which are trended forward. Federal law requires that drug manufacturers enter into rebate agreements with the federal government to provide their drugs through Medicaid. Lastly, federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Within the annual DSH allotments to states and hospital specific limits, states have considerable flexibility on how to distribute DSH funds.

Federal standards do not address how states structure the delivery system used to provide services to Medicaid enrollees. However, if a state uses managed care, it must meet certain standards related to plan choice and provide certain consumer protections.

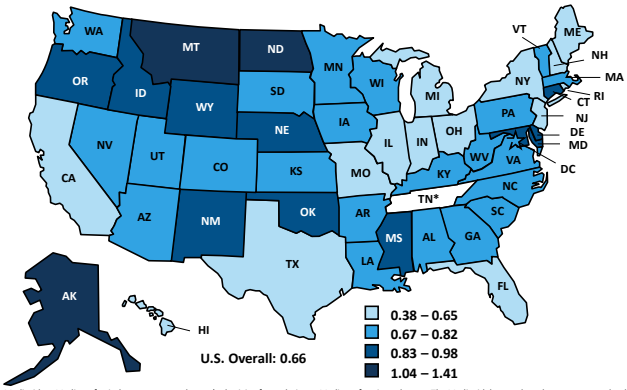
State Options

Given the broad authority available to states to set provider payments, there is significant variation across states in how provider rates are determined as well as in payment levels. States use a variety of payment methodologies for hospitals, including diagnosis related groups (DRGs) similar to Medicare, per diem amounts, or costs. Fee-for-service payments for physicians also vary significantly across states. For example, rates for office visits in California are 19% below the national Medicaid average while Oklahoma pays 29% above the average.[20] On average, states pay fee-for-service providers about 66% of what Medicare pays, although this ratio differs across states (Figure 5). For managed care, some states set rates based on fee-for-service claims while others base rates on risk adjustments for different populations. Information is limited regarding the rates paid to providers in managed care.

Figure 5

Medicaid Provider Payment Levels Relative to Medicare Payments by State, 2014

Medicaid-to-Medicare Physician Fee Index for Fee-for-Service Payments, 2014



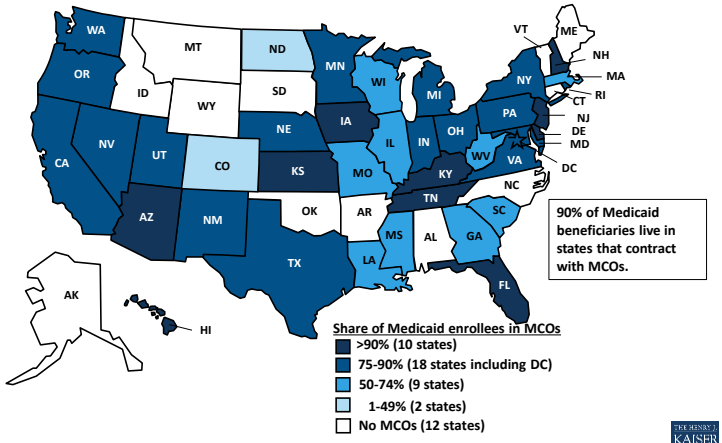
NOTES: The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on surveys sent by the Urban Institute to the 49 states and DC that have a fee-for-service (FFS) component in their Medicaid programs. These fees represent only those payments made under FFS Medicaid. *Tennessee does not have a FFS program.

SOURCE: Stephen Zuckerman, Laura Skopec, and Kristen McCormack, "Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?," Urban Institute, December 2014.

States choose what type of delivery system to use to serve Medicaid enrollees. They can choose to serve enrollees through a fee-for-service system, a primary care case management model, or through capitated managed care plans. As of July 2016, 48 states had some form of managed care in place, including primary care case management and/or comprehensive risk-based managed care organizations (MCOs). Among the 39 states that contract with MCOs, 28 states reported that at least 75% of their enrollees were in MCOs, including four of the five states (California, New York, Texas, and Florida) with the largest total Medicaid enrollment across the country (Figure 6).

Figure 6

Percentage of Medicaid Beneficiaries Enrolled in Managed Care Organizations (MCOs), as of July 2016



Sources: KFF Medicaid Managed Care Market Tracker and *July 2016 Medicaid & CHIP Monthly Application, Eligibility Determination, and Enrollment Report*, CMS.

An increasing number of states are adopting capitated managed care models that integrate physical, behavioral health, and long-term services and supports. As of 2016, nearly half (24) states operate a capitated managed long-term care program for at least some seniors and people with disabilities.[21] Other states are providing access to HCBS in fee-for-service delivery systems.

State Medicaid programs have been expanding their use of payment and delivery system reform models including patient-centered medical homes, health homes, ACOs, and episode of care payments. These initiatives may be implemented through fee-for-service or managed

care. State innovation in delivery and payment systems has been influenced and catalyzed by new demonstration and pilot programs and state plan authorities provided by the ACA. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) to test, evaluate, and expand innovative care and payment models to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid and CHIP. CMMI launched the State Innovation Models (SIM) initiative which has awarded nearly $950 million in grants to states to design, implement, and evaluate multi-payer health care delivery and payment reforms aimed at improving the quality of care and health system performance while decreasing costs for Medicaid, CHIP, and Medicare beneficiaries.[22] Many state Medicaid programs report adopting and promoting alternative provider payment models as part of their SIM projects.[23] Additionally, 8 states' Medicaid programs are participating in the CMMI Comprehensive Primary Care Plus (CPC+) initiative, a multi-payer advanced primary care medical home model.[24]

DEMONSTRATION AUTHORITY

State Options

Federal law also provides Section 1115 waiver authority, which allows the Secretary of HHS to waive certain requirements in Medicaid and to allow federal Medicaid matching funds for purposes not otherwise allowed under federal rules. This provision authorizes the Secretary to allow approaches that do not meet federal rules, as long as the Secretary determines that the initiative is a "research and demonstration project" that "furthers the purposes" of the program. While the Secretary's waiver authority is very broad, there are some elements of the program that the Secretary does not have authority to waive, such as the federal matching payment system for states. As of January 2017, 37 states have 50 approved Section 1115 waivers.[25] States have used Section 1115 waivers for many purposes, including to expand eligibility, change delivery systems, alter benefits and cost-sharing, modify provider payments, and quickly extend coverage during an emergency.

The ACA created an additional Section 1115A waiver authority. Using Section 1115A authority, CMS along with 13 states launched financial and administrative alignment demonstrations that seek to improve care and control costs for people who are dually eligible for Medicare and Medicaid.

Looking Ahead

Debate around increased flexibility within Medicaid will likely emerge within the context of proposals to fundamentally restructure financing of the program to a block grant or per capita cap and reduce federal financing. Calls for increased Medicaid flexibility are not new, and the balance of standards and options has shifted over time. Today, states have broad flexibility over many aspects of their programs and can gain increased flexibility under Section 1115 waiver authority. What additional flexibilities would be provided beyond these options under such proposals would have implications for states, enrollees, and providers. What federal standards would remain in place will affect the extent of accountability for the federal investment in the program and the scope of nationwide protections available for enrollees. Additionally, how such proposals would address existing program variation in establishing base levels for the caps will be key, including variation as a result of 32 states, including DC, adopting the ACA expansion. Setting the caps based on current spending could lock historical state choices and program variation in place potentially rewarding states with higher historic spending and creating "winners" or "losers" across states.

Endnotes

[1] The federal medical assistance percentage (FMAP) is determined by a statutory formula based on state per capita income, which varies across states and adjusts over time. The federal government has temporarily increased the matching rate to provide fiscal relief to states during economic downturns and established an enhanced matching rate for some purposes, including the Affordable Care Act (ACA) Medicaid expansion to low-income adults.

[2] The minimum is 133% of poverty, but the law includes a standard income disregard of five percentage points of the federal poverty level, which effectively raises this limit to 138% FPL.

[3] Ibid.

[4] To be eligible for SSI, beneficiaries must have low incomes, limited assets, and an impaired ability to work at a substantial gainful level as a result of old age or significant disability.

[5] As of 2015, 10 states elect the § 209(b) option to use disability or financial eligibility standards that are more restrictive than the federal SSI rules, so long as the state's rules are not more restrictive than those in effect in January 1972. Section 209(b) states must allow SSI beneficiaries to establish Medicaid eligibility through a spend-down by deducting unreimbursed out-of-pocket medical expenses from their countable income. Section 209(b) states also must provide Medicaid to children who receive SSI and who meet the state's financial eligibility rules for the AFDC program as of July 16, 1996.

[6] There are 3 Medicare Savings Programs: Medicaid pays Medicare premiums and cost-sharing for Qualified Medicare Beneficiaries (up to 100% FPL). Medicaid pays Medicare premiums for Specified Low-Income Medicare Beneficiaries (100-120% FPL) and Qualified Individuals (up to 135% FPL). There also are asset limits for these programs.

[7] States can cover "Katie Beckett" children through a state plan option or HCBS waiver; waiver coverage allows enrollment to be capped.

[8] States electing the medically needy coverage option must cover certain groups of people, such as pregnant women and children, and also can choose to extend medically needy coverage to other groups, such as seniors and people with disabilities.

[9] Additionally, as of 2016, six states are offering HCBS to people at risk of institutionalization through Section 1115 managed long-term care waivers.

[10] Kaiser Commission on Medicaid and the Uninsured, *Medicaid's New 'Health Home' Option* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2011), http://kff.org/health-reform/issue-brief/medicaids-new-health-home-option/.

[11] States can offer HCBS through their traditional Medicaid state plan benefit package or through a waiver; waivers allow enrollment to be capped.

[12] Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier, *Medicaid Expenditures for Long Term Services and Supports (LTSS) in FY 2014*, (Bethesda, MD: Truven Health Analytics, April 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2014.pdf.

[13] Certain groups are exempt from mandatory enrollment in an alternative benefit plan and instead must have access to the traditional state plan benefit package. These include mandatory pregnant women, mandatory parents, and those who are medically frail (including individuals with disabilities or special medical needs, dual eligible beneficiaries, and people with long-term care needs). MaryBeth Musumeci, *The Affordable Care Act's Impact on Medicaid, Eligibility, Enrollment, and Benefits for People with Disabilities* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2014), http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities/.

[14] 42 C.F.R. § 440.330.

[15] Joan Alker, Sean Miskell, MaryBeth Musumeci, and Robin Rudowitz, Medicaid Premium Assistance Programs: What Information is Available About Benefit and Cost-Sharing Wrap-Around Coverage? (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2015), http://kff.org/report-section/medicaid-premium-assistance-programs-what-information-is-available-about-benefit-and-cost-sharing-wrap-around-coverage-introduction/ (*citing* United States Government Accountability Office, *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs* (Washington, DC: United States Government Accountability Office, Jan. 19, 2010), http://www.gao.gov/new.items/d10258r.pdf).

[16] Iowa had waiver approval for and implemented a premium assistance program for some Medicaid expansion enrollees, but the program was discontinued by the state.

[17] Kaiser Commission on Medicaid and the Uninsured, *Deficit Reduction Act of 2005*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2006), http://kff.org/medicaid/issue-brief/deficit-reduction-act-of-2005-implications-for/.

[18] Ibid.

[19] Institutional providers (hospitals) and nursing facilities: States are required to publish payment methodologies for public review and comment and payments are subject to upper payment limits for these providers based on what Medicare would have paid in aggregate. Physicians, other providers and managed care organizations: States are required to pay rates that are sufficient to ensure access equal to the rest of the area population. For MCOs, payment mush be actuarially sound. Federally Qualified Health Centers (FQHCs): Under

legislation enacted in 2001, states are required to pay these health centers and clinics based on a prospective payment system that relies on costs in a base year and trended forward. Prescription Drugs: Federal law requires that drug manufacturers enter into rebate agreements with HHS to provide their drugs through Medicaid.

[20] Stephen Zuckerman, Laura Skopec, and Kristen McCormack, *Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?* (Washington, DC: Urban Institute, December 2014), http://www.urban.org/research/publication/reversing-medicaid-fee-bump-how-much-could-medicaid-physician-fees-primary-care-fall-2015.

[21] Vernon K. Smith et al., *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017* at 47 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2016) (citing 23 states using private health plans to deliver LTSS), http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017/. In addition, Vermont uses a state entity acting as a prepaid health plan to deliver MLTSS on an at-risk basis.

[22] Kaiser Commission on Medicaid and the Uninsured, *The State Innovation Models (SIM) Program: A Look at Round 2 Grantees* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2015), http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/.

[23] Vernon K. Smith et al., *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2016), http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017/.

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Average Individual Health Insurance Premiums Increased 99% Since 2013, the Year Before Obamacare, & Family Premiums Increased 140%, According to eHealth.com Shopping Data

eHealth reports that average premiums for people not receiving Obamacare **subsidies were $393 for individual coverage and $1,021 for family coverage during the first two months of open enrollment; in 2013 individual premiums averaged $197, or $426 for families**

January 23, 2017 09:08 PM Eastern Standard Time

MOUNTAIN VIEW, Calif.--(BUSINESS WIRE)--Today eHealth, Inc. (NASDAQ: EHTH) (eHealth.com), the nation's first and largest private online health insurance exchange, released an analysis of individual and family health insurance shopping trends for the first two months of the 2017 open enrollment period. Open enrollment for 2017 health insurance plans under the Affordable Care Act (ACA or Obamacare) began on November 1, 2016 and is scheduled to continue through January 31, 2017.

eHealth's analysis provides an aggregated, anonymized examination of individual and family health insurance premiums and deductibles for plans selected by eHealth shoppers not receiving government subsidies under the ACA from November 1 through December 31, 2016. It also includes demographic information on shoppers and a review of individual and family costs previously published by eHealth since 2008.

This is the latest installment in eHealth's continuing Health Insurance Price Index reports, which have tracked costs and trends in the self-purchased health insurance market since 2014. Prior to 2014, eHealth published an annual Cost and Benefits report, which tracked cost and benefit trends in the self-purchased health insurance market since 2005.

Prior years' reports are available online:

- 2016 open enrollment period Price Index report
- 2015 open enrollment period Price Index report
- 2014 open enrollment period Price Index report
- 2013 Costs and Benefits Report (includes historic cost data to 2006)
- Previous Costs and Benefits Reports

Individual coverage highlights

- Average individual premium: $393 per month for an individual not receiving subsidies in the first two months of the 2017 open enrollment period
- In 2013, the year before major Obamacare provisions came into effect, the average individual premium was $197 per month
- Between 2013 and the first two months of the 2017 open enrollment period, average individual premiums have increased 99%

Family coverage highlights

- Average family premium: $1,021 per month for a family not receiving subsidies in the first two months of the 2017 open enrollment period
- In 2013, the year before major Obamacare provisions came into effect, the average family's premium was $426 per month
- Between the end of 2013 and the first two months of the 2017 open enrollment period, average family premiums have increased 140%

Notes about historical data

Premium data for the 2014-2017 open enrollment periods reflect premiums for plans selected by eHealth customers not receiving government subsidies. Government subsidies were not available prior to 2014.

The health insurance plans available from eHealth or selected by eHealth shoppers each year are not the same from year to year. In addition, health insurance plans available before implementation of the Affordable Care Act often provided more limited benefits and coverage than plans available after implementation of Obamacare provisions. For example, such earlier plans did not have to meet Obamacare's minimum essential benefit requirements and, in many cases, were not required to cover pre-existing medical conditions.

Ten Years of Health Insurance Costs:

Average Costs from 2008 through the First Two Months of the 2017 Open Enrollment Period[1]

	Average Individual Health Insurance Premium	Average Individual Health Insurance Deductible	Average Family Health Insurance Premium	Average Family Health Insurance Deductible
First two months of 2017 open enrollment	$393	$4,328	$1,021	$8,352
2016 open enrollment	$321	$4,385	$833	$7,983
2015 open enrollment	$286	$4,120	$727	$7,760
2014 open enrollment	$271	$4,164	$667	$7,771
2013	$197	$3,319	$426	$4,230
2012	$190	$3,079	$412	$4,079
2011	$183	$2,935	$414	$3,879
2010	$167	$2,632	$392	$3,531
2009	$161	$2,326	$383	$3,128
2008	$159	$2,084	$369	$2,760

- Average individual health insurance premiums increased 147% between 2008 and the first two months of the 2017 open enrollment period
- Average family health insurance premiums increased 177% between 2008 and the first two months of the 2017 open enrollment period

The benefits offered under individual and family health insurance plans prior to the 2014 plan year often differed significantly from the benefits available under plans for 2014-2017 due to regulations introduced by the Affordable Care Act which came into effect in 2014.

Additional information describing consumer shopping trends and demographics during the first two months of the 2017 open enrollment period was published by eHealth on January 13, 2016 and is available at the company's media center.

About the eHealth Price Index

eHealth is one of the few organizations with national source health insurance data that broadly reflects consumer buying patterns and purchase prices in the self-purchased individual and family health insurance market. eHealth's Price Index reports provide insights into the large segment of the individual and family health insurance market which may not qualify for or elect to use government subsidies, and which may shop for coverage through sources other than government-run exchanges.

eHealth's Price Index 2017 figures are based on thousands of health insurance applications submitted by eHealth shoppers during the first two months of the 2017 open enrollment period (November 1 through December 31, 2016). These figures do not include data from individual or family health insurance shoppers who have applied for government subsidies or selected subsidy-eligible plans through their state's government-run health insurance exchange with the assistance of licensed agents from eHealth. Information from prior years was previously published in other eHealth reports using the methodologies indicated in those reports.

Information presented in eHealth's report is based solely on rates quoted for health insurance applications selected by consumers through the company's website in the specified time period. Figures have been rounded to the nearest full dollar or nearest full percentage point. The information provided here does not offer a comprehensive view of costs for all plans available through eHealth, through the market as a whole, or through government exchanges. Certain data may have been excluded. For example, applications missing key data fields relevant for analysis may have been removed from the sample.

Notes:

[1]2016 figures were previously published in eHealth's October 2016 Health Insurance Price Index Report for the 2016 Open Enrollment Period. 2015 and 2014 figures were previously published in eHealth's March 2015 Health Insurance Price Index Report for the 2015 Open Enrollment Period. 2008-2013 figures were previously published in eHealth's Cost and Benefits of Individual and Family Health Insurance Plans report from December 2013.

eHealth

eHealth, Inc. (NASDAQ: EHTH) owns eHealth.com, the nation's first and largest private online health insurance exchange where individuals, families and small businesses can compare health insurance products from leading insurers side by side and purchase and enroll in coverage online. eHealth offers thousands of individual, family and small business health plans underwritten by many of the nation's leading health insurance companies. eHealth (through its subsidiaries) is licensed to sell health insurance in all 50 states and the District of Columbia. eHealth also offers educational resources and powerful online and pharmacy-based tools to help Medicare beneficiaries navigate Medicare health insurance options, choose the right plan and enroll in select plans online through Medicare.com (www.Medicare.com), eHealthMedicare.com (www.eHealthMedicare.com) and PlanPrescriber.com (www.PlanPrescriber.com).

For more health insurance news and information, visit eHealth's Consumer Resource Center.

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JANUARY 2017

AN EVALUATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET AND IMPLICATIONS OF POTENTIAL CHANGES

American Academy of Actuaries
Individual and Small Group Markets
Committee

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Executive Summary

In this issue paper, the American Academy of Actuaries' Individual and Small Group Markets Committee examines experience in the Affordable Care Act (ACA) individual market. It outlines the conditions necessary for a sustainable individual health insurance market, examines whether these conditions are currently being met, and discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

What is necessary for a sustainable individual health insurance market?

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Slow spending growth and high quality of care.

How does the ACA individual market measure up to these conditions?

- Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected.
- For the most part, competing plans face the same rules; however, some rules might disadvantage insurers participating on the ACA marketplaces (or exchanges) compared to off the marketplaces.
- The uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.
- In recent years, health care spending has been growing relatively slowly compared with historical averages, but there are signs that growth rates are increasing.

What options have been proposed to improve the sustainability of the individual market?

Many options have been put forward to improve the sustainability of the individual market under the ACA. In addition, ACA replacement approaches have been proposed. The impact of any option or set of options depends on the specific details. This paper makes no recommendations and instead assesses the positive and negative implications of various options, including:

- **Stronger incentives to purchase coverage.** Strengthening the incentives to purchase coverage, through increased penalties for non-enrollment, increased premium subsidies, or a permanent reinsurance program, could help increase enrollment and improve the risk pool. Reducing the 90-day grace period and tightening special enrollment period (SEP) eligibility also have the potential to improve the risk pool by decreasing the potential for abuse of these protections.
- **Greater variation in premiums by age.** Widening premium variations by age could increase participation by young adults, but could result in higher uninsured rates among older adults and increased federal costs for premium subsidies, due to higher premiums for older adults.
- **Restructured premium subsidies.** Current premium subsidies are based on premium levels relative to income. The impact on enrollment, net premiums, and federal spending of basing premium subsidies instead on age or other factors depends on the amount of the subsidies relative to premiums.
- **Reduced regulatory uncertainty.** Releasing rules in a timely fashion would help reduce uncertainty for insurers. In addition, applying rules consistently among insurers is important to maintain a level playing field.
- **Allow insurance sales across state lines.** Allowing insurers to sell coverage across state lines, which states already have the ability to permit, could create an unlevel playing field and threaten the viability of insurance markets in states with more restrictive rules. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.
- **Enhanced state flexibility.** States could pursue approaches tailored to their specific situations through Section 1332 State Innovation Waivers or through other enhancements to state flexibility. Such efforts could include the pursuit of different enrollment incentives, subsidy structures, benefit coverage requirements, premium rating rules, etc.

An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes

Now that the individual market under the Affordable Care Act (ACA) is entering its fourth year of operation, experience is available from 2014–2016 that can be used to help assess the sustainability of the market over the longer term. In this paper, the American Academy of Actuaries' Individual and Small Group Markets Committee outlines the conditions necessary for the individual health insurance market to be sustainable over the long term and examines whether these conditions are currently being met. The paper then discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

SECTION 1

What Is Necessary for a Sustainable Individual Health Insurance Market?

This section outlines the conditions necessary for the sustainability of the individual health insurance market. In general, a financial security program is sustainable if it can be reasonably expected to be maintained over time without requiring significant curtailment or restructuring.[1] This determination involves considering whether all significant stakeholders accept the balance of benefits and costs and whether the program will achieve its goals over its time horizon. The ACA's goals include increasing access to affordable health insurance coverage, enhancing the quality of care, and addressing health spending growth.

With respect to the individual market, the conditions necessary for a sustainable market include achieving enrollment that is sufficient and balanced, a regulatory environment that is stable and facilitates fair competition, participation by health plans that is sufficient for market competition and consumer choice, and slow spending growth and high quality of care. These factors will affect premium affordability; in turn, premium affordability will affect enrollment numbers and risk pools. Subsequent sections of this paper will examine the extent to which the ACA individual market meets these conditions, including the feedback between enrollment and premiums.

Individual enrollment at sufficient levels and a balanced risk pool

Sufficient enrollment levels.

At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year. In states that fund health insurance marketplace operations through user fees, market-wide enrollment must be sufficient to generate adequate user fee revenues. At the insurer level, enrollment must be high enough to achieve stability and predictability of claims and to benefit from economies of scale, so that per-enrollee administrative costs are low relative to average claims.

A balanced risk pool.

Because the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less-healthy individuals can be spread. Enrollment of only individuals with high health care needs, typically referred to as adverse selection, can produce unsustainable upward premium spirals. Attracting healthier individuals (e.g., through the ACA individual mandate and premiums subsidies) is needed to keep premiums more affordable and stable.

A stable regulatory environment that facilitates fair and sufficient insurer competition

Consistent rules and regulations applied to competing health plans.

Health plans competing to enroll the same participants must operate under the same rules. If one set of plans operates under rules that are more advantageous to healthy individuals, then those individuals will migrate to those plans; less-healthy individuals will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to higher-risk individuals will suffer from adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to higher-risk individuals.

Stable effective regulatory environment.

The rules and regulations governing the health insurance market need to be announced with sufficient lead time, relatively stable over time, and not overly burdensome in terms of costs or restrictions on innovation.

Reasonable expectation of earning a fair return.

Insurers operating in the ACA-compliant individual market rely on premium payments from enrollees, federal funding for premium tax credits and cost-sharing reduction subsidies, and risk-mitigation transfers. In total, these revenues must be adequate to cover claims and administrative costs. They must also provide a reasonable margin for contribution to reserves and surplus in order to meet solvency requirements and support ongoing business activities.

Sufficient health insurer participation and plan offerings

Sufficient number of participating health insurers.

Health insurance market competition can provide incentives for health plans to improve the efficiency of health care delivery, lower administrative costs, and provide products that are attractive to consumers. The optimal number of insurers likely differs by area and local market conditions (e.g., the number of eligible enrollees, the degree of provider concentration). Rural areas can support fewer insurers, for instance, due to low potential enrollment numbers and the presence of sole community providers.

Sufficient plan offerings.

The number and range of plan offerings must be sufficient to provide appropriate choice to consumers with respect to plan design features including a variety of out-of-pocket costs, provider networks, and plan type. This does not preclude requiring standardized plan designs. Offerings should not be so numerous that they impose an overwhelming burden on consumers that results in less-than-optimal choices.

Slow health spending growth and high quality of care

Reasonable health care costs and moderate health spending growth.

Long-term sustainability of the individual market requires containing the growth in health spending.

High quality of care.

There must be a focus not only on containing the growth in health care spending but also on improving health care quality, measured for instance based on health care outcomes.

SECTION 2

Assessment of Progress to Date

This section addresses each of the conditions for sustainability identified in Section 1 and assesses progress that has been made as well as challenges that remain to be addressed. Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. For the most part, competing plans face the same rules. However, the uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and declined further in 2017.

Individual enrollment at sufficient levels and a balanced risk profile

Sufficient enrollment levels.

The number of individuals selecting marketplace plans during the annual open enrollment periods increased from 8.0 million in 2014 to 11.6 million in 2015, and to 12.7 million in 2016.[2] Enrollment numbers decline during the year, as individuals shift to other coverage sources (or to being uninsured) and insurers cancel coverage for consumers who don't pay their premiums. Offsetting part of this decline is enrollment during special enrollment periods (SEPs) for individuals who experience a qualifying event, such as a loss of coverage through a job. At the end of 2015, 8.8 million individuals had marketplace coverage, down from 11.6 million during the open enrollment period.[3]

Because of differences in populations and other factors, such as consumer outreach and enrollment systems, marketplace enrollment varies among the states. In 2016, the number of individuals with marketplace selections ranged from about 15,000 in Hawaii to 1.7 million in Florida.[4] Hawaii had a state-based marketplace, but moved to using the federal marketplace because its low enrollment numbers were not enough to generate sufficient revenues to sustain marketplace operations.[5] Other state-based marketplaces with relatively low enrollment numbers could be at similar risk. For instance, of the 13 remaining state-based marketplaces in 2016, three had fewer than 35,000 individuals with plan selections through the marketplaces during open enrollment (District of Columbia, Rhode Island, and Vermont).[6]

The ACA requires that insurers use a single risk pool when developing premiums. ACA-compliant off-marketplace plans are included as part of this single risk pool. In other words, insurers must pool all of their individual market enrollees together when setting the prices for their products. Therefore, premiums reflect insurer expectations of medical spending for enrollees both inside and outside of the marketplace. Although there are no official off-marketplace enrollment numbers, the Department of Health and Human Services (HHS) estimates that in 2016, about 7 million individuals enrolled in individual market coverage outside of the marketplace.[7] The majority of these individuals are likely to have ACA-compliant coverage; the Kaiser Family Foundation estimates that in 2016, only 12 percent of all individual market plans are non-ACA-compliant (i.e., grandfathered and transitional plans).[8, 9] This suggests a total ACA-compliant individual market enrollment in 2016 of about 17-18 million.

Enrollment, both on the marketplace and in total, was lower than initially projected by the Congressional Budget Office (CBO) and others. In its May 2013 baseline estimates, CBO projected a total individual market enrollment in 2016 of about 37 million—22 million on the marketplace and about 15 million off marketplace.[10] In updated estimates from its March 2016 baseline, CBO lowered its 2016 enrollment projection to 21 million—12 million on the marketplace and 9 million off.[11] One major reason for the downward adjustment is that more employers than projected are continuing to offer coverage, resulting in fewer individuals moving from employer coverage to coverage in the individual marketplace. Lower-than-expected enrollment also suggests that affordability remains a challenge—in 2015, 46 percent of uninsured adults said that they had tried to obtain coverage but it was too expensive.[12] In addition, the ACA's individual mandate may be too weak to provide sufficient enrollment incentives. Outreach efforts may be insufficient to raise consumer awareness of the mandate and availability of premium assistance.

Even with enrollment lower than expected, uninsured rates have declined under the ACA. For instance, the National Health Interview Survey reports that the share of individuals under age 65 who were uninsured at the time of the interview declined from 18.2 percent in 2010 to 10.4 percent during the first six months of 2016.[13]

Despite these coverage gains, about 27 million nonelderly people remain uninsured in 2016.[14] Of these, the Kaiser Family Foundation estimates that 19 percent are eligible for a premium tax credit and 24 percent are eligible for Medicaid. These individuals may be unaware of their eligibility or, in the case of those eligible for premium subsidies, they may still find premiums unaffordable. Forty-seven percent of the uninsured are ineligible for premium assistance—20 percent due to their immigration status, 17 percent because they have an employer offer of coverage that is deemed affordable, and 11 percent because they have incomes that are too high. Another 10 percent of the uninsured would have been eligible for Medicaid if their state had expanded Medicaid coverage. Affordability may also be an issue for these groups. Notably, these are national estimates; percentages will vary among and within states.

A balanced risk pool.

A sustainable market requires not only enrollment at sufficient numbers, but also a balanced risk profile. That is, enrollment should not be skewed toward those with high health care costs; sustainability requires the enrollment of healthy individuals as well. The ACA includes several provisions that aim to reduce the potential adverse selection effects of allowing guaranteed access to coverage at standard premiums regardless of pre-existing health conditions. These provisions include providing premium and cost-sharing subsidies to lower the cost of coverage and imposing a financial penalty for individuals who remain uninsured. Each encourages even healthy individuals to obtain coverage. However, affordability issues and the weakness of the individual mandate could have disproportionately suppressed enrollment among individuals with low expected health care costs.

Lower-than-expected marketplace enrollment has been accompanied by concerns that the risk profile of enrollees was worse than many insurers expected.[15] The average risk profile for a given population in a guaranteed issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher individual market participation rates will tend to reflect a larger share of healthy individuals enrolling, and therefore a more balanced risk profile. In contrast, lower participation rates will tend to reflect a less-healthy risk profile, and in turn higher average costs. This is because those previously uninsured individuals with greater health care needs are more likely to enroll than those with lesser needs.

As expected, evidence from the 2014 open enrollment period suggests that less-healthy individuals were more apt to sign up first. For instance, early marketplace enrollees were more likely to be older and use more medications than later enrollees.[16] Examinations of how the risk pool has been changing over time have yielded some mixed results. A Center for Consumer Information and Insurance Oversight (CCIIO) analysis of per-enrollee costs in 2014 and 2015 suggests that slower cost growth may have resulted from a broader and healthier risk pool and that states with stronger enrollment growth had greater improvements in their enrollee risk profiles.[17] Similarly, an analysis of Covered California marketplace data found that the risk profile at the end of the open enrollment period improved from 2014 to 2015[18] and nationwide estimates suggest an improvement from 2014 to 2015 in the share of marketplace enrollees self-reporting very good or excellent health status.[19] In contrast, an analysis of the ACA risk adjustment program shows an increase in risk scores from 2014 to 2015.[20] Although this result suggests a deterioration of the risk pool, other factors could have played a role, such as increased diagnostic coding and better data submission to the Centers for Medicare & Medicaid Services (CMS). In addition, similar to the CCIIO analysis, the report finds that enrollment growth is correlated with an improvement in the risk profile when other factors such as a state's transition policy and Medicaid expansion decisions are controlled for.

The risk corridor results for 2014 and 2015 also support assertions that enrollment was sicker than insurers expected; for many insurers, 2014 and 2015 premiums were too low relative to actual claims.[21] Some of this understatement was likely due to the implementation of the transitional policy that allowed individuals to keep their prior non-ACA-compliant coverage. In states adopting the transition policy, ACA-compliant plans exhibited less favorable experience because lower-cost individuals were more likely to retain their prior policies. But even in many states that didn't allow for transition policies, insurers were more likely to receive risk corridor payments, suggesting that market average claim costs were higher than assumed in premium pricing.

Except for grandfathered plans, individuals will not be allowed to renew non-ACA-compliant plans beyond Dec. 31, 2017. In states that allowed transition policies, an influx of individuals from these plans to ACA-compliant plans could help improve the risk profile in 2018.

Risk profile concerns may have continued into 2016. The Kaiser Family Foundation estimated that during the 2016 open enrollment period, nationwide only 46 percent of the potential marketplace population selected a marketplace plan, ranging from a low of 22 percent in Iowa to a high of 74 percent in the District of Columbia.[22] However, these figures understate total ACA-compliant enrollment to the extent that individuals enrolled off marketplace (notably, the District of Columbia does not offer plans off marketplace).

