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Talking SHOP: Revisiting the Small-Business Marketplaces in California and Colorado

July 18, 2017

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Citation

Abstract

Issue: The Small Business Health Options Program (SHOP), established alongside the Affordable Care Act's individual insurance marketplaces, has weathered the storms of its early implementation. But the program's future is uncertain.

Goal: To evaluate the impact of changes to SHOP since 2014, focusing on California and Colorado — two states that run their own marketplaces and have full-featured SHOPs.

Methods: Interviews conducted with more than 50 stakeholders and policymakers, as well as employee surveys.

Key Findings: Although SHOP has made modest gains in enrollment in California and Colorado, and in the many states in which it is managed by the federal government, the program still covers fewer

than 150,000 people nationwide. The relative fortunes of SHOP appear closely tied to the performance of the ACA insurance exchanges for individuals and families. Though the California and Colorado programs are similar in design, California's has had more success, largely because of its stability and the broad political acceptance of the ACA within the state.

Conclusion: While SHOP has the potential to grow, especially if it evolves into more of a "one-stop shop" for employee benefits, the program has a long way to go if it is to become a focal point of the small-group insurance market.

Introduction

The Small Business Health Options Program (SHOP) — the health insurance marketplaces established under the Affordable Care Act (ACA) for small employers — has weathered the storms that marked its early implementation. However, it still faces an uncertain future, as the program covers fewer than 150,000 people nationwide.[1 (#/#1)]

In California and Colorado, two states that set up their own marketplaces and began full-featured SHOPs in 2014, the early problems associated with the ACA — balky and unusable websites, delayed vendor payments, and broker hostility — are largely a thing of the past.

Moreover, another obstacle to potential growth has been removed in these states. "Grandmothered" plans that were noncompliant with the ACA, and which locked up three-quarters of the small-group insurance market (usually defined as serving businesses with 50 or fewer employees) are no longer available.

These changes have allowed a true test of the advantages that SHOP intended to bring to the small-group marketplace — such as employee choice, ease of administration, and affordability. (See the box below and our previous report for more background on SHOP and the program's history.[2 (#/#2)])

To evaluate the impact of these developments, we interviewed more than 50 stakeholders and policymakers in Colorado and California and surveyed several dozen employers in these states.

SHOP: A Brief History

Small businesses — those with one to 50 workers — are less likely to offer health care coverage than larger companies. Those that do offer coverage usually do not offer their employees a choice of plans, nor do they typically offer as wide a range of benefits as do larger employers. Small businesses lack the purchasing power of larger groups, have fewer workers over whom to spread the risk of high medical costs, and face higher administrative costs.

Ninety-seven percent of all companies with more than 100 employees in the United States offer health insurance benefits, while only 57 percent of small businesses do. Just over 20 percent of small businesses offer two or more insurance plans, compared with more than two-thirds of companies with 50 or more employees.

Under the ACA, the Small Business Health Options Program (SHOP) requires small-business marketplaces to be set up in every state alongside individual exchanges. SHOP attempts to make it easier for employers to compare health plans, and to give their employees choice in coverage at an affordable price. The Affordable Care Act (ACA) also offers an incentive to buy coverage in the form of a temporary sliding-scale tax credit, available only through plans purchased through SHOP.

Like the individual marketplaces, SHOP was initially affected by hard-to-navigate websites in both the state-run and federally operated exchanges. Publicity and marketing were scant. Brokers — who handle about 80 percent of the insurance business for small employers — were wary. Most brokers encouraged small businesses to renew coverage on existing terms to avoid ACA-related changes, such as community rating and standardized benefits. Some 70 percent to 80 percent of small employers retained these so-called grandmothered plans. Thus, it was not until 2017 that most small employers in a majority of states purchased plans fully meeting ACA standards.

Currently, 17 states and the District of Columbia operate their own SHOP exchanges, while the remaining SHOPs are run by the federal government (FF-SHOP). Mississippi, New Mexico, and Utah have state-run SHOPs, but their individual marketplaces are federally run.

In spring 2017, the federal government reported that SHOP had enrolled 232,698 employees from 27,205 firms. Of this total, over 80 percent were enrolled through state-run SHOP programs. The number of businesses electing the tax credit has not been released.[a]

Just as enrollment varies widely by state, so does the number of insurers participating in SHOP. Employers in Massachusetts, New York, and Oregon, for instance, can choose from eight or more insurers. But Alabama, Nebraska, North Carolina, and Tennessee have just a single insurer offering products through the small-business marketplace.

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[a] E. Curran, S. Corlette, and K. Lucia, "State-Run SHOPs: An Update Three Years Post ACA Implementation (/publications/blog/2016/jul/state-run-shops)," *To the Point,* The Commonwealth Fund, July 29, 2016.

Covered California for Small Business: Overcoming Turbulence

California's individual ACA marketplace launched relatively smoothly. Political opposition to the law in the state was muted, and many market reforms were already in place.

By contrast, the SHOP rollout was rocky. Insurance brokers complained, and those managing the rollout often acknowledged, that the software and website were not tailored to small groups, that exchange staff were unfamiliar with the commercial small-group market, and that agents were paid slowly or not at all.

Since then, most of the glitches have been overcome, and the number of enrollees in SHOP almost doubled between early 2015 and July 2016, to 28,964 from 15,671, with an average group size of 7.5 members.[3 (#/#3)] As of spring 2017, 32,684 enrollees from 4,315 employers were covered.[4 (#/#4)]

The problems were addressed by turning over day-to-day administration and marketing to a Southern California general agent, Pinnacle TPA; rebranding SHOP in California as "Covered California for Small Business" (CCSB); and hiring executives well versed in selling to small businesses. Brokers and general agents write the policies on paper and then process them through Pinnacle, which also markets SHOP as a distribution channel. This arrangement appears to be working smoothly. In most cases, agents are being paid promptly. As one agent put it, "We are selling the product, not dealing with the flubs."

Brokers Come on Board

Brokers told us that the state's ACA marketplace, Covered California, is increasingly perceived as a trusted brand. This is a turnaround from the early implementation of SHOP, when association with the ACA was far more likely to induce wariness and a "wait and see" mentality.

After a slow start, brokers have been working closely as partners with Covered California. Over 14,000 brokers serve the individual market, while 2,000 are certified to sell through CCSB. According to industry sources, 20 percent of brokers control 55 percent of the CCSB market, while half of all brokers who have done business with CCSB have just one account with the program. A small fraction, perhaps 200 altogether, are responsible for writing the bulk of policies through the program. One policymaker said, "Brokers are at the forefront of the distribution of plans in the individual marketplace, and this has carried over to SHOP."

CCSB has found a niche, in particular, among brokers new to the business, according to an experienced benefits administrator. Some of these brokers are more liberal politically than the previous norm, and they have not established tight relationships with insurers.

CCSB in the California Marketplace

Most stakeholders felt that CCSB had carved out a viable niche in the marketplace or had at least bought itself enough time to do so. One health insurance executive said: "CCSB is working. … It has created the same value proposition as other small-group exchanges, one that we know can be successful because it has been successful in the past. They are making steady progress. In the context of a normal marketplace, they should be doing a bit better, if they hadn't fouled up the administration."

Another executive believed that the "greatest struggle for Covered California is 'carrier content' (i.e., access to specific insurers and their products)," but that this disadvantage could be overcome. Cal Choice, the private marketplace competitor to CCSB, has exclusive access to Anthem in the small-group market, an insurer which tends to appeal to companies that want more comprehensive coverage. This executive felt that if Covered California could persuade Blue Shield of California to offer more robust plans and a wider network than it currently offers through CCSB, then CCSB would be able to compete against Cal Choice.

Other analysts disputed this "glass half-full" perspective. They argued that being similar to Cal Choice — the "800-pound gorilla" of private exchanges for the small-group market in California, run by Southern California general agent Word & Brown, with more than 180,000 covered lives — would put CCSB at a permanent competitive disadvantage and at risk for failure. They also pointed to the demise of Pac Advantage, a state-run, voluntary, small-employer purchasing pool, which ceased operations in 2006. When early growth petered out, carriers stopped participating, and the marketplace attracted a larger share of individuals who were more expensive to insure.