The availability of SEPs for individuals who encounter certain life events—such as losing health insurance coverage, moving, or getting married—also can affect average claim costs. Eligibility requirements for SEPs in the marketplaces have not been stringently enforced, thereby creating opportunities for individuals to delay enrollment until health care services are needed. On average, SEP enrollees have had higher claim costs and higher lapse rates than individuals enrolling during the open enrollment period.[23] The worse experience exhibited by SEP enrollees could be resulting from a combination of higher enrollment among SEP-eligible higher-cost individuals, lower enrollment among SEP-eligible low-cost individuals, and enrollment among higher-cost individuals who would not meet SEP eligibility criteria if validation were required. CCIIO is exploring additional verification requirements for individuals who purchase coverage on the marketplaces.

The availability of long premium payment grace periods for subsidized enrollees could also contribute to an unhealthy risk profile. Individuals who receive premium subsidies on the marketplace and have paid at least one month's premium are allowed a grace period of 90 days for future premium payments. States govern the grace period, typically 30 days, for individuals not receiving subsidies and those purchasing coverage off marketplace. Longer grace periods for on-marketplace plans can worsen the risk pool profile by allowing healthy people to pay premiums for nine months and be assured of 12 months of coverage if needed. In other words, individuals who develop health problems can retroactively pay premiums in order to maintain coverage; individuals who remain healthy can skip payments for the last three months of the year and simply enroll for the next year's coverage during the open enrollment period. The risk adjustment program does not mitigate lost revenue problems arising due to healthy people not paying a full year of premium. It's unclear the extent to which subsidized enrollees may be taking advantage of the extended grace period.

A recognition by insurers of worse-than-expected risk pool profiles in 2015 was likely a factor that contributed to 2017 premium increases. Insurers have more information now than they did last year regarding the risk profile of the enrollee population and used that information to adjust their 2017 assumptions accordingly.[24]

A stable regulatory environment facilitating fair competition

Consistent rules and regulations applied to competing health plans.

A stable marketplace requires that rules be consistently applied to all competitors in order to prevent particular insurers from being inappropriately advantaged or disadvantaged. Inconsistent regulations distort the market, reducing competition and limiting consumer choices. Fair competition also requires rules to prevent insurers from gaming the system. These conditions are generally met under the ACA, but not completely.

The same issue and rating requirements apply to all individual market insurers in a state, regardless of whether coverage is offered on or off the state marketplace. However, many states decided to take up the federal option of allowing individuals to keep non-ACA-compliant coverage, which put ACA-compliant plans at a disadvantage with respect to enrolling healthier individuals. This transition policy expires at the end of 2017; beginning in 2018, individuals in these plans will need to purchase ACA-compliant coverage.

ACA-compliant plans on and off the marketplaces participate in the risk adjustment program. By transferring funds between insurers based on the relative risk of their plan participants, the risk adjustment program aims to reduce incentives for insurers to avoid enrolling people at risk of high health spending. An Academy analysis found that for the 2014 plan year, the risk adjustment program compressed the loss ratio differences among health plans—risk adjustment transfers increased average loss ratios among health plans with low loss ratios and reduced loss ratios for health plans with high loss ratios, indicating that the program generally worked as intended for the individual market.[25] Nevertheless, risk adjustment payments can be affected by diagnostic coding and operational issues, and risk adjustment transfers as a percent of premium are much more variable among smaller insurers, which can produce unexpected results.

Non-ACA-compliant plans are not part of the risk adjustment program. Therefore, the program cannot mitigate the differences in enrollment patterns between non-ACA-compliant plans, which are more attractive to healthy individuals, and ACA-compliant plans.

One example of rules that apply differently on and off marketplace is the length of the premium grace period. As noted above, a 90-day grace period is available for individuals receiving premium subsidies, whereas the grace period is typically 30 days for other enrollees, including those purchasing coverage off the marketplaces. This can create a minor advantage for insurers selling off marketplace only.

There are also some differences in how fees are levied among insurers. Marketplace user fees are collected to support marketplace operations. The fee is charged only on marketplace business, but insurers must spread the fee across its marketplace and off-marketplace business. Insurers that operate only off marketplace do not need to reflect the fee in their premiums.

Stable effective regulatory environment.

Uncertainty in the regulatory environment can impact premium adequacy and stability, and ultimately insurer solvency. ACA regulations put into place standardized and effective processes for premium rate development, actuarial value determinations, and rate review processes that contribute to relative stability in the year-by-year rate filing processes. However, certain regulatory and legislative changes have seriously undermined this stability, negatively affecting the risk pool profiles, premium adequacy, and insurer financial results. In addition, delays in the release of important information can negatively affect stability.

- **Allowing individuals to retain pre-ACA coverage.** The decision to allow individuals to retain pre-ACA coverage was not made until 2014 premiums were finalized. In states that allowed pre-ACA plans to be renewed, this decision resulted in the risk pool profiles of ACA-compliant coverage being worse than expected and contributed to premiums being low relative to actual claims.

- **Constraints on risk corridor payments.** Risk corridors were included in the ACA to mitigate the pricing risk in the early years of the program. Although originally not specified to be budget neutral, subsequent legislative and regulatory actions have limited risk corridor payments to those that can be paid through risk corridor collections. If there is a shortfall, risk corridor payments are made on a pro rata basis. Due to such a shortfall for the 2014 plan year, only 12.6 percent of risk corridor payments were made.[26] The failure to pay the full amounts led to financial difficulty for many plans, in particular many Consumer Operated and Oriented Plans (CO-Ops). For instance, the Kentucky Health Cooperative specifically cited the lack of full risk corridor payments as a reason for closure.[27] HHS has indicated that no funds will be available for 2015 risk corridor payments, as any 2015 risk corridor collections will be used toward remaining 2014 risk corridor payments.[28]

- **Legal challenges to the ACA.** The steady flow of lawsuits has created additional costs and uncertainty. For instance, many states using the federal marketplace required dual premium submissions for the 2016 plan year because the Supreme Court had not yet

ruled on *King v. Burwell* (regarding the availability of premium subsidies) at the time premium filings had to be submitted for review. This required additional resources and expenses. Other cases are currently working their way through the courts. One that could have significant implications for premiums and insurer financial stability involves whether the administration has the legal authority to make cost-sharing reduction payments to health plans.[29]

- **Timing of available risk adjustment information.** Because the risk adjustment program depends on the market-wide risk profile, there is uncertainty regarding the amount that insurers expect to pay or receive under the program. Risk adjustment results in 2014 and 2015 were much different than expected for some insurers, resulting in unexpected losses. This risk adjustment "shock" is another reason cited for causing solvency problems for CO-OPs and other smaller plans.[30] Because of the lag in reporting, final risk adjustment results for a given plan year are not released until the middle of the next year, after premiums have already been filed for the year after that. In recognition of this time lag, CCIIO has begun to release interim reports that provide summary risk adjustment information. This information is not available for all states and insurers using the reports must do so with caution because the final results can differ significantly from interim estimates.

- **Timing of final rules.** The rulemaking process is understandably long and involved. Nevertheless, the earlier that rules are finalized, the easier it is for insurers to meet deadlines for product and rate filings in May. The final rules applicable to 2018 premium filings were released in December, earlier than in prior years. This earlier release will reduce rulemaking uncertainty, especially if this timeframe is continued in future years.

Reasonable expectation of earning a fair return.

Like all businesses, insurers participating in the individual market have an obligation to protect their viability and solvency, requiring that they must earn a fair return that supports ongoing business activities. Premiums net any of other payments or receipts (e.g., through the risk adjustment and reinsurance programs) must be adequate to cover claims and all administrative costs, taxes, and fees, and still provide a margin for profit or contribution to reserves and surplus.

The ACA reforms implemented in 2014 significantly changed insurance market rules and increased business risks. The most fundamental of these risks is related to projecting claim costs. Insurers had very limited data available to estimate who would enroll in plans under the new rules and what their health spending would be. It was likely that the composition of the insured population would change dramatically due to the elimination of underwriting and the introduction of premium subsidies. The risk adjustment and transitional reinsurance programs also needed to be factored in, while the temporary risk corridor program could be viewed as providing a partial safety net for premium rate development uncertainty.

Even with all the known risks, issuers were further subject to circumstances that could not reasonably have been anticipated. As noted above, these include the ability for individuals in many states to continue non-ACA-compliant transitional coverage in 2014 and beyond, as well as the federal government's failure to make risk corridor payments in full.

In an analysis of 2014 experience, McKinsey & Company found much variation in financial performance among insurers, with about 40 percent of the market covered by insurers with positive margins; the aggregate post-tax margin in 2014 was -4.8 percent.[31] The transition policy may have contributed to losses, as did insurer-specific factors, with CO-OPs and insurers offering preferred provider organization (PPO) plans and broad networks experiencing larger losses. Health maintenance organizations (HMOs), insurers with narrower networks, and Medicaid-based plans had more favorable experience, on average.

Once financial losses have been suffered, they cannot easily be recouped through future gains in the individual marketplace. Pricing margins can be limited by the rate review process and competitive pressures, which often puts downward pressure on rates, and health plans are not allowed to build in provisions to recoup past losses into premium rates.

Prior to the ACA, normal fluctuations in year-by-year margins could result in poorer-than-expected margins being offset by better-than-expected margins in subsequent years. The ACA's medical loss ratio (MLR) requirements limit the extent to which this can occur. These requirements stipulate that if claims plus quality improvement expenses fall below 80 percent of premium net of taxes and fees (in effect meaning that administrative costs and profit exceed 20 percent of premium), insurers may be required to return the difference to plan members.

Insurers and regulators now have more experience that can be used to develop and review future premiums. S&P Global Ratings recently forecast that insurer financial performance will improve, with smaller aggregate losses in 2016 than in 2015 and continued improvement in 2017 with more insurers becoming profitable.[32]

Nevertheless, continuing uncertainty and ACA legal challenges mean that pricing and solvency challenges in the market remain. This has caused many issuers to question their ability to earn a fair return—resulting in some issuers withdrawing from existing markets and fewer issuers having an interest in entering new markets.

Sufficient health plan participation and plan offerings

Sufficient number of participating health insurers.

Although there is no definitive minimum number of health insurers that are needed to ensure a competitive marketplace, it is generally recognized that competition can be difficult with fewer than three insurers.[33] This threshold may be lower than in other markets due to consumers' ability to compare plans under the ACA.[34]

The average number of ACA marketplace insurers per state increased from 5.0 in 2014 to 6.1 in 2015, and then declined to 5.7 in 2016.[35] Due to the failure of a number of small carriers, especially the CO-OPs, and market withdrawal announcements by some larger carriers (e.g., Aetna, Humana, UnitedHealth), the number of insurers is decreasing further in 2017. These averages mask tremendous variation among states. For instance, in 2017, five federal marketplace states (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming) have only one insurer. On the other end of the spectrum, Wisconsin has 15 insurers, Ohio has 11, and Texas has 10. Within states, the number of insurers offering coverage can vary by county, with rural counties having fewer participating insurers. Avalere estimates that in states using the federal marketplace, the average number of insurers per county has fallen from 5.3 in 2016 to 2.9 in 2017, and 21 percent of enrollees have only one participating insurer for 2017.[36]

It was expected that insurer exits and entries would occur during the early years of the ACA as insurers adjust to the new market rules. Nevertheless, recent marketplace pullbacks, especially among some major insurers, raise a concern that the current ACA marketplace environment is not viable from a business perspective. (Notably, some of the insurers pulling back from offering marketplace coverage continue to offer ACA-compliant coverage outside of the marketplace.) A reduction in competition due to fewer participating insurers can reduce consumer options as well as impact premiums. The ability of insurers to effectively compete depends in large part on their ability to manage costs, which in turn reflects their ability to effectively negotiate with providers to lower utilization and costs (e.g., through narrower networks). Insurers with larger market shares in a particular area may have more leverage in provider contracting. (The dynamic may be different in rural areas with a limited number of providers—rural providers can have more negotiating power even if there is only one insurer.) On the other hand, having a more competitive market could provide insurers more incentives to negotiate aggressively and to pass along savings to consumers. Research based on 2014 and 2015 ACA premiums suggest that the addition of an additional competitor leads to lower premium increases, but the competitive effects shrink after two or three additional entrants.[37]

Due in part to lower potential enrollment, rural areas can support fewer insurers, so it is not surprising that there are fewer participating insurers in rural counties and states. Nevertheless, having only one or even no participating insurers in some areas is a cause for concern.

Sufficient plan offerings.

Consumers have choices with respect to their particular plans. The ACA provides for four metal levels, which reflect relative plan generosity, as well as a catastrophic plan available to young adults and individuals who qualify for a hardship exemption from the individual mandate. Insurers offering marketplace coverage must offer silver and gold metal plans, but are not required to offer the other metal levels. In most states, insurers have flexibility within metal levels to set particular benefit design and cost-sharing requirements. Some state marketplaces impose standardized plan options, but may allow non-standardized options as well. Standardized benefit options may help simplify consumer choices and facilitate plan comparisons,[38] but could also inhibit innovative plan designs. For the 2017 plan year, the federal marketplace is offering standardized benefit designs, called Simple Choice plans, on an optional basis. Insurers can also offer choices across additional plan dimensions, such as plan type (e.g., HMO, PPO), which can affect the level of care management, how broad or narrow the provider network is, and the availability of out-of-network benefits.

Over the first three years of the ACA, the average number of marketplace plans offered per county in federal marketplace states increased from 51 in 2014 to 55 in 2015, and then decreased to 48 in 2016; plan offerings per county is further decreasing to 30 in 2017.[39] Plan offerings and enrollment are concentrated in silver plans, which would be expected given that premium subsidies are based on silver plans and cost-sharing subsidies are available only for silver plans.

Forty-seven percent of 2017 federal marketplace plans are silver plans; 33 percent are bronze. On average, only one platinum plan is offered per county, and many areas have no platinum plan offerings at all. Enrollment has been even more concentrated; as of March 31, 2016, 70 percent of enrollment nationwide is in silver plans and 22 percent is in bronze.[40]

The type of plans offered in the marketplaces has been changing, with a decline in less restrictive network PPO offerings. This shift may reflect consumers' willingness to forgo access to a broad set of providers and looser utilization management in return for lower premiums and cost sharing. Among silver plan offerings, PPO plans have declined from 52 percent of plan offerings in 2014 to 35 percent in 2016, and were expected to decline further in 2017, especially among competitively priced plans.[41] Some areas have few or no PPO marketplace offerings.[42] More restrictive network plans, such as HMOs and exclusive provider organizations (EPOs), are becoming a larger share of marketplace offerings. Low- and moderate-income consumers may be more open to narrower networks,[43] and Medicaid-based marketplace plans are particularly based on HMO and EPO plans.[44] Nevertheless, the high deductibles associated with lower-metal-level plans have generated concerns regarding high out-of-pocket costs.[45] On average, plan offerings are broader off marketplace, both in terms of plan type and metal tier,[46] but premium subsidies are not available for off-marketplace plans.

Insurers are shifting toward narrower provider networks in marketplace plans to lower premiums.[47] Health insurers negotiate provider payment rates and other network participation terms, such as those related to quality and sharing financial risk. Providers often accept lower payment rates in return for being included on a plan's network. Deep provider discounts have been negotiated in some cases, particularly when the health insurer is able to leverage rate negotiations between two competing health care systems.

Slow health spending growth and high quality of care

Because most premium dollars go toward paying medical claims, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires controlling health care costs. Medical spending trends for the individual market reflect those for the health system as a whole. In recent years, health spending has been growing relatively slowly compared with historical averages. Nevertheless, national health spending made up 17.8 percent of the economy in 2015.[48] Because health spending has been growing faster than the gross domestic product (GDP), this share is increasing.

There are signs that health spending growth rates are beginning to increase. Prescription drug spending growth has been particularly high recently, due to price increases and the introduction of high-cost specialty drugs. According to national health spending projections from the CMS Office of the Actuary, annual per capita spending growth for those with private health insurance will increase from 3.2 percent in 2014 to 4.9 percent from 2016 to 2019.[49] This higher growth rate remains lower than the 7.1 percent annual growth rate from 2007 to 2013, but exceeds projected annual per capita GDP growth by 1.0 percentage point. Growth in per capita health spending will directly result in premium increases.

Not only is national health spending high and growing, there is evidence that we are not spending our health care dollars wisely. For instance, the Institute of Medicine estimated that 10-30 percent of health spending is for unnecessary care or other system inefficiencies and that missed prevention opportunities also add to excess spending.[50] Although the medical care that people receive can vary dramatically across and within geographic regions, those variations are unrelated to health outcomes,[51] also indicating inefficient spending. In addition, medical errors are now the third leading cause of death,[52] raising quality concerns.

SECTION 3

Addressing ACA Individual Market Challenges

This section discusses the potential implications—both positive and negative—of several options that have been proposed to address the challenges in the individual market under the ACA. This section focuses on options to improve the risk pool profile, increase insurer participation, and improve the regulatory environment. Although the long-term sustainability of the individual market depends on containing health care spending, this is a health system-wide issue and not unique to the individual market. As such, an examination of payment and delivery system reform options is beyond the scope of this paper.

Options to Achieve Sufficient Enrollment Levels and a Balanced Risk Profile

One of the most popular elements of the ACA is that people with pre-existing health conditions cannot be denied health insurance coverage or charged more for that coverage. For this provision to work, however, healthy people must enroll at levels high enough to spread the costs of those who are sick. Otherwise, average costs, and therefore premiums, will rise. This section explores options related to approaches that aim to increase enrollment and attain a balanced risk profile.

Impose penalties for non-enrollment

One way of increasing enrollment is to penalize individuals who do not enroll. An individual mandate may be the best way of using penalties to increase enrollment, but only if it is effective and enforceable. Other options that impose penalties on individuals who initially forgo coverage but later enroll may provide some incentives to enroll when first eligible. However, their effect on the risk pool may come more from suppressing later enrollment or mitigating the costs of future adverse selection.

- **Individual mandate.** The ACA individual mandate penalty ($695 or 2.5 percent of income, whichever is greater) may not be strong enough to encourage healthy consumers to enroll. For instance, an annual income of $50,000 would result in a tax penalty of $1,250, which is about half of the national average premium for a bronze plan.[53] A larger financial penalty would increase the incentives for individuals to enroll, especially as the amount of the penalty approaches the amount of the premium.

  Strengthening the mandate's enforcement could also increase its effectiveness. Currently, the mandate penalty is reported on the federal income tax form and is deducted from any tax refund. If no refund is owed, however, there are no consequences to the taxpayer if the penalty goes unpaid. Enforcing payment regardless of whether there is a tax refund would increase the mandate's effectiveness.

  Increased outreach to ensure that consumers are aware of and understand the penalty as well as their coverage options and potential eligibility for premium subsidies would help increase the mandate's effectiveness, as would reducing allowed exemptions to the mandate.

- **Continuous coverage requirement/reduce access to coverage for late enrollees.** Another form of a late enrollment penalty would be to remove the pre-existing condition coverage protections for late enrollees or for those who haven't had continuous coverage for a specified period of time, such as 18 months. In other words, insurers would be allowed to underwrite individuals who do not enroll when first eligible or do not meet continuous coverage requirements. Individuals with pre-existing conditions could be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions.

If this type of approach were structured to allow insurers to offer preferred premiums to individuals who meet underwriting requirements, however, the marketplace would in effect return to a pre-ACA environment. Healthy individuals, even those who had continuous coverage, would have an incentive to undergo underwriting. As a result, healthy individuals would be charged lower premiums and less healthy individuals would face higher premiums and potentially less generous or no coverage options. Similarly, if this approach moved away from requiring a single risk pool with risk adjustment among all plans, market fragmentation could occur and plans insuring higher-cost individuals would require higher premiums and could become less viable.

A continuous coverage requirement in effect imposes a one-time open enrollment period. Instead of having only a one-time open enrollment period, or annual open enrollment periods as under the ACA, an intermediate approach would be to offer open enrollment periods every two to five years.

- **Late enrollment premium penalty.** In addition to or instead of an individual mandate penalty, individuals who do not enroll in coverage when it is first available could be subjected to a premium surcharge if they later enroll. For instance, the Medicare program increases Part B and D premiums by 10 percent of premium for every 12 months that enrollment is delayed past the initial eligibility date. (Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums probably play a larger role.) The higher premium is paid for the lifetime of the enrollee. Such a penalty would be more challenging to implement under the ACA. It would be difficult to track an individual's eligibility and enrollment over time, especially when individuals change employers or move between different coverages. Communicating the nature of the penalty to consumers could also be difficult. In addition, as the penalty accumulates over time, premiums could become prohibitively expensive, potentially further suppressing subsequent enrollment, potentially more so among healthy individuals.

Provide enrollment incentives

In the ACA, the individual mandate is the stick and premium subsidies are the carrot used to encourage enrollment, especially among healthy individuals. Although much attention is focused on the enrollment experience among young adults, who on average have lower health care costs, enrolling low-cost individuals of all ages should be the goal. Enrolling healthy older adults can be even more advantageous than enrolling healthy younger adults, because of the higher premiums paid by older adults. Regardless of age, attracting low-cost individuals depends on whether they deem that the value of the health insurance available exceeds the premiums charged. Reducing premiums through premium subsidies, tax credits, or other means could increase the perceived value of insurance, even to healthy individuals. The impact of any change in subsidies on enrollment, premiums, and government spending would depend on the details of the approach.

- **Premium subsidies.** Premium subsidies for ACA coverage are based on income and the cost of the second-lowest silver tier plan, and are available for individuals with incomes up to 400 percent of the federal poverty level (FPL). Nevertheless, premium affordability appears to continue to be a problem. Premium subsidies could be increased, perhaps targeting different subsets of enrollees. One option would be to increase the premium subsidies for all individuals currently eligible for premium subsidies—those with incomes between 100 and 400 percent of FPL. This would help address the concern that premiums remain unaffordable for low- and moderate-income individuals. Another option would be to increase subsidies for a subset of individuals currently eligible for premium subsidies (e.g., individuals with incomes of 250-400 percent of FPL, younger adults, older adults) if affordability issues are seen as greater for those subgroups. A third approach would be to extend subsidies to individuals with incomes exceeding 400 percent of FPL, in recognition that even higher-income individuals can face affordability problems. By increasing subsidies, net premiums would decline, increasing the incentives for even healthy individuals to obtain coverage.

- **Restructured premium subsidies.** The ACA premium subsidy structure sets a cap on premiums as a share of income, and the cap increases with income as a share of FPL. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit, which can be used toward any plan in the marketplace. If the plan chosen costs less than the second-lowest silver tier plan (e.g., the lowest silver tier plan, a bronze tier plan), the enrollee will pay less than the premium cap. Because premiums for older adults are more expensive than premiums for younger adults, older adults will receive a higher premium subsidy than younger adults with the same income. Using that subsidy toward a lower-priced plan could result in an older adult paying a lower net premium than a younger adult with the same income. Conversely, if a higher-cost plan is chosen, older adults would pay a higher net premium than younger adults with the same income.

  The subsidy structure could be changed so that subsidies vary by age, instead of or in addition to varying by income. For instance, subsidies could be targeted to increase enrollment among young adults. Regardless of how they are structured, subsidies need to be sufficient so that premiums are affordable, especially for low- and moderate-income households.

- **Reimbursement for high-risk enrollees.** The ACA includes a transitional reinsurance program that uses contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. To the extent that the group insurance market (including self-funded plans) has a healthier risk profile than the individual market, this mechanism in effect acts as a risk adjustment program between the individual and group markets. The program was in effect from 2014-2016 only. A permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums. For instance, during the reinsurance program's first year, the $10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.[54] Such a program to pool high risks could be implemented at the state or federal level and could use the current funding mechanism or another. For instance, the state of Alaska recently established a comprehensive health insurance fund that will act like a reinsurance program, thereby lowering 2017 premium rate increases.

Modify insurance rules

Under the ACA, premiums cannot vary by health status, but are allowed to vary by age, up to a 3:1 ratio. The ACA also imposes rules regarding the comprehensiveness of coverage. These rules can affect average premiums and out-of-pocket costs. They also affect how premiums vary across individuals.

- **Wider premium variations by age.** Widening the allowable age variation from a 3:1 ratio to a 5:1 ratio would more closely align premiums to underlying costs by age. One study estimates that such a change would reduce premiums for 21-year-olds by 22 percent ($70 per month), resulting in an increase in young adult enrollment.[55] However, premiums for 64-year-olds would increase by 29 percent ($274 per month), likely reducing older adult enrollment while also increasing federal costs for premium subsidies due to the higher premiums. Unsubsidized healthy older adults may be the most likely to drop coverage. On net, the study estimates that loosening the age bands would increase federal premium and cost-sharing subsidies by $11 billion in 2018 under the current ACA subsidy structure.

- **Increased access to catastrophic coverage or the addition of a lower tier "copper" plan.** Less generous coverage could be appealing to younger adults and healthy people of all ages more generally. The ACA offers a catastrophic plan option to adults under age 30 and older adults who have a hardship exemption from the individual mandate. However, individuals are not allowed to use premium tax credits toward catastrophic plans and the actuarial value of catastrophic plans is similar to bronze plans. As a result, current participation in catastrophic plans is quite low—less than 1 percent of marketplace enrollees.[56]

  Allowing broader access to catastrophic coverage with even lower actuarial values and allowing premium tax credits to be used toward this coverage could increase enrollment, especially among healthy individuals. Under current law, however, increased enrollment in catastrophic plans won't affect premiums for the metal level plans—although catastrophic plans are part of the single risk pool, catastrophic plan premiums are allowed to be adjusted to reflect the expected impact of catastrophic plan eligibility. In addition, catastrophic plans are treated separately in the risk adjustment program.

Adding a copper tier plan, with an actuarial value lower than that of the bronze tier plans, could result in increased enrollment among young and healthy individuals. However, the lower premiums associated with these plans mean that it would be more difficult to spread the risk of higher-cost enrollees in more generous plans. In addition, by their nature, both catastrophic plans and copper tier plans would have higher out-of-pocket cost-sharing requirements than other plans. This may be less of an issue for high-income individuals, but these types of plans are a less viable option for low- and perhaps even moderate-income individuals. (Individuals with incomes less than 250 percent FPL are eligible for cost sharing subsidies, but only if they purchase silver tier plans.)

- **Increased benefit design flexibility.** Designing benefit packages that would be more attractive to healthy enrollees could increase their participation. For instance, offering primary care visits or generic drugs with low copayments before the deductible could be a way to increase the value of benefits. Although insurers already have flexibility to vary plan designs within the actuarial value constraints, the HSA rules prohibit paying most non-preventive benefits prior to the deductible. Relaxing those rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits while also potentially reducing costs.

Make risk pools less susceptible to adverse selection

Even with provisions such as an individual mandate and premium subsidies that aim to reduce the adverse selection effects of prohibiting discrimination against individuals with pre-existing conditions, some degree of adverse selection will occur. In addition, many individuals enroll after the year begins, either later during the open enrollment period or during a special enrollment period. And many individuals drop coverage prior to the end of the year. Partial-year enrollment is not unexpected in the individual market, as individuals move between it and other sources of coverage, such as employer group coverage. Nevertheless, partial-year enrollment can be especially prone to adverse selection. Further mitigating adverse selection and encouraging full-year enrollment can improve the risk pool profile and market stability.

- **Modify the open enrollment period.** Shortening the open enrollment period or ending it prior to January 1 would increase the confirmed enrollment in January. As a comparison, the 2017 open enrollment period runs from November 1 to January 31 for ACA plans, but only from October 15 to December 7 for Medicare. Having an ACA open enrollment as short as that for Medicare might not be currently feasible—more time may be needed for outreach and enrollment efforts. In addition, individuals may need until December to know what their financial situation for the next year will be (e.g., whether they get a raise can affect enrollment decisions). Nevertheless, an enrollment period that ends prior to January 1 could reduce the potential for adverse selection, thus improving the average risk profile. In addition, it would help insurers understand their enrollee population sooner, direct members into care management programs earlier, provide more time to send welcome materials to enrollees, and better ensure enrollees access to insurance benefits closer to January 1.

- **Reduce the 90-day grace period.** Individuals receiving premium subsidies are allowed a 90-day grace period for premium payment. This can enable enrollees to select against the market by paying premiums retrospectively only if they use services during that time; those who don't use services can let their coverage lapse. This can destabilize the market and increase average costs per enrollee. Reducing the grace period so that it is the same as that for individuals not receiving subsidies, typically 30 days, could keep enrollees participating regardless of need, and for a longer duration. Concerns regarding premium affordability could be addressed through other mechanisms, such as increased or restructured premium subsidies.

- **Tighten SEP eligibility and enrollment verification.** Recent changes by CMS to eliminate some SEP categories and tighten the eligibility requirements for certain SEPs have been reported to have resulted in a 15 percent decline in SEP enrollment.[57] CMS has also announced plans to test procedures that would verify SEP eligibility.[58] Further limiting SEP eligibility and tightening enforcement could reduce any abuses of SEP eligibility that might be occurring. Although potentially difficult to implement, an additional option is to prohibit SEP enrollees from choosing richer plans than their prior coverage. Any requirements regarding SEP enrollment should not be so onerous as to reduce participation among those legitimately eligible, otherwise the consequence could be to reduce participation among healthy SEP eligibles, thus worsening the risk pool. Because higher claim costs among SEP enrollees likely reflects not only abuse of SEP eligibility, but also higher enrollment among high-cost SEP eligibles, consideration

should be made to increase outreach regarding SEP eligibility and the individual mandate (e.g., notices to employees losing group coverage). Doing so could reduce adverse selection by increasing participation among low-cost SEP eligibles. Nevertheless, late-year SEP enrollment among healthy eligibles could be low because deductibles aren't prorated.

- **Limit third-party premium and cost-sharing payments.** Adverse selection can occur when third parties pay an individual's insurance premiums and cost sharing, as these payments are more typically made on behalf of individuals with high health care needs. Payments from certain third parties may be appropriate. For instance, CMS requires insurers to accept third-party payments from federal, state, and local programs. However, it is less appropriate for providers who will receive payments for their services to be making payments on behalf of enrollees. CCIIO has expressed concerns that provider organizations could be steering Medicaid and Medicare patients to marketplace plans in order to obtain higher reimbursement rates.[59] Dialysis providers in particular appear to be benefiting from such steerage, even if it is not the best coverage option for patients. To address this issue, CMS issued rules to improve dialysis facility disclosure requirements and transparency around third-party premium payments.

- **Establish high-risk pools.** Rather than directly increasing the participation of healthy individuals, high-risk pools could be established to remove high-cost enrollees from the risk pool, reducing premiums for the remaining enrollment. If the issue and rating requirements were relaxed to allow insurers to deny coverage or charge higher premiums to individuals with pre-existing conditions, average standard premiums would be lower but high-risk individuals could have difficulty obtaining coverage. High-risk pools have been used to facilitate coverage for high-risk individuals, but enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss.[60] Substantial funding would be required for high-risk pools to be sustainable. In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums. As discussed above, an alternative is to use funding that would have been directed to external high-risk pools toward a program that reimburses plans the costs of high-risk enrollees.

Increase sources of potential individual market enrollment

Another approach to increasing enrollment in the individual market is expanding eligibility to other groups:

- **Incorporate Medicaid expansion population into the individual market.** The ACA expanded Medicaid eligibility to 138 percent of the FPL. Arkansas and New Hampshire received federal waivers to expand Medicaid by purchasing marketplace coverage for newly Medicaid-eligible adults; the Arkansas waiver began in 2014 and the New Hampshire waiver began in 2016. Iowa had implemented a similar program but subsequently terminated it when the remaining marketplace insurer would no longer accept Medicaid enrollees. Other states could pursue the approach of using Medicaid funds to purchase marketplace coverage. Incorporating the Medicaid expansion population into the individual market would increase marketplace enrollment, potentially increasing marketplace stability. But the impact on the risk profile and resulting premiums is unclear—having a lower income is often associated with having poorer health. In 2015, Arkansas had the highest average risk score in the individual market (but closer to the average risk score in the small group market), perhaps reflecting in part the Medicaid waiver. In addition, there is evidence that marketplace premiums are lower on average in states that expanded Medicaid compared to those that have not.[61] These findings suggest that expanding traditional Medicaid could improve marketplace risk profiles, although marketplace enrollment would decline.

- **Merge the individual and small group markets.** Merging the individual and small group markets into a single risk pool would increase the size of the risk pool. Whether it would lead to greater market stability and lower premiums, at least compared to the individual market, would depend on the relative size and risk of the individual market compared to the small group market. For instance, if a state's small group market is relatively large and lower risk than its individual market, the small group market would more easily absorb the individual market, lowering premiums for those previously in the individual market without substantially increasing premiums for those previously in the small group market. In contrast, if the small group market in a state is relatively small compared to the individual market, merging the markets could increase small group premiums without a significant reduction in individual market premiums. Other factors that could impact outcomes are whether merged market premiums would be allowed to vary between individuals and groups and the extent to which a self-funding option is available for small groups with lower expected health care spending. Adverse

selection against the ACA market could occur if low-cost small groups pursue self-funding options. Currently, self-funding is relatively infrequent among small groups. Of establishments with fewer than 100 workers that offer health insurance, 14.2 percent offered a self-funded plan in 2015, up from 13.4 percent in 2014.[62] Nevertheless, to limit additional adverse selection, rules might need to be considered to discourage further self-funding among small groups.

- **Remove option for adult children up to age 26 to remain on a parent's insurance plan.** The ACA allows adult children to remain on a parent's plan up to age 26. This likely suppresses young adult enrollment in the individual market. Eliminating that provision could increase young adult enrollment in the individual market, but could also lead to an increase in uninsured rates among young adults. The potential impact on the individual market risk pool profile depends on the extent of adverse selection among younger adults, with healthy young adults opting to forgo coverage.

Increasing Insurer Participation and Improving the Regulatory Environment

Options to level the playing field

It is important for competing plans to operate under the same rules. For the most part, the ACA applies the same rules to all plans in the individual market. However, there are some instances in which plans are treated differently. Options to address these inconsistencies include:

- **Reduce the grace period for subsidized enrollees.** As noted above, reducing the grace period for subsidized enrollees could improve the risk pool profile. It would also increase consistency between individuals with premium subsidies and those without, including those purchasing coverage off the marketplace.

- **Consistent SEP enforcement mechanisms.** Stricter SEP enforcement mechanisms have the potential to improve the risk profile. In addition, more consistent SEP verification processes between plans on and off the marketplace could reduce any related disadvantages for on-marketplace plans.

- **Modifying marketplace fee assessments.** Marketplace fees should be assessed in a manner that does not disadvantage insurers participating in the marketplace. Currently, marketplace fees are assessed only on insurers selling coverage on the marketplace, but these insurers are required to spread the fee to both their on- and off-marketplace enrollees. Insurers selling off marketplace only avoid these fees. Potential solutions include allowing insurers to vary their administrative charges for on-marketplace and off-marketplace members, with the marketplace business being charged the entire marketplace fee. Another option would be to charge the marketplace fee to all insurers operating in the market, even those operating exclusively off marketplace. This would spread the costs of the marketplace over a broader base and allow the charge to be a lower percentage of premium. Even off-marketplace-only insurers benefit from marketplace functions that increase enrollment, because they can improve the overall market's risk profile.

Prohibit off-marketplace plans

Another option that would create a level playing field is to require all insurers and plans to be offered only through the marketplace. This would prevent insurers from choosing to market only off marketplace to avoid some of the fees and additional marketplace rules and may help with some risk selection problems to the extent that risk adjustment does not fully compensate for risk differences between on- and off-marketplace plans. In general, a wider array of insurance plans is available off the marketplace than on the marketplace. Prohibiting off-marketplace plans could potentially increase the options available to enrollees receiving premium subsidies. On the other hand, insurers may choose to continue offering only the narrower set of on-marketplace options, thus reducing plan choice among individuals previously purchasing off-marketplace plans. Also, some insurers may decide not to participate in the market at all.

Continue to improve the risk adjustment program

The risk adjustment program should fairly compensate insurers for the risk of their enrollees so that insurers do not have incentives to avoid any particular type of potential enrollee. CCIIO has indicated plans to modify the risk adjustment program so that it better reflects differences in the underlying risk among participating insurers. These modifications include the incorporation of prescription drug data, the incorporation of preventive services, and better accounting for partial-year enrollees. In addition, CCIIO will begin using data collected from the ACA-compliant individual and small group markets for purposes of calculating risk scores and making risk adjustment transfers to also calibrate the

model. This will improve the model's accuracy for these markets compared to the current calibration method that uses experience from large employer plans. CCIIO is also exploring the incorporation of a high-risk enrollee pool to improve risk adjustment for extremely high-cost enrollees. The risk adjustment program should continue to be monitored. If experience suggests that the risk model systematically over- or under-compensates for certain enrollee subgroups, the model should be revised as appropriate. Except under exceptional circumstances, changes should be made on a prospective basis only. In addition, CCIIO should continue to provide and improve interim reports to help reduce uncertainty for insurers.

Conduct effective rate review

A sustainable insurance market requires that premiums be adequate but not excessive. Although much focus is often given to ensuring that rates are not too high, it is equally important that rates not be approved if they are too low. Low rates may help an insurer attract a large membership, but rates that are too low have numerous adverse consequences, including:

- **Higher risk of insurer insolvency.** Insurer insolvencies not only cause coverage disruption for enrollees, but the cost can be borne by other insurers through state guaranty funds or special assessments that increase premiums.

- **Inadequate premium subsidies.** If premium subsidies are based on the second-lowest silver tier plan with a premium that is set too low, those subsidies will be insufficient to purchase a more adequately priced plan.

- **Insufficient risk adjustment transfers.** The risk adjustment program bases transfers on market average premiums. If those averages are understated due to an insurer having rates that are too low, the risk adjustment transfers will be too low to adequately adjust for risk profile differences among insurers.

Another issue with the rate review process is the availability of insurer premiums and pricing assumptions to competing insurers. The ACA requires rate filing transparency and an opportunity to allow for consumer feedback, although the level of detail required varies by state. Because there are multiple rate filing rounds, this transparency means that rates could be publically available, even before they are approved. As a result, insurers would be able to mimic another's pricing strategy, sometimes referred to as shadow pricing. In other words, premiums can go up or down relative to initially filed rates for reasons other than the adequacy of rates. This further emphasizes the need for an effective rate review that considers not only whether premiums are excessive, but also whether they are inadequate.

Allow insurance sales across state lines

Under this option, insurers licensed to sell insurance in any particular state would be allowed to sell insurance under that state's rules in other states. The intention is to spur more competition, which could increase consumer choice, lower premiums, and improve services. For instance, an insurer could choose to follow the rules of a state with less restrictive benefit requirements in order to offer lower-cost coverage in another state. Although states currently have the ability to permit the sale of insurance across state lines, few have done so to date and no out-of-state insurers have entered the market in those states.[63]

Health insurance is licensed and regulated primarily by state authority. Prior to the ACA, the rules regarding insurance issue, premium rating, and benefit requirements varied considerably by state. The ACA narrowed state differences in these rules by imposing more standardized requirements. Premium rate review and approvals continue to be conducted primarily at the state level, as are other consumer protections such as network adequacy requirements.

Allowing insurance licensed in one state to be sold in another would raise concerns regarding how insurers would set up local provider networks and how consumer protections would be enforced. In addition, with many of the rules currently harmonized across states, there is less ability for insurers to take advantage of differences in rules in order to lower premiums by avoiding certain requirements.

If the ACA issue, rating, and benefit requirements were relaxed and the state variation in rules returned, there would be more opportunity for insurers to take advantage of these differences. However, this could create an unlevel playing field, with plans in a single market competing under different market rules. Less-healthy individuals would purchase plans licensed in states with stricter regulations (e.g., guaranteed issue, community rating, comprehensive benefit requirements), and healthier people would purchase plans licensed in states with looser regulations. Such a result could lead to healthier people benefiting from less-expensive insurance, but those who are older and have more health issues would face higher premiums. Premiums for the plans licensed in states with stricter regulations would increase accordingly. Such a situation could threaten the viability of the insurance market in states with more restrictive rules and create a situation in which states would have incentives to reduce insurance regulations and consumer protections. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.

Include a public plan option

In order to increase plan availability and consumer choice, a public plan option could be offered as a marketplace competitor. This could be structured as a fallback option in areas with no or few participating insurers or could be offered more broadly. In order to compete on a comparable basis with private plans, a public plan would need to follow the same rules as those governing private plans and set premiums that are self-supporting. These rules could include the establishment of a premium stabilization fund that would function similarly to private plan surplus and cover any unexpected differences between plan expenditures and premiums, rather than relying on general government funds.

A public plan could provide consumers with an additional option, especially in areas with no or few other participating insurers. Nevertheless, a public plan would face the same underlying issues as private plans, such as low enrollment and sole community providers, which make it difficult for insurers to cover costs and earn a reasonable return. A public plan could potentially support lower premiums than traditional health plans, especially if such plans are able to use the federal government's clout with providers to negotiate payment rates at, or somewhat above, Medicare rates. Such an approach could lead to a more affordable coverage option, but would create an unlevel playing field relative to other competing private plans. If a public plan can achieve much lower provider payment rates than other plans, thereby allowing it to offer lower premiums, the effect could be to eliminate competition, making the public plan the sole option. In addition, there could be concerns regarding health care access if providers opt to not participate at the lower payment rates.

A variant of the public plan option is to allow older adults, (e.g., 50 or 55 and older), to buy into Medicare. There are many design considerations involved, such as whether the benefits would be structured similarly to current Medicare benefits, how the premium would be determined, and whether subsidies would be available. A Medicare buy-in could have a large impact on the individual marketplace. In 2016, 26 percent of individuals enrolling during the open enrollment period were age 55–64.[64] If a large portion of these individuals were to move to a Medicare buy-in, it could lower average premiums in the individual market. However, by reducing the size of the individual market pools, the financing of the marketplaces and the predictability of experience could be affected.

Allowing consumers a choice between the individual market and a Medicare buy-in could create opportunities for adverse selection for both markets, depending on the plan generosity and premium differences between the two options. For instance, because Medicare does not cap out-of-pocket costs, individuals with high expected health care costs could be more likely to opt for individual market coverage rather than Medicare. This selection against the individual market would at least partially offset any premium reductions resulting from a younger average enrollment age.

Offering a Medicare buy-in option would also have implications for employer coverage. Employers are concerned about health care costs for workers and covered retirees in the very age group that a Medicare buy-in program would target. Their support for early retiree coverage has already diminished in the past 25 years. A Medicare buy-in option could be seen as a potential replacement for remaining early retiree coverage, depending on benefit and premium levels. If federal premium subsidies are available for Medicare buy-in coverage, such a shift would increase the costs of federal premium subsidies.

CONCLUSION

To be sustainable, the individual market under the ACA requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings. Experience from the first three years of the ACA varies, with the markets in some states faring relatively well. More typically however, the results thus far indicate the need for improvement along most of these measures.

Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has generally been lower than expected and enrollees have been sicker than expected. Both of these factors have contributed to substantial premium increases in many, but not all, states. For the most part, competing plans face the same rules; however, some rules might be disadvantaging insurers participating in the marketplaces compared to off the marketplaces. The uncertain and changing regulatory environment, including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments, contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.

Many options have been put forward to improve the short- and long-term sustainability of the individual market, either through changes to the ACA or by replacing the ACA with a different approach. If as part of this a goal is to provide coverage to people with pre-existing conditions at standard premiums, it is vital to enroll enough healthy people to spread the costs of those who are sick. The ACA's individual mandate, annual open enrollment period, and premium subsidies aim to achieve a balanced risk profile. Increased penalties for non-enrollment could help improve the risk profile, as could improving premium affordability, for instance through increased premium subsidies or additional funding for high-risk enrollees. Weakening the incentives for participation, however, could further exacerbate adverse selection issues and lead to higher premiums and more uninsured.

Achieving a balanced enrollee risk profile, along with providing consistent rules in a timely fashion to insurers, could lead to a more stable and sustainable market. Insurer participation could increase as a result, leading to more consumer choice.

Individual market experience varies by state. The ACA's section 1332 waivers could be used by states to pursue different approaches to improving the individual market. These approaches could reflect the particular situations of each state.

Finally, it's important not to overlook the need for a continued focus on controlling health care spending. Most premium dollars go toward paying medical claims. Therefore, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires keeping health spending in check. Moderating health spending growth is a key to the sustainability of not only the individual market, but also the health care system as a whole.

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How Accessible and Affordable were Individual Market Health Plans before the Affordable Care Act? Depends Where You Lived

By Sandy Ahn

Robert Wood Johnson Foundation

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The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

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Summary

Before the Affordable Care Act (ACA), the landscape of the individual market looked much different than it does today, particularly for those in less than perfect health. For the most part, what state you lived in determined how easily you could purchase a health plan, the price you would pay, and what the plan would cover. Rules for insurers in the individual market varied from state to state, but in most states, if you had a pre-existing condition, you could be denied coverage, pay more, or have coverage for your pre-existing condition excluded from your health plan. As Congress debates repeal of the ACA and its protections for people with pre-existing conditions, many policymakers have called for greater state flexibility in insurance regulation than currently exists under the ACA. It therefore is helpful to understand the range of consumer protections in the states before the ACA, and why the ACA included the insurance reforms it did. This issue brief summarizes state rules for the individual market on the eve of the Affordable Care Act.

The Individual Market

In general, consumers use the individual market when they cannot get health insurance through their employer or are ineligible for Medicare or Medicaid.[1] The majority of people who have health insurance through the individual market are self-employed, work in small businesses with less than 20 employees, or are unemployed. Before implementation of the ACA, approximately 16 million people, or 6 percent of the U.S. population had coverage through the individual market.[2]

Guaranteed Issue

One of the major protections under the ACA is the requirement that all insurance companies issue a health plan if you apply, regardless of your health status or other factors like age, gender or occupation. This is called "guaranteed issue." Before the ACA, only six states required guaranteed issue in the individual market. See Table.

Preexisting Condition Exclusions

A common feature among policies sold on the individual market was the exclusion of coverage for preexisting conditions either permanently through an elimination rider or for a period of time, referred to as an exclusion period. Forty-one states allowed exclusion periods for preexisting conditions ranging from 6 to 36 months; nine states and D.C. allowed insurers to impose permanent exclusions.

Community Rating

State regulation of how insurers calculated premiums also varied state by state. Before the ACA, common rating practices of insurers in the individual market included using: the existence or history of a medical condition to charge higher premiums (health status rating); age, gender and geographic location to charge higher premiums to older individuals, and those living in areas with higher medical costs (demographic rating); people's jobs (industry rating) to charge higher premiums for jobs with a greater likelihood of injury like construction; or the length of time you had health insurance and whether you were renewing coverage (durational rating). Before the ACA, 32 states imposed no rating restrictions on insurers. Only one state, New York, required insurers to charge the same premium across the market, regardless of health status or other factors like age or gender. The remaining seventeen states and D.C. restricted insurers' ability to impose higher rates based on health status or other factors.

Looking Ahead

The ACA created a minimum level of protections for those seeking and enrolling into coverage on the individual market. While we're back to the debate of how our individual health insurance market should work, a look back at the insurance protections that existed before the ACA highlights just how much consumers with health issues have to lose.

Table. Existence of Consumer Protections in the Individual Market, as of 2012[3]

State	Guaranteed Issue?	Preexisting Condition Exclusion Period? (months)	Restrictions on Health Status Rating?
Alabama	No	24	No
Alaska	No	No limit	No
Arizona	No	No limit	No
Arkansas	No	No limit	No
California	No	12	No
Colorado	No	12	No
Connecticut	No	12	No
Delaware	No	No limit	No
District of Columbia	No[b]	No limit	Yes
Florida	No	24	No
Georgia	No	24	No
Hawaii	No	36	No
Idaho	No	12	Yes
Illinois	No	24	No
Indiana	No	12[c]	No
Iowa	No	24	Yes
Kansas	No	24	No
Kentucky	No	12	Yes
Louisiana	No	No limit	Yes
Maine	Yes	12	Yes
Maryland	No	12	No
Massachusetts	Yes	6	Yes
Michigan	No[b]	12	No
Minnesota	No	18	Yes
Mississippi	No	12	No
Missouri	No	No limit	No
Montana	No	12	No
Nebraska	No	No limit	No
Nevada	No	No limit	Yes
New Hampshire	No	9	Yes
New Jersey	Yes	12	Yes
New Mexico	No	6	Yes
New York	Yes	12	Yes
North Carolina	No	12	No
North Dakota	No	12	Yes
Ohio	No	12	No
Oklahoma	No	No limit	No
Oregon	No	6	Yes
Pennsylvania	No[b]	12	No
Rhode Island	No[b]	12	No
South Carolina	No	24	No
South Dakota	No	12	Yes

State	Guaranteed Issue?	Preexisting Condition Exclusion Period? (months)	Restrictions on Health Status Rating?
Tennessee	No	24	No
Texas	No	12	No
Utah	No	12	Yes
Vermont	Yes	12	Yes
Virginia	No[b]	9	No
Washington	Yes[a]	12	Yes
West Virginia	No	24	No
Wisconsin	No	12	No
Wyoming	No	12	No

[a] In Washington, guaranteed issue applied to individuals who achieved a minimum score on the state's health status questionnaire.

[b] Designated Blue Cross and Blue Shield as the insurer of last resort and required them to guarantee issue at least one health plan.

[c] Allowed insurers to impose preexisting conditions for certain conditions up to 10 years.

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Perspective

Success and Failure in the Insurance Exchanges

Craig Garthwaite, Ph.D., and John A. Graves, Ph.D.

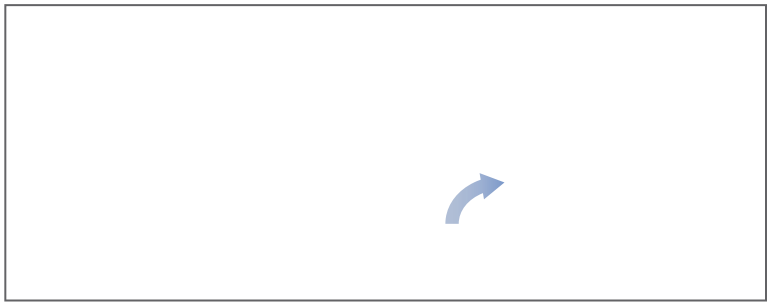
The results of the 2016 election portend a vigorous 2017 debate about the future of the Affordable Care Act (ACA). Both President Donald Trump and large fractions of the Republican majority party in the House and Senate campaigned on an explicit pledge to repeal and replace the ACA. At least part of the impetus for these promises is a general belief that the ACA's state-based insurance marketplaces are unworkable and are resulting in higher prices and fewer choices.

In 2016, the ACA marketplaces facilitated coverage purchases for approximately 13 million people nationwide.[1] But many prominent national insurers have struggled in these markets. Both UnitedHealth and Aetna experienced heavy financial losses and, in 2016, announced they would exit many of the areas they had been serving; Anthem recently warned that it would also consider leaving if its financial results do not improve.[2,3]

The actions of these large national insurers are part of a broader trend of marketplace exits. We estimate that in the 34 states for which we have data, the number of insurers offering plans on the exchanges fell by nearly half between 2016 and 2017 (see diagram). This decline reversed a pattern seen in earlier years, when the number of insurers entering the market far outpaced the number leaving.

Many of the exiting firms have claimed they were leaving because the ACA's unfulfilled risk-corridor payments and insufficient risk-adjustment policies created unstable risk pools that have caused steep losses unrelated to their market strategies. However, though these factors probably caused difficulties for many participating firms, the creation of any new market is an inherently uncertain process, and it's reasonable to expect that some firms will fail while others thrive. In particular, the ACA's insurance-market reforms required firms to develop and market new products that were attractive to low-income Americans who faced few access and pricing restrictions based on their underlying health status.

An individual insurance market that shares many of these features is a centerpiece of current GOP reform efforts. For example, Trump and numerous Republican leaders have signaled their desire to maintain certain consumer protections, such as guarantees of coverage to people with preexisting conditions. Moreover, through either the use of refundable tax credits or increased privatization of Medicaid as the result of turning the program into block grants, most of the ACA-replacement proposals would actually increase the role of private firms in providing insurance to millions



Market Entries and Exits in State Insurance Marketplaces, 2014–2017.

The analysis included insurers participating in the ACA's health insurance marketplaces in 428 rating areas in 34 states (Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming). The unit of observation was the insurer–rating-area dyad.

of Americans. It is therefore important to understand how much the inability of some private insurers to succeed under the ACA reflects a failure of existing policies and how much it indicates a mismatch between firms' capabilities and the newly created market.

Anecdotal evidence supports the argument that the skills of particular insurers may not have been well suited to these marketplaces. Many of the exiting firms, such as UnitedHealth, have primarily covered enrollees in the self-insured–employer market, in which insurers provide administrative services and are not primarily responsible for bearing actuarial risk or for developing products targeting low-income consumers. In addition, many of the assets that have proven quite valuable in the self-insured market — such as a large national footprint that is attractive to multistate employers — may not be particularly useful in state-based individual insurance marketplaces.

Furthermore, smaller and more focused insurers are earning profits in the new market and are aggressively entering new geographic areas. For example, Centene and Molina have both had financial success in the ACA marketplaces.[4] Unlike the firms whose exit decisions have attracted so much attention, these two insurers have historically operated in the Medicaid managed-care market — that is, they are private firms that contract with state governments to offer managed-care plans to Medicaid enrollees. Success in these markets requires, among other factors, setting premiums and managing the health risks of a low-income population.

To examine more systematically whether poor insurer strategies may have contributed to market exits, we combined information on insurer participation in the marketplaces for the 34 states with available data for 2016 and 2017. These data included information on premiums, provider networks, and insurers' local experience with other populations such as Medicaid beneficiaries. We used this information to investigate factors associated with a sustained presence in the ACA's nascent insurance markets.

The differences between Silver plans (the most frequently purchased plan type in the marketplaces; see the Supplementary Appendix, available at NEJM.org) that continue to be offered and those whose issuers exited the market in 2017 are summarized in the table. The reported adjusted differences are based on comparisons between exiting and remaining plans within the same market. (Additional details about the data and statistical methods appear in the Supplementary Appendix.)

Our data show that the exiting plans offered an unappealing combination of smaller provider networks and higher premiums. For example, an unsubsidized 35-year-old person enrolled in one of the plans that was discontinued would have paid, on average, $16 more per month for a plan with 8% fewer local in-network hospitals than a similar person enrolled in a plan that was not discontinued. Exiting plans were similar to remaining plans in terms of primary care physician networks, but they had substantially smaller networks of behavioral health clinicians.

We also considered the association between the prior experience of firms in managing risk and setting premiums and the decision about whether to exit the market. First, we examined whether plans with more experience in the Medicaid managed-care market were more likely to remain. Regardless of whether we defined such experience at the national, state, or market level, we found a consistent positive association between this experience and remaining in the exchange market in 2017. We also examined exit decisions among insurers with experience operating private insurance plans in which they bear actuarial risk, as opposed to plans in which they

Plan and Issuer Characteristics by 2017 Marketplace Participation Status.*

Characteristic	Mean	Unadjusted Difference (95% CI)	Adjusted Difference (95% CI)
Plan characteristics			
Monthly premium (unsubsidized individual policy for 35-year-old nonsmoker)			
Participating in 2016 and 2017	$326	Reference group	Reference group
Exiting marketplace after 2016	$340	14.0 (11.7 to 16.4)	16.1 (14.3 to 17.8)
Hospital network breadth			
Participating in 2016 and 2017	67.1%	Reference group	Reference group
Exiting marketplace after 2016	61.9%	–5.2 (–6.5 to –3.9)	–7.9 (–8.9 to –6.9)
Primary care physician network breadth			
Participating in 2016 and 2017	63.7%	Reference group	Reference group
Exiting marketplace after 2016	66.1%	2.4 (1.2 to 3.6)	0.01 (–0.9 to 0.9)
Behavioral health physician network breadth			
Participating in 2016 and 2017	65.3%	Reference group	Reference group
Exiting marketplace after 2016	46.8%	–18.5 (–20.0 to –17.0)	–25.2 (–26.4 to –24.0)
Insurer characteristics			
Medicaid managed care: company has any experience			
Participating in 2016 and 2017	51.5%	Reference group	Reference group
Exiting marketplace after 2016	43.5%	–8.0 (-10.1 to -5.9)	–17.8 (–19.8 to –15.9)
Fully insured commercial market share			
Participating in 2016 and 2017	30.4%	Reference group	Reference group
Exiting marketplace after 2016	36.0%	5.6 (4.1 to 7.1)	–8.8 (–9.7 to -7.9)

* Data are from our analyses of Silver plan characteristics in 34 states, based on data from the Centers for Medicare and Medicaid Services, issuers' provider networks, and county-level issuer enrollment data from Decision Resources Group. States included Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. The unit of observation is the market–plan dyad, with markets defined by health insurance rating areas within each state (N=8824). The 95% confidence intervals were calculated with the use of bootstrapping. Adjusted differences are the average differences among comparisons of plans within the same market (see the Supplementary Appendix). The network-breadth measures quantify the percentage of local hospitals or physicians (by specialty) within the plan's network. Market share was based on the health insurance rating area.

provide only administrative services to self-insured groups. Here, too, we found that the insurers that remained in the exchange market had a greater local market share of fully insured products.

In supplementary analyses, we also compared characteristics of insurers and plans entering the exchange market in 2017 and found that new plans had substantially lower premiums than their local competitors (premiums are $30 per month lower for a 35-year-old enrollee). Moreover, issuers of these new plans were more likely to have experience with Medicaid managed care but less likely to have direct experience in the markets they entered. This finding is consistent with the existence of a functioning market in which firms that were initially successful are moving into new geographic areas.

Taken together, our estimates demonstrate that the insurers participating in the exchange market in 2017 are systematically different from the firms that have exited it. Furthermore, the dimensions on which they differ, such as experience in pricing premiums and managing risk for low-income populations, may be those most likely to contribute to commercial success in a reformed nongroup market. It is possible that the experience of insurers operating in the 17 state-based marketplaces we did not examine could be different; further work examining those marketplaces would be useful. But claims that the failure of certain insurers is

evidence of unworkable policies seems misguided. The available data reveal patterns of market entry and exit that are consistent with natural competitive processes separating out firms that are best suited to adapt to a new market. We believe that efforts to reform or replace the ACA should therefore proceed with the knowledge that highly publicized market exits are a poor and probably inaccurate signal of a failing market.

Disclosure forms provided by the authors are available at NEJM.org.

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ACA Implementation—Monitoring and Tracking

Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices

January 2017

By Sabrina Corlette, Kevin Lucia, Justin Giovannelli and Dania Palanker

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) is facing an uncertain future, with a new president and Congress committed to its repeal. Health insurers have no legal obligation to participate in the ACA's marketplaces, but without them, millions of consumers would be unable to obtain the federal premium subsidies that help make health insurance affordable.

Through a set of structured interviews with a range of insurers participating in the ACA marketplaces, this paper explores how they are likely to respond to different potential repeal scenarios that have been floated by opponents of the law. These include an immediate repeal of the ACA's requirement that individuals purchase insurance or pay a penalty (the "individual mandate") but a delay in repealing the law's financial subsidies, a "repeal and delay" strategy in which Congress repeals the law but delays the effective date for one or more years, and a midyear cutoff of the ACA's cost-sharing subsidies for low-income enrollees. Insurers outlined the following responses to these potential repeal scenarios:

- An immediate repeal of the individual mandate will not lead insurers to exit the market in 2017, in part because of their contractual obligation to remain. However, insurers reported they would "seriously consider" a market withdrawal in 2018 if the mandate is repealed without an effective replacement. Insurers reported that at a minimum, their premiums would need to increase in 2018 to reflect the likelihood of a sicker risk pool.
- A "repeal and delay" strategy without a concurrent replacement for the ACA would destabilize the individual market. Although insurers saw value in a buffer period to adjust to a new regulatory structure and educate consumers about changes, they perceived "significant" downside risk in remaining in the marketplaces while the details of an ACA replacement are in doubt. There was no consensus among insurers about how long a transition period should be, but most insurers estimated that the task of adapting to a new regulatory framework would take multiple years.
- The elimination of cost-sharing reduction payments in 2017 would cause insurers significant financial harm. Most insurers believed they would be forced to exit the marketplaces or the entire individual market as quickly as state and federal law would allow; other insurers indicated they would try to implement a midyear premium increase.

The anticipated partial or total repeal of the ACA has given rise to considerable uncertainty about the future of the law's health insurance marketplaces and coverage for the projected 13.8 million people who will be enrolled in marketplace plans in 2017. We find that so long as policymakers enact concrete replacement policies and provide the insurance industry significant time to implement them, insurers are generally confident that they could manage a transition to a new regulatory regime. However, if the ACA is repealed after a delay but not concurrently replaced, or if the individual mandate is immediately ended, insurers expect material market exits and significant premium increases in 2018. If cost-sharing subsidies cease in mid-2017, the destabilization of the marketplaces will accelerate regardless of whether the ACA is repealed.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) is facing an uncertain future, with a new president and Congress committed to its repeal. How policymakers approach a rollback of the law is of critical importance, not just to the estimated 22 million people who have gained coverage, but also to the private health insurers upon whom much of the ACA's coverage expansion depends.[1] Health insurers have no legal obligation to participate in the ACA's marketplaces, but without them, millions of consumers would be unable to obtain insurance or the federal premium subsidies that help make that insurance affordable.

Insurers participating in the ACA's marketplaces, which launched in 2014, had a rocky experience for the first few years. In part because of fierce price competition, many experienced significant financial losses, particularly in 2014 and 2015, and some decided to discontinue their participation as a result.[2,3] In many markets, insurers raised their premiums significantly; other markets saw more moderate premium growth.[4] Emerging data for 2016 suggest that the financial picture is improving for many marketplace insurers, with market analysts predicting continued improvement in 2017.[5] However, this emerging market stability is threatened by the considerable uncertainty over whether and for how long the marketplaces will continue to exist if the ACA is repealed.

Through a set of structured interviews with a range of insurers participating in the ACA marketplaces, this paper explores how they are likely to respond to different potential repeal scenarios that have been floated by opponents of the law.[6,7] These include a "repeal and delay" strategy in which Congress repeals the law but delays the effective date for one or more years, an immediate repeal of the ACA's requirement that individuals purchase insurance (the "individual mandate") but a delay in repealing the law's financial subsidies, and a midyear cutoff of the ACA's cost-sharing subsidies for low-income enrollees. We find that the uncertainty over how Congress will act and when insurers will obtain information about the rules under which they must operate will lead many to reassess their participation in these markets and others to significantly increase premiums.

BACKGROUND AND METHODOLOGY

A key goal of the ACA is to help consumers obtain affordable coverage through health insurance marketplaces, where private insurance companies would compete on price and quality. Achieving this goal was premised on a three-part social bargain: First, insurers would no longer be allowed to deny coverage or charge higher rates to people with pre-existing conditions. Second, to prevent people from waiting until they are sick to sign up for insurance, consumers would be expected to maintain health coverage or pay a penalty (the individual mandate). Third, to make that coverage more affordable, low- and moderate-income consumers buying through the marketplaces could receive income-based premium tax credits and cost-sharing subsidies. These three policies are often referred to as the "three-legged stool" of the ACA because repealing or dismantling any one of them would cause the insurance market to collapse.[8,9]

These reforms, along with an expansion of the Medicaid program, were implemented in 2014 and have resulted in 22 million people gaining coverage.[1] Approximately 11.1 million people have enrolled through the marketplaces, with a projected 13.8 million enrolling for 2017.[10] The vast majority—85 percent—of marketplace consumers receive premium tax credits, and 57 percent have deductibles and other cost-sharing reduced through federal cost-sharing subsidies.[11] However, the marketplaces depend on private insurance companies to deliver these benefits, and many of these companies struggled financially in the first two years of the marketplaces. Several factors contributed to these financial difficulties, including a lack of data about new enrollees' health status and utilization of services, aggressive pricing by new market entrants, and the decision by Congress to cut a key risk mitigation (the "risk corridor") program after insurers were locked into their prices. The resulting shortfalls in revenue caused a number of insurers, including the large national carriers UnitedHealthcare, Aetna, and Humana, to curtail their marketplace participation.[12] Other insurers significantly increased their premiums for 2016 and 2017, and some smaller plans became insolvent. However, emerging financial data from 2016 suggest that price hikes and the implementation of cost containment strategies have helped insurers find their financial footing and chart a path to profitability.[5]

Yet just as the health insurance marketplaces have begun to achieve stability, a new Congress and administration committed to repeal of the ACA are taking office. At the time of this writing, congressional leaders have begun the process of repealing key provisions of the law through a legislative procedure known as budget reconciliation. While the specific content of a repeal bill is not yet certain, lawmakers are expected to take steps to end the ACA's individual mandate and financial subsidies, among other provisions. Further, repeal legislation would likely take effect in stages. Though some parts of the ACA, such as the individual mandate, may go away immediately, other provisions, including the financial subsidies, may continue for a limited time. Republican leaders suggest that such a transition period, which may last for multiple years, will provide a buffer for consumers and give Congress additional time to decide how to replace what it has repealed.[13] But there is another, more immediate threat to the ACA's marketplaces: Without need for congressional action, the new administration could cease subsidies that help reduce the cost-sharing of low-income marketplace enrollees. However, under the law, insurers would still be legally required to provide cost-sharing reductions (CSRs) to eligible enrollees, leaving them with significant financial shortfalls under such a program.[14] These potential administrative and legislative actions create an environment of great uncertainty and risk for insurers participating in the individual market and for consumers that rely on their coverage.

To better understand how insurers might respond to this uncertainty, researchers conducted structured interviews with executives of 13 insurance companies participating in the individual market in 28 states. The companies included large, for-profit carriers operating across multiple states, regional nonprofits, former Medicaid-only plans, and integrated, provider-sponsored plans. Interviews were conducted between December 5, 2016, and January 11, 2017.