Colorado and California are among the few states that followed the original ACA prescription to change the definition of the small-group marketplace upward to companies with one to 100 employees, from those with one to 50 employees. While the increase was intended to improve the stability of small-group coverage inside and outside the marketplaces, some analysts were concerned it could have the opposite effect.[5 (#/#5)] This reflected, in large part, employer worries about the

impact of switching to ACA-compliant plans. However, the actual rise in premiums in the statewide small-group marketplace, and in SHOP, have been modest — just over 3 percent in 2016 and 2 percent in 2017 for the market as a whole.[6 (#/#6)]

A jump in fees to carriers, intended to cover the cost of running the exchange, might also slow take-up of CCSB plans. Covered California has proposed increasing the assessment to 4 percent of premiums, shifting from a flat fee of $13.95 per policy, which insurers argue may exceed their actual net margin on the sales of small-group plans.

One way insurers can meet the demand for better service and less expensive CCSB products will be to invest in more efficient technology. For instance, online quoting through Pinnacle, the general agent that administers the program in California, began in spring 2017. This will position CCSB to compete more effectively against off-exchange sales.

Connect for Health Colorado: Glitches Overcome, Headwinds Persist

In Colorado, most stakeholders concurred with the broker who said that "the SHOP website is much better, the connectivity to carriers is better, and Connect for Health Colorado has the right people in place."

After an initial, unsatisfactory rollout of SHOP, senior officials at Connect for Health Colorado (CFHC) brought in a broker team in 2016 to help manage the site and make it much easier to navigate. An official in the Colorado Governor's Office of Information Technology who had prior experience with the credit card industry led the overhaul of the website from scratch. Prior to their intervention, two different tech vendors, CGI and Deloitte, worked simultaneously on the individual and SHOP systems. Many users of the site and marketplace administrators felt this work tended to be at cross purposes.

Some dissatisfaction with the site remains. A Fort Collins-based broker said that "a better platform would yield more broker interest." For instance, it remains burdensome to add an employee after the initial purchase of a product through the SHOP portal. The owner of a civil engineering firm said: "Other than the choice aspect, it has been an administrative nightmare. Tech is kluge. Incorrect invoices both on group plan payments and EHBs for employees. Emergency room declines occurred saying the employee has no coverage."

In Colorado, political opposition to the ACA remains significant, skepticism among businesses persists, and turnover in the insurance marketplace has created obstacles. During the second open enrollment session in the individual marketplace, enrollment actually dipped in Colorado, and it only partially recovered in 2016. Thanks in large part to the federal failure to pay promised risk-adjustment payments, Colorado HealthOP, which had covered 60,000 lives, ceased operation in 2016. Although Colorado HealthOP did not cover small businesses, its termination had a strong ripple effect on exchange operations generally.[7 (#/#7)]

A survey of 300 Colorado small-business owners whose companies ranged in size from five to 100 employees, conducted in 2015 by Delta Dental, found that 61 percent of them believed the main result of implementation of the ACA was higher costs.[8 (#/#8)] This rise, however, was not reflected in the most recent round of premium increases in the small-group market, which went up a modest 2 percent in 2017. While higher premiums related to the redefinition of the small-group market may yet materialize in the next cycle of renewals, there is little sign of such a trend to date.

Both business owners and some advocates for health care reform have reservations about the ACA. While a 2016 ballot initiative recommending a single-payer plan for Colorado failed to pass, it highlighted the difficulties the ACA faces in getting traction in Colorado. One backer of the initiative told us: "There is a lack of momentum for Obamacare in the state. Part of what is making the ACA in Colorado less desirable is that companies are finding ways to get out of it."

The Connect for Health Colorado staff has been under constant pressure from the state legislature, which passed a bill increasing state oversight of the exchange. Legislators also introduced a measure, which failed, to transfer the marketplace to federal control.

The political pressure has stretched the capacity of CFHC and left it with limited options to market SHOP. Although everyone we interviewed wanted to expand SHOP in theory, competing priorities make this difficult. In practice, the effort to publicize SHOP has been placed on a back burner.

This, combined with business wariness and lack of knowledge of SHOP, explains why uptake in Colorado has been slow. In October 2014, 2,521 individuals were enrolled. In 2015, enrollment reached 3,314, from 472 businesses. By May 2016, that number had declined to 2,897, but it has rebounded somewhat to reach the current high of 3,753 enrollees from 536 companies.

One insurance executive remarked: "The exchange is fighting history and culture in Colorado. I don't think much about SHOP when I think about the exchange. There wasn't a ton broken in the small-business market, and growth has been anemic."

Finding a Niche

Employee Choice

Most owners taking the survey in both Colorado and California reacted positively to SHOP's offering of a wider choice of plans for employees. As one Colorado employer with eight workers put it: "We like the versatility and choice it gives my employees. While we are mostly a younger group of people we all have different priorities it seems." An owner of a media company with 35 employees, whose workers range in age from their twenties to their sixties, likewise said: "SHOP allows more choice to adequately cover the age range. Older workers buy on the relationship with the doctor, younger ones choose lower price mostly." The owner of a civil engineering consulting firm, in business for 22 years, said, "I highly value choice and driving the decision on coverage down to my employees."

Employee choice also drew kudos from several Colorado brokers, especially in the eastern half of the state, which tends to have more-affordable products. SHOP's ability to offer multiple carriers on multiple tiers is unique in Colorado. One broker observed, "SHOP has a mandate to offer those multiple plans. No one else can." Another said, "I think some brokers are coming back into SHOP" who did not write policies initially.

In mountainous Western Colorado, which has some of the highest rates in the country, up to three times Denver's rate, employee choice also drew praise. A broker in Grand Junction, noting that small nonprofits and new marijuana businesses were in her book of business, said that some of her clients wanted a mix of less expensive insurance products and more traditional PPO plans. She said that SHOP was the right vehicle to make this combination work.

Tax Credits

In our previous research, we found that many small-business owners did not know about the tax credit available exclusively through SHOP. Two years later, most owners who responded to our more recent survey were now aware of the incentive, but were for the most part ineligible to take it, with one exception, because their wage structure was too high to qualify.

In California, one-half of the businesses covered under SHOP appear to have had no prior insurance coverage. In particular, small not-for-profits seem to be electing this coverage and are more likely to take up the tax credit.

While national surveys show that the tax credit is a primary reason small employers consider SHOP, few employers actually qualify for the credit because of its low limit on the average wage of a firm's employees. For those that do, however, SHOP is valuable. According to a number of policymakers, expanding the length of time the credit is available and increasing the average wage ceiling could prompt many small businesses to take a second look.

Overcoming the "Family Glitch"

One unexpected way CCSB has attracted customers is by surmounting the "family glitch" that affects a number of workers covered by the ACA.

This glitch was a largely unforeseen consequence of the way the law was drafted. Under the ACA, if one family member has an employer offer of single coverage that meets the standard of affordability — costing less than 9.66 percent of family income in 2016 — then all family members including the employee are ineligible for subsidies on the individual marketplaces, even if the cost of providing coverage to the whole family exceeds that percentage. Insurance plans, though nominally affordable, appear so only because the full family costs of health do not count toward the affordability criteria. More than six million people nationwide live in such families.[9 (#/#9)]

SHOP plans, however, allow employers to exclude dependents from participating in their plans. With employee-only coverage, families are free to seek coverage on the individual exchange and remain eligible for subsidies. Broker sources indicated that as many as one-quarter of CCSB plans written in California were employee-only, many reflecting the aim of employers to circumvent the "family glitch."

Our research reflected the interest in using SHOP to overcome this problem. A custom crating and shipping company with six full-time employees, based near Denver, explicitly made its coverage "employee only" so that the spouses and children of its workers could receive tax credits on the individual exchange.

In addition, because employers have the option of choosing a single plan for employees in and out of state or creating new SHOP accounts in each state and offering different plans, some brokers feel that SHOP is an easier platform through which to cover small businesses with multistate employees. This

accounts for a small but steady book of business.[10 (#/#10)]

End of "Grandmothered" Plans

Most policymakers, stakeholders, and brokers expected that SHOP enrollment would pick up once noncompliant "grandmothered" plans were phased out in 2015. (California and Colorado were among the handful of states that followed this timetable.) While California's enrollment almost doubled, few experts thought this had been a principal factor, citing instead the much improved technology and broker comfort with the products, better management by the third-party vendor, and more successful outreach and rebranding.

The Future of SHOP: Portal to a Range of Employer Benefits?

The links between employment and health care in the U.S. have remained strong since the passage of the ACA. In California, for instance, the share of companies offering employer-based coverage and the share of employees working at companies offering health insurance remained stable between 2013 and 2015.[11 (#/#11)] According to a 2016 study by the insurer Aflac, millennial workers were more likely than others to consider benefits when looking for a job and to trade off salary for benefits if the latter were sufficiently appealing.[12 (#/#12)] The owner of a roofing company in California told us he lost eight of his twenty younger and middle-aged employees to a competitor because it offered health benefits; he signed up for SHOP and quickly found replacements.

The challenge small businesses face in finding affordable health insurance and choice in coverage still needs to be addressed. However, there is no consensus that SHOP is the right vehicle through which to achieve these goals. A Colorado-based policy analyst spoke for many in saying that "SHOP is trying to solve a real problem but has the wrong set of incentives to do it." Small employers tended to feel that the benefits offered by SHOP, including the tax credit, are too limited. Attractive features like employee choice are not enough to eclipse the appeal of an off-exchange market that offers competitively priced insurance products.

SHOP has done reasonably well attracting small firms without any history of providing benefits, historically the hardest to reach, and in particular small urban start-ups and not-for-profits. In California and Colorado, at least, it has had trouble attracting, as one small-business owner put it, "the non-boutique businesses, such as family-run mom-and-pop Laundromats, drugstores, and independent food stores, especially in rural areas, which are not served well by the current health care system."

In interviews and through our survey, multiple small-business owners, brokers, and other stakeholders expressed the hope that a new and comprehensive approach to employer benefits would be taken, one promoting employee health through a variety of ways, including disability insurance and financial security instruments such as expanded 401(k)s.

"In financing health care, you have to look beyond just health insurance," one Colorado broker said. Colorado's exchange has in fact created a public benefits corporation with the express goal of widening the range of insurance benefits SHOP can sell while remaining compliant with the law.

Several respondents mentioned online HR tools, like BerniePortal and Zenefits, as models for the "all in one" solutions demanded by small-business clients.[13 (#/#13)] They suggested that SHOP's migration to an online platform would help it offer comparable solutions. The better the online platform, the better the customer will be able to understand benefits and switch plans easily. If SHOP can become a conduit to a range of bundled insurance products, available with minimum hassle, it may vault from being a niche player to a small-group-market leader.

But features that may seem redundant or rudimentary in mature small-group marketplaces may be crucial in less developed ones, such as in many states that now participate in FF-SHOP, the federally run small-group marketplaces.[14 (#/#14)] SHOP has had early, full-fledged trials in places that probably need its existing benefits the least.

Notes

[1] K. Counihan, *Update on SHOP Marketplaces for Small Businesses* (Centers for Medicare and Medicaid Services, July 2, 2015).

[2] L. W. Haase, D. Chase, and T. Gaudette, *Lessons from the Small Business Health Options Program: The SHOP Experience in California and Colorado (/publications/fund-reports/2015/aug/lessons-shop-california-colorado)* (The Commonwealth Fund, Aug. 2015).

[3] P. V. Lee, *Executive Director's Report (http://board.coveredca.com/meetings/2016/8-18/PPT%20-%20Executive%20Director's%20Report%20August%2018,%202016%20-%20FINAL.pdf)* (Covered California, Aug. 18, 2016).

[4] Center for Consumer Information and Insurance Oversight, "CMS Offers New Health Coverage Enrollment Option for Small Business (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPs-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf)," News release (CCIIO, May 15, 2017).

[5] American Academy of Actuaries, *Potential Implications of the Small Group Definition Expanding to Employers with 51–100 Employees (http://www.actuary.org/files/Small_group_def_ib_030215.pdf)* (AAA, March 2015).

[6] L. Norris, *Colorado Health Insurance Marketplace: History and News of the State's Exchange (https://www.healthinsurance.org/colorado-state-health-insurance-exchange/)* (healthinsurance.org, June 22, 2017).

[7] N. Stein, "Here's What Happened to Colorado HealthOP (http://www.coloradoindependent.com/155753/heres-what-happened-to-colorados-health-co-

op)," *Colorado Independent,* Oct. 23, 2015.

[8] M. Dano, "What's the Word on the Affordable Care Act Three Years In?" *ColoradoBiz,* June 9, 2016.

[9] M. Buettgens, L. Dubay, and G. M. Kenney, "Marketplace Subsidies: Changing the 'Family Glitch' Reduces Family Health Spending But Increases Government Costs (http://content.healthaffairs.org/content/35/7/1167.full)," *Health Affairs,* July 2016 35(7):1167–75.

[10] See HealthCare.gov, *SHOP Marketplace Insurance for Multiple Locations and Businesses (https://www.healthcare.gov/small-businesses/provide-shop-coverage/business-in-more-than-one-state/)* (CMS, n.d.).

[11] L. Hartman, *California Employers Continue to Offer Insurance, But Fewer Workers Enroll (http://www.chcf.org/aca-411/insights/ca-employers-continue-offering-insurance)* (California Health Care Foundation, Aug. 4, 2016).

[12] Aflac, *2016 Aflac WorkForces Report (https://www.aflac.com/business/resources/aflac-workforces-report/archived-results/default.aspx)* (Aflac, 2016).

[13] See BerniePortal, *Benefits Administration and HR Software (https://www.bernieportal.com/)* (BerniePortal, n.d.).

[14] See M. A. Morrissey, *Health Insurance,* 2nd ed. (Health Administration Press, 2014), on the differences between state small-group health care insurance markets. As of May 2017, the Centers for Medicare and Medicaid Services (CMS) announced that as of the end of 2017 it would no longer handle enrollment and other functions for the FF-SHOP exchange, essentially shuttering that wing of the SHOP program. T. Jost, "CMS Announces Plans to Effectively End the SHOP Exchange (http://healthaffairs.org/blog/2017/05/15/cms-announces-plans-to-effectively-end-the-shop-exchange/)," *Health Affairs Blog,* May 15, 2017.

The Effects of Terminating Payments for Cost-Sharing Reductions

Summary

The Affordable Care Act (ACA) requires insurers to offer plans with reduced deductibles, copayments, and other means of cost sharing to some of the people who purchase plans through the marketplaces established by that legislation. The size of those reductions depends on those people's income. In turn, insurers receive federal payments arranged by the Secretary of Health and Human Services to cover the costs they incur because of that requirement.

At the request of the House Democratic Leader and the House Democratic Whip, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have estimated the effects of terminating those payments for cost-sharing reductions (CSRs). In particular, the agencies analyzed what would happen under this policy: By the end of this month, it is known that CSR payments will continue through December 2017 but not thereafter.