FINDINGS

Most of the insurers we interviewed had not anticipated the election outcome and, just a few weeks after the election, were still assessing the range of potential policy changes they could face in 2017 and beyond, as well as the impact on their companies. However, all of them are still actively selling their plans to consumers via the ACA's marketplaces and remain committed to these markets at least through the current year. These insurers have had a mix of experiences. Many have lost money on their marketplace business, and others are barely breaking even. A few have made money. Some have dramatically reduced their offerings in the ACA marketplaces, while others have expanded their presence. All viewed the uncertainty about federal policy towards the marketplaces as bad for their businesses and for the overall stability of the individual market, both inside and outside the marketplaces. At the same time, the insurers we interviewed expressed confidence that they could manage policy changes, even dramatic ones, as long as the rules are made clear and they are given sufficient time to implement them. However, all expressed significant concerns with one or more of three potential scenarios floated by policymakers: (1) immediate repeal of the individual mandate with delayed repeal of financial subsidies, (2) delayed repeal of the ACA without its concurrent replacement, and (3) a cutoff of cost-sharing subsidies in 2017. We discuss their responses below.

Repeal of Individual Mandate Likely to Lead to Higher Premiums, Market Exits

Marketplace insurers have faced, and often overcome, a number of regulatory and financial challenges. However, they have not yet experienced a regulatory environment in which one of the fundamental pillars of the ACA is eliminated. Prior congressional efforts to repeal the ACA have included an immediate repeal of the individual mandate, coupled with a delayed repeal of the law's premium and cost-sharing subsidies.[15] Respondents noted that the individual mandate is a key part of an interlocking set of policies designed to ensure a viable risk pool in the reformed individual market. In surveys, as many as 40 percent of marketplace enrollees have indicated they would not have enrolled without the mandate.[16] The insurers we interviewed worried about the ramifications of removing it: "Pulling one leg out of the stool, we crash [individual market insurers] to the ground," one respondent predicted. Insurers, particularly those mission-driven to serve low-income people in the individual market, were reluctant to state categorically that the elimination of the mandate would cause them to exit the marketplaces. Most expressed that at a minimum, repealing this incentive to remain in coverage would be an additional blow to a marketplace that has had difficulty finding its footing and would lead to higher premium rates.

As one insurer put it, the belief of some federal policymakers that "you [could] remove [the individual mandate] and not do something damaging to the individual market" was not realistic.

Repeal of the Individual Mandate Is Likely to Affect Insurer Participation in 2018

Insurers have contractual and legal obligations to continue to offer their current year (2017) marketplace coverage and respondents did not view the repeal of the individual mandate as changing that reality.[17] One insurer stated, "We have [in our state] a market that is hanging on by a lifeline, and if you remove the individual mandate, that in and of itself is like the last nail in the coffin, but it is not in and of itself going to dramatically change things [at least in 2017]." Another respondent pointed out that open enrollment for this year likely would be over by the time repeal occurred, and another suggested that even if legally possible, "insurers absolutely won't look for an escape clause" in 2017.

The story was different for 2018, however. In the absence of a mandate or an effective replacement policy for 2018, some insurer respondents indicated they would seriously consider a marketplace exit. One respondent noted that for those insurers "already losing money" and on "the edge of pulling out of the marketplace," participation in 2018 in the wake of a mandate repeal is unlikely. Other insurers may hedge their bets by filing proposed 2018 plans and rates with state regulators in time for the May 2017 deadline. However, under current regulatory timeframes, they have until September 2017 to assess enrollment and disenrollment in their own plans, the stability of their risk pool, and the position of their competitors in the marketplace, before making a final decision about whether or not to participate in the 2018 marketplace. One insurer suggested that if there are indications going into 2018 that an individual mandate repeal has significantly deteriorated the risk pool, "you would likely see carriers pull off the marketplace in 2018."

Some insurers hoped to continue to participate in the marketplace in 2018, "if there is a fiscally sound way" to do it. For one large insurer, this intention was grounded in a long-term commitment to serve the individual market; others, especially smaller, nonprofit plans, were driven by their mission to serve the community. For example, a former Medicaid-only plan noted that its commitment "to serve [lower-income] people with affordable health insurance" meant its leadership would seek to continue participation in the 2018 marketplace, even in the event of an individual mandate repeal.

Insurers to Raise Premiums in Response to an Individual Mandate Repeal

Insurers who believe their company will stay in the marketplaces for as long as possible acknowledged that their premiums would have to increase to accommodate an individual mandate repeal. One large insurer noted that the prevailing industry estimate puts the likely premium increase effect of a repeal in the range of 5 to 15 percent, although at least one analysis put this even higher, at above 20 percent. Because increasing premiums can act as a strong deterrent to healthy people buying coverage, one insurer suggested that if members of Congress are committed to repealing the individual mandate, they should counteract that decision by pulling every policy lever to help sustain the market. The insurer noted that "levers" should address areas the industry believes are contributing to adverse selection in the marketplace and could include implementing more stringent criteria for people seeking to enroll outside of the open enrollment period or preventing the steering of people with high health costs from Medicaid and Medicare to marketplace plans. Another respondent warned that in order to ensure continued insurer participation in 2018, it would be critical to replace the individual mandate with another mechanism that has a "binding effect on [consumers]" and is effective enough to maintain a viable risk pool.

Without a Concrete Replacement for the ACA, Delayed Repeal Is Unlikely to Calm Markets

The insurers we interviewed described "repeal and delay" without concurrent replacement of the ACA as fundamentally destabilizing. These insurers were not shy in offering criticism of the ACA's implementation or in identifying targeted policy changes they said would help put the marketplaces on more secure footing. However, they were deeply wary of wholesale revisions to the health law that would undermine its incentives to maintain continuous coverage without providing a concrete alternative.

These concerns carried over to scenarios in which repeal did not take effect right away. Should new legislation establish a sunset date for certain ACA provisions like the mandate and subsidies but not end them immediately, respondents still anticipated market deterioration in the absence of a coherent replacement structure. As one insurer put it, "if there is substantial writing on the wall" that the markets are going to cease to exist because of legislative changes, the company would start making plans to unwind its participation.

Uncertainty Over the Timing and Substance of Replacement Legislation Is Likely to Affect Insurer Pricing and Participation

The asserted justification of the "repeal and delay" strategy is to provide consumers a transition period under the current coverage framework and policymakers additional time to decide on what comes next. Though insurers saw value in a buffer to adjust to a replacement regulatory structure and to help educate consumers about coverage changes (see the next section), they perceived "significant" downside risk in remaining in the marketplaces as long as the details of an ACA replacement were in doubt. One respondent suggested a multiyear transition period would be needed, "but the problem is, how long is it going to take before [we] know" what the replacement is? This theme, that uncertainty was perhaps the "biggest risk," recurred throughout our discussions: "Not knowing what replacement means, it's very hard to plan. … There [are] so many different possibilities" that might follow repeal, said one insurer. The respondent noted that "it's concerning" and will cause a rethink around pricing and participation. Another insurer expanded on this sentiment:

> Having clarity on where we're going as soon as possible is the most important factor in getting carriers to play and stabilizing the markets. One of the things that causes rates to go up, adverse selection, etc., is a lack of certainty in what to do—it keeps carriers out of the marketplace, it keeps carriers from being aggressive in their rating. … Clarity sometimes, even if the situation is not ideal … is better than the absolute perfect solution.

Other respondents agreed that the consequences of uncertainty would manifest in higher premium rates, as insurers attempt to protect themselves against market fluctuations and the likelihood of losses from a deteriorating risk pool. Respondents suggested it was too early to tell whether consumers were already behaving differently in light of the possibility of repeal; they speculated that some individuals might be more likely to buy in the near term to secure coverage while the marketplaces remained open, but others might be more likely to stay out of the market in anticipation of the new administration's replacement policy. Respondents observed that their 2017 products were not priced to reflect any of these possibilities. They indicated that in future years, they would need to be more conservative in developing their rates, and worried that this dynamic—rising prices, deteriorating risk pool—increased the risk of a death spiral.

Uncertainty is likely to undermine business decisions beyond pricing as well. Respondents suggested their companies would have to "shrink back," rethinking staff contracts, for example, or declining additional capital investments or new lines of business. One insurer with a limited footprint in the individual market noted it would be stuck in a holding pattern until learning what the replacement plan would be. Another with much broader marketplace involvement said it hoped to remain in the states in which it participated but was concerned about the consequences of being the last insurer left in markets that, in effect, were slated to expire.

Insurers Favor a Transition Period *After* a Replacement Plan is Enacted

Insurers expressed optimism about their ability to adapt to an ACA replacement structure emphasizing continuous coverage, provided they are given sufficient lead time with the new plan to make appropriate adjustments. Respondents stressed that developing a product, pricing it, and bringing it to market takes a long time. Products for 2018 are already well under development and filing deadlines for 2018 coverage are only a few months away.[18] One insurer reported "making our decisions" about next year (2018) in the first quarter of 2017. Several insurers also pointed out—sometimes with reference to the extended ramp-up period for the ACA itself—that the process of promulgating and implementing regulations for a new statutory scheme can be extremely time-intensive at the federal level and may involve significant input from states as well.

Although no consensus emerged from our discussions on exactly how long a transition period ought to be, insurers generally estimated that the task of adapting to a new regulatory framework would require multiple years. One insurer, citing reports of a proposed two-year transition between the ACA and its replacement, suggested such a proposal created only a "very narrow path," and another respondent argued that three years were needed "at minimum." One large insurer observed that a lot of its current advocacy efforts focused on ensuring that people understand "how long this stuff takes"—two to three years—"and that's after the [replacement] legislation gets signed."

Many insurers suggested, consistent with findings already discussed, that business decisions were more likely to be affected by the rules governing markets during the transition period than by the precise length of the transition. One respondent stated, "I'm not so jazzed about the idea of 'Let's push it out, push it out, push it out,'" because if parts of the ACA's three-legged stool framework are repealed without immediate replacement, the transition period "could really suck."

Elimination of Cost-Sharing Reduction Payments Could Lead to a Collapse of the Individual Market as Insurers Drop Products

The insurers we interviewed foresaw huge disruption for health insurers and the individual health insurance market if the ACA's cost-sharing reduction payments are eliminated. The law requires health insurers to enroll individuals in cost-sharing reduction (CSR) plans if they have income between 100 and 250 percent of the federal poverty level and choose the silver level of coverage. CSR plans have higher actuarial values and lower cost-sharing than regular silver plans. Silver plans have an actuarial value of 70 percent, compared with actuarial values of 73 percent, 87 percent, and 94 percent for CSR plans; the level of cost-sharing reduction is graduated based on the enrollee's income. For example, an enrollee with income between 100 and 150 percent of the federal poverty level would be eligible for a CSR plan of 94 percent actuarial value. The premium for a CSR plan is no different from the premium for a regular silver plan. The additional cost to the insurer is reimbursed by the federal government through CSR payments.

Cost-Sharing Reduction Payments May Cease in the Middle of 2017, Leaving Insurers with Billions of Dollars in Unreimbursed Costs

Federal CSR payments to insurers may cease either because of a pending lawsuit or because of action taken by the Trump administration. In July 2014, the U.S. House of Representatives passed a resolution authorizing a lawsuit, House v. Burwell. The suit alleges that the Obama administration unlawfully spent funds not appropriated by Congress by reimbursing health insurers for the CSR costs.[19] A district court judge found in favor of the plaintiffs and the Obama administration appealed the decision. The appeals court could rule in favor of the House plaintiffs, the Trump administration could drop the defense of the lawsuit, or the Trump administration could unilaterally decide to discontinue the CSR payments. In all three situations, insurers would still be legally obligated to provide CSR plans to eligible enrollees, but they would no longer receive compensation from the federal government. If any of the above scenarios occur, the timing of the cessation of CSR payments is unknown. They could end sometime in the middle of 2017, leaving insurers with unreimbursed costs for people enrolled in those plans for the 2017 plan year. Alternatively, the Trump administration may choose to cease payments for 2018 or a future plan year.

Eliminating CSR reimbursements would cause significant financial harm to insurers. More than half of the individuals enrolled in the federally facilitated marketplace receive cost-sharing subsidies. One insurer in our study has about 70 percent of its marketplace enrollees in CSR plans. The cost of the CSRs is estimated to be $9 billion in 2017 and $11 billion in 2018.1 The insurers we interviewed indicated almost unanimously that failing to provide CSR reimbursement would be financially devastating.[20] One respondent stated that ending CSR payments midyear would "undermine the [health insurance] industry," causing a negative effect on stock value. Multiple respondents asserted that they could not financially support CSR plans without the reimbursement, especially given that some plans are already losing money in the marketplaces. Two respondents discussed the damage to the business relationship between insurance companies and the federal government if the payments ceased midyear, with one noting that if the federal government were to "renege on a promise midyear, [it] would be a huge blow to companies across the country."

Fear of a Death Spiral Would Drive Many Insurers to Leave the ACA Marketplaces or the Entire Individual Health Insurance Market if Cost-Sharing Reduction Payments Cease

Most respondents said they would exit the marketplaces or the entire individual market if CSR payments ceased. These insurers want to remain in the marketplaces and see them stabilize, but the loss of CSR payments would lead to a nonviable insurance market. One respondent referred to available choices if CSR payments cease as "a lot of bad options." None of the respondents mentioned receiving information or guidance from state regulators about options available for midyear changes if the payments were to cease. However, most of the respondents were unequivocal that maintaining CSR plans without reimbursement was not sustainable and that the insurers would eventually drop out of the marketplace or the entire individual market.

A number of respondents said they would consider raising rates. Four insurers thought regulators might exempt them from the prohibition on midyear rate increases if the CSR reimbursements were terminated because a "material assumption" used in the creation of the 2017 rates would change in the middle of the year. But several insurers were concerned that the market would be destabilized by raising rates, leading to adverse selection problems for the risk pool. One respondent noted that his company would be left with the "sickest of the sick" because of the increased cost and that he was "not sure [premiums] could ever be priced [high enough] to achieve … more stability."

One respondent from a nonprofit community health plan said that the loss of CSR payments midyear was the "only thing" that would cause plans to exit the marketplaces in 2017. This respondent said that if payments were eliminated midyear, "for us and any other plan like us, from what I've heard, there's no

way that we could financially stay in the market, because those are so critical to the financial integrity of our pool and of our finances."

State law would govern timing of departure and whether insurers are able to exit a market midyear. One respondent did not envision a midyear departure in 2017 because of limits under state law, but expected to use the company's experience in 2017 to determine the feasibility of remaining in the market in 2018. This respondent noted that under state law, they would need to notify enrollees of their departure 90 days before the start of the open enrollment period, so they would need to make that determination by the middle of 2017. Another respondent said that state insurance commissioners would have to declare an emergency under state law to "provide cover for the industry to depart." A third respondent expected to depart from the marketplaces between 30 and 90 days after the termination of CSR payments, stating that "in an environment where we're losing tens of millions of dollars per year, we will take whatever action [is] necessary and legal."

Dropping out of the ACA marketplace while remaining in the individual health insurance market did not seem to be a viable option because adverse selection would make the individual market unsustainable. Two respondents noted that such a move would create a death spiral in the outside market. One mentioned that their enrollment would be reduced by at least 70 to 80 percent without the CSR plans or the premium tax credits available only through the marketplaces.

Although insurers have a statutory obligation to offer the reduced cost-sharing plans if they participate in the marketplace, a few respondents thought that the CSR plans would need to be eliminated if the payments are eliminated. Absent such a change in law, an insurer might choose to drop out of the marketplace and offer plans on the outside market, where no such requirement applies. The respondents who suggested that dropping CSR plans might be necessary still saw chaos in the market because cost-sharing would increase so dramatically for enrollees. One respondent noted that there would be a 3000 percent increase in the deductible for an individual losing the most generous CSR. Health care would no longer be affordable with cost-sharing under a silver plan. Thus, insurers predicted much smaller enrollment. One respondent representing an integrated care plan noted that the enrolled population would also become less healthy because enrollees would not be able to afford to attend to their health care needs. This respondent also expressed concern about the impact on providers when enrollees are not able to pay the cost-sharing associated with services.

Although insurers have not planned for the elimination of CSR payments, they do have significant concerns about its adverse effects. During our discussions with the respondents, we saw that most viewed CSR plans and CSR payments as integral to the sustainability of the individual health insurance market. Removing the payments would undermine the ability of insurers to offer CSR plans, and many respondents foresaw adverse selection leading to a death spiral in the market.

CONCLUSION

The anticipated partial or total repeal of the ACA has given rise to considerable uncertainty about the future of the health insurance marketplaces and coverage for the projected 13.8 million people who will be enrolled in marketplace plans in 2017. In a series of structured interviews with 13 insurers participating in marketplaces in 28 states, we discussed possible insurer responses to three repeal scenarios: (1) immediate repeal of the individual mandate with delayed repeal of financial subsidies, (2) delayed repeal of the ACA without a concurrent replacement, and (3) a cutoff of cost-sharing subsidies in 2017. We find that as long as policymakers enact concrete replacement policies and provide the insurance industry sufficient time to implement them, insurers are generally confident that they could manage a transition to a new regulatory regime. However, if the ACA is repealed after a delay but not concurrently replaced, or if the individual mandate is immediately ended, insurers expect material market exits and significant premium increases for the 2018 plan year. If the third scenario occurs and cost-sharing subsidies cease in mid-2017, the destabilization of the marketplaces will accelerate regardless of whether the ACA is repealed, with insurers exiting or raising premiums midyear.

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17. To sell on the marketplaces, insurers entered into contracts with federal and state marketplace officials that require them to maintain coverage for enrollees during the 2017 plan year. Apart from these contractual obligations—which would likely remain in force even if the individual mandate is repealed—insurers are also subject to federal and state laws limiting how quickly they may withdraw their products from the market during the middle of a plan year. For example, federal law requires insurers to provide 90 days' notice to enrollees before discontinuing an insurance product, and 180 days' notice before a complete market exit.
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WEB FIRST

By Sean P. Keehan, Devin A. Stone, John A. Poisal, Gigi A. Cuckler, Andrea M. Sisko, Sheila D. Smith, Andrew J. Madison, Christian J. Wolfe, and Joseph M. Lizonitz

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National Health Expenditure Projections, 2016–25: Price Increases, Aging Push Sector To 20 Percent Of Economy

ABSTRACT Under current law, national health expenditures are projected to grow at an average annual rate of 5.6 percent for 2016–25 and represent 19.9 percent of gross domestic product by 2025. For 2016, national health expenditure growth is anticipated to have slowed 1.1 percentage points to 4.8 percent, as a result of slower Medicaid and prescription drug spending growth. For the rest of the projection period, faster projected growth in medical prices is partly offset by slower projected growth in the use and intensity of medical goods and services, relative to that observed in 2014–16 associated with the Affordable Care Act coverage expansions. The insured share of the population is projected to increase from 90.9 percent in 2015 to 91.5 percent by 2025.

Over the next decade (2016–25), growth in nominal (not adjusted for inflation) national health expenditures (NHE) is projected to average 5.6 percent, outpacing average growth in gross domestic product (GDP) by 1.2 percentage points. As a result, the health share of the economy is expected to climb from 17.8 percent in 2015 to 19.9 percent in 2025 (Exhibit 1).

The NHE projections are constructed using a current-law framework[1] and thus do not assume potential legislative changes over the projection period, nor do they attempt to speculate on possible deviations from current law. While there is currently significant debate involving potential future health-sector policy changes, the scope, timing, and impact of such possible changes on health spending and health insurance coverage are all uncertain at this time.

In 2014 and 2015, when the largest impacts of the major coverage provisions of the Affordable Care Act (ACA) were observed, health spending growth averaged 5.5 percent.[2] For the period 2016–25, spending is projected to grow similarly (5.6 percent) but to be largely influenced by changes in economic growth and population aging and not as much by changes in insurance coverage. This expectation leads to slower growth in the use and intensity (or complexity) of medical goods and services, relative to the expansion-related growth of 2014–15. However, medical price growth is projected to quicken in the coming decade compared to recent history, as both overall prices and medical-specific price inflation grow faster.

The first two years of the projection period feature the slowest expected rates of growth for the period (4.8 percent in 2016 and 5.4 percent in 2017), as both Medicaid and private health insurance spending growth slow and Medicare spending growth remains low (Exhibit 1). Medicaid spending growth is projected to be low (3.7 percent) for both 2016 and 2017, compared to 11.6 percent growth in 2014 (data not shown) and 9.7 percent growth in 2015 (Exhibit 2), largely due to enrollment growth slowing from an average of 8.4 percent for 2014–15 (data not shown) to less than 2 percent by 2017 (Exhibit 2). Growth in private health insurance spending is expected to also decelerate from its recent peak in 2015 (7.2 percent), but its slow-

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EXHIBIT 1

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and average annual growth from previous year shown, by source of funds, selected calendar years 2007–25

Source of funds	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,295.7	$3,029.3	$3,205.6	$3,358.2	$3,539.3	$3,965.5	$5,548.8
Health consumption expenditures	2,157.3	2,878.4	3,050.8	3,200.1	3,375.4	3,784.9	5,299.9
Out of pocket	289.9	329.7	338.1	350.4	365.8	401.2	542.3
Health insurance	1,609.7	2,228.2	2,384.5	2,508.5	2,652.0	2,990.1	4,234.1
Private health insurance	776.6	1,000.0	1,072.1	1,135.4	1,208.8	1,351.3	1,809.1
Medicare	432.8	618.5	646.2	678.6	718.7	824.9	1,277.8
Medicaid	325.8	497.2	545.1	565.5	586.5	658.1	929.0
Federal	185.5	305.5	344.0	353.3	361.5	404.5	567.6
State and local	140.3	191.7	201.1	212.2	225.0	253.6	361.4
Other health insurance programs[c]	74.6	112.6	121.1	129.0	138.1	155.8	218.1
Other third-party payers and programs and public health activity	257.6	320.5	328.2	341.2	357.6	393.6	523.5
Investment	138.4	150.9	154.7	158.1	163.9	180.6	248.9
Population (millions)	301.0	318.4	320.9	323.8	326.7	332.9	351.2
GDP, billions of dollars	$14,477.6	$17,393.1	$18,036.6	$18,559.7	$19,357.7	$21,270.3	$27,885.1
NHE per capita	7,628.0	9,514.8	9,989.9	10,372.3	10,832.5	11,911.6	15,800.0
GDP per capita	48,106.0	54,631.1	56,209.7	57,323.5	59,247.6	63,891.6	79,402.2
Prices (2009 = 100.0)							
GDP Implicit Price Deflator, chain weighted	0.973	1.088	1.100	1.114	1.137	1.188	1.353
Personal Health Care Price Index	0.949	1.099	1.107	1.121	1.138	1.193	1.398
NHE as percent of GDP	15.9%	17.4%	17.8%	18.1%	18.3%	18.6%	19.9%
ANNUAL GROWTH							
NHE	7.3%	4.0%	5.8%	4.8%	5.4%	5.9%	5.8%
Health consumption expenditures	7.3	4.2	6.0	4.9	5.5	5.9	5.8
Out of pocket	4.7	1.9	2.6	3.6	4.4	4.7	5.2
Health insurance	8.2	4.8	7.0	5.2	5.7	6.2	6.0
Private health insurance	7.7	3.7	7.2	5.9	6.5	5.7	5.0
Medicare	8.4	5.2	4.5	5.0	5.9	7.1	7.6
Medicaid	9.7	6.2	9.7	3.7	3.7	5.9	5.9
Federal	9.7	7.4	12.6	2.7	2.3	5.8	5.8
State and local	9.6	4.6	4.9	5.5	6.0	6.2	6.1
Other health insurance programs[c]	7.8	6.1	7.5	6.5	7.0	6.2	5.8
Other third-party payers and programs and public health activity	6.1	3.2	2.4	4.0	4.8	4.9	4.9
Investment	6.8	1.2	2.6	2.2	3.6	5.0	5.5
Population[d]	1.0	0.8	0.8	0.9	0.9	0.9	0.9
GDP	5.4	2.7	3.7	2.9	4.3	4.8	4.6
NHE per capita	6.2	3.2	5.0	3.8	4.4	4.9	4.8
GDP per capita	4.3	1.8	2.9	2.0	3.4	3.8	3.7
Prices (2009 = 100.0)							
Gross Domestic Product Implicit Price Deflator, chain weighted	2.3	1.6	1.1	1.3	2.0	2.2	2.2
Personal Health Care Price Index	3.3	2.1	0.8	1.3	1.6	2.4	2.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2017 Jan 11]. 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. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected. [c]Includes health-related spending for Children's Health Insurance Program, Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [d]Estimates 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, and 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 population) adjustment to reflect census undercounts. Projected estimates reflect the area population growth assumptions found in the 2016 *Medicare Trustees Report* (see Note 5 in text).

down is projected to be not nearly as sharp as Medicaid's (Exhibit 1). Average private health insurance spending growth of 6.2 percent is expected in 2016–17, largely reflecting slowing expected private health insurance enrollment growth (from 2.6 percent in 2015 to less than 1.0 percent in both 2016 and 2017) as expansion-related gains diminish (Exhibit 2). Medicare spending growth is expected to remain low early in the projection period relative to its long-term history, with projected growth staying under 6.0 percent in both 2016 and 2017 and extending a trend that began in 2010 (Exhibit 1).

For 2018 and beyond, both Medicare and Medicaid expenditures are projected to grow faster than in the 2016–17 period, and more rapidly than private health insurance spending, for several reasons. First, growth in the use of Medicare services is expected to increase from its recent historical lows (though still remain below longer-term averages). Second, the Medicaid population mix is projected to trend more toward somewhat older, sicker, and therefore costlier beneficiaries. Third, baby boomers will continue to age into Medicare, with some of them dropping private health insurance as a result. And finally, growth in the demand for health care for those with private coverage is projected to slow as the relative price of health care—the difference between medical prices and economy-wide prices—is expected to begin gradually increasing in 2018 and as income growth slows in the later years of the projection period.

Within personal health care, which reflects the amount spent to treat people with specific medical conditions, the two sectors with the highest projected average spending growth for the entire projection period are home health care (6.7 percent average) and retail prescription drugs (6.3 percent average). Home health care spending growth is expected to be largely driven by growth in Medicare, where spending is projected

EXHIBIT 2

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and average annual growth from previous year shown, by source of funds, selected calendar years 2007–25

Source of funds	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
Private health insurance	$776.6	$1,000.0	$1,072.1	$1,135.4	$1,208.8	$1,351.3	$1,809.1
Medicare	432.8	618.5	646.2	678.6	718.7	824.9	1,277.8
Medicaid	325.8	497.2	545.1	565.5	586.5	658.1	929.0
ANNUAL GROWTH IN EXPENDITURE							
Private health insurance	7.7%	3.7%	7.2%	5.9%	6.5%	5.7%	5.0%
Medicare	8.4	5.2	4.5	5.0	5.9	7.1	7.6
Medicaid	9.7	6.2	9.7	3.7	3.7	5.9	5.9
PER ENROLLEE EXPENDITURE							
Private health insurance	$ 3,933	$ 5,200	$ 5,433	$ 5,702	$ 6,040	$ 6,679	$ 8,736
Medicare	10,003	11,702	11,904	12,096	12,456	13,497	17,755
Medicaid	7,143	7,585	7,869	7,956	8,103	8,797	11,627
ANNUAL GROWTH IN PER ENROLLEE EXPENDITURE							
Private health insurance	7.1%	4.1%	4.5%	4.9%	5.9%	5.2%	4.6%
Medicare	6.8	2.3	1.7	1.6	3.0	4.1	4.7
Medicaid	5.0	0.9	3.8	1.1	1.8	4.2	4.8
ENROLLMENT (MILLIONS)							
Private health insurance	197.5	192.3	197.3	199.1	200.1	202.3	207.1
Medicare	43.3	52.8	54.3	56.1	57.7	61.1	72.0
Medicaid	45.6	65.5	69.3	71.1	72.4	74.8	79.9
Uninsured	41.1	35.6	29.2	28.0	27.2	26.8	29.8
Population	301.0	318.4	320.9	323.8	326.7	332.9	351.2
Insured share of total population	86.4%	88.8%	90.9%	91.4%	91.7%	91.9%	91.5%
ANNUAL GROWTH IN ENROLLMENT							
Private health insurance	0.5%	–0.4%	2.6%	0.9%	0.5%	0.5%	0.4%
Medicare	1.5	2.9	2.7	3.3	2.8	2.9	2.8
Medicaid	4.5	5.3	5.7	2.6	1.8	1.7	1.1
Uninsured	1.7	–2.0	–17.9	–4.2	–3.0	–0.6	1.8
Population	1.0	0.8	0.8	0.9	0.9	0.9	0.9

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

to average 7.8 percent for 2020–25 as the leading edge of the baby boomers reach their mid-70s and use home health care services more often.[3] Prescription drug spending growth is anticipated to be influenced by higher spending on expensive specialty drugs, with that growth somewhat mitigated by the expectation that the share of prescriptions that are lower-cost generic drugs will continue to increase slowly throughout the projection period.

Following disparate trends in 2014 and 2015, the average growth rates in spending among the major sponsors of health care are projected to be more similar. Private businesses, households, and other private payers are projected to collectively incur average increases of 5.4 percent in the period 2016–25, while combined spending by federal and state and local governments is expected to average 5.9 percent. That 0.5-percentage-point average differential is smaller than the 3.7-percentage-point average differential observed in 2014 and 2015, when the federal government incurred significant cost growth associated with sponsoring the ACA's major coverage expansions. The federal government is expected to continue representing the highest share among all sponsors of care, at 30 percent in 2025. Although states are expected to absorb an increasing share of the responsibility of paying for adults who are newly enrolled in Medicaid, state and local government expenditures as a share of total expenditures are projected to remain unchanged at 17 percent throughout the projection period.

Finally, the insured as a share of the population are projected to increase during the projection period, from 90.9 percent in 2015 to 91.5 percent in 2025 under current law (Exhibit 2). This is mainly a result of continued growth in enrollment in private health insurance—in particular, employer-sponsored health insurance—in the first year of the projection period, as well as enrollment growth in public programs throughout the period.

Model And Assumptions

The annual national health expenditure projections are largely based on current law[1] and the existing regulatory environment.[4] They use the economic and demographic assumptions from the 2016 *Medicare Trustees Report*,[5] which were updated to reflect the latest macroeconomic data, and the latest Medicaid projections from the CMS Office of the Actuary. Finally, these projections are developed using actuarial and econometric modeling methods, as well as judgments about future trends that influence health spending.[6]

Medical price growth is projected to quicken in the coming decade compared to recent history.

These projections remain inherently subject to substantial uncertainty that increases in future years. The uncertainty is related to multiple factors, some of which are in turn related to macroeconomic conditions and others of which are specific to the health care industry. Fluctuations in overall economic growth can affect the job market and growth in economywide price inflation, which will affect health spending growth. Health-specific factors adding to the uncertainty include providers' responses to new payment reforms, trends in population health and medical treatments, and employers' actions and employees' responses to incentives related to employer-provided health insurance benefits. Finally, potential future changes in legislation add to the uncertainty of these projections.

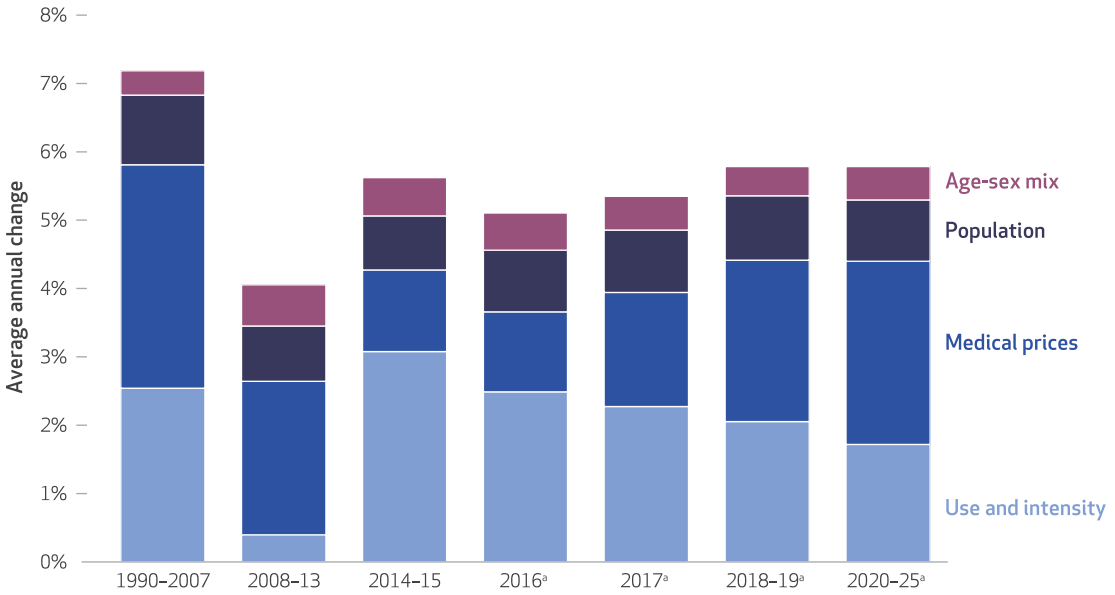
Factors Accounting For Growth

The two primary drivers of growth in personal health care spending during the projection period are medical prices and use and intensity of services; population growth and the population's age-sex mix have smaller impacts (Exhibit 3).

For the most recent two historical years (2014 and 2015), growth rates for both economywide prices (averaging 1.4 percent, as measured by the GDP deflator) and medical prices (1.1 percent, as measured by the personal health care price deflator) have been near historic lows. These trends continued in 2016, when the GDP deflator and the personal health care price index are both projected to have grown at 1.3 percent (Exhibit 1). Medical prices are influenced by both economywide factors and medical-specific price inflation (the latter being the difference between medical and economywide price inflation). For the period 2014–16, medical-specific price inflation averaged –0.2 percent, the lowest rate since 1973. Overall medical price inflation is expected to grow faster in 2017 (1.6 percent) and then average 2.4 percent for 2018–19, driven primarily by anticipated increases in economywide

EXHIBIT 3

Factors accounting for growth in personal health care expenditures, selected calendar years 1990–2025



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** "Use and intensity" includes quantity and mix of services. As a residual, this factor also includes any errors in measuring prices or total spending. "Medical prices" reflect a chain-weighted index of the price for all personal health care deflators. "Population" is population growth. "Age-sex mix" refers to that mix in the population. [a]Projected.

price inflation. For 2020–25, medical price growth (Personal Health Care Price Index) is expected to accelerate to an average of 2.7 percent as a result of medical-specific price inflation, whose average growth is projected to be about 0.5 percentage point faster than economywide price growth. Medical input prices (including wage growth for health care workers) are expected to rise faster than the price growth for inputs for other sectors of the economy. As a result, growth in medical prices is expected to account for 46 percent of total growth in personal health care spending during the second half of the projection period, up from a share of 25 percent in 2016 (Exhibit 3).

The category of use and intensity of services is projected to have grown 2.4 percent in 2016, slower than the average growth of 3.2 percent for 2014–15 (Exhibit 3), as fewer people gained insurance coverage in 2016 compared to 2014–15. However, this projected rate of use and intensity growth in 2016 remains higher than the growth observed for 2008–13 (which averaged 0.4 percent) as a result of continued strong use of health care goods and services—driven in part by recent gains in disposable personal income (which tends to influence health spending with a lag).[6] Growth in the use and intensity of services is expected to decelerate (averaging 2.1 percent for 2018–19), as employers are expected to continue trying to keep growth in benefit costs low, implementing strategies that include imposing higher cost-sharing requirements and utilization management tools such as prior authorization.[7,8] For the remainder of the projection period (2020–25), use and intensity are projected to grow more slowly, at 1.7 percent per year—because of less demand for care in lagged response to slowing disposable personal income growth and the continuing impact of more people being enrolled in high-deductible health plans and their associated higher cost sharing.[9] As a result, the impact of use and intensity on personal health care spending growth is expected to decrease and account for 30 percent of that growth during the second half of the projection period, down from its share of 47 percent in 2016.

The effects of population growth and the changing age-sex mix are expected to be minor, contributing 0.9 percent and 0.5 percent, respectively, to annual growth for the period 2016–25 (Exhibit 3). As baby boomers age into Medicare, there will be a shift in coverage away from private insurance and into Medicare, with a modest effect on overall growth in health care spending (as estimates of spending for younger [nondisabled] Medicare beneficiaries show that spending is only marginally higher than spending for enrollees in private health insurance who are near the Medicare eligibility age).[10] The share

of the population ages sixty-five and older is projected to increase from 15 percent in 2015 to 18 percent in 2025.

Chronological Outlook Of Yearly Trends

2016 National health spending is projected to have grown 4.8 percent in 2016, compared to 5.8 percent in 2015 (Exhibit 1), and to have reached nearly $3.4 trillion. Even with slower health spending growth, national health expenditures as a share of GDP are projected to have increased to 18.1 percent in 2016, from 17.8 percent in 2015—as nominal GDP grew just 2.9 percent in 2016. Although there were larger decreases in 2014 and 2015, the uninsured population is projected to have fallen by 1.2 million in 2016, to 28.0 million (Exhibit 2), driven mainly by increases in the populations with employer-sponsored insurance and Medicaid.

From the standpoint of payers, the overall slowdown in spending growth primarily reflects a significant deceleration in Medicaid spending growth, from 9.7 percent in 2015 to just 3.7 percent in 2016 (Exhibit 1). This deceleration is driven in part by an expectation of slower enrollment growth, from 5.7 percent in 2015 to 2.6 percent in 2016 (Exhibit 2), as most of the impacts from the ACA's Medicaid expansion were experienced in 2014 and 2015. Also contributing to the slowdown in spending growth was an actual decline in Medicaid's net cost of health insurance (or the difference between premiums received by Medicaid managed care organizations and the benefits paid on behalf of the Medicaid beneficiaries enrolled in them), which is projected to have fallen 5.2 percent in 2016, compared to an increase of 24.9 percent in 2015 (data not shown). This shift in trend is due to the 2016 collection of Medicaid risk mitigation payments made in 2014 and 2015 for newly eligible beneficiaries in managed care plans.[11] Finally, the projected deceleration in Medicaid spending in 2016 was associated with slower Medicaid hospital spending growth—a change from 9.5 percent in 2015, when many states had adopted higher reimbursement rates, to 4.5 percent in 2016.[12]

Private health insurance spending growth is projected to have decelerated to 5.9 percent in 2016, from 7.2 percent in 2015 (Exhibit 2). This pattern of growth reflects a slowdown in enrollment growth that is partially offset by an increase in growth of per enrollee spending. Private health insurance enrollment growth is projected to have slowed to 0.9 percent in 2016 (from 2.6 percent in 2015) as the major impacts of initial enrollment in Marketplace plans waned. However, per enrollee private health insurance spending growth is expected to have accelerated to 4.9 percent in 2016 (from 4.5 percent in 2015), a change related to greater demand for care associated with lagged increases in disposable personal income growth.

Partially offsetting slower growth in Medicaid and private health insurance spending were projected accelerations in Medicare spending growth (reaching 5.0 percent in 2016 from 4.5 percent in 2015) and out-of-pocket spending growth (to 3.6 percent in 2016 from 2.6 percent in 2015) (Exhibit 1). This rise in growth in Medicare spending is largely explained by faster enrollment growth and an expected rebound in the growth in the use of inpatient hospital services, which declined in 2015.[5] The faster expected growth in out-of-pocket spending is primarily attributable to increasing cost sharing and a higher proportion of private health insurance enrollees being in high-deductible health plans.[13]

Among the major goods and services sectors, the category with the largest projected slowdown in 2016 is prescription drug spending, which is projected to have grown 5.0 percent in 2016, down from 9.0 percent in 2015 (Exhibit 4). The main reason for the expectation of decelerating growth is that the use of drugs to treat hepatitis C is expected to have fallen in 2016.[14] In addition, there was an increase between 2015 and 2016 in the dollar value of brand-name drugs whose patents had recently expired—leading to a shift in use from those drugs to less expensive generic drugs in 2016.[15]

One sector that is projected to have experienced faster growth in 2016 than in 2015 (6.6 percent and 6.3 percent, respectively) is physician and clinical services, a change in line with preliminary survey data on health care revenues in this sector.[16] Underlying this increase in growth is a 1.3-percentage-point acceleration in prices for these services in 2016 to 0.2 percent, rebounding from historically slow growth of –1.1 percent in 2015 (which was due primarily to the expiration of the temporary increase in Medicaid payments to primary care providers).[17]

Overall medical price inflation (Personal Health Care Price Index) is projected to have remained low in 2016, growing 1.3 percent—higher than its historically low rate of 0.8 percent in 2015 (Exhibit 1). Hospital price growth is expected to have also remained modest in 2016 at 1.2 percent (data not shown), in part as a result of Medicare's documentation and coding adjustments to its inpatient hospital payment updates and the continuing effects of productivity adjustments to payments for hospitals mandated under the ACA.[5] Although the 2016 growth rate in

EXHIBIT 4

National health expenditures (NHE), amounts and annual growth from previous year shown, by spending category, selected calendar years 2007–25

Spending category	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,295.7	$3,029.3	$3,205.6	$3,358.2	$3,539.3	$3,965.5	$5,548.8
Health consumption expenditures	2,157.3	2,878.4	3,050.8	3,200.1	3,375.4	3,784.9	5,299.9
Personal health care	1,918.8	2,562.8	2,717.2	2,856.3	3,008.1	3,365.9	4,716.6
Hospital care	692.0	981.0	1,036.1	1,086.8	1,140.8	1,269.1	1,776.0
Professional services	615.6	792.8	840.2	891.0	942.1	1,054.1	1,445.1
Physician and clinical services	458.6	597.1	634.9	677.1	717.0	804.1	1,110.6
Other professional services	60.1	82.8	87.7	92.0	97.1	108.6	149.4
Dental services	97.0	112.8	117.5	121.9	128.0	141.3	185.0
Other health, residential, and personal care	108.3	151.5	163.3	170.0	179.0	201.0	287.5
Long-term care services	182.4	236.2	245.6	256.4	269.4	300.5	430.0
Home health care	57.5	83.6	88.8	94.1	99.9	113.5	170.0
Nursing care facilities and continuing care retirement communities	124.9	152.6	156.8	162.4	169.5	187.0	260.0
Retail outlet sales of medical products	320.5	401.4	432.0	452.1	476.8	541.3	778.1
Prescription drugs	235.6	297.9	324.6	340.7	360.1	412.3	597.1
Durable medical equipment	37.1	46.6	48.5	50.5	53.0	58.7	84.4
Other nondurable medical products	47.8	56.9	59.0	60.9	63.7	70.3	96.7
Government administration	29.1	41.2	42.6	45.0	46.8	55.7	82.9
Net cost of health insurance	143.5	195.3	210.1	216.3	235.1	271.1	384.8
Government public health activities	65.9	79.0	80.9	82.5	85.4	92.2	115.5
Investment	138.4	150.9	154.7	158.1	163.9	180.6	248.9
Noncommercial research	42.6	45.9	46.7	47.9	49.7	54.4	72.2
Structures and equipment	95.8	105.0	108.0	110.2	114.1	126.3	176.7
ANNUAL GROWTH							
NHE	7.3%	4.0%	5.8%	4.8%	5.4%	5.9%	5.8%
Health consumption expenditures	7.3	4.2	6.0	4.9	5.5	5.9	5.8
Personal health care	7.2	4.2	6.0	5.1	5.3	5.8	5.8
Hospital care	6.4	5.1	5.6	4.9	5.0	5.5	5.8
Professional services	6.8	3.7	6.0	6.0	5.7	5.8	5.4
Physician and clinical services	6.7	3.8	6.3	6.6	5.9	5.9	5.5
Other professional services	8.2	4.7	5.9	4.9	5.5	5.8	5.5
Dental services	6.9	2.2	4.2	3.7	5.0	5.1	4.6
Other health, residential, and personal care	9.4	4.9	7.8	4.1	5.3	6.0	6.1
Long-term care services	7.6	3.8	4.0	4.4	5.1	5.6	6.2
Home health care	10.1	5.5	6.3	5.9	6.2	6.6	7.0
Nursing care facilities and continuing care retirement communities	6.8	2.9	2.7	3.5	4.4	5.0	5.6
Retail outlet sales of medical products	9.0	3.3	7.6	4.6	5.5	6.5	6.2
Prescription drugs	11.2	3.4	9.0	5.0	5.7	7.0	6.4
Durable medical equipment	6.5	3.3	3.9	4.2	5.0	5.2	6.2
Other nondurable medical products	4.7	2.5	3.7	3.2	4.6	5.1	5.4
Government administration	8.6	5.1	3.2	5.8	4.0	9.0	6.9
Net cost of health insurance	9.6	4.5	7.6	3.0	8.7	7.4	6.0
Government public health activities	7.5	2.6	2.4	1.9	3.5	3.9	3.8
Investment	6.8	1.2	2.6	2.2	3.6	5.0	5.5
Noncommercial research	7.4	1.1	1.8	2.5	3.8	4.6	4.8
Structures and equipment	6.5	1.3	2.9	2.0	3.6	5.2	5.8

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

prices for physician and clinical services is expected to be faster than the previous year, at just 0.2 percent (data not shown), the growth is still low relative to average growth over the previous decade.

2017 National health spending growth is projected to accelerate to 5.4 percent in 2017, up from 4.8 percent in 2016 (Exhibit 1). Although growth in the GDP is expected to accelerate to 4.3 percent, health spending as a share of the economy is projected to increase again by 0.2 percentage point to 18.3 percent, as growth of health spending exceeds that of the overall economy. The uninsured population is projected to decrease once more, but by just 0.8 million to 27.2 million (Exhibit 2)—partly because of expected small enrollment increases in employer-sponsored insurance and the Children's Health Insurance Program.

From a payer perspective, Medicare spending growth is projected to accelerate to 5.9 percent in 2017, from 5.0 percent in 2016 (Exhibit 1). This trend is due to spending associated with Medicare physician and clinical services (5.3 percent growth in 2017, up from 3.9 percent in 2016) and Medicare hospital services (4.9 percent growth in 2017, up from 4.2 percent in 2016) (data not shown). Higher growth in the use of Medicare hospital services is expected in part as the downward pressure on growth attributable to the readmission penalties and the two-midnight rule that occurred during 2011–15 is not expected to continue.[5]

Private health insurance spending growth is projected to be 6.5 percent in 2017, up somewhat from 5.9 percent in 2016 (Exhibit 2). In anticipation of slower growth in private health insurance enrollment (0.5 percent in 2017, down from 0.9 percent in 2016), private health insurance spending per enrollee is expected to increase at a faster rate of 5.9 percent in 2017 (from 4.9 percent in 2016). One factor contributing to faster growth is a significant acceleration in premium growth for Marketplace plans because of previous underpricing of premiums and the elimination of risk corridor payments.[18] Prescription drug spending growth is also expected to accelerate, reaching 5.7 percent in 2017—up from 5.0 percent in 2016 (Exhibit 4). The increase is primarily due to faster growth in the number of prescriptions dispensed.

In contrast, a slowdown in spending growth for physician care is expected in 2017. Physician and clinical services spending growth is projected to slow 0.7 percentage point, to 5.9 percent in 2017, as the effects of the coverage expansions moderate—particularly for private health insurance and Medicaid.

Medical price growth (Personal Health Care Price Index) is projected to accelerate to 1.6 percent in 2017, up from 1.3 percent in 2016 (Exhibit 1), driven by expectations of an acceleration in economywide price inflation in 2017. However, the acceleration is mitigated by the expectation that patent expirations will moderate the growth in prescription drug prices.

2018–19 National health expenditure growth is projected to accelerate from 5.4 percent in 2017 to an average of 5.9 percent for 2018–19, driven mainly by faster growth in both Medicare and Medicaid. Medicare spending growth is expected to average 7.1 percent for 2018–19 (up from 5.9 percent in 2017), largely related to an expectation that the use and intensity of medical services will increase from historically low rates to rates that are more consistent with Medicare's longer-term historical experience. As a result, Medicare per enrollee average spending growth is projected to accelerate to 4.1 percent for 2018–19, from 3.0 percent in 2017 (Exhibit 2).

Medicaid spending growth is projected to accelerate to an average of 5.9 percent for 2018–19 (from 3.7 percent in 2017) (Exhibit 1), largely because of more rapid projected growth in the use and intensity of care required to meet the needs of Medicaid's increasingly larger proportion of aged and disabled enrollees (who tend to be comparatively more expensive). Medicaid net-cost spending growth is projected to accelerate sharply to 18.8 percent in 2018 (data not shown) after negative growth in 2017, when Medicaid is expected to collect previous risk mitigation payments to Medicaid managed care plans. Overall, projected average Medicaid spending growth per enrollee accelerates to 4.2 percent for 2018–19, from 1.8 percent in 2017 (Exhibit 2).

Growth in private health insurance spending is projected to begin decelerating and average 5.7 percent for 2018–19 (down from 6.5 percent in 2017). The relative price of health care is projected to begin climbing during this period, which is expected to slightly dampen growth in the use and intensity of services demanded by those covered by private health insurance. Additionally, the continued aging of the baby boomers keeps the growth of private health insurance enrollment low, as many boomers reach the age of Medicare entitlement.

Prescription drug spending growth is anticipated to accelerate from 5.7 percent in 2017 to an average of 7.0 percent for 2018–19 (Exhibit 4). This expected higher rate of growth is driven by faster price growth as a result of fewer brand-name drugs losing patent protection. In 2017 a subset of drugs that represents $11.1 billion of brand-name drug spending is expected to lose patent protection and to be mostly replaced by

Health care enrollment and spending trends are projected to revert to being fundamentally driven by changes in economics and demographics.

less expensive generic versions. This compares to $27.7 billion in 2015 and $18.9 billion in 2016.[15] As a result, there is expected to be a significantly smaller amount of brand-name drug purchases shifted to generics in 2018, leading to a faster rate of growth in drug prices.[19]

Growth in prices for hospital services is projected to accelerate during this time period as a result of anticipated increases in input costs, along with stronger projected growth in the use and intensity of hospital services by Medicare beneficiaries. Hospital spending growth for the Medicare program is projected to rise from 4.9 percent in 2017 to an average of 6.4 percent for 2018–19 (data not shown).

2020–25 National health expenditure growth is projected to grow at an average rate of 5.8 percent during the second half of the projection period (2020–25), similar to the average growth rate of 5.9 percent for 2018–19 (Exhibit 1) and still more rapidly than growth in GDP. These trends combine to result in a projected increase in the health share of the economy to 19.9 percent by 2025 (Exhibit 1). The years 2020–25 are the portion of the entire projection period when Medicare spending growth is projected to be at its highest, and spending growth by private health insurers is projected to fall to its lowest rates.

Medicare spending growth is projected to peak in 2020 at 8.0 percent and grow at an average rate of 7.6 percent for 2020–25, up from an average of 7.1 percent for 2018–19 (Exhibit 2). Driving growth in Medicare spending is continued strong enrollment growth from baby boomers (averaging 2.8 percent) and the aging of the existing Medicare population. Both of these effects contribute to increases in growth in the use and intensity of medical services.

Private health insurance spending growth is projected to decelerate to an average of 5.0 percent for 2020–25, from 5.7 percent for 2018–19 (Exhibit 2)—including growth of 4.8 percent in 2020 when the excise tax on high-cost health plans under current law is to be implemented. This slower growth in private health insurance spending is primarily attributable to a lagged response to projected slower growth in disposable personal income near the end of the projection period. Out-of-pocket spending growth is projected to average 5.2 percent for 2020–25, up from 4.7 percent for 2018–19 (Exhibit 1), driven partly by the reduction in the scope of insurance coverage and the accompanying increase in cost sharing associated with employers' being affected by the excise tax.

Average growth in Medicaid spending for 2020–25 (5.9 percent) is expected to be similar to that projected in 2018–19 (Exhibit 1) and about the same as total health spending growth. This rate is the net result of somewhat offsetting trends. First, enrollment growth is expected to average only 1.1 percent for 2020–25, down from an average of 1.7 percent in 2018–19 (Exhibit 2). However, average per enrollee expenditure growth is projected to accelerate 0.6 percentage point between the two time periods, to 4.8 percent—in part because of the aging of the program's population and the expiration of cuts to disproportionate-share hospital payments late in the projection period.

Medical price growth (Personal Health Care Price Index) is projected to accelerate somewhat from a 2.4 percent average for 2018–19 to a 2.7 percent average for 2020–25 (Exhibit 1). Higher input prices associated with the provision of health care (relative to inputs required for other sectors of the economy) are expected to continue to drive growth in medical prices during this phase of the projection period.

Trends By Type of Sponsor

National health expenditures sponsored by federal, state, and local governments are projected to account for 47 percent of total payments by 2025, up from 46 percent in 2015 (Exhibit 5). Driven mainly by continued growth in Medicare enrollment from baby boomers and by ongoing subsidies paid for lower-income Marketplace plan enrollees, spending sponsored by the federal government is projected to reach 30 percent of national health expenditures in 2025, up from 29 percent in 2015 (Exhibit 5). The share of total spending sponsored by state and local governments is projected to remain steady at 17 percent through 2025 (Exhibit 5), with an average annual rate of 5.7 percent growth for the period 2016–

EXHIBIT 5

National health expenditures (NHE) amounts, average annual growth from previous year shown, and percent distribution, by type of sponsor, selected calendar years 2007–25

Type of sponsor	2007[a]	2014	2015	2016[b]	2017[b]	2019[b]	2025[b]
EXPENDITURE, BILLIONS							
NHE	$2,295.7	$3,029.3	$3,205.6	$3,358.2	$3,539.3	$3,965.5	$5,548.8
Businesses, households, and other private revenues	1,369.8	1,662.8	1,739.4	1,827.8	1,942.5	2,173.3	2,942.9
Private businesses	506.5	605.6	637.5	676.3	718.6	803.9	1,059.5
Households	693.2	846.6	886.8	927.9	990.1	1,111.2	1,533.8
Other private revenues	170.1	210.5	215.1	223.6	233.7	258.3	349.6
Governments	925.8	1,366.5	1,466.2	1,530.4	1,596.8	1,792.2	2,605.9
Federal government	528.2	843.1	918.5	959.7	994.7	1,116.9	1,649.6
State and local governments	397.7	523.4	547.7	570.8	602.2	675.3	956.3
ANNUAL GROWTH							
NHE	7.3%	4.0%	5.8%	4.8%	5.4%	5.9%	5.8%
Businesses, household, and other private revenues	6.5	2.8	4.6	5.1	6.3	5.8	5.2
Private businesses	6.9	2.6	5.3	6.1	6.3	5.8	4.7
Households	6.1	2.9	4.7	4.6	6.7	5.9	5.5
Other private revenues	6.8	3.1	2.2	4.0	4.5	5.1	5.2
Governments	8.9	5.7	7.3	4.4	4.3	5.9	6.4
Federal government	9.4	6.9	8.9	4.5	3.6	6.0	6.7
State and local governments	8.2	4.0	4.6	4.2	5.5	5.9	6.0
DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private revenues	60	55	54	54	55	55	53
Private businesses	22	20	20	20	20	20	19
Households	30	28	28	28	28	28	28
Other private revenues	7	7	7	7	7	7	6
Governments	40	45	46	46	45	45	47
Federal government	23	28	29	29	28	28	30
State and local governments	17	17	17	17	17	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts methodology paper, 2015 (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007. [b]Projected.

25 (data not shown).

National health expenditures collectively sponsored by private businesses, households, and other private revenues are projected to represent 53 percent of total expenses by 2025, down from 54 percent in 2015 (Exhibit 5). As baby boomers reach Medicare eligibility age, many are expected to switch from private coverage, thereby shifting spending to the Medicare program. Although Medicare spending sponsored by private businesses and households is expected to increase 1 percentage point as a share of NHE by 2025, out-of-pocket and private health insurance premium contributions sponsored by these sources are projected to fall by 2 percentage points as a share of NHE over the same period (data not shown).

Conclusion

There is considerable uncertainty regarding how the nation's health care will be delivered and paid for going forward. This analysis finds that under current law and following the recent significant period of transition associated with coverage expansions, health care enrollment and spending trends are projected to revert to being fundamentally driven by changes in economics and demographics. As a result, health care spending is projected to grow 5.6 percent per year, on average, over the period 2016–25 and increase to 19.9 percent of GDP by 2025. Irrespective of any changes in law, it is expected that because of continued cost pressures associated with paying for health care, employers, insurers, and other payers will continue to pursue strategies that seek to effectively manage the use and cost of health care goods and services. ■

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NOTES

1 One exception is that the projections assume that the level of funding for the Children's Health Insurance Program does not expire throughout the projection period.

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19 The biggest impact is usually seen in the year following the patent's expiration. For many drugs losing patent protection, there are restrictions in the number of generic competitors for the first six months after patent expiration, which mean lower immediate price declines, and some patents expire late in the year.

NATIONAL CENTER FOR HEALTH STATISTICS
National Health Interview Survey Early Release Program

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2016

by Michael E. Martinez, M.P.H., M.H.S.A., Emily P. Zammitti, M.P.H., and Robin A. Cohen, Ph.D.,
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What's New?

- This report provides health insurance estimates for 38 selected states using 2016 National Health Interview Survey data.

Highlights

- In the first 9 months of 2016, 28.2 million (8.8%) persons of all ages were uninsured at the time of interview—20.4 million fewer persons than in 2010 and 0.4 million fewer persons than in 2015 (a nonsignificant difference).
- In the first 9 months of 2016, among adults aged 18–64, 12.3% were uninsured at the time of interview, 20.3% had public coverage, and 69.0% had private health insurance coverage.
- In the first 9 months of 2016, among children aged 0–17 years, 5.0% were uninsured, 43.4% had public coverage, and 53.5% had private coverage.
- Among adults aged 18–64, the percentage with private coverage through the Health Insurance Marketplace or state-based exchanges has not changed significantly—from 4.9% (9.5 million) in the third quarter of 2015 to 4.8% (9.4 million) in the third quarter of 2016.
- The percentage of persons under age 65 with private insurance enrolled in a high-deductible health plan (HDHP) increased, from 36.7% in 2015 to 39.1% in the first 9 months of 2016.

Introduction

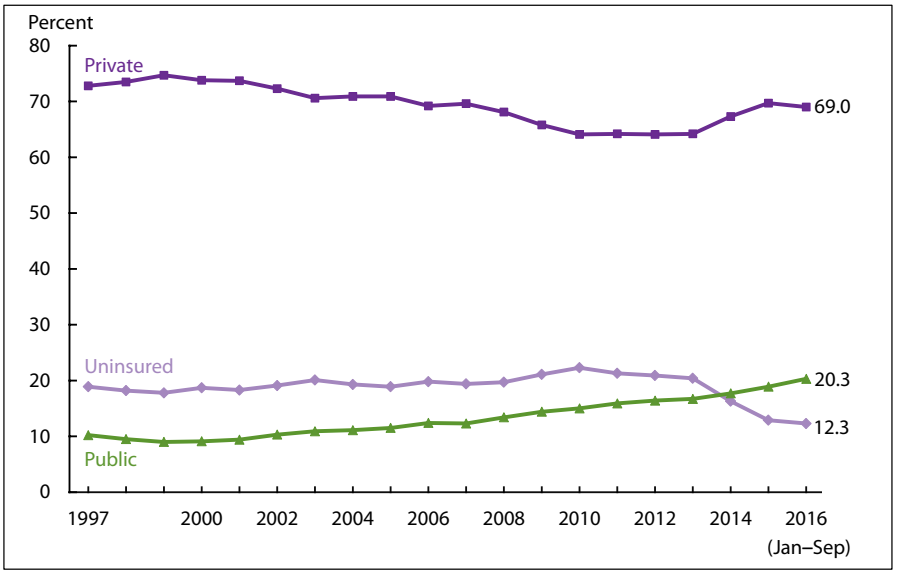
This report from the National Center for Health Statistics (NCHS) presents selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–September 2016 National Health Interview Survey (NHIS), along with comparable estimates from previous calendar years. Estimates for 2016 are based on data for 73,223 persons.

Three estimates of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. Estimates of public and private coverage, coverage through exchanges, and enrollment in high-deductible health plans (HDHPs) and consumer-directed health plans (CDHPs) are also presented. Detailed appendix tables at the end of this report show estimates by selected demographics. Definitions are provided in the Technical Notes at the end of this report.

This report is updated quarterly and is part of the NHIS Early Release (ER) Program, which releases updated selected estimates that are available from the NHIS website at http://www.cdc.gov/nchs/nhis.htm.

Estimates for each calendar quarter, by selected demographics, are also available as a separate set of tables through the ER Program. For more information about NHIS and the ER Program, see Technical Notes and Additional Early Release Program Products at the end of this report.

Figure 1. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview: United States, 1997–September 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2016, Family Core component.

Results

From January through September 2016, the percentage of persons of all ages who were uninsured at the time of interview was 8.8% (28.2 million). The decrease of 0.3 percentage points from the 2015 uninsured rate of 9.1% (28.6 million) was not statistically significant. About 20.4 million fewer persons lacked health insurance coverage in the first 9 months of 2016 compared with 2010 (48.6 million or 16.0%).

Long-term trends

In the first 9 months of 2016, among adults aged 18–64, 12.3% were uninsured at the time of interview, 20.3% had public coverage, and 69.0% had private health insurance coverage (Figure 1). From 1997 through 2013, the percentage of adults aged 18–64 who were uninsured at the time of interview generally increased. More recently, the percentage of uninsured adults aged 18–64 decreased, from 20.4% in 2013 to 12.3% in the first 9 months of 2016. During this 3-year period, corresponding increases were seen in both public and private coverage among adults aged 18–64.

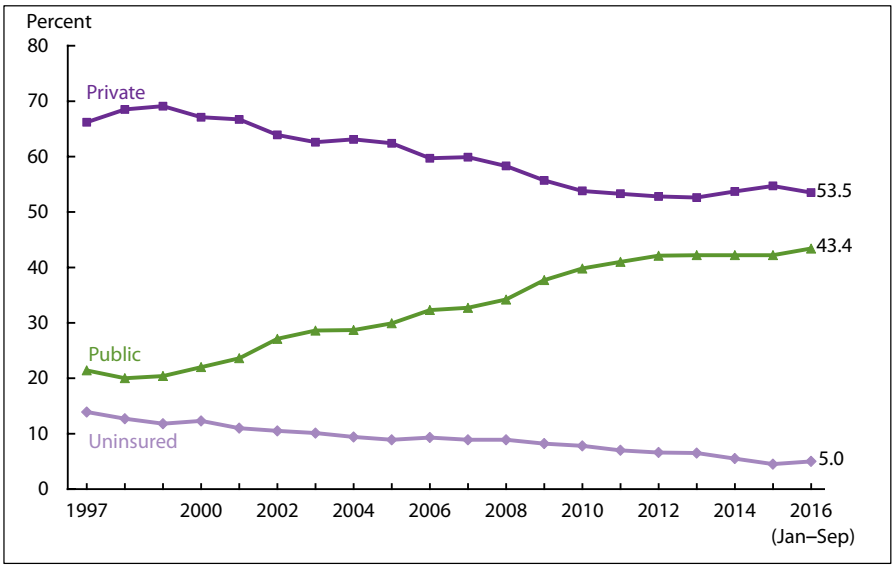
In the first 9 months of 2016, among children aged 0–17 years, 5.0% were uninsured, 43.4% had public coverage, and 53.5% had private coverage (Figure 2). The percentage of children who were uninsured generally decreased, from 13.9% in 1997 to 5.0% in the first 9 months of 2016. From 1997 through 2012, the percentage of children with private coverage generally decreased, and the percentage of children with public coverage generally increased. However, more recently, the percentage of children with public or private coverage has leveled off. From 2011 through the first 9 months of 2016, public coverage for children ranged between 41.0% and 43.4%. The percentage of children with private coverage was unchanged from 2011 (53.3%) through the first 9 months of 2016 (53.5%).

Short-term trends by age

In the first 9 months of 2016, adults aged 25–34 were almost twice as likely as adults aged 45–64 to lack health insurance coverage (16.4% compared with 8.6%) (Figure 3). The observed difference in uninsured rates for adults aged 18–24 (13.6%) and 35–44 (14.7%) was not significant.

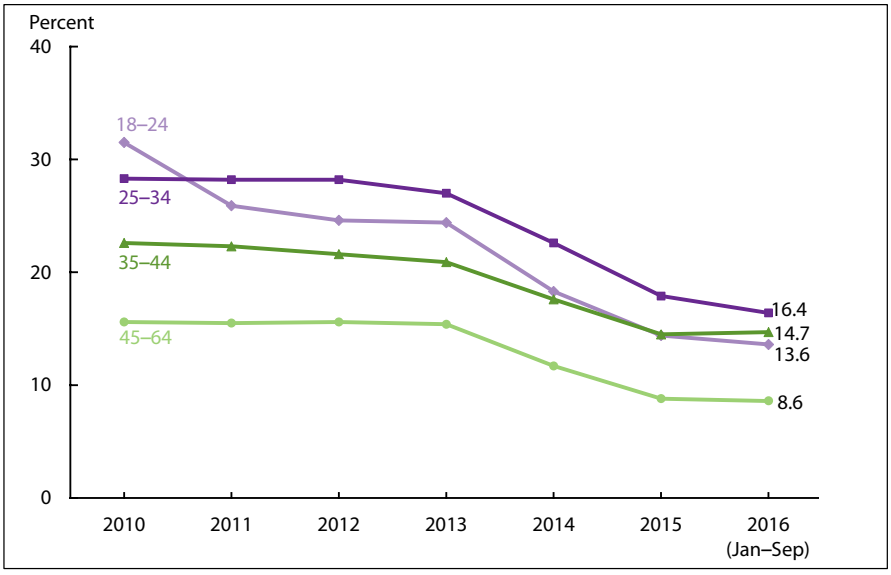
The rates of uninsurance at the time of interview remained relatively stable from 2010 through 2013 for all age groups except adults aged 18-24 (Figure 3). Among adults aged 18–24, the percentage of those uninsured decreased, from 31.5% in 2010 to 25.9% in 2011, and then remained stable through 2013. For all age groups, the percentage who were uninsured decreased significantly from 2013 through the first 9 months of 2016. The magnitude of the decreases ranged from –6.2 percentage points for adults aged 45–64 to –10.8 percentage points for adults aged 18–24. For adults aged 18–24, 35–44, and 45–64, the rates of uninsurance at the time of interview did not change significantly between 2015 and the first 9 months of 2016. Among adults aged 25–34, the percent uninsured decreased from 17.9% in 2015 to 16.4% in the first 9 months of 2016.