Effects on Market Stability and Premiums

CBO and JCT expect that insurers in some states would withdraw from or not enter the nongroup market because of substantial uncertainty about the effects of the policy on average health care costs for people purchasing plans. In the agencies' estimation, under the policy, about 5 percent of people live in areas that would have no insurers in the nongroup market in 2018. By 2020, though, insurers would have observed the operation of markets in many areas under the policy and CBO and JCT expect that more insurers would participate, so people in almost all areas would be able to buy nongroup insurance (as is projected to be the case throughout the next decade under CBO's baseline projection).[1]

Because they would still be required to bear the costs of CSRs even without payments from the government, participating insurers would raise premiums of "silver" plans to cover the costs. In order to qualify for CSRs, most enrollees must purchase a silver plan through the nongroup insurance marketplace in their area, generally have income between 100 percent and 250 percent of the federal poverty level (FPL), receive premium tax credits toward the silver plan, and not be eligible for other types of coverage, such as employment-based coverage or Medicaid. According to CBO and JCT's projections, for single policyholders, gross premiums (that is, before premium tax credits are accounted for) for silver plans offered through the marketplaces would, on average, rise by about 20 percent in 2018 relative to the amount in CBO's March 2016 baseline and rise slightly more in later years. Such premiums for other plans would rise a few percent during the next two years, on average, above the increases already projected in the baseline in response to uncertainty among states and insurers about how to respond under the policy. In later years, the agencies anticipate, premiums for other plans would not generally rise above baseline projections because CSRs are not available for those plans.

When premiums for silver plans increased under the policy, tax credit amounts per person for purchasing insurance in the nongroup market would increase because the credits are directly linked to those premiums. According to CBO and JCT's projections, many people eligible for the credits with income between 100 percent and 200 percent of the FPL—who, under the baseline, receive most of the cost-sharing reductions paid—would use their increased tax credits to purchase the same silver plans with low cost sharing that they would purchase

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1. Under the policy analyzed, because of the timing, insurers would know about the termination of the CSR payments before having to finalize premiums for next year. But if the timing was different,

if CSR payments were stopped after premiums were finalized or were already being charged, CBO and JCT expect that additional insurers would exit the marketplaces in 2018 to reduce their financial losses.

under the baseline, and they would pay net premiums (with the tax credits factored in) that were similar to what they would pay if the CSR payments were continued. Alternatively, they could buy insurance that covered less of their health care expenses, and in many of those cases, the tax credits would cover the premiums entirely. Because CBO and JCT anticipate that most insurance commissioners would eventually permit insurers to substantially increase the gross premiums for silver plans in the marketplaces and not to do so for other plans, almost all people at other income levels would then buy other plans. (Under the baseline, some of those people would buy silver plans, and some would buy other plans.)

Effects on the Federal Budget and Health Insurance Coverage

Implementing the policy would increase the federal deficit, on net, by $194 billion from 2017 through 2026, CBO and JCT estimate. Total federal subsidies for health insurance in the nongroup market—in particular, the sum of the premium tax credits and the CSR payments—would increase for two reasons: The average amount of subsidy per person would be greater, and more people would receive subsidies in most years.

Because the tax credits would increase when premiums for silver plans rose, the agencies estimate that the average subsidy per person receiving premium tax credits to purchase nongroup health insurance would increase. Increases in those tax credits for people with income between 100 percent and 200 percent of the FPL would roughly offset the reductions in CSR payments. However, increases in premium tax credits for those with income between 200 percent and 400 percent of the FPL would substantially exceed the small reductions in CSR payments for this group.

By CBO and JCT's estimates, the number of people receiving subsidies for nongroup health insurance would increase under the policy in most years. In particular, because tax credits would increase and gross premiums for plans other than silver plans in the marketplaces would not change substantially, many people with income between 200 percent and 400 percent of the FPL would, compared with outcomes under the baseline, be able to pay lower net premiums for insurance that pays for the same share (or an even greater share) of covered benefits. As a result, more people would purchase plans in the marketplaces than would have otherwise and fewer people would purchase employment-based health

insurance—reducing the number of uninsured people, on net, in most years. (Under the policy, demand for employment-based insurance among some employees would be weaker because insurance in the marketplaces would be more attractive, and the agencies expect fewer employers would offer health insurance to their workers in most years.)

During the next two years, the increase in subsidies stemming from those two reasons would be partially offset by lower spending in areas where no insurers participated in the marketplaces in response to the policy, CBO and JCT estimate. In those years, the number of uninsured people would be slightly higher or about the same as under the baseline.

Overall Effects

As a result of the increase in total subsidies under the policy, CBO and JCT project these outcomes, compared with what would occur if the CSR payments were continued:

■ The fraction of people living in areas with no insurers offering nongroup plans would be greater during the next two years and about the same starting in 2020;

■ Gross premiums for silver plans offered through the marketplaces would be 20 percent higher in 2018 and 25 percent higher by 2020—boosting the amount of premium tax credits according to the statutory formula;

■ Most people would pay net premiums (after accounting for premium tax credits) for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise—although the share of people facing slight increases would be higher during the next two years;

■ Federal deficits would increase by $6 billion in 2018, $21 billion in 2020, and $26 billion in 2026; and

■ The number of people uninsured would be slightly higher in 2018 but slightly lower starting in 2020.

Those effects are uncertain and would depend on how the policy was implemented.

For this analysis, the agencies have measured the budgetary effects relative to CBO's March 2016 baseline to

produce estimates most comparable to those published earlier this year for legislation related to the budget reconciliation process for 2017. In an analysis using a preliminary version of updated projections of spending to subsidize health insurance purchased through the marketplaces that will be published soon, CBO and JCT find most of the results to be similar to those discussed here.[2] The main exception is this: Premiums under the policy would rise by a smaller amount in 2018—as the updated projections incorporate some increase in premiums next year as a result of current uncertainty about future CSR payments. Specifically, the agencies now expect that some insurers will assume that CSR payments will not be made in full during 2018 (as some insurers have indicated in preliminary filings), will incorporate the associated costs into their premiums for that year, and will, if CSR payments continue to be made, make adjustments in 2019 to account for them. Those expectations will be reflected in the updated projections but were not included in the March 2016 baseline.

How Key Elements of the Current System Work

In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the average percentage of the total cost of covered medical expenses paid by the insurer (that is, the actuarial value of the plan) differs. The share of medical expenses that is not paid by the insurer is paid by enrollees in the form of deductibles and other cost sharing.

Silver plans differ from other plans because they must provide CSRs to eligible enrollees: The actuarial value depends on the policyholder's income as a percentage of the FPL.[3] Insurers are required to offer such plans to participate in the marketplaces. For people at most income levels, the actuarial value for a silver plan is 70 percent; the average deductible for a single policyholder, for medical and drug expenses combined, is about $3,600 in 2017. People with income between 100 percent and 250 percent of the FPL, however, are generally eligible

for silver plans with higher actuarial values (and with lower deductibles), as follows:

- For people with income between 100 percent and 150 percent of the FPL, 94 percent (with an average deductible of about $300);

- For people with income between 150 percent and 200 percent of the FPL, 87 percent (with an average deductible of about $800); and

- For people with income between 200 percent and 250 percent of the FPL, 73 percent (with an average deductible of about $2,900).

Insurance companies can cover those higher shares of health care costs at current premium rates because they receive CSR payments from the federal government based on the number of enrollees they have in each eligibility category. To pay such shares of the cost of benefits in the absence of CSR payments, insurers would raise premiums.

The premium tax credits also reduce the amount that certain low-income people pay for health care in the nongroup market. The eligibility for such tax credits and the method for calculating the credit amounts in the nongroup market would be unchanged under the policy. The size of the premium tax credits depends on household income and on the premiums for a benchmark plan—the second-lowest-cost silver plan—in an enrollee's geographic area. An enrollee eligible for the tax credits pays a certain maximum percentage of his or her income toward the premiums for that benchmark plan, and the credits cover the amount by which the premiums for the benchmark plan exceed that percentage of income.

When the premiums for the benchmark plan go up, the amount of the tax credits goes up, and the amount of the premiums paid by an enrollee who is eligible for the credits is generally unchanged. Hence, an enrollee eligible for the premium tax credits is insulated from variations in premiums in different geographic locations and is also largely insulated from increases in the premiums for the benchmark plan. If a person chooses a plan with premiums higher than those for the benchmark plan, then he or she pays the difference as an additional amount toward the premiums, providing some incentive to choose lower-priced insurance. Similarly, if the person

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2. Those updated estimates will be used to adjust the current set of baseline projections of such spending, which were published in June 2017. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www. cbo.gov/publication/52801.

3. In addition, certain Native Americans are eligible for plans with no deductibles or other cost sharing; the eligibility rules for those plans differ.

chooses a plan with premiums lower than the benchmark plan's, then he or she pays a lower cost.

In addition, the federal requirement that health insurers maintain a minimum medical loss ratio, which is equivalent to capping the share of premiums that may go toward insurers' administrative costs and profits, would be unchanged under the policy analyzed here. That requirement, combined with the competitive pressure to attract enrollees to lower-priced insurance in markets with more than one insurer, would eventually constrain increases in premiums for silver plans—even though the sums paid by subsidized enrollees in the marketplaces would largely be determined by their income, and the increases would primarily be borne by the federal government in the form of larger premium tax credits.

Effects on Market Stability

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people living in areas with participating insurers and on the likelihood of premiums' not rising in an unsustainable spiral. The market for insurance purchased individually with premiums not based on one's health status would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable.

Although premiums have been rising, subsidized enrollees purchasing health insurance coverage in the nongroup market are insulated from increases in premiums when they purchase a plan with premiums at or below those for the benchmark plan because the net premiums they pay are based on a percentage of their income. The subsidies to purchase coverage, combined with the requirement that most people obtain health insurance coverage (also known as the individual mandate), are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas as the ACA is currently being implemented. Under the baseline, fewer than one-half of one percent of people live in areas of the country that are projected to have no participation by insurers in the nongroup market. Several factors may affect insurers' decisions to not participate—including lack of profitability and substantial uncertainty about enforcement of the individual mandate and about future payments for CSRs.

CBO and JCT anticipate that, under this policy, the nongroup insurance market would also continue to be stable in most areas of the country. Subsidies to purchase insurance combined with the individual mandate would maintain sufficient demand for insurance by people with low health care expenditures. Substantial uncertainty about how consumers might respond to the significant increases in premiums following the termination of CSR payments would lead some insurers to withdraw from or not enter the nongroup market in some states, but the agencies anticipate that the situation would be temporary. Under the policy, CBO and JCT estimate, about 5 percent of people live in areas of the country in which insurers would not participate in the nongroup market in 2018, but insurers would participate in nearly all areas by 2020. (If the timing of the policy was different, its effects in 2018 would be different.)

Effects on Gross Premiums Charged by Insurers

Under this policy, average premiums for the second-lowest-cost silver plan offered through the marketplaces for single policyholders would be about 20 percent higher in 2018 than the premiums projected in CBO's March 2016 baseline, mainly because gross premiums alone, rather than premiums in combination with CSR payments, would have to cover the insurer's share of enrollees' health care costs. In 2020 and subsequent years, by CBO and JCT's estimates, the premiums for such benchmark plans would be about 25 percent higher than under the baseline.

Those increases would occur, CBO and JCT expect, because most state insurance commissioners would eventually allow insurers to compensate for the termination of CSR payments by raising premiums substantially for silver plans offered through the marketplaces. The agencies anticipate that insurers would propose to raise premiums for those plans because they are the plans required to bear—through cost-sharing reductions—the costs of having actuarial values of 87 percent or 94 percent for people with income between 100 percent and 200 percent of the FPL who enroll. Many insurance commissioners would favor that increase, CBO and JCT expect, because it would result in larger increases in premium tax credits for people in their states and, thus, lower net premiums paid by enrollees than alternatives that insurers might propose. Very few people at other income levels (facing the same gross premiums but for coverage with an actuarial value of 73 percent or lower)

would then enroll in silver plans in the marketplaces under the policy. Instead, they would purchase other plans, the agencies project.

The gross premiums for bronze plans with actuarial values around 60 percent and gold plans with actuarial values around 80 percent would change much less as a result of the policy, CBO and JCT anticipate, although some increases would occur during the next two years because of insurers' uncertainty about the policy's effects. The agencies expect that most state insurance commissioners would not allow insurers to significantly raise premiums for bronze and gold plans under the policy, especially after a year or two of experience, as those plans are not accompanied with cost-sharing reductions. Allowing premium increases for bronze and gold plans because of increases in costs for silver plans would distort prices in the market, because the increases would not correspond to changes in costs for those plans and would result in lower premium tax credits than if the increases were concentrated among silver plans.

However, for some bronze plans in the marketplaces, CBO and JCT project that gross premiums would modestly increase: those with an actuarial value that insurers would increase (within the allowable range) in an attempt to attract people who would have bought silver plans under the baseline but would not under the policy because of the large premium increases for them.

For gold plans in the marketplaces, the agencies project that gross premiums would be modestly lower under the policy because those plans would attract a larger share of healthier people who, under the baseline, would have bought silver plans. Under the baseline, gold plans tend to attract less healthy people who expect to have high health care expenditures, whereas silver plans attract healthier people as well.[4]

Effects on Net Premiums Paid by Enrollees
CBO and JCT anticipate that many people with income between 100 percent and 200 percent of the FPL

purchasing insurance through the marketplaces would enroll in a silver plan with net premiums, after accounting for premium tax credits, that were similar under this policy and under the baseline. Some people in that income range would purchase bronze or gold plans for which the tax credits would cover the premiums entirely; however, in doing so, they would not be eligible for CSRs.

In general, CBO and JCT expect that most purchasers in the nongroup market with income between 200 percent and 400 percent of the FPL could pay net premiums equal to or less than those under the baseline for insurance with an actuarial value the same as (or even greater than) under the baseline. The main reason that purchasers could pay less or obtain a higher actuarial value is that the higher premiums for silver plans would boost the premium tax credit amounts.[5]

For purchasers in the nongroup market with income above 400 percent of the FPL, net and gross premiums would be the same because they are not eligible for premium tax credits. Under the policy, they could pay about the same premiums for bronze or silver plans (by purchasing outside the marketplaces) as under the baseline and lower premiums for gold plans (because of the health of enrollees in the plans), CBO and JCT project.

Effects for People With Income Between 100 Percent and 200 Percent of the FPL
To assess the potential effects of the policy change, CBO and JCT constructed a set of examples to illustrate average amounts for gross premiums, premium tax credits, and net premiums (after accounting for the tax credits) in 2026. The agencies project, for instance, that people with income at 125 percent of the FPL, regardless of age, would pay a net premium of $500 in 2026 to purchase a silver plan—the plan with the highest actuarial value for them—under the policy and $450 under the baseline (see Table 1, at the end of this document).[6] People

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4. Federal risk-adjustment payments—which are made under the baseline and would be under the policy as well—aim to compensate insurers whose plans cover less healthy people, but the payments can address the risk only imperfectly. As a result, CBO and JCT anticipate that the greater share of healthy enrollees in gold plans under the policy would contribute to the modest reduction in premiums for those plans even though risk-adjustment payments would be made.

5. For related projections in California's market, see Wesley Yin and Richard Domurat, *Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding* (commissioned by Covered California, January 26, 2017), http://tinyurl.com/yb86m89v.

6. Those estimates of net premiums are determined by CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026, which differs under the policy and under the baseline. That projection takes into account the difference in the probability, as estimated under the policy and

with income at 175 percent of the FPL, the agencies estimate, would pay a net premium of $1,850 under the policy and $1,700 under the baseline for a silver plan. Although gross premiums would be higher because of the termination of CSR payments under the policy, net premiums would be determined as a percentage of people's income, and larger premium tax credits would make up most of the difference.

Under the policy, because of the larger premium tax credits (reflecting the higher costs of silver plans), some people in this income range would pay no net premiums for a plan with a higher actuarial value than one they could have purchased with no net premiums under the baseline. For example, under the policy, a 64-year-old with income at 125 percent of the FPL could purchase a gold plan and pay no net premiums but, under the baseline, could obtain only a bronze plan with no net premiums.