Figure 2. Percentage of children aged 0-17 years who were uninsured or had private or public coverage at the time of interview: United States, 1997–September 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2016, Family Core component.

Figure 3. Percentage of adults aged 18–64 who were uninsured at the time of interview, by age group: United States, 2010–September 2016



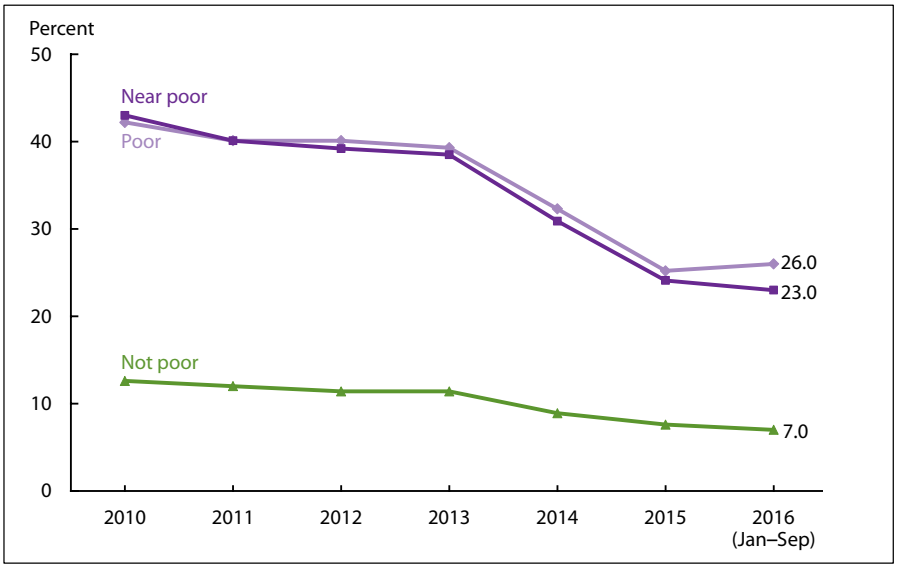
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Short-term trends by poverty status

In the first 9 months of 2016, among adults aged 18–64, 26.0% of those who were poor, 23.0% of those who were near poor, and 7.0% of those who were not poor lacked health insurance coverage at the time of interview (Figure 4). A decrease was noted in the percentage of uninsured adults from 2010 through the first 9 months of 2016 among all three poverty groups. However, the greatest decreases in the uninsured rate since 2013 were among adults who were poor or near poor. More recently, among adults who were poor, near poor, and not poor, there was no significant change in the percent uninsured between 2015 and the first 9 months of 2016.

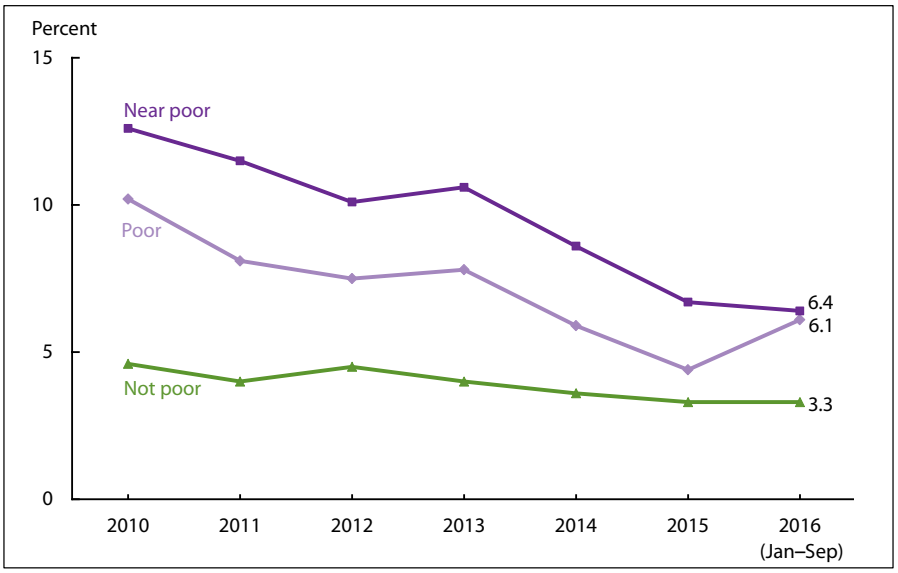
In the first 9 months of 2016, among children aged 0–17 years, 6.1% of those who were poor, 6.4% of those who were near poor, and 3.3% of those who were not poor lacked health insurance coverage at the time of interview (Figure 5). A general decrease in the percentage of uninsured children was observed among the poor, near poor, and not poor from 2010 through 2015. More recently, among children who were poor, near poor, and not poor, there was no significant change in the percent uninsured between 2015 and the first 9 months of 2016. The observed increase in the percentage of poor children who were uninsured, from 4.4% in 2015 to 6.1% in the first 9 months of 2016, was not significant.

Figure 4. Percentage of adults aged 18–64 who were uninsured at the time of interview, by poverty status: United States, 2010–September 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Figure 5. Percentage of children aged 0–17 years who were uninsured at the time of interview, by poverty status: United States, 2010–September 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Short-term trends by race and ethnicity

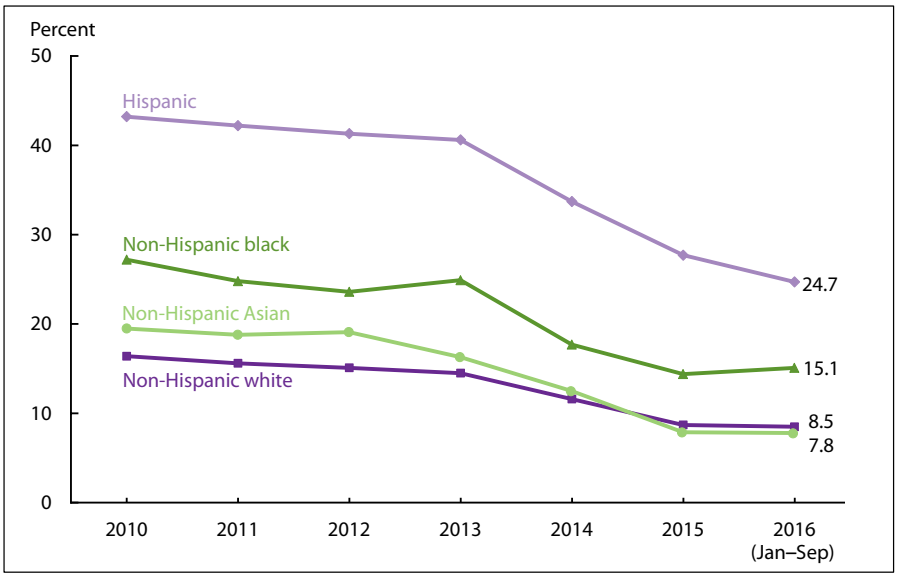
In the first 9 months of 2016, 24.7% of Hispanic, 15.1% of non-Hispanic black, 8.5% of non-Hispanic white, and 7.8% of non-Hispanic Asian adults aged 18–64 lacked health insurance coverage at the time of interview (Figure 6). Significant decreases in the percentage of uninsured adults were observed between 2013 and the first 9 months of 2016 for Hispanic, non-Hispanic black, non-Hispanic white, and non-Hispanic Asian adults. Hispanic adults had the greatest percentage point decrease in the uninsured rate between 2013 (40.6%) and the first 9 months of 2016 (24.7%). For all non-Hispanic groups shown in Figure 6, the rates of uninsurance at the time of interview did not significantly change from 2015 through the first 9 months of 2016. However, for Hispanic adults the percentage uninsured decreased from 27.7% in 2015 to 24.7% in the first 9 months of 2016.

Periods of noncoverage

Among adults aged 18–64, the percentage of those who were uninsured at the time of interview decreased, from 22.3% (42.5 million) in 2010 to 12.3% (24.3 million) in the first 9 months of 2016 (Figure 7). The percentage of adults who were uninsured for at least part of the past year decreased, from 26.7% (51.0 million) in 2010 to 17.1% (33.7 million) in the first 9 months of 2016. The percentage of adults who were uninsured for more than a year decreased, from 16.8% (32.0 million) in 2010 to 7.6% (15.0 million) in the first 9 months of 2016.

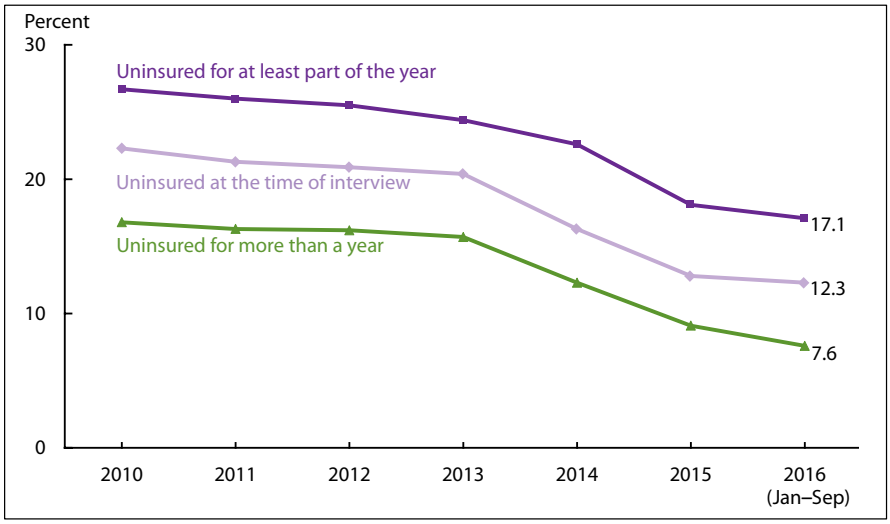
More recently, the observed changes in the percentage of adults aged 18–64 who were uninsured at least part of the year or at the time of interview between 2015 and the first 9 months of 2016 were not significant. However, the decrease in the percentage of adults who were uninsured for more than a year between 2015 (9.1%) and the first 9 months of 2016 (7.6%) was significant.

Figure 6. Percentage of adults aged 18–64 who were uninsured at the time of interview, by race and ethnicity: United States, 2010–September 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Figure 7. Percentage of adults aged 18–64 without health insurance, by three measures of uninsurance: United States, 2010–September 2016



NOTES: In 2016, answer categories for those who are currently uninsured concerning the length of noncoverage were modified. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable with previous years. For more information on this change, see Technical Notes in report. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

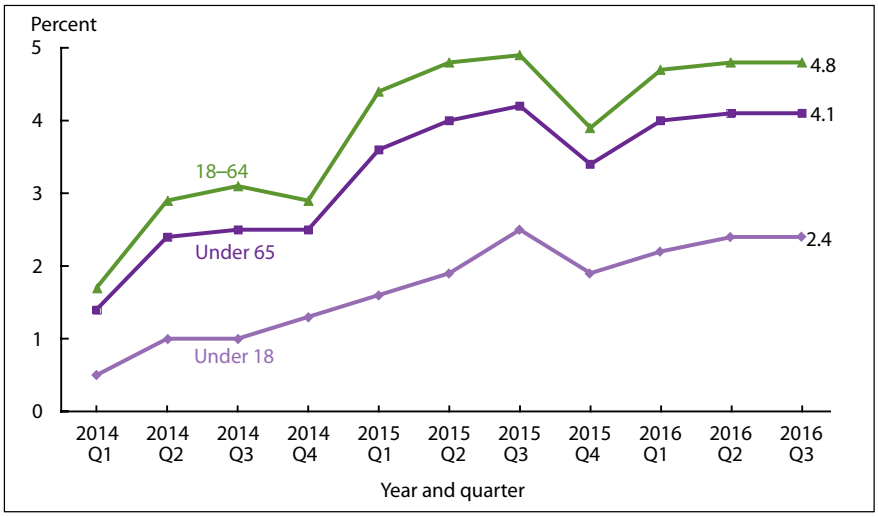
Private exchange coverage

Among persons under age 65, 64.8% (175.3 million) were covered by private health insurance plans at the time of interview in the first 9 months of 2016. This includes 4.1% (11.0 million) covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. There was no significant change in the percentage of persons under age 65 who were enrolled in exchange plans, from 4.2% (11.3 million) in the third quarter of 2015 to 4.1% (11.1 million) in the third quarter of 2016 (Figure 8).

Among adults aged 18–64, 69.0% (136.0 million) were covered by private health insurance plans at the time of interview in the first 9 months of 2016. This includes 4.7% (9.3 million) covered by private health insurance plans obtained through the Health Insurance Marketplace or state-based exchanges. The percentage of adults aged 18–64 covered by exchange plans did not significantly change from the third quarter of 2015 (4.9% or 9.5 million) to the third quarter of 2016 (4.8% or 9.4 million). However, this percentage increased significantly, from 3.9% (7.8 million) in the fourth quarter of 2015 to 4.8% (9.4 million) in the third quarter of 2016 (Figure 8). The percentage of persons aged 18–64 who were enrolled in exchange plans did not change significantly from the first quarter of 2016 (4.7% or 9.2 million) to the third quarter of 2016 (4.8% or 9.4 million) (Figure 8).

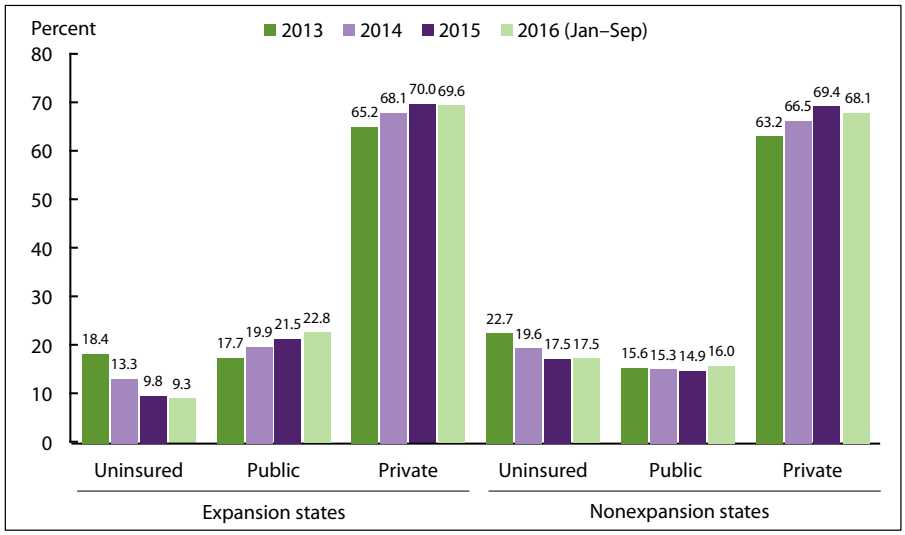
Among children aged 0–17 years, 53.5% (39.3 million) were covered by private health insurance at the time of interview in the first 9 months of 2016. This includes 2.3% (1.7 million) covered by plans obtained through the Health Insurance Marketplace or state-based exchanges. The percentage of children enrolled in exchange plans was relatively unchanged from 2.5% (1.8 million) in the third quarter of 2015 to 2.4% (1.7 million) in the third quarter of 2016 (Figure 8).

Figure 8. Percentage of persons under age 65 with private health insurance obtained through the Health Insurance Marketplace or state-based exchanges, by age group and quarter: United States, January 2014–September 2016



NOTES: Includes persons who have purchased a private health insurance plan through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). 2014 is the first year that all states had exchange-based coverage. All persons who have exchange-based coverage are considered to have private health insurance. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2014–2016, Family Core component.

Figure 9. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview, by year and state Medicaid expansion status: United States, 2013–September 2016



NOTES: For 2013 and 2014, there were 26 Medicaid expansion states. For 2015, there were 29 Medicaid expansion states. For 2016, there were 32 Medicaid expansion states. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2013–2016, Family Core component.

Health insurance coverage by state Medicaid expansion status

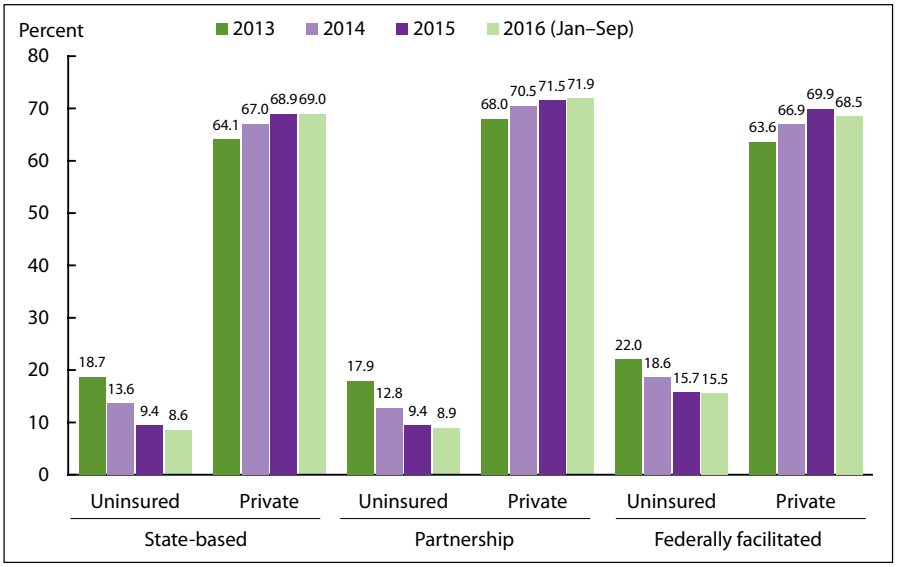
Under provisions of the Affordable Care Act (ACA) of 2010, states have the option to expand Medicaid coverage to those with low income. From January through September 2016, adults aged 18–64 residing in Medicaid expansion states were less likely to be uninsured than those residing in nonexpansion states (Figure 9). In Medicaid expansion states, the percentage of uninsured adults decreased, from 18.4% in 2013 to 9.3% in the first 9 months of 2016. In nonexpansion states, the percentage of uninsured adults decreased, from 22.7% in 2013 to 17.5% in the first 9 months of 2016. In both Medicaid expansion states and nonexpansion states, the percentage of adults aged 18–64 who were uninsured or had private or public coverage did not change significantly between 2015 and the first 9 months of 2016.

Health insurance coverage by state Health Insurance Marketplace type

Under provisions of ACA, states have the option to set up and operate their own Health Insurance Marketplace, rely on a Federally Facilitated Marketplace operated solely by the federal government, or have a hybrid partnership Marketplace that is operated by the federal government but where the state runs certain functions and makes key decisions. From January through September 2016, adults aged 18–64 in states with a Federally Facilitated Marketplace were more likely to be uninsured than those in states with a state-based Marketplace or states with a partnership Marketplace (Figure 10).

Among adults aged 18–64, decreases were seen in the uninsured rates between 2013 and the first 9 months of 2016 in states with a state-based Marketplace, a partnership Marketplace, and a Federally Facilitated Marketplace. For all three state Health Insurance Marketplace types, the rates of uninsurance and private coverage at the time of interview among adults aged 18–64 did not change significantly from 2015 through the first 9 months of 2016 (Figure 10).

Figure 10. Percentage of adults aged 18–64 who were uninsured or had private coverage at the time of interview, by year and state Health Insurance Marketplace type: United States, 2013–September 2016

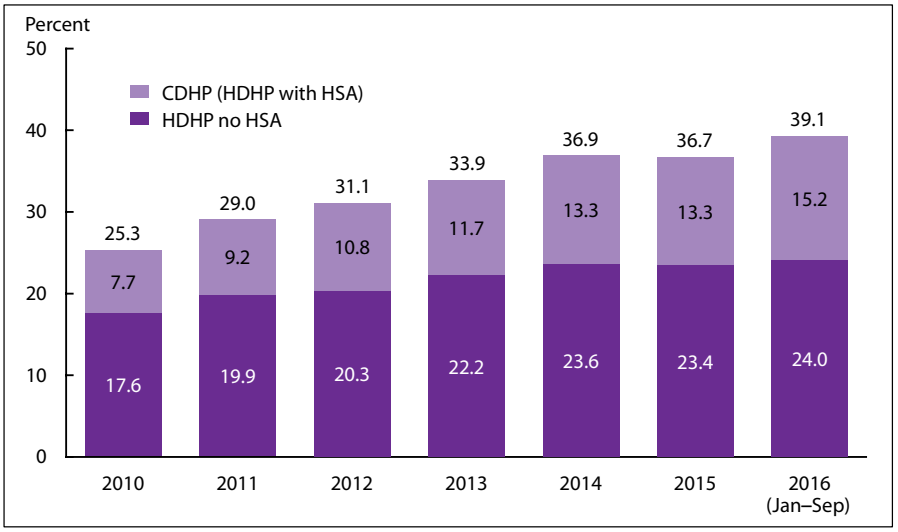


NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2013–2016, Family Core component.

Estimates of enrollment in HDHPs and CDHPs

In the first 9 months of 2016, 39.1% of persons under age 65 with private health insurance were enrolled in an HDHP, including 15.2% who were enrolled in a CDHP (an HDHP with a health savings account [HSA]) and 24.0% who were enrolled in an HDHP without an HSA (Figure 11) (see Technical Notes for definitions of HDHP, CDHP, and HSA). Among those with private insurance, enrollment in HDHPs has generally increased since 2010. The percentage who were enrolled in an HDHP increased over 13 percentage points, from 25.3% in 2010 to 39.1% in the first 9 months of 2016. More recently, the percentage who were enrolled in an HDHP increased, from 36.7% in 2015 to 39.1% in the first 9 months of 2016. The percentage who were enrolled in a CDHP almost doubled, from 7.7% in 2010 to 15.2% in the first 9 months of 2016. More recently, the percentage who were enrolled in a CDHP increased, from 13.3% in 2015 to 15.2% in the first 9 months of 2016.

Figure 11. Percentage of persons under age 65 enrolled in a high-deductible health plan without a health savings account, or in a consumer-directed health plan, among those with private health insurance coverage: United States, 2010–September 2016

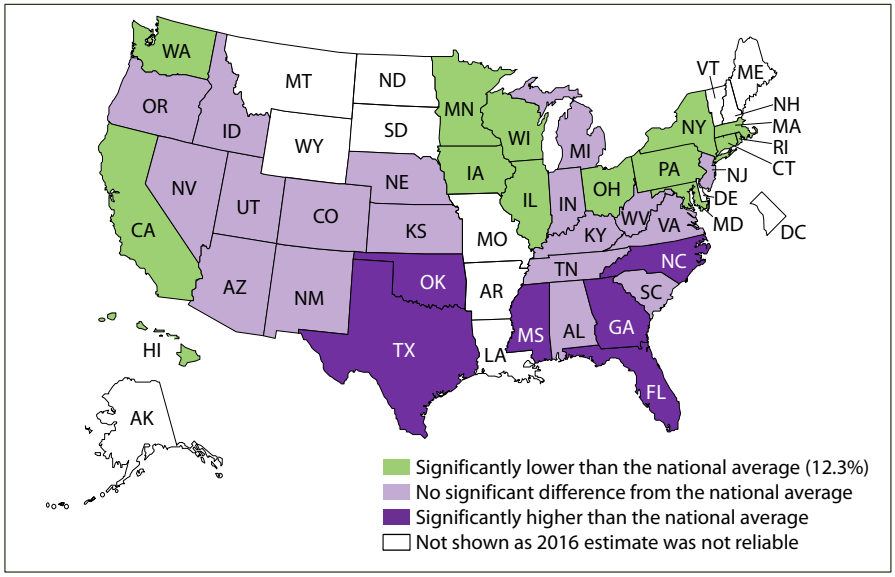


NOTES: CDHP is consumer-directed health plan, which is a high-deductible health plan (HDHP) with a health savings account (HSA). HDHP no HSA is a high-deductible health plan without an HSA. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Health insurance coverage in selected states

State-specific health insurance estimates for persons aged 18–64 are presented for 38 states (Figure 12). Among these 38 states presented for the first 9 months of 2016, California, Connecticut, Hawaii, Illinois, Iowa, Maryland, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, Washington, and Wisconsin had significantly lower percentages of uninsured adults than the national average (12.3%). Florida, Georgia, Mississippi, North Carolina, Oklahoma, and Texas had significantly higher percentages of uninsured adults than the national average in the first 9 months of 2016. Among the 38 states presented in this report, only California had a significant decrease in the percentage of adults aged 18–64 who were uninsured between 2015 (11.1%) and the first 9 months of 2016 (9.3%).

Figure 12. Uninsured at the time of interview—Comparisons of states and national percentages for adults aged 18–64: United States, January–September 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

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Technical Notes

The National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–September 2016 National Health Interview Survey (NHIS), along with comparable estimates from previous calendar years.

To reflect different policy-relevant perspectives, three measures of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured for at least part of the year prior to interview (which also includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. The three time frames are defined as:

- *Uninsured at the time of interview* provides an estimate of persons who, at the given time, may have experienced barriers to obtaining needed health care.
- *Uninsured for at least part of the past year* provides an annual caseload of persons who may experience barriers to obtaining needed health care. This measure includes persons who have insurance at the time of interview but who had a period of noncoverage in the year prior to interview, as well as those who are currently uninsured and who may have been uninsured for a long period of time.
- *Uninsured for more than a year* provides an estimate of those with a persistent lack of coverage who may be at high risk of not obtaining preventive services or care for illness and injury.

These three measures are not mutually exclusive, and a given individual may be counted in more than one of the measures. Estimates of enrollment in public and private coverage are also provided.

Persons who were uninsured at the time of interview were asked the following question (HILAST): *Not including Single Service Plans, about how long has it been since [you/Alias] last had health care coverage?* In 2016, the answer categories for the HILAST questions were modified to align NHIS responses to those of other national federal surveys. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. Prior to 2016, the answer categories for the HILAST question were: 6 months or less; More than 6 months, but not more than 1 year ago; More than 1 year, but not more than 3 years ago; More than 3 years; and Never. Beginning in 2016, the answer categories for the HILAST question are: 6 months or less; More than 6 months, but less than 1 year; 1 year; More than 1 year, but less than 3 years; 3 years or more; and Never.

This report also includes estimates for three types of consumer-directed private health care. Consumer-directed health care may enable individuals to have more control over when and how they access care, what types of care they use, and how much they spend on health care services. National attention to consumer-directed health care increased following enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173), which established tax-advantaged health savings accounts (HSAs) (1). In 2007, three questions were added to the health insurance section of NHIS to monitor enrollment in consumer-directed health care among persons with private health insurance. Estimates are provided for enrollment in high-deductible health plans (HDHPs), plans with high deductibles coupled with HSAs (i.e., consumer-directed health plans or CDHPs), and being in a family with a flexible spending account (FSA) for medical expenses not otherwise covered. For a more complete description of consumer-directed health care, see the "Definitions of selected terms."

The 2016 health insurance estimates are being released prior to final data editing and final weighting to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. However, preliminary estimates of persons without health insurance coverage are generally 0.1–0.3 percentage points lower than the final estimates due to the editing procedures used for the final data files.

Estimates for 2016 are stratified by age group, sex, race and ethnicity, poverty status, marital status, employment status, region, and educational attainment.

Data source

NHIS is a multistage probability sample survey of the civilian noninstitutionalized population of the United States, and is the source of data for this report. The survey is conducted continuously throughout the year by NCHS through an agreement with the U.S. Census Bureau.

NHIS is a comprehensive health survey that can be used to relate health insurance coverage to health outcomes and health care utilization. It has a low item nonresponse rate (about 1%) for the health insurance questions. Because NHIS is conducted throughout the year—yielding a nationally representative sample each month—data can be analyzed monthly or quarterly to monitor health insurance coverage trends.

A new sample design was implemented with the 2016 NHIS. Sample areas were reselected to take into account changes in the distribution of the U.S. population since 2006, when the previous sample design was first implemented. Commercial address lists were used as the main source of addresses, rather than field listing; and the oversampling procedures for black, Hispanic, and Asian persons that were a feature of the previous sample design were not implemented in 2016. Some of the differences between estimates for 2016 and estimates for earlier years may be attributable to the new sample design. Visit the NCHS website at http://www.cdc.gov/nchs/nhis.htm for more information on the design, content, and use of NHIS.

The data for this report are derived from the Family Core component of the 1997–2016 NHIS, which collects information on all family members in each household. Data analyses for the January–September 2016 NHIS were based on 73,223 persons in the Family Core.

Data on health insurance status were edited using a system of logic checks. Information from follow-up questions, such as plan name(s), were used to reassign insurance status and type of coverage to avoid misclassification. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year).

Data points for all figures can be found in the detailed appendix tables at the end of this report, appendix tables from previous reports, and quarterly tables available separately through the ER program.

Estimation procedures

NCHS creates survey weights for each calendar quarter of the NHIS sample. The NHIS data weighting procedure is described in more detail at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_165.pdf. Estimates were calculated using NHIS survey weights, which are calibrated to census totals for sex, age, and race and ethnicity of the U.S. civilian noninstitutionalized population. Weights for 2010 and 2011 were derived from 2000 census-based population estimates. Beginning with 2012 NHIS data, weights were derived from 2010 census-based population estimates.

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account for the complex sample design of NHIS, taking into account stratum and primary sampling unit (PSU) identifiers. The Taylor series linearization method was chosen for variance estimation.

Trends in coverage were generally assessed using Joinpoint regression (2), which characterizes trends as joined linear segments. A Joinpoint is the year where two segments with different slopes meet. Joinpoint software uses statistical criteria to determine the fewest number of segments necessary to characterize a trend and the year(s) when segments begin and end. Trends from 2010 through 2016 were also evaluated using logistic regression analysis.

State-specific health insurance estimates are presented for 38 states for persons of all ages, persons under age 65, and adults aged 18–64. State-specific estimates are presented for 8 states for children aged 0–17 years. Estimates are not presented for all 50 states and the District of Columbia due to considerations of sample size and precision. States with fewer than 1,000 interviews for persons of all ages are excluded. In addition, estimates for children in states that did not have at least 300 children with completed interviews are not presented.

For the 10 states with the largest populations (California, Florida, Georgia, Illinois, Michigan, New York, North Carolina, Ohio, Pennsylvania, and Texas), standard errors (SEs) were calculated using SUDAAN. Because of small sample size and limitations of the NHIS design, similarly estimated SEs for other states could be statistically unstable or negatively biased. Consequently, for states other than the largest 10 states, an estimated design effect was used to calculate SEs. For this report, the design effect, *deff*, of a percentage is the ratio of the sampling variance of the percentage (taking into account the complex NHIS sample design) to the sampling variance of the percentage from a simple random sample (SRS) based on the same observed number of persons.

Therefore, for each health insurance measure and domain, SEs for smaller states were calculated by multiplying the SRS SE by *A*, where *A* is the average value of the square root of *deff* over the 10 most populous states. Values of *A* ranged from 1.45 for adults aged 18–64 with public coverage to 2.47 for persons under 65 with private coverage.

Unless otherwise noted, all estimates shown meet the NCHS standard of having less than or equal to 30% relative standard error (RSE). Unless otherwise noted, differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. All differences discussed are significant unless otherwise noted. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

Definitions of selected terms

Private health insurance coverage—Includes persons who had any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care.

Public health plan coverage—Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

Uninsured—A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

Directly purchased coverage—Private insurance that was originally obtained through direct purchase or other means not related to employment.

Employment-based coverage—Private insurance that was originally obtained through a present or former employer, union, or professional association.

Exchange-based coverage—A private health insurance plan purchased through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act (ACA) of 2010 (P.L. 111–148, P.L. 111–152). In response to ACA, several questions were added to NHIS to capture health care plans obtained through exchange-based coverage.

In general, if a family member is reported to have coverage through the exchange, that report is considered accurate unless there is other information (e.g., plan name or information about premiums) that clearly contradicts that report. Similarly,

if a family member is not reported to have coverage through the exchange, that report is considered accurate unless other information clearly contradicts that report. For a more complete discussion of the procedures used in classifying exchange-based coverage, see http://www.cdc.gov/nchs/nhis/insurance.htm.

Based on these classification procedures, an average of 4.1% (standard error [SE] 0.16) of persons under age 65, 4.7% (SE 0.18) of adults aged 18–64, 2.3% (SE 0.21) of children under age 18 years, and 3.3% (SE 0.23) of adults aged 19–25 had exchange-based private health insurance coverage in the first 9 months of 2016. This equates to 11.0 million persons under age 65, 9.3 million adults aged 18–64, 1.7 million children, and 1.0 million adults aged 19–25. If these procedures had not been used and reports of coverage through the exchanges (or lack thereof) had been taken at face value, the estimates would have been higher. For example, an average of 5.1% (13.6 million) of persons under age 65 would have been reported to have obtained their coverage through exchanges in the first 9 months of 2016.