Effects for People With Income Between 200 Percent and 400 Percent of the FPL

Under the policy, CBO and JCT anticipate, people with income between 200 percent and 400 percent of the FPL would continue to have access to the same silver plans that they are projected to purchase under the baseline—with net premiums being similar in 2026. For those people, silver plans would have an actuarial value between bronze and gold plans. In the marketplaces, the gross premiums for silver plans would be higher than under the baseline, but premium tax credits for many people in that income range would be larger (see Table 2, at the end of this document). Outside the marketplaces, where such tax credits could not be used, CBO and JCT expect that silver plans would be offered with gross premiums about the same as those charged under the baseline because insurers would design slightly different products for sale there and could therefore price them differently than the plans sold in the marketplaces. Plans outside the marketplaces could be attractive to younger people whose premiums were not a large enough percentage of their income to qualify them for tax credits.

in CBO's March 2016 baseline, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be greater under the policy than it is under the baseline.

However, CBO and JCT project that, under the policy, people with income between 200 percent and 400 percent of the FPL who are eligible for premium tax credits would mostly use those larger amounts to purchase bronze or gold plans rather than silver plans—eventually boosting enrollment in the marketplaces. Bronze plans would have a lower actuarial value and lower premiums than silver or gold plans, offering potential enrollees a trade-off. But gold plans would have a higher actuarial value than silver plans available to people in this income range and, for many of those people, lower net premiums—such that very few of them would choose a silver plan.

For instance, in the agencies' set of illustrative examples for 2026 under the policy, a 40-year-old with income at 225 percent of the FPL could pay a net premium of $1,150 for a bronze plan or $3,050 for a gold plan. (A silver plan would be available with a net premium of $3,350—more than the cost for a gold plan with a higher actuarial value.) Under the baseline, that person could pay $2,050 for a bronze plan, $3,050 for a silver plan, or $4,900 for a gold plan. Thus, under the policy, that person would have lower net premiums for a plan of equal or higher actuarial value.

Gold plans would attract a larger share of enrollees under the policy—mostly people with income between 200 percent and 400 percent of the FPL who would have purchased a silver plan under the baseline. In addition to the larger premium tax credits under the policy, lower gross premiums would eventually contribute to higher enrollment. Under the policy, gross premiums for gold plans would eventually be lower than those for silver plans because, the agencies expect, silver plans would almost exclusively insure people with income between 100 percent and 200 percent of the FPL and (with CSRs) provide actuarial values of 87 percent or 94 percent—significantly higher than the actuarial value of around 80 percent for gold plans. Gross premiums for gold plans under the policy would be modestly lower than under the baseline because, in CBO and JCT's estimation, enrollees would be healthier and therefore have lower health care expenditures.

Enrollees' ages would make a bigger difference in their net premiums for those at the higher end of this income range. A 21-year-old with income at 375 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan ($4,300) or a silver plan ($5,100)

under the policy (by purchasing outside the marketplace) as under the baseline, and $350 less for a gold plan.[7] A 64-year-old with that income would see more attractive options. Such a person could pay a net premium of $6,800 for a gold plan under the policy, compared with $6,750 for a silver plan under the baseline. For a bronze plan, that person could pay $2,300 under the policy, compared with $4,350 under the baseline. Older people's much larger premium tax credits under the policy explain the difference.

Effects for People With Income Above 400 Percent of the FPL

For people with income above 400 percent of the FPL, silver plans offered through the marketplaces would be less attractive than other plans. Because those people are not eligible for premium tax credits, however, the increase in their purchases of gold plans would be proportionately smaller than the increase for people with income between 200 percent and 400 percent of the FPL—and the increase in their purchases of plans outside the marketplaces, proportionately larger. In the agencies' set of illustrative examples, a 40-year-old with income at 450 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan or a silver plan under the policy (by purchasing outside the marketplace) as under the baseline, and $450 less for a gold plan.

Effects on the Federal Budget

CBO and JCT estimate that, on net, adopting this policy would increase the federal deficit by a total of $194 billion over the 2017–2026 period. That change would result from a $201 billion increase in outlays and a $7 billion increase in revenues (see Table 3, at the end of this document).

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7. CBO and JCT expect that, under the policy, gross premiums for bronze and silver plans offered outside the marketplaces would be about the same as under the baseline and lower than those for plans offered through the marketplaces in most areas. For bronze plans, the agencies anticipate, some insurers would raise the actuarial value of plans offered through the marketplaces to 65 percent (the maximum currently allowed) to try to attract enrollees who might have purchased silver plans if the premiums were lower. Bronze plans offered outside the marketplaces with an actuarial value of 60 percent would have lower premiums. For silver plans, premiums would be lower for ones offered outside the marketplaces because plans offered through the marketplaces would have premiums covering the costs of people eligible for higher actuarial values (of 87 percent and 94 percent).

The total increase in the deficit that would result under the policy includes the following amounts:

■ Costs of $247 billion from net increases in marketplace subsidies (an increase of $365 billion for premium tax credits offset by a reduction in CSR payments of $118 billion) stemming from increases in the average subsidy per person for people receiving the ACA's tax credits for premium assistance to purchase nongroup health insurance and in the number of people receiving those subsidies in most years and

■ A net increase of $7 billion in federal outlays for Medicaid because of higher enrollment resulting from a reduction in the number of employers offering health insurance to their workers in most years.

Those increases in the deficit would be partially offset by:

■ Savings of $47 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation—resulting in more taxable income—from a net decrease in most years in the number of people estimated to enroll in employment-based health insurance coverage, and

■ A net increase of $11 billion in revenues resulting from an increase in most years in the number of employers subject to penalties for not offering health insurance.

Effects on Health Insurance Coverage

According to CBO and JCT's estimates, the number of people uninsured under this policy would be about 1 million higher than under the baseline in 2018 but about 1 million lower in each year starting in 2020 (see Table 4, at the end of this document). In 2018, under the policy, the largest effect on coverage would derive from the drop in the number of insurers participating in the nongroup market.

By 2020, the effect on coverage would stem primarily from the increases in premium tax credits, which would make purchasing nongroup insurance more attractive for some people. As a result, a larger number of people would purchase insurance through the marketplaces, and a smaller number of people would purchase employment-based health insurance.

Uncertainty Surrounding the Estimates

CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this policy are all difficult to predict.

Under this policy, the responses by states and insurers in the short term are particularly uncertain. For example, under the policy, total federal subsidies would be smaller and the number of uninsured people would be larger if more people lived in areas with no insurers in the marketplaces than the agencies project, and vice versa. Also, the increases in premium tax credits could be larger than CBO and JCT project if states allowed very large increases in premiums in 2018 to ensure that they had at least one insurer in an area. But the increases in tax credits could be smaller than projected if more people than the agencies expect lived in states requiring insurers to spread premium increases in 2018 across bronze, silver, and gold plans in the marketplaces as well as outside them, rather than focusing the increases on silver plans in the marketplaces.

Additional Issues Depending on How the Policy Was Implemented

CBO and JCT analyzed the effects of eliminating the Administration's authority to make CSR payments. For their analysis, the agencies assumed that hypothetical legislation with that end would be enacted by August 31, 2017, and that CSR payments would not be made after December 31, 2017. If the Administration, either of its own volition or in response to a court order, announced by August 31, 2017, that it would not make CSR payments after December 31, 2017, the agencies expect that the results would be similar to those discussed here. If the policy was implemented differently, various additional issues would arise.

Timing

If the announcement date and the effective date for the policy differed from what CBO and JCT used in this analysis, then the effects of the policy would differ. For example, if CSR payments were terminated after insurers had finalized or had begun charging premiums not incorporating such a change, insurers would suffer significant financial losses. To reduce those losses, some insurers would exit the marketplaces in the middle of the

year. Some of those marketplaces would have no insurers remaining—reducing federal costs but increasing the number of people who were uninsured. Also, subsequent lawsuits might result in outlays by the federal government. If the effective date for terminating CSR payments was the beginning of 2019 instead of 2018, the effects in 2018 would be much smaller.