High-deductible health plan (HDHP)—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. HDHP was defined in 2015 and 2016 as a private health plan with an annual deductible of at least $1,300 for self-only coverage or $2,600 for family coverage. The deductible is adjusted annually for inflation. For 2013 and 2014, the annual deductible was $1,250 for self-only coverage and $2,500 for family coverage. For 2010 through 2012, the annual deductible was $1,200 for self-only coverage and $2,400 for family coverage.

Consumer-directed health plan (CDHP)—An HDHP with a special account to pay for medical expenses. Unspent funds are carried over to subsequent years. For plans considered to be HDHPs, a follow-up question was asked regarding these special accounts. A person is considered to have a CDHP if there is a "yes" response to the following question: *With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.*

Health savings account (HSA)—A tax-advantaged account or fund that can be used to pay medical expenses. It must be coupled with an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike FSAs, HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual. Funds may be used to pay qualified medical expenses at any time without federal tax liability. HSAs may also be referred to as Health Reimbursement Accounts (HRAs), Personal Care Accounts, Personal Medical funds, or Choice funds. The term "HSA" in this report includes accounts that use these alternative names.

Flexible spending account (FSA) for medical expenses—Persons are considered to be in a family with an FSA if there is a "yes" response to the following question*: [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pretax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.*

The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive; a person may be counted in more than one measure.

Medicaid expansion status—Under provisions of ACA, states have the option to expand Medicaid eligibility to cover adults who have income up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of October 31, 2013, 26 states and the District of Columbia were moving forward with Medicaid expansion. As of January 1, 2016, 32 states and the District of Columbia were moving forward with Medicaid expansion.

Health Insurance Marketplace—A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on cost, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low-to-moderate income and resources pay for coverage. There are three types of Health Insurance Marketplaces: (a) a state-based Marketplace set up and operated solely by the state; (b) a hybrid partnership Marketplace in which the state runs certain functions, makes key decisions, and may tailor the Marketplace to local needs and market conditions, but which is operated by the federal government; and (c) the Federally Facilitated Marketplace operated solely by the federal government.

Education—Categories are based on the years of school completed or highest degree obtained for persons aged 18 and over.

Employment—Employment status is assessed at the time of interview and is obtained for persons aged 18 and over. In this report, it is presented only for persons aged 18–64.

Hispanic or Latino origin and race—Hispanic or Latino origin and race are two separate and distinct categories. Persons of Hispanic or Latino origin may be of any race or combination of races. Hispanic or Latino origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. Race is based on the family respondent's description of his or her own racial background, as well as the racial background of other family members. More than one race may be reported for a person. For conciseness, the text, tables, and figures in this report use shorter versions of the 1997 Office of Management and Budget terms for race and Hispanic or Latino origin. For example, the category "Not Hispanic or Latino, black or African American, single race" is referred to as "non-Hispanic black, single race" in the text, tables, and figures. Estimates for non-Hispanic persons of races other than white only, black only, and Asian only, or of multiple

races, are combined into the "Other races and multiple races" category.

Poverty status—Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children), as defined by the U.S. Census Bureau for that year (3–11). Persons categorized as "Poor" have a ratio less than 1.0 (i.e., their family income is below the poverty threshold); "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes that are 200% of the poverty threshold or greater. The remaining group of respondents is coded as "Unknown" with respect to poverty status. The percentage of respondents with unknown poverty status (19.1% in 1997, 28.9% in 2005, 12.2% in 2010, 11.5% in 2011, 11.4% in 2012, 10.2% in 2013, 8.8% in 2014, 8.8% in 2015, and 7.9% in the first three quarters of 2016) is disaggregated by age and insurance status in Tables IV, V, and VI.

For more information on unknown income and unknown poverty status, see the NHIS Survey Description documents for 1997–2015 (available from: http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm).

NCHS imputes income for approximately 30% of NHIS records. The imputed income files are released a few months after the annual release of NHIS microdata and are not available for the ER updates. Therefore, ER health insurance estimates stratified by poverty status are based on reported income only and may differ from similar estimates produced later (e.g., in *Health, United States* [12]) that are based on both reported and imputed income.

Region—In the geographic classification of the U.S. population, states are grouped into the following four regions used by the U.S. Census Bureau:

Region	*States included*
Northeast	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin
South	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia
West	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming

Expanded regions—Based on a subdivision of the four regions into nine divisions. For this report, the nine Census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (13).

Additional Early Release Program Products

Two additional periodical reports are published through the NHIS ER Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* (14) is published quarterly and provides estimates of 15 selected measures of health, including insurance coverage. Other measures of health include estimates of having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

Wireless Substitution: Early Release of Estimates From the National Health Interview Survey (15) is published semiannually and provides selected estimates of telephone coverage in the United States.

Other ER reports and tabulations on special topics are released on an as-needed basis; see http://www.cdc.gov/nchs/nhis/releases.htm.

In addition to these reports, preliminary microdata files containing selected NHIS variables are produced as part of the ER Program. For each data collection year (January through December), these variables are made available four times approximately 5–6 months following the completion of data collection. NHIS data users can analyze these files through the NCHS Research Data Centers (http://www.cdc.gov/rdc/) without having to wait for the final annual NHIS microdata files to be released.

New measures and products may be added as work continues and in response to changing data needs. Feedback on these releases is welcome (nhislist@cdc.gov).

Announcements about ERs, other new data releases, and publications, as well as corrections related to NHIS, will be sent to members of the HISUSERS electronic mailing list. To join, visit the CDC website at: http://www.cdc.gov/nchs/products/nchs_listservs.htm, click on the "National Health Interview Survey (NHIS) researchers" button, and follow the directions on the page.

Suggested Citation

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Table I. Percentages (and standard errors) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and selected years: United States, 1997–September 2016

Age group and year	Uninsured[1] at the time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than a year[2]
All ages			
1997	15.4 (0.21)	19.5 (0.24)	10.4 (0.18)
2005	14.2 (0.21)	17.6 (0.23)	10.0 (0.18)
2010	16.0 (0.27)	19.8 (0.29)	11.7 (0.22)
2011	15.1 (0.25)	19.2 (0.29)	11.2 (0.21)
2012	14.7 (0.23)	18.6 (0.27)	11.1 (0.22)
2013	14.4 (0.26)	17.8 (0.27)	10.7 (0.23)
2014	11.5 (0.23)	16.5 (0.25)	8.4 (0.19)
2015	9.1 (0.19)	13.2 (0.23)	6.2 (0.15)
2016 (Jan–Sep)	8.8 (0.28)	12.5 (0.30)	5.2 (0.23)
Under 65 years			
1997	17.4 (0.24)	21.9 (0.28)	11.8 (0.21)
2005	16.0 (0.24)	19.9 (0.26)	11.3 (0.21)
2010	18.2 (0.30)	22.5 (0.33)	13.3 (0.24)
2011	17.3 (0.29)	21.8 (0.33)	12.7 (0.25)
2012	16.9 (0.27)	21.3 (0.31)	12.7 (0.24)
2013	16.6 (0.30)	20.4 (0.32)	12.4 (0.27)
2014	13.3 (0.26)	19.0 (0.29)	9.7 (0.22)
2015	10.5 (0.22)	15.3 (0.27)	7.2 (0.17)
2016 (Jan–Sep)	10.3 (0.32)	14.5 (0.34)	6.1 (0.26)
0–17 years			
1997	13.9 (0.36)	18.1 (0.41)	8.4 (0.29)
2005	8.9 (0.29)	12.6 (0.33)	5.3 (0.24)
2010	7.8 (0.32)	11.6 (0.37)	4.5 (0.23)
2011	7.0 (0.27)	10.9 (0.36)	3.7 (0.19)
2012	6.6 (0.27)	10.4 (0.35)	3.7 (0.19)
2013	6.5 (0.26)	10.0 (0.33)	3.6 (0.20)
2014	5.5 (0.27)	9.4 (0.40)	3.0 (0.19)
2015	4.5 (0.24)	7.7 (0.32)	2.3 (0.16)
2016 (Jan–Sep)	5.0 (0.36)	7.7 (0.37)	2.1 (0.25)
18–64 years			
1997	18.9 (0.23)	23.6 (0.26)	13.3 (0.21)
2005	18.9 (0.26)	22.8 (0.28)	13.8 (0.23)
2010	22.3 (0.35)	26.7 (0.37)	16.8 (0.30)
2011	21.3 (0.34)	26.0 (0.37)	16.3 (0.31)
2012	20.9 (0.31)	25.5 (0.34)	16.2 (0.29)
2013	20.4 (0.37)	24.4 (0.38)	15.7 (0.34)
2014	16.3 (0.31)	22.6 (0.34)	12.3 (0.27)
2015	12.8 (0.27)	18.1 (0.33)	9.1 (0.22)
2016 (Jan–Sep)	12.3 (0.36)	17.1 (0.40)	7.6 (0.31)
19–25 years			
1997	31.4 (0.63)	39.2 (0.67)	20.8 (0.51)
2005	31.2 (0.65)	37.9 (0.68)	21.6 (0.54)
2010	33.9 (0.73)	41.7 (0.78)	24.1 (0.61)
2011	27.9 (0.71)	36.1 (0.77)	20.1 (0.61)
2012	26.4 (0.72)	33.0 (0.72)	19.6 (0.62)
2013	26.5 (0.71)	31.3 (0.79)	19.8 (0.61)
2014	20.0 (0.65)	26.9 (0.73)	14.2 (0.56)
2015	15.8 (0.58)	22.2 (0.68)	10.2 (0.43)
2016 (Jan–Sep)	14.6 (0.75)	20.3 (0.82)	7.5 (0.65)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview. In 2016, answer categories for those who are currently uninsured concerning the length of non-coverage were modified. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. For more information on this change, see Technical Notes.
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table II. Numbers (in millions) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and selected years: United States, 1997–September 2016

Age group and year	Uninsured[1] at the time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than a year[2]
All ages			
1997	41.0	51.9	27.7
2005	41.2	51.3	29.2
2010	48.6	60.3	35.7
2011	46.3	58.7	34.2
2012	45.5	57.5	34.1
2013	44.8	55.4	33.4
2014	36.0	51.6	26.3
2015	28.6	41.7	19.6
2016 (Jan–Sep)	28.2	39.9	16.6
Under 65 years			
1997	40.7	51.4	27.6
2005	41.0	50.9	29.0
2010	48.2	59.6	35.4
2011	45.9	58.0	33.9
2012	45.2	56.8	33.9
2013	44.3	54.7	33.1
2014	35.7	50.8	26.1
2015	28.4	41.1	19.4
2016 (Jan–Sep)	27.9	39.4	16.5
0–17 years			
1997	9.9	12.9	6.0
2005	6.5	9.3	3.9
2010	5.8	8.7	3.4
2011	5.2	8.1	2.7
2012	4.9	7.7	2.7
2013	4.8	7.3	2.6
2014	4.0	6.9	2.2
2015	3.3	5.7	1.7
2016 (Jan–Sep)	3.6	5.7	1.5
18–64 years			
1997	30.8	38.5	21.7
2005	34.5	41.7	25.2
2010	42.5	51.0	32.0
2011	40.7	49.9	31.2
2012	40.3	49.2	31.2
2013	39.6	47.4	30.5
2014	31.7	44.0	23.9
2015	25.1	35.5	17.8
2016 (Jan–Sep)	24.3	33.7	15.0
19–25 years			
1997	7.7	9.7	5.1
2005	8.8	10.7	6.1
2010	10.0	12.3	7.1
2011	8.4	10.8	6.0
2012	7.9	9.9	5.9
2013	8.0	9.5	6.0
2014	6.0	8.1	4.3
2015	4.8	6.7	3.1
2016 (Jan–Sep)	4.4	6.1	2.2

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview. In 2016, answer categories for those who are currently uninsured concerning the length of non-coverage were modified. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. For more information on this change, see Technical Notes.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table III. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–September 2016

Age group and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
All ages			
1997	15.4 (0.21)	23.3 (0.27)	70.7 (0.32)
2005	14.2 (0.21)	26.4 (0.30)	67.3 (0.37)
2010	16.0 (0.27)	31.4 (0.39)	60.2 (0.48)
2011	15.1 (0.25)	32.4 (0.37)	60.1 (0.48)
2012	14.7 (0.23)	33.4 (0.35)	59.6 (0.43)
2013	14.4 (0.26)	33.8 (0.36)	59.5 (0.49)
2014	11.5 (0.23)	34.6 (0.37)	61.8 (0.45)
2015	9.1 (0.19)	35.6 (0.42)	63.2 (0.46)
2016 (Jan–Sep)	8.8 (0.28)	37.1 (0.40)	62.4 (0.50)
Under 65 years			
1997	17.4 (0.24)	13.6 (0.25)	70.8 (0.35)
2005	16.0 (0.24)	16.8 (0.29)	68.4 (0.39)
2010	18.2 (0.30)	22.0 (0.38)	61.2 (0.50)
2011	17.3 (0.29)	23.0 (0.37)	61.2 (0.51)
2012	16.9 (0.27)	23.5 (0.37)	61.0 (0.47)
2013	16.6 (0.30)	23.8 (0.35)	61.0 (0.52)
2014	13.3 (0.26)	24.5 (0.36)	63.6 (0.46)
2015	10.5 (0.22)	25.3 (0.43)	65.6 (0.50)
2016 (Jan–Sep)	10.3 (0.32)	26.6 (0.46)	64.8 (0.56)
0–17 years			
1997	13.9 (0.36)	21.4 (0.48)	66.2 (0.57)
2005	8.9 (0.29)	29.9 (0.56)	62.4 (0.60)
2010	7.8 (0.32)	39.8 (0.73)	53.8 (0.75)
2011	7.0 (0.27)	41.0 (0.74)	53.3 (0.76)
2012	6.6 (0.27)	42.1 (0.72)	52.8 (0.73)
2013	6.5 (0.26)	42.2 (0.70)	52.6 (0.76)
2014	5.5 (0.27)	42.2 (0.65)	53.7 (0.68)
2015	4.5 (0.24)	42.2 (0.79)	54.7 (0.78)
2016 (Jan–Sep)	5.0 (0.36)	43.4 (0.81)	53.5 (0.91)
18–64 years			
1997	18.9 (0.23)	10.2 (0.20)	72.8 (0.30)
2005	18.9 (0.26)	11.5 (0.22)	70.9 (0.36)
2010	22.3 (0.35)	15.0 (0.30)	64.1 (0.46)
2011	21.3 (0.34)	15.9 (0.29)	64.2 (0.45)
2012	20.9 (0.31)	16.4 (0.29)	64.1 (0.42)
2013	20.4 (0.37)	16.7 (0.30)	64.2 (0.47)
2014	16.3 (0.31)	17.7 (0.32)	67.3 (0.43)
2015	12.8 (0.27)	18.9 (0.36)	69.7 (0.43)
2016 (Jan–Sep)	12.3 (0.36)	20.3 (0.40)	69.0 (0.47)
19–25 years			
1997	31.4 (0.63)	11.2 (0.46)	58.4 (0.71)
2005	31.2 (0.65)	12.9 (0.51)	56.5 (0.79)
2010	33.9 (0.73)	15.7 (0.55)	51.0 (0.84)
2011	27.9 (0.71)	16.8 (0.60)	56.2 (0.85)
2012	26.4 (0.72)	17.5 (0.59)	57.2 (0.85)
2013	26.5 (0.71)	16.1 (0.54)	58.1 (0.84)
2014	20.0 (0.65)	19.1 (0.64)	61.9 (0.88)
2015	15.8 (0.58)	19.5 (0.68)	65.7 (0.81)
2016 (Jan–Sep)	14.6 (0.75)	22.5 (0.89)	64.3 (0.95)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table IV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–September 2016

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	32.7 (0.80)	46.1 (1.01)	22.9 (0.93)
2005	28.4 (0.78)	50.6 (0.98)	22.1 (0.89)
2010	29.5 (0.83)	56.0 (0.98)	15.5 (0.70)
2011	28.2 (0.66)	56.2 (0.82)	16.6 (0.77)
2012	28.3 (0.65)	57.1 (0.83)	16.1 (0.83)
2013	27.3 (0.68)	59.0 (0.81)	14.7 (0.72)
2014	22.3 (0.66)	62.1 (0.80)	16.6 (0.69)
2015	17.2 (0.63)	65.6 (0.87)	18.5 (0.78)
2016 (Jan–Sep)	18.4 (0.89)	67.9 (1.00)	15.4 (0.73)
Near poor (≥ 100% and < 200% FPL)			
1997	30.4 (0.70)	18.2 (0.56)	53.5 (0.80)
2005	28.6 (0.63)	30.0 (0.72)	43.2 (0.89)
2010	32.3 (0.69)	36.2 (0.63)	33.2 (0.77)
2011	30.4 (0.58)	37.7 (0.73)	33.5 (0.75)
2012	29.5 (0.56)	37.1 (0.66)	35.2 (0.75)
2013	29.3 (0.70)	39.1 (0.77)	33.4 (0.79)
2014	23.5 (0.60)	41.1 (0.74)	37.3 (0.81)
2015	18.2 (0.51)	45.1 (0.77)	39.1 (0.77)
2016 (Jan–Sep)	17.3 (0.68)	49.5 (0.97)	35.5 (0.96)
Not poor (≥ 200% FPL)			
1997	8.9 (0.22)	5.3 (0.19)	87.6 (0.27)
2005	9.1 (0.22)	7.4 (0.22)	84.7 (0.30)
2010	10.7 (0.24)	9.7 (0.28)	81.0 (0.36)
2011	10.1 (0.25)	9.9 (0.26)	81.4 (0.36)
2012	9.8 (0.23)	10.3 (0.33)	81.3 (0.39)
2013	9.6 (0.24)	10.5 (0.29)	81.2 (0.39)
2014	7.6 (0.20)	9.9 (0.28)	83.7 (0.36)
2015	6.6 (0.19)	10.6 (0.31)	84.1 (0.38)
2016 (Jan–Sep)	6.2 (0.25)	11.1 (0.24)	84.2 (0.36)
Unknown			
1997	21.6 (0.59)	13.2 (0.49)	66.7 (0.71)
2005	18.5 (0.48)	16.4 (0.48)	66.2 (0.68)
2010	22.7 (0.95)	21.0 (0.69)	57.3 (1.08)
2011	21.0 (0.64)	26.2 (0.95)	53.9 (1.09)
2012	20.4 (0.73)	28.8 (0.89)	52.1 (1.00)
2013	20.5 (0.76)	24.2 (0.94)	56.8 (1.24)
2014	15.0 (0.80)	22.2 (0.91)	64.1 (1.24)
2015	11.9 (0.80)	24.4 (1.16)	64.9 (1.20)
2016 (Jan–Sep)	13.9 (1.23)	27.7 (1.13)	60.4 (1.42)

[1]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table V. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–September 2016

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	40.2 (0.88)	34.3 (0.93)	26.8 (1.09)
2005	38.5 (0.95)	35.6 (0.98)	26.8 (1.03)
2010	42.2 (0.99)	38.8 (0.97)	19.6 (0.89)
2011	40.1 (0.92)	39.6 (0.93)	21.2 (1.02)
2012	40.1 (0.90)	40.8 (0.94)	20.2 (1.09)
2013	39.3 (1.00)	42.4 (0.95)	19.0 (0.97)
2014	32.3 (0.93)	46.6 (0.95)	21.9 (0.92)
2015	25.2 (0.90)	51.7 (1.08)	24.3 (1.04)
2016 (Jan–Sep)	26.0 (1.25)	55.0 (1.34)	20.6 (0.93)
Near poor (≥ 100% and < 200% FPL)			
1997	34.9 (0.71)	14.6 (0.51)	52.6 (0.76)
2005	36.6 (0.73)	20.0 (0.61)	45.0 (0.85)
2010	43.0 (0.74)	23.7 (0.55)	34.7 (0.74)
2011	40.1 (0.72)	25.9 (0.69)	35.4 (0.75)
2012	39.2 (0.68)	25.2 (0.57)	37.2 (0.74)
2013	38.5 (0.84)	26.6 (0.78)	36.4 (0.78)
2014	30.9 (0.72)	29.6 (0.76)	41.2 (0.81)
2015	24.1 (0.62)	34.2 (0.80)	43.8 (0.79)
2016 (Jan–Sep)	23.0 (0.81)	38.6 (1.03)	40.5 (1.03)
Not poor (≥ 200% FPL)			
1997	9.9 (0.22)	5.0 (0.18)	87.1 (0.26)
2005	10.7 (0.24)	6.2 (0.20)	84.4 (0.29)
2010	12.6 (0.27)	8.1 (0.27)	80.8 (0.36)
2011	12.0 (0.28)	8.3 (0.23)	81.1 (0.35)
2012	11.4 (0.26)	8.7 (0.29)	81.3 (0.38)
2013	11.4 (0.27)	8.9 (0.26)	81.2 (0.37)
2014	8.9 (0.23)	8.5 (0.26)	83.9 (0.35)
2015	7.6 (0.22)	9.1 (0.27)	84.7 (0.33)
2016 (Jan–Sep)	7.0 (0.27)	9.6 (0.24)	84.8 (0.32)
Unknown			
1997	22.9 (0.58)	10.1 (0.41)	68.6 (0.65)
2005	21.2 (0.52)	11.3 (0.36)	68.7 (0.61)
2010	27.1 (1.10)	15.6 (0.63)	58.4 (1.11)
2011	25.6 (0.77)	17.6 (0.73)	58.1 (0.96)
2012	25.7 (0.88)	18.9 (0.76)	56.9 (0.92)
2013	24.3 (0.87)	17.6 (0.77)	59.5 (1.11)
2014	17.2 (0.88)	17.2 (0.81)	67.0 (1.20)
2015	13.8 (0.82)	19.6 (0.94)	67.7 (1.09)
2016 (Jan–Sep)	15.3 (1.06)	22.2 (0.95)	64.6 (1.13)

[1]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table VI. Percentages (and standard errors) of children aged 0–17 years who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–September 2016

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	22.4 (0.99)	62.1 (1.31)	17.5 (1.09)
2005	13.0 (0.92)	73.3 (1.32)	15.0 (1.10)
2010	10.2 (0.96)	82.0 (1.22)	9.2 (0.70)
2011	8.1 (0.62)	84.4 (0.87)	8.9 (0.72)
2012	7.5 (0.58)	85.9 (0.80)	8.8 (0.78)
2013	7.8 (0.62)	86.1 (0.88)	7.7 (0.69)
2014	5.9 (0.52)	87.3 (0.72)	8.0 (0.62)
2015	4.4 (0.47)	87.9 (0.86)	9.1 (0.81)
2016 (Jan–Sep)	6.1 (0.78)	88.7 (1.04)	7.1 (0.84)
Near poor (≥ 100% and < 200% FPL)			
1997	22.8 (0.96)	24.3 (0.93)	55.0 (1.15)
2005	14.7 (0.79)	47.3 (1.21)	40.0 (1.31)
2010	12.6 (0.73)	59.2 (1.16)	30.5 (1.18)
2011	11.5 (0.69)	60.8 (1.17)	29.9 (1.07)
2012	10.1 (0.70)	61.0 (1.30)	31.1 (1.18)
2013	10.6 (0.72)	64.4 (1.16)	27.3 (1.17)
2014	8.6 (0.65)	64.3 (1.23)	29.4 (1.19)
2015	6.7 (0.59)	66.4 (1.17)	29.8 (1.14)
2016 (Jan–Sep)	6.4 (0.69)	70.4 (1.27)	25.9 (1.26)
Not poor (≥ 200% FPL)			
1997	6.1 (0.33)	6.3 (0.32)	88.9 (0.43)
2005	4.6 (0.30)	10.7 (0.47)	85.6 (0.52)
2010	4.6 (0.29)	14.9 (0.57)	81.4 (0.61)
2011	4.0 (0.27)	15.0 (0.55)	82.1 (0.58)
2012	4.5 (0.31)	15.2 (0.62)	81.3 (0.64)
2013	4.0 (0.28)	15.6 (0.62)	81.2 (0.65)
2014	3.6 (0.28)	14.4 (0.56)	83.1 (0.58)
2015	3.3 (0.26)	15.5 (0.69)	82.1 (0.74)
2016 (Jan–Sep)	3.3 (0.32)	16.1 (0.57)	82.1 (0.68)
Unknown			
1997	18.3 (0.90)	21.4 (0.97)	61.7 (1.18)
2005	11.0 (0.66)	30.8 (1.05)	59.3 (1.16)
2010	8.8 (0.89)	38.1 (1.71)	53.7 (1.74)
2011	10.4 (0.76)	45.9 (1.70)	44.5 (1.66)
2012	8.2 (0.77)	51.8 (1.50)	41.2 (1.49)
2013	9.2 (1.00)	43.7 (2.16)	48.6 (2.20)
2014	8.0 (1.41)	37.9 (2.01)	54.8 (2.05)
2015	6.3 (1.36)	37.9 (2.33)	56.6 (2.24)
2016 (Jan–Sep)	10.0 (2.61)	44.3 (2.59)	47.7 (3.14)

[1]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table VII. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and sex: United States, January–September 2016

Age group and sex	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Age group (years)			
All ages	8.8 (0.28)	37.1 (0.40)	62.4 (0.50)
Under age 65	10.3 (0.32)	26.6 (0.46)	64.8 (0.56)
0–17	5.0 (0.36)	43.4 (0.81)	53.5 (0.91)
18–64	12.3 (0.36)	20.3 (0.40)	69.0 (0.47)
18–24	13.6 (0.62)	24.1 (0.86)	63.6 (0.90)
25–34	16.4 (0.55)	20.0 (0.67)	64.5 (0.77)
35–44	14.7 (0.58)	16.7 (0.63)	69.7 (0.75)
45–64	8.6 (0.33)	20.8 (0.50)	73.0 (0.51)
65 and over	0.6 (0.11)	96.0 (0.23)	49.0 (0.95)
19–25	14.6 (0.75)	22.5 (0.89)	64.3 (0.95)
Sex			
Male:			
All ages	10.1 (0.31)	34.6 (0.38)	63.0 (0.46)
Under age 65	11.7 (0.35)	24.8 (0.44)	65.2 (0.52)
0–17	4.8 (0.38)	43.3 (0.87)	53.8 (0.96)
18–64	14.4 (0.43)	17.6 (0.41)	69.6 (0.46)
18–24	15.8 (0.83)	18.8 (0.89)	66.7 (1.04)
25–34	20.2 (0.72)	15.5 (0.81)	65.3 (0.90)
35–44	17.1 (0.84)	13.7 (0.64)	70.1 (0.97)
45–64	9.5 (0.45)	20.1 (0.61)	72.8 (0.56)
65 and over	0.6 (0.12)	95.5 (0.36)	49.3 (1.01)
19–25	17.1 (0.91)	16.7 (0.85)	67.6 (1.08)
Female:			
All ages	7.6 (0.28)	39.5 (0.49)	61.8 (0.60)
Under age 65	9.0 (0.33)	28.4 (0.54)	64.4 (0.65)
0–17	5.1 (0.42)	43.5 (0.95)	53.2 (1.08)
18–64	10.4 (0.35)	22.9 (0.49)	68.4 (0.56)
18–24	11.4 (0.86)	29.4 (1.21)	60.5 (1.43)
25–34	12.8 (0.61)	24.5 (0.88)	63.7 (0.99)
35–44	12.4 (0.59)	19.6 (0.79)	69.3 (0.90)
45–64	7.9 (0.31)	21.4 (0.52)	73.2 (0.59)
65 and over	0.7 (0.14)	96.4 (0.24)	48.9 (1.05)
19–25	12.2 (0.99)	28.3 (1.26)	60.9 (1.52)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

Table VIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–September 2016

Race and ethnicity and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	31.9 (0.72)	32.0 (0.78)	36.6 (0.81)
2011	31.1 (0.68)	33.6 (0.74)	36.1 (0.82)
2012	30.4 (0.71)	34.0 (0.71)	36.4 (0.74)
2013	30.3 (0.66)	33.4 (0.62)	37.0 (0.76)
2014	25.2 (0.59)	34.6 (0.78)	41.2 (0.89)
2015	20.8 (0.56)	36.2 (0.84)	43.8 (0.81)
2016 (Jan–Sep)	18.9 (0.88)	38.3 (1.17)	44.1 (1.14)
Non-Hispanic white, single race			
2010	13.7 (0.30)	16.4 (0.42)	71.4 (0.57)
2011	13.0 (0.32)	17.1 (0.39)	71.4 (0.55)
2012	12.7 (0.28)	17.3 (0.39)	71.5 (0.51)
2013	12.1 (0.29)	17.9 (0.38)	71.6 (0.53)
2014	9.8 (0.25)	18.1 (0.41)	73.6 (0.50)
2015	7.4 (0.21)	18.9 (0.48)	75.4 (0.54)
2016 (Jan–Sep)	7.4 (0.26)	20.0 (0.46)	74.5 (0.53)
Non-Hispanic black, single race			
2010	20.8 (0.63)	36.3 (0.79)	44.6 (0.84)
2011	19.0 (0.51)	36.9 (0.83)	45.6 (0.85)
2012	17.9 (0.50)	38.2 (0.77)	45.4 (0.79)
2013	18.9 (0.51)	37.5 (0.92)	44.9 (1.01)
2014	13.5 (0.49)	40.3 (0.76)	47.7 (0.86)
2015	11.2 (0.48)	39.2 (1.01)	51.3 (1.02)
2016 (Jan–Sep)	11.9 (0.62)	39.5 (1.35)	50.5 (1.16)
Non-Hispanic Asian, single race			
2010	16.8 (0.76)	14.9 (0.98)	69.1 (1.17)
2011	16.0 (0.89)	17.6 (1.14)	67.0 (1.40)
2012	16.4 (0.93)	16.6 (0.85)	67.5 (1.24)
2013	13.8 (0.81)	17.5 (1.00)	69.4 (1.27)
2014	10.6 (0.61)	16.7 (0.86)	73.4 (1.01)
2015	6.7 (0.51)	18.0 (1.34)	75.9 (1.44)
2016 (Jan–Sep)	6.6 (0.85)	20.4 (1.46)	73.3 (1.53)
Non-Hispanic other races and multiple races			
2010	22.4 (4.83)	30.3 (2.14)	48.7 (3.83)
2011	19.1 (1.78)	32.5 (1.60)	50.6 (1.89)
2012	16.4 (1.33)	35.8 (1.77)	50.8 (2.16)
2013	16.0 (1.17)	35.9 (1.75)	50.1 (1.97)
2014	12.8 (1.30)	36.2 (1.69)	52.7 (2.01)
2015	11.1 (1.00)	37.0 (1.86)	53.7 (1.99)
2016 (Jan–Sep)	13.2 (1.15)	36.5 (2.26)	52.8 (2.44)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table IX. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–September 2016

Race and ethnicity and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	43.2 (0.91)	16.3 (0.64)	41.1 (0.85)
2011	42.2 (0.89)	18.1 (0.63)	40.3 (0.82)
2012	41.3 (0.89)	19.0 (0.64)	40.4 (0.73)
2013	40.6 (0.88)	18.0 (0.62)	42.1 (0.70)
2014	33.7 (0.76)	20.6 (0.73)	46.4 (0.86)
2015	27.7 (0.72)	23.0 (0.84)	50.0 (0.85)
2016 (Jan–Sep)	24.7 (1.17)	25.8 (1.32)	50.8 (1.21)
Non-Hispanic white, single race			
2010	16.4 (0.35)	12.8 (0.34)	72.2 (0.52)
2011	15.6 (0.35)	13.4 (0.31)	72.5 (0.48)
2012	15.1 (0.31)	13.7 (0.33)	72.7 (0.46)
2013	14.5 (0.34)	14.4 (0.32)	72.7 (0.49)
2014	11.6 (0.29)	14.6 (0.36)	75.3 (0.47)
2015	8.7 (0.25)	15.7 (0.42)	77.3 (0.47)
2016 (Jan–Sep)	8.5 (0.27)	16.8 (0.37)	76.5 (0.47)
Non-Hispanic black, single race			
2010	27.2 (0.75)	25.3 (0.70)	49.3 (0.81)
2011	24.8 (0.65)	26.2 (0.75)	50.5 (0.79)
2012	23.6 (0.61)	27.0 (0.68)	50.8 (0.75)
2013	24.9 (0.62)	26.6 (0.80)	50.0 (0.91)
2014	17.7 (0.60)	30.5 (0.73)	53.4 (0.84)
2015	14.4 (0.57)	29.7 (0.84)	57.8 (0.90)
2016 (Jan–Sep)	15.1 (0.69)	29.6 (1.17)	57.0 (1.05)
Non-Hispanic Asian, single race			
2010	19.5 (0.92)	11.2 (0.72)	70.2 (1.05)
2011	18.8 (0.96)	13.6 (0.87)	68.0 (1.27)
2012	19.1 (0.92)	13.2 (0.83)	68.2 (1.15)
2013	16.3 (0.88)	14.1 (0.91)	70.4 (1.28)
2014	12.5 (0.65)	13.7 (0.84)	74.5 (1.01)
2015	7.9 (0.58)	15.5 (1.16)	77.2 (1.27)
2016 (Jan–Sep)	7.8 (0.92)	17.4 (1.36)	75.3 (1.37)
Non-Hispanic other races and multiple races			
2010	32.8 (5.76)	20.6 (1.94)	48.5 (4.77)
2011	27.1 (2.01)	23.6 (1.53)	52.1 (2.17)
2012	24.9 (1.78)	26.1 (1.62)	52.0 (2.24)
2013	23.8 (1.66)	26.8 (1.84)	51.6 (2.26)
2014	19.5 (1.65)	25.2 (1.51)	56.9 (2.06)
2015	16.1 (1.42)	29.0 (1.76)	56.9 (1.88)
2016 (Jan–Sep)	18.0 (1.49)	28.0 (1.86)	56.0 (2.44)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table X. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by selected demographic characteristics: United States, January–September 2016

Selected characteristic	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Race and ethnicity			
Hispanic or Latino	24.7 (1.17)	25.8 (1.32)	50.8 (1.21)
Non-Hispanic:			
White, single race	8.5 (0.27)	16.8 (0.37)	76.5 (0.47)
Black, single race	15.1 (0.69)	29.6 (1.17)	57.0 (1.05)
Asian, single race	7.8 (0.92)	17.4 (1.36)	75.3 (1.37)
Other races and multiple races	18.0 (1.49)	28.0 (1.86)	56.0 (2.44)
Region			
Northeast	8.0 (0.84)	22.1 (0.84)	71.7 (1.49)
Midwest	9.5 (0.40)	18.5 (0.60)	73.8 (0.82)
South	17.5 (0.62)	17.8 (0.54)	66.2 (0.72)
West	10.4 (0.52)	24.1 (0.93)	66.9 (1.02)
Education			
Less than high school	28.7 (1.11)	37.2 (1.09)	35.7 (1.10)
High school diploma or GED[4]	16.3 (0.49)	26.1 (0.54)	59.4 (0.65)
More than high school	7.4 (0.27)	14.5 (0.37)	79.6 (0.39)
Employment status			
Employed	11.3 (0.36)	11.6 (0.32)	78.1 (0.40)
Unemployed	32.3 (1.42)	38.7 (1.61)	29.5 (1.51)
Not in workforce	11.6 (0.53)	45.2 (0.72)	47.3 (0.71)
Poverty status[5]			
< 100% FPL	26.0 (1.25)	55.0 (1.34)	20.6 (0.93)
≥ 100% and ≤ 138% FPL	24.5 (1.45)	45.7 (1.81)	31.8 (1.57)
> 138% and ≤ 250% FPL	19.6 (0.63)	27.8 (0.77)	54.5 (0.83)
> 250% and ≤ 400% FPL	9.9 (0.59)	13.6 (0.58)	78.3 (0.69)
> 400% FPL	3.9 (0.22)	5.9 (0.25)	91.5 (0.23)
Unknown	13.6 (0.96)	19.1 (0.83)	69.1 (1.12)
Marital status			
Married	9.4 (0.39)	14.1 (0.40)	78.2 (0.51)
Widowed	12.6 (1.73)	38.8 (2.15)	52.3 (2.27)
Divorced or separated	13.8 (0.71)	31.1 (0.91)	57.2 (1.01)
Living with partner	19.2 (0.80)	26.2 (1.27)	55.7 (1.26)
Never married	15.2 (0.53)	25.5 (0.62)	60.6 (0.71)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]GED is General Educational Development high school equivalency diploma.