Certainty

Implementation of the policy through legislation, as opposed to executive or judicial action, would provide greater certainty about how the ACA would be carried out in the short term. Executive or judicial action could very well be challenged in lawsuits that would take some time to resolve—potentially extending the number of years insurers might not participate in the marketplaces.

CBO's Baseline

In CBO and JCT's initial cost estimate for the ACA and in subsequent baseline projections, the agencies have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action)—a conclusion reached because the cost-sharing subsidies were viewed as a form of entitlement authority. The statute that specifies construction of the baseline requires that CBO assume full funding of entitlement authority.[8]

In 2014, the government began making payments for cost-sharing subsidies, and the House of Representatives subsequently brought a lawsuit challenging the department's authority to make such payments. On May 12, 2016, the District Court for the District of Columbia held that the government did not have the authority to make payments for cost-sharing subsidies but allowed it to continue making payments pending appeal. On February 22, 2017, at the request of the House of Representatives and the Administration, the U.S. Court of Appeals for the District of Columbia Circuit agreed to hold the appeal in abeyance while the Congress and the Administration seek a resolution, presumably through legislation. On August 1, 2017, that court allowed 17 states and the District of Columbia to intervene in the case, so future actions in the case will now involve those parties in addition to the House of Representatives and the Administration.

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8.   See section 257(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985; 2 U.S.C. §907(b)(1).

CBO has not made any changes to its baseline projections in response to that court case because the case is on appeal and the Administration has continued to make the payments for cost-sharing subsidies. CBO typically updates its baseline budget projections at specific times each year to reflect legislative action, economic changes, and other developments. During the course of a year, however, events occur (usually, the enactment of legislation, actions by the courts, or decisions by executive branch agencies) that are different from those anticipated in developing the baseline projections. If new information indicates that an action or event that would affect CBO's baseline has happened or definitely will happen, CBO incorporates that information in its next regular update of its baseline. In addition, CBO immediately takes that information into account in assessing what will happen under current law when it analyzes the effects of legislation being considered by the Congress, even if the agency has not published new baseline projections.

If the Administration stopped making CSR payments because of executive or judicial action, CBO's typical procedures for updating its baseline would not necessarily apply because of the conflict between that action and the statutory requirements for constructing the baseline. Specifically, because the CSR payments are considered an entitlement, projections incorporating that action would differ from ones reflecting the statutory requirement that CBO assume full funding of entitlement authority. Hence, CBO would consult with the Budget Committees to decide whether and how to reflect the action in the agency's baseline and cost estimates. If the policy was implemented through legislation, no such conflict would arise, and its effects would be reflected in the baseline and cost estimates immediately.

Methodology

This policy's effects would depend in part on how individuals responded to changes in the prices, after subsidies, they had to pay for nongroup insurance and on their underlying desire for such insurance. Effects would also stem from how businesses responded to changes in those prices for nongroup insurance and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the

net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models to project tax revenues, models of spending and actions by states, projections of trends in early retirees' health insurance coverage, and other available information—to inform their estimates of the numbers of people with certain types of coverage and the associated federal budgetary costs.[9]

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9. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed August 14, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

Table 1. Illustrative Examples, for Single Individuals With Income Under 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Gold Plan				Silver Plan			
	Premium[a] -	Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a] -	Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a] -	Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]
Single Individual With Annual Income of $18,900 (125 percent of FPL) and Not Eligible for Medicaid[d]												
Under the Baseline												
21 years old	4,300	4,300	0		6,550	4,650	1,900		5,100	4,650	450	
40 years old	5,500	5,500	0		8,350	6,050	2,300		6,500	6,050	450	
64 years old	12,900	12,900	0		19,650	14,850	4,800		15,300	14,850	450	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,700	0		6,200	5,900	300		6,400	5,900	500	
40 years old	6,000	6,000	0		7,900	7,700	200		8,200	7,700	500	
64 years old	*14,100*	*14,100*	*0*		18,600	18,600	0		19,200	18,700	500	
Single Individual With Annual Income of $26,500 (175 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	3,400	900		6,550	3,400	3,150		5,100	3,400	1,700	
40 years old	5,500	4,800	700		8,350	4,800	3,550		6,500	4,800	1,700	
64 years old	12,900	12,900	0		19,650	13,600	6,050		15,300	13,600	1,700	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,550	150		6,200	4,550	1,650		6,400	4,550	1,850	
40 years old	6,000	6,000	0		7,900	6,350	1,550		8,200	6,350	1,850	
64 years old	14,100	14,100	0		18,600	17,350	1,250		19,200	17,350	1,850	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under the baseline and under a policy in which CSR payments to insurers are eliminated. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. Premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage grows over time. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The subsidy amounts in this example would range from $1,600 for a 21-year-old with income at 125 percent of the FPL to $4,750 for a 64-year-old at the same income level and from $1,100 for a 21-year-old with income at 175 percent of the FPL to $3,350 for a 64-year-old at the same income level. Under current law, CSRs generally have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $18,900 will equal 125 percent of the FPL and an income of $26,500 will equal 175 percent of the FPL.

Table 2. Illustrative Examples, for Single Individuals With Income Over 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Silver Plan				Gold Plan			
	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]	Premium[a] -	Premium Tax Credit[b] =	Net Premium Paid	Actuarial Value of Plan (Percent)[c]
Single Individual With Annual Income of $34,100 (225 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	2,050	2,250		5,100	2,050	3,050		6,550	2,050	4,500	
40 years old	5,500	3,450	2,050		6,500	3,450	3,050		8,350	3,450	4,900	
64 years old	12,900	12,250	650		15,300	12,250	3,050		19,650	12,250	7,400	
Under the Policy, In the Marketplaces												
21 years old	4,700	3,050	1,650		6,400	3,050	3,350		6,200	3,050	3,150	
40 years old	6,000	4,850	1,150		8,200	4,850	3,350	73	7,900	4,850	3,050	
64 years old	14,100	14,100	0		19,200	15,850	3,350		18,600	15,850	2,750	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500		6,500	0	6,500	73	7,900	0	7,900	
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	
Single Individual With Annual Income of $56,800 (375 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	8,550	4,350		15,300	8,550	6,750		19,650	8,550	11,100	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		6,400	0	6,400		6,200	0	6,200	
40 years old	6,000	800	5,200	65	8,200	800	7,400	70	7,900	800	7,100	80
64 years old	14,100	11,800	2,300		19,200	11,800	7,400		18,600	11,800	6,800	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	0	12,900		15,300	0	15,300		19,650	0	19,650	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		6,400	0	6,400		6,200	0	6,200	
40 years old	6,000	0	6,000	65	8,200	0	8,200	70	7,900	0	7,900	80
64 years old	14,100	0	14,100		19,200	0	19,200		18,600	0	18,600	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	

Table 2 continued.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under the baseline and under a policy in which CSR payments to insurers are eliminated. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. Premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage grows over time. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The subsidy amounts in this example would range from $150 for a 21-year-old with income at 225 percent of the FPL to $450 for a 64-year-old at the same income level. Under current law, CSRs generally have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

Because plans and premiums available in and outside the marketplaces would differ more under the policy than they do under current law, individuals would have a greater incentive to compare options in both markets.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $34,100 would equal 225 percent of the FPL, an income of $56,800 will equal 375 percent of the FPL, and an income of $68,200 will equal 450 percent of the FPL.