[5]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. The percentage of respondents with "Unknown" poverty status for this five-level categorization is 9.0%. This value is greater than the corresponding value for the three-level poverty categorization of poor, near poor, and not poor, because of greater uncertainty when assigning individuals to more detailed poverty groups. For more information on poverty status, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

Table XI. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, in a high-deductible health plan without a health savings account, and in a consumer-directed health plan, and who were in a family with a flexible spending account for medical expenses, by year: United States, 2010–September 2016

Year	Enrolled in high-deductible health plan (HDHP)[1]	Enrolled in HDHP without health savings account (HSA)[2]	Enrolled in consumer-directed health plan (CDHP)[3]	In family with flexible spending account (FSA) for medical expenses
2010	25.3 (0.54)	17.6 (0.46)	7.7 (0.33)	20.4 (0.50)
2011	29.0 (0.54)	19.9 (0.41)	9.2 (0.35)	21.4 (0.53)
2012	31.1 (0.57)	20.3 (0.42)	10.8 (0.34)	21.6 (0.45)
2013	33.9 (0.68)	22.2 (0.48)	11.7 (0.43)	21.6 (0.48)
2014	36.9 (0.77)	23.6 (0.52)	13.3 (0.47)	21.2 (0.49)
2015	36.7 (0.68)	23.4 (0.50)	13.3 (0.42)	21.7 (0.51)
2016 (Jan–Sep)	39.1 (0.72)	24.0 (0.56)	15.2 (0.50)	22.0 (0.45)

[1]HDHP was defined in 2016 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in the Technical Notes.

[2]HSA is a tax-advantaged account or fund that can be used to pay for medical expenses. It must be coupled with an HDHP.

[3]CDHP is an HDHP coupled with an HSA.

NOTES: The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive. Therefore, a person may be counted in more than one measure. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XII. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, by year and source of coverage: United States, 2010–September 2016

Year	Employment based[1]	Directly purchased[2]
2010	23.3 (0.54)	48.0 (1.48)
2011	26.9 (0.53)	52.4 (1.49)
2012	29.2 (0.60)	54.7 (1.61)
2013	32.0 (0.67)	56.4 (1.50)
2014	36.2 (0.73)	54.1 (1.43)
2015	36.6 (0.72)	50.9 (1.50)
2016 (Jan–Sep)	39.1 (0.77)	52.6 (1.63)

[1]Private insurance that was originally obtained through a present or former employer or union, or through a professional association.

[2]Private insurance that was originally obtained through direct purchase or other means not related to employment.

NOTES: For persons under age 65, approximately 8% of private health plans were directly purchased from 2010 through 2013. In 2014 through September 2016, approximately 10% of private plans were directly purchased. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Medicaid expansion status, and year: United States, 2010–September 2016

Age group, state Medicaid expansion status, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
Medicaid expansion states[4]:			
2010	16.4 (0.42)	21.8 (0.54)	63.1 (0.70)
2011	15.3 (0.35)	23.1 (0.56)	62.9 (0.72)
2012	15.0 (0.34)	23.1 (0.50)	63.3 (0.63)
2013	14.9 (0.40)	24.1 (0.48)	62.3 (0.68)
2014	10.9 (0.29)	25.6 (0.49)	64.9 (0.59)
2015	8.2 (0.23)	26.7 (0.57)	66.4 (0.64)
2016 (Jan–Sep)	8.0 (0.32)	28.1 (0.60)	65.7 (0.77)
Non-Medicaid expansion states[5]:			
2010	20.3 (0.48)	22.1 (0.51)	59.0 (0.76)
2011	19.6 (0.50)	22.7 (0.50)	59.1 (0.78)
2012	19.2 (0.45)	24.0 (0.55)	58.3 (0.75)
2013	18.4 (0.48)	23.4 (0.51)	59.6 (0.80)
2014	16.0 (0.44)	23.2 (0.52)	62.1 (0.76)
2015	14.0 (0.41)	23.2 (0.58)	64.4 (0.78)
2016 (Jan–Sep)	14.2 (0.52)	24.1 (0.58)	63.2 (0.82)
0–17 years			
Medicaid expansion states[4]:			
2010	6.7 (0.46)	38.2 (1.05)	56.5 (1.06)
2011	5.9 (0.33)	40.2 (1.11)	55.4 (1.09)
2012	5.3 (0.32)	40.4 (1.00)	55.9 (1.07)
2013	5.6 (0.33)	41.3 (0.86)	54.5 (0.95)
2014	4.3 (0.33)	41.0 (0.84)	56.2 (0.88)
2015	3.8 (0.28)	41.1 (0.99)	56.7 (1.00)
2016 (Jan–Sep)	4.3 (0.45)	42.7 (1.14)	55.1 (1.27)
Non-Medicaid expansion states[5]:			
2010	9.0 (0.47)	41.7 (0.99)	50.7 (1.08)
2011	8.3 (0.46)	42.0 (1.02)	50.9 (1.11)
2012	8.0 (0.46)	43.9 (1.11)	49.4 (1.07)
2013	7.5 (0.40)	43.1 (1.12)	50.5 (1.23)
2014	6.7 (0.43)	43.5 (1.06)	51.0 (1.11)
2015	5.5 (0.42)	43.7 (1.27)	52.0 (1.26)
2016 (Jan–Sep)	6.1 (0.54)	44.6 (1.17)	50.9 (1.35)
18–64 years			
Medicaid expansion states[4]:			
2010	20.1 (0.47)	15.5 (0.40)	65.6 (0.62)
2011	18.9 (0.41)	16.6 (0.41)	65.8 (0.61)
2012	18.5 (0.39)	16.7 (0.38)	66.0 (0.53)
2013	18.4 (0.49)	17.7 (0.44)	65.2 (0.65)
2014	13.3 (0.34)	19.9 (0.46)	68.1 (0.56)
2015	9.8 (0.28)	21.5 (0.49)	70.0 (0.56)
2016 (Jan–Sep)	9.3 (0.33)	22.8 (0.46)	69.6 (0.64)
Non-Medicaid expansion states[5]:			
2010	24.8 (0.58)	14.4 (0.45)	62.2 (0.70)
2011	24.1 (0.60)	15.1 (0.42)	62.3 (0.71)
2012	23.7 (0.54)	16.1 (0.44)	61.8 (0.69)
2013	22.7 (0.59)	15.6 (0.41)	63.2 (0.69)
2014	19.6 (0.54)	15.3 (0.41)	66.5 (0.69)
2015	17.5 (0.52)	14.9 (0.44)	69.4 (0.67)
2016 (Jan–Sep)	17.5 (0.65)	16.0 (0.49)	68.1 (0.72)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes

plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]For 2010 through 2014, states moving forward with Medicaid expansion included: AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV (as of October 31, 2013). Beginning with 2015, three additional states were included as expansion states: IN, NH, and PA. Beginning with 2016, three additional states were included as expansion states: AK, LA, and MT.

[5]For 2010 through 2014, states not moving forward with Medicaid expansion included: AL, AK, FL, GA, ID, IN, KS, LA, ME, MS, MO, MT, NE, NH, NC, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013). Beginning with 2015, three states have been removed from this grouping: IN, NH, and PA. Beginning with 2016, three additional states have been removed from this grouping: AK, LA, and MT.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Health Insurance Marketplace type, and year: United States, 2010–September 2016

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
State-based Marketplace states[4]:			
2010	16.3 (0.46)	21.6 (0.66)	63.2 (0.80)
2011	15.9 (0.46)	23.6 (0.70)	61.8 (0.88)
2012	15.2 (0.43)	24.2 (0.66)	61.8 (0.83)
2013	15.2 (0.48)	25.0 (0.56)	61.0 (0.83)
2014	11.1 (0.38)	26.4 (0.63)	63.7 (0.78)
2015	7.7 (0.30)	28.1 (0.80)	65.4 (0.92)
2016 (Jan–Sep)	7.4 (0.36)	28.9 (0.80)	65.3 (0.90)
Partnership Marketplace states[5]:			
2010	14.7 (0.87)	22.5 (1.15)	64.8 (1.73)
2011	14.3 (0.71)	22.7 (1.28)	64.5 (1.72)
2012	14.1 (0.70)	20.8 (1.12)	66.7 (1.53)
2013	14.2 (0.83)	21.8 (1.07)	65.6 (1.42)
2014	10.2 (0.57)	24.4 (1.06)	67.2 (1.28)
2015	8.0 (0.59)	26.1 (1.20)	67.7 (1.42)
2016 (Jan–Sep)	7.1 (0.61)	26.2 (1.28)	68.9 (1.76)
Federally Facilitated Marketplace states[6]:			
2010	20.1 (0.48)	22.1 (0.50)	59.1 (0.70)
2011	18.8 (0.45)	22.6 (0.47)	60.0 (0.71)
2012	18.6 (0.41)	23.6 (0.50)	59.3 (0.67)
2013	17.9 (0.44)	23.3 (0.49)	60.2 (0.74)
2014	15.3 (0.40)	23.3 (0.50)	62.8 (0.69)
2015	12.8 (0.33)	23.4 (0.54)	65.3 (0.66)
2016 (Jan–Sep)	12.9 (0.43)	25.2 (0.57)	63.6 (0.76)
0–17 years			
State-based Marketplace states[4]:			
2010	6.7 (0.50)	38.0 (1.32)	56.4 (1.31)
2011	6.4 (0.47)	40.9 (1.43)	54.2 (1.39)
2012	5.4 (0.43)	42.2 (1.37)	53.9 (1.46)
2013	5.7 (0.37)	42.8 (1.05)	52.6 (1.18)
2014	4.2 (0.40)	42.0 (1.11)	54.9 (1.13)
2015	3.1 (0.34)	42.4 (1.32)	55.8 (1.41)
2016 (Jan–Sep)	3.8 (0.54)	43.2 (1.47)	54.7 (1.65)
Partnership Marketplace states[5]:			
2010	4.1 (0.78)	40.7 (2.21)	57.9 (2.31)
2011	4.2 (0.53)	39.6 (2.44)	58.0 (2.39)
2012	3.6 (0.69)	38.5 (2.20)	59.9 (2.26)
2013	4.2 (0.53)	38.4 (1.95)	59.2 (2.08)
2014	3.2 (0.51)	40.8 (1.88)	58.4 (1.99)
2015	4.3 (0.73)	40.3 (2.53)	57.5 (2.34)
2016 (Jan–Sep)	2.0 (0.55)	40.5 (3.00)	60.5 (2.91)
Federally Facilitated Marketplace states[6]:			
2010	9.2 (0.48)	40.7 (0.91)	51.3 (0.97)
2011	8.0 (0.40)	41.4 (0.93)	51.8 (1.01)
2012	7.9 (0.41)	42.7 (1.00)	50.8 (0.98)
2013	7.5 (0.39)	42.6 (1.02)	51.3 (1.11)
2014	6.6 (0.41)	42.6 (0.94)	52.0 (1.00)
2015	5.3 (0.35)	42.4 (1.06)	53.6 (1.04)
2016 (Jan–Sep)	6.2 (0.49)	44.0 (1.07)	51.6 (1.17)

See footnotes at end of table.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age, state Health Insurance Marketplace type, and year: United States, 2010–September 2016—*Continued*

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
18–64 years			
State-based Marketplace states[4]:			
2010	19.9 (0.52)	15.3 (0.48)	65.9 (0.68)
2011	19.5 (0.53)	17.1 (0.52)	64.7 (0.75)
2012	18.8 (0.50)	17.7 (0.49)	64.7 (0.69)
2013	18.7 (0.60)	18.4 (0.52)	64.1 (0.80)
2014	13.6 (0.45)	20.6 (0.57)	67.0 (0.75)
2015	9.4 (0.37)	22.9 (0.69)	68.9 (0.81)
2016 (Jan–Sep)	8.6 (0.38)	23.9 (0.62)	69.0 (0.72)
Partnership Marketplace states[5]:			
2010	18.9 (1.12)	15.3 (0.90)	67.6 (1.59)
2011	18.4 (0.92)	15.9 (0.87)	67.1 (1.52)
2012	18.1 (0.85)	13.9 (0.79)	69.3 (1.36)
2013	17.9 (0.98)	15.7 (0.91)	68.0 (1.29)
2014	12.8 (0.68)	18.2 (0.98)	70.5 (1.22)
2015	9.4 (0.74)	20.8 (0.95)	71.5 (1.26)
2016 (Jan–Sep)	8.9 (0.72)	21.2 (0.87)	71.9 (1.48)
Federally Facilitated Marketplace states[6]:			
2010	24.5 (0.56)	14.7 (0.43)	62.2 (0.66)
2011	23.0 (0.54)	15.1 (0.39)	63.3 (0.64)
2012	22.8 (0.48)	16.1 (0.41)	62.7 (0.61)
2013	22.0 (0.54)	15.9 (0.41)	63.6 (0.64)
2014	18.6 (0.49)	15.8 (0.41)	66.9 (0.63)
2015	15.7 (0.42)	16.0 (0.43)	69.9 (0.57)
2016 (Jan–Sep)	15.5 (0.52)	17.6 (0.47)	68.5 (0.66)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]State-based Marketplace states: CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, VT, and WA (as of October 31, 2013).

[5]Partnership Marketplace states: AR, DE, IL, IA, MI, NH, and WV (as of October 31, 2013).

[6]Federally Facilitated Marketplace states: AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013).

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XV. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and expanded region: United States, January–September 2016

Age group and expanded region[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All regions	8.8 (0.28)	37.1 (0.40)	62.4 (0.50)
New England	3.9 (0.37)	39.1 (1.52)	67.4 (0.84)
Middle Atlantic	6.4 (0.75)	38.0 (0.95)	65.1 (1.52)
East North Central	6.4 (0.30)	36.4 (0.90)	68.0 (1.15)
West North Central	7.1 (0.74)	31.5 (1.35)	71.2 (1.50)
South Atlantic	11.6 (0.32)	37.1 (1.01)	59.3 (0.84)
East South Central	9.1 (0.71)	41.9 (1.02)	58.6 (2.02)
West South Central	16.5 (1.10)	34.2 (0.81)	55.4 (0.94)
Mountain	9.8 (0.77)	36.7 (1.60)	60.2 (1.73)
Pacific	7.0 (0.50)	39.2 (1.34)	60.0 (1.46)
Under 65 years			
All regions	10.3 (0.32)	26.6 (0.46)	64.8 (0.56)
New England	4.7 (0.43)	27.0 (1.73)	70.6 (1.26)
Middle Atlantic	7.5 (0.90)	27.1 (1.15)	67.3 (1.90)
East North Central	7.5 (0.35)	25.1 (0.89)	69.3 (1.25)
West North Central	8.4 (0.83)	19.7 (1.48)	73.8 (1.68)
South Atlantic	13.7 (0.41)	25.1 (1.05)	62.5 (0.90)
East South Central	10.6 (0.83)	31.9 (1.65)	60.0 (2.00)
West South Central	18.8 (1.17)	25.0 (0.64)	57.5 (0.96)
Mountain	11.1 (0.90)	27.8 (1.57)	62.8 (1.78)
Pacific	8.0 (0.61)	30.5 (1.56)	63.0 (1.67)
0–17 years			
All regions	5.0 (0.36)	43.4 (0.81)	53.5 (0.91)
New England	*1.0 (0.41)	40.7 (2.27)	61.3 (2.44)
Middle Atlantic	5.2 (1.17)	41.2 (2.46)	55.8 (2.69)
East North Central	2.8 (0.45)	37.6 (1.81)	61.9 (2.31)
West North Central	4.4 (0.92)	34.0 (3.52)	64.1 (3.47)
South Atlantic	5.0 (0.91)	47.1 (1.68)	49.0 (1.74)
East South Central	3.4 (0.83)	52.7 (3.14)	46.4 (3.23)
West South Central	8.9 (0.93)	48.6 (1.23)	44.0 (1.20)
Mountain	6.4 (1.22)	42.1 (1.96)	53.2 (2.11)
Pacific	4.4 (0.97)	45.6 (2.74)	51.7 (2.97)
18–64 years			
All regions	12.3 (0.36)	20.3 (0.40)	69.0 (0.47)
New England	5.9 (0.53)	22.6 (1.91)	73.6 (1.49)
Middle Atlantic	8.3 (0.96)	21.9 (0.74)	71.5 (1.64)
East North Central	9.2 (0.39)	20.5 (0.76)	72.0 (1.01)
West North Central	10.0 (0.95)	14.0 (0.94)	77.6 (1.24)
South Atlantic	16.9 (0.65)	17.2 (0.91)	67.4 (0.79)
East South Central	13.3 (1.00)	24.3 (1.24)	64.9 (1.70)
West South Central	23.1 (1.36)	14.7 (0.78)	63.3 (1.08)
Mountain	13.1 (0.90)	21.8 (1.60)	66.8 (1.65)
Pacific	9.2 (0.58)	25.1 (1.14)	67.0 (1.28)

*Estimate has a relative standard error greater than 30% and less than or equal to 50% and should be used with caution, because it does not meet standards of reliability or precision.

[1]The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes: DE, DC, MD, NJ, NY, and PA. The East North Central region includes: IL, IN, MI, OH, and WI. The West North Central region includes: IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes: FL, GA, NC, SC, VA, and WV. The East South Central region includes: AL, KY, MS, and TN. The West South Central region includes: AR, LA, OK, and TX. The Mountain region includes: AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes: AK, CA, HI, OR, and WA.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2016

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All states[5]	8.8 (0.28)	37.1 (0.40)	62.4 (0.50)
Alabama	9.9 (1.71)	35.4 (2.63)	61.5 (3.52)
Arizona	11.1 (1.70)	41.5 (2.56)	53.9 (3.42)
California	7.1 (0.47)	40.1 (1.69)	57.6 (1.90)
Colorado	7.8 (1.45)	37.7 (2.51)	61.2 (3.32)
Connecticut	*3.5 (1.06)	43.4 (2.75)	61.4 (3.57)
Florida	13.3 (0.56)	39.4 (1.31)	55.1 (1.41)
Georgia	13.3 (1.77)	30.7 (1.89)	61.4 (3.03)
Hawaii	*2.3 (0.77)	40.6 (2.42)	68.5 (3.02)
Idaho	10.1 (1.57)	34.2 (2.37)	63.6 (3.18)
Illinois	6.1 (0.95)	33.8 (1.77)	70.8 (1.91)
Indiana	7.6 (1.34)	32.4 (2.27)	69.6 (2.94)
Iowa	4.0 (1.07)	38.5 (2.54)	66.8 (3.24)
Kansas	7.0 (1.47)	34.6 (2.63)	69.4 (3.36)
Kentucky	6.5 (1.47)	46.7 (2.87)	57.1 (3.75)
Maryland	5.4 (1.34)	37.3 (2.78)	68.8 (3.51)
Massachusetts	*3.1 (1.02)	40.2 (2.78)	68.4 (3.48)
Michigan	6.7 (1.15)	38.6 (3.22)	66.8 (3.34)
Minnesota	5.8 (1.16)	25.4 (2.08)	78.2 (2.60)
Mississippi	13.1 (2.00)	44.2 (2.83)	50.6 (3.76)
Nebraska	10.0 (1.64)	28.7 (2.37)	72.1 (3.10)
Nevada	11.1 (1.63)	35.0 (2.38)	59.8 (3.23)
New Jersey	8.2 (1.35)	37.9 (2.30)	62.4 (3.03)
New Mexico	11.9 (1.92)	54.6 (2.84)	39.6 (3.68)
New York	5.4 (0.72)	37.6 (0.57)	64.9 (1.13)
North Carolina	11.1 (0.97)	35.2 (2.76)	61.2 (3.00)
Ohio	6.5 (1.04)	40.0 (1.87)	63.5 (2.35)
Oklahoma	16.3 (2.03)	39.0 (2.58)	51.3 (3.48)
Oregon	9.2 (1.52)	36.2 (2.43)	63.4 (3.21)
Pennsylvania	7.4 (1.53)	38.4 (2.12)	65.1 (3.04)
Rhode Island	3.6 (1.02)	28.8 (2.36)	77.2 (2.89)
South Carolina	10.2 (1.73)	41.7 (2.70)	59.6 (3.55)
Tennessee	8.6 (1.60)	42.2 (2.70)	61.0 (3.52)
Texas	18.0 (1.45)	31.9 (0.49)	55.8 (1.75)
Utah	7.3 (1.25)	17.3 (1.75)	80.2 (2.43)
Virginia	8.6 (1.33)	37.4 (2.20)	63.6 (2.89)
Washington	5.2 (1.19)	37.2 (2.48)	68.3 (3.16)
West Virginia	5.5 (1.36)	49.3 (2.87)	56.4 (3.75)
Wisconsin	5.0 (1.13)	35.7 (2.38)	71.0 (2.97)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2016 —*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Under 65 years			
All states[5]	10.3 (0.32)	26.6 (0.46)	64.8 (0.56)
Alabama	11.5 (1.99)	25.9 (2.61)	64.6 (3.85)
Arizona	12.9 (2.01)	31.6 (2.65)	57.2 (3.82)
California	8.0 (0.59)	32.1 (1.91)	61.0 (2.14)
Colorado	8.7 (1.64)	30.4 (2.56)	62.7 (3.63)
Connecticut	*4.2 (1.31)	31.5 (2.89)	64.6 (4.01)
Florida	16.3 (0.79)	25.3 (1.33)	59.4 (1.45)
Georgia	15.2 (2.05)	20.1 (1.97)	65.8 (3.63)
Hawaii	*2.7 (0.94)	27.1 (2.47)	71.8 (3.37)
Idaho	11.7 (1.83)	24.2 (2.32)	66.5 (3.46)
Illinois	7.1 (1.09)	23.2 (1.00)	71.7 (1.88)
Indiana	8.9 (1.57)	22.1 (2.19)	70.7 (3.25)
Iowa	4.8 (1.28)	27.8 (2.57)	69.2 (3.57)
Kansas	8.2 (1.73)	24.1 (2.58)	70.0 (3.73)
Kentucky	7.6 (1.75)	37.1 (3.05)	57.3 (4.22)
Maryland	6.1 (1.62)	25.5 (2.81)	69.5 (4.01)
Massachusetts	*3.7 (1.24)	29.1 (2.86)	70.7 (3.87)
Michigan	7.8 (1.36)	27.2 (2.90)	67.7 (3.65)
Minnesota	6.7 (1.36)	14.5 (1.83)	80.2 (2.79)
Mississippi	15.2 (2.36)	34.2 (2.97)	52.1 (4.23)
Nebraska	11.9 (1.96)	15.8 (2.11)	73.5 (3.45)
Nevada	12.4 (1.86)	27.0 (2.40)	62.4 (3.53)
New Jersey	9.4 (1.56)	29.0 (2.32)	63.9 (3.32)
New Mexico	14.0 (2.27)	46.9 (3.12)	41.1 (4.16)
New York	6.5 (0.88)	26.6 (0.51)	68.7 (1.34)
North Carolina	12.7 (1.16)	24.7 (2.93)	64.2 (3.36)
Ohio	7.8 (1.19)	28.3 (2.01)	65.7 (2.48)
Oklahoma	18.9 (2.37)	29.1 (2.63)	53.9 (3.89)
Oregon	10.6 (1.76)	26.9 (2.43)	64.0 (3.56)
Pennsylvania	8.7 (1.80)	26.8 (2.44)	66.7 (3.53)
Rhode Island	4.2 (1.20)	16.7 (2.13)	82.2 (2.95)
South Carolina	12.5 (2.12)	29.3 (2.80)	60.7 (4.05)
Tennessee	10.3 (1.91)	31.8 (2.80)	61.8 (3.95)
Texas	20.2 (1.57)	23.2 (0.47)	57.7 (1.86)
Utah	7.9 (1.38)	9.9 (1.46)	82.5 (2.51)
Virginia	10.1 (1.58)	26.7 (2.21)	64.6 (3.23)
Washington	6.2 (1.43)	25.6 (2.48)	71.0 (3.48)
West Virginia	6.7 (1.71)	37.4 (3.16)	58.2 (4.35)
Wisconsin	6.0 (1.36)	23.1 (2.32)	72.4 (3.32)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2016 —*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
0–17 years			
All states[5]	5.0 (0.36)	43.4 (0.81)	53.5 (0.91)
Arizona	12.1 (2.97)	42.8 (4.38)	45.8 (5.06)
California	4.5 (1.05)	47.8 (3.06)	49.1 (3.59)
Colorado	†	49.1 (4.60)	50.3 (5.28)
Florida	7.2 (0.89)	46.9 (2.08)	46.6 (2.07)
Georgia	*5.3 (2.29)	43.8 (3.45)	52.0 (5.02)
Hawaii	†	38.2 (4.27)	61.6 (4.90)
Idaho	*4.0 (1.64)	44.5 (4.07)	53.6 (4.69)
Illinois	*1.5 (0.72)	37.2 (3.73)	63.6 (3.79)
Indiana	†	36.9 (4.06)	62.8 (4.66)
Iowa	†	49.7 (4.63)	51.6 (5.31)
Kansas	*4.4 (1.94)	42.5 (4.57)	56.2 (5.26)
Michigan	*3.3 (1.29)	36.5 (4.88)	63.7 (4.42)
Minnesota	*3.6 (1.73)	20.3 (3.65)	78.0 (4.32)
Nebraska	*8.7 (2.62)	28.1 (4.06)	65.6 (4.93)
Nevada	*5.8 (2.14)	45.7 (4.44)	51.5 (5.11)
New Jersey	*4.7 (1.71)	46.7 (3.95)	52.0 (4.54)
New York	*3.8 (1.61)	36.4 (1.27)	61.2 (2.30)
North Carolina	4.2 (1.00)	47.4 (5.15)	49.4 (4.27)
Ohio	*3.6 (1.17)	41.1 (4.54)	57.1 (5.43)
Oklahoma	9.3 (2.58)	52.8 (4.31)	39.9 (4.85)
Pennsylvania	*8.0 (2.74)	42.2 (3.29)	52.8 (4.14)
Texas	9.9 (1.28)	46.8 (1.27)	44.4 (1.87)
Utah	*2.7 (1.20)	15.3 (2.57)	82.0 (3.15)
Virginia	†	48.7 (4.32)	50.1 (4.96)
Wisconsin	*3.7 (1.76)	34.2 (4.33)	64.2 (5.02)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2016 —*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
18–64 years			
All states[5]	12.3 (0.36)	20.3 (0.40)	69.0 (0.47)
Alabama	14.7 (2.35)	17.1 (2.12)	69.9 (3.44)
Arizona	13.3 (2.21)	26.4 (2.43)	62.5 (3.56)
California	9.3 (0.53)	26.4 (1.44)	65.4 (1.62)
Colorado	10.7 (1.90)	23.7 (2.21)	67.1 (3.27)
Connecticut	5.8 (1.60)	25.7 (2.54)	68.8 (3.60)
Florida	19.5 (1.11)	17.8 (1.01)	63.8 (1.39)
Georgia	19.3 (2.15)	10.2 (1.76)	71.5 (3.41)
Hawaii	*2.8 (1.03)	22.6 (2.21)	76.0 (3.02)
Idaho	15.6 (2.27)	14.0 (1.84)	72.9 (3.14)
Illinois	9.0 (1.40)	18.5 (0.73)	74.4 (1.47)
Indiana	11.4 (1.89)	15.9 (1.84)	74.0 (2.95)
Iowa	6.3 (1.56)	18.7 (2.11)	76.5 (3.07)
Kansas	10.0 (2.07)	15.3 (2.10)	76.5 (3.30)
Kentucky	8.7 (1.99)	31.7 (2.78)	61.9 (3.87)
Maryland	6.9 (1.75)	20.5 (2.37)	74.0 (3.44)
Massachusetts	*4.6 (1.43)	25.4 (2.52)	72.9 (3.44)
Michigan	9.4 (1.58)	23.9 (2.59)	69.2 (3.53)
Minnesota	7.7 (1.50)	12.7 (1.58)	80.9 (2.50)
Mississippi	19.9 (2.81)	21.9 (2.46)	59.8 (3.90)
Nebraska	13.4 (2.24)	10.3 (1.69)	77.0 (3.12)
Nevada	14.8 (2.13)	20.2 (2.03)	66.3 (3.19)
New Jersey	11.4 (1.85)	21.3 (2.02)	69.0 (3.04)
New Mexico	17.3 (2.67)	38.0 (2.89)	46.8 (3.97)
New York	7.3 (1.02)	23.4 (0.65)	71.1 (1.26)
North Carolina	15.8 (1.76)	16.4 (2.40)	69.6 (3.23)
Ohio	9.3 (1.42)	23.6 (1.22)	68.8 (1.77)
Oklahoma	23.9 (2.86)	16.9 (2.13)	61.2 (3.69)
Oregon	11.6 (1.91)	24.2 (2.16)	65.7 (3.20)
Pennsylvania	9.0 (1.63)	20.4 (1.95)	72.5 (3.08)
Rhode Island	5.4 (1.40)	15.2 (1.89)	82.4 (2.68)
South Carolina	15.5 (2.50)	21.2 (2.39)	65.7 (3.70)
Tennessee	12.8 (2.19)	25.4 (2.41)	65.5 (3.52)
Texas	24.7 (1.82)	12.9 (0.68)	63.5 (2.06)
Utah	10.8 (1.78)	6.9 (1.23)	82.8 (2.45)
Virginia	12.8 (1.82)	19.7 (1.83)	69.2 (2.84)
Washington	7.6 (1.63)	20.6 (2.09)	74.4 (3.01)
West Virginia	8.6 (1.94)	31.2 (2.71)	62.0 (3.80)
Wisconsin	6.9 (1.54)	18.9 (2.01)	75.5 (2.95)

*Estimate has a relative standard error greater than 30% and less than or equal to 50% and should be used with caution, because it does not meet standards of reliability or precision.

†Estimate has a relative standard error (RSE) greater than 50% and is not shown.

[1]Estimates are presented for fewer than 50 states and the District of Columbia due to considerations of sample size and precision.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, or purchased through local or community programs. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[5]Includes all 50 states and the District of Columbia.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.