Table 3. Estimate of the Net Budgetary Effects of Terminating Payments for Cost-Sharing Reductions

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2026
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	6	13	22	28	32	35	36	37	37	247
Medicaid	0	-1	-1	*	1	1	1	2	2	2	7
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	*	*	-1	-1	-2	-2	-2	-3	-11
Change in Penalty Payments by Uninsured People	0	0	*	*	*	*	*	*	*	*	*
Medicare[d]	0	0	*	*	*	*	*	*	*	*	-2
Other Effects on Revenues and Outlays[e]	0	1	1	-1	-4	-7	-8	-9	-10	-10	-47
Total Effect on the Deficit	**0**	**6**	**14**	**21**	**24**	**25**	**26**	**26**	**26**	**26**	**194**
Memorandum:											
Total Changes in Direct Spending	0	4	9	17	23	26	30	31	31	31	201
Total Changes in Revenues[f]	0	-3	-5	-4	-1	2	3	5	5	5	7
Details of Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues											
Premium tax credits											
Effects on outlays	0	13	22	29	35	38	41	43	44	44	309
Effects on revenues	0	2	4	5	6	7	8	8	8	8	56
Subtotal	0	15	25	35	41	45	49	51	52	52	365
Cost-sharing outlays	0	-8	-12	-13	-13	-13	-14	-14	-15	-16	-118
Outlays for the Basic Health Program	0	*	*	*	*	*	*	*	*	*	*
Collections for risk adjustment	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-6
Payments for risk adjustment	0	0	1	1	1	1	1	1	1	1	6
Total	0	6	13	22	28	32	35	36	37	37	247

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. Budget authority would be equal to the outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. Related spending and revenues includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 4. Effects of Terminating Payments for Cost-Sharing Reductions on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the Policy										
Medicaid[a]	0	*	*	*	*	*	*	*	*	*
Nongroup coverage, including marketplaces	0	-1	*	2	3	3	4	4	3	3
Employment-based coverage	0	1	*	-1	-2	-3	-3	-3	-3	-3
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	1	*	-1	-1	-1	-1	-1	-1	-1
Uninsured Under the Policy	26	27	27	27	26	27	27	27	27	27
Percentage of the Population Under Age 65 With Insurance Under the Policy										
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	93	92	93	93	93	93	93	93	93	93

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under the age of 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and 500,000.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges

Rabah Kamal, Cynthia Cox, Care Shoaibi, Brian Kaplun, Ashley Semanskee, and Larry Levitt

Each year insurers submit filings to state regulators detailing their plans to participate on the Affordable Care Act marketplaces (also called exchanges). These filings include information on the premiums insurers plan to charge in the coming year and which areas they plan to serve. Each state or the federal government reviews premiums to ensure they are accurate and justifiable before the rate goes into effect, though regulators have varying types of authority and states make varying amounts of information public.

In this analysis, we look at preliminary premiums and insurer participation in the 20 states and the District of Columbia where publicly available rate filings include enough detail to be able to show the premium for a specific enrollee. As in previous years, we focus on the second-lowest cost silver plan in the major city in each state. This plan serves as the benchmark for premium tax credits. Enrollees must also enroll in a silver plan to obtain reduced cost sharing tied to their incomes. About 71% of marketplace enrollees are in silver plans this year.

States are still reviewing premiums and participation, so the data in this report are preliminary and could very well change. Rates and participation are not locked in until late summer or early fall (insurers must sign an annual contract by September 27 in states using Healthcare.gov).

Insurers in this market face new uncertainty in the current political environment and in some cases have factored this into their premium increases for the coming year. Specifically, insurers have been unsure whether the individual mandate (which brings down premiums by compelling healthy people to buy coverage) will be repealed by Congress or to what degree it will be enforced by the Trump Administration. Additionally, insurers in this market do not know whether the Trump Administration will continue to make payments to compensate insurers for cost-sharing reductions (CSRs), which are the subject of a lawsuit, or whether Congress will appropriate these funds. (More on these subsidies can be found here).

The vast majority of insurers included in this analysis cite uncertainty surrounding the individual mandate and/or cost sharing subsidies as a factor in their 2018 rates filings. Some insurers explicitly factor this uncertainty into their initial premium requests, while other companies say if they do not receive more clarity or if cost-sharing payments stop, they plan to either refile with higher premiums or withdraw from the market. We include a table in this analysis highlighting examples of companies that have factored this uncertainty into their initial premium increases and specified the amount by which the uncertainty is increasing rates.

Changes in the Second-Lowest Cost Silver Premium

The second-lowest silver plan is one of the most popular plan choices on the marketplace and is also the benchmark that is used to determine the amount of financial assistance individuals and families receive. The table below shows these premiums for a major city in each state with available data. (Our analyses from 2017, 2016, 2015, and 2014 examined changes in premiums and participation in these states and major cities since the exchange markets opened nearly four years ago.)

Across these 21 major cities, based on preliminary 2018 rate filings, the second-lowest silver premium for a 40-year-old non-smoker will range from $244 in Detroit, MI to $631 in Wilmington, DE, before accounting for the tax credit that most enrollees in this market receive.

Of these major cities, the steepest proposed increases in the unsubsidized second-lowest silver plan are in Wilmington, DE (up 49% from $423 to $631 per month for a 40-year-old non-smoker), Albuquerque, NM (up 34% from $258 to $346), and Richmond, VA (up 33% from $296 to $394). Meanwhile, unsubsidized premiums for the second-lowest silver premiums will decrease in Providence, RI (down -5% from $261 to $248 for a 40-year-old non-smoker) and remain essentially unchanged in Burlington, VT ($492 to $491).

As discussed in more detail below, this year's preliminary rate requests are subject to much more uncertainty than in past years. An additional factor driving rates this year is the return of the ACA's health insurance tax, which adds an estimated 2 to 3 percentage points to premiums.

Most enrollees in the marketplaces (84%) receive a tax credit to lower their premium and these enrollees will be protected from premium increases, though they may need to switch plans in order to take full advantage of the tax credit. The premium tax credit caps how much a person or family must spend on the benchmark plan in their area at a certain percentage of their income. For this reason, in 2017, a single adult making $30,000 per year would pay about $207 per month for the second-lowest-silver plan, regardless of the sticker price (unless their unsubsidized premium was less than $207 per month). If this person enrolls in the second lowest-cost silver plan is in 2018 as well, he or she will pay slightly less (the after-tax credit payment for a similar person in 2018 will be $201 per month, or a decrease of 2.9%). Enrollees can use their tax credits in any marketplace plan. So, because tax credits rise with the increase in benchmark premiums, enrollees are cushioned from the effect of premium hikes.

Table 1: Monthly Silver Premiums and Financial Assistance for a 40 Year Old Non-Smoker Making $30,000 / Year

State	Major City	2nd Lowest Cost Silver Before Tax Credit			2nd Lowest Cost Silver After Tax Credit			Amount of Premium Tax Credit		
		2017	2018	% Change from 2017	2017	2018	% Change from 2017	2017	2018	% Change from 2017
California*	Los Angeles	$258	$289	12%	$207	$201	-3%	$51	$88	71%
Colorado	Denver	$313	$352	12%	$207	$201	-3%	$106	$150	42%
Connecticut	Hartford	$369	$417	13%	$207	$201	-3%	$162	$216	33%
DC	Washington	$298	$324	9%	$207	$201	-3%	$91	$122	35%
Delaware	Wilmington	$423	$631	49%	$207	$201	-3%	$216	$430	99%
Georgia	Atlanta	$286	$308	7%	$207	$201	-3%	$79	$106	34%
Idaho	Boise	$348	$442	27%	$207	$201	-3%	$141	$241	70%
Indiana	Indianapolis	$286	$337	18%	$207	$201	-3%	$79	$135	72%
Maine	Portland	$341	$397	17%	$207	$201	-3%	$134	$196	46%
Maryland	Baltimore	$313	$392	25%	$207	$201	-3%	$106	$191	81%
Michigan*	Detroit	$237	$244	3%	$207	$201	-3%	$29	$42	44%
Minnesota**	Minneapolis	$366	$383	5%	$207	$201	-3%	$159	$181	14%
New Mexico	Albuquerque	$258	$346	34%	$207	$201	-3%	$51	$144	183%
New York***	New York City	$456	$504	10%	$207	$201	-3%	$249	$303	21%
Oregon	Portland	$312	$350	12%	$207	$201	-3%	$105	$149	42%
Pennsylvania	Philadelphia	$418	$515	23%	$207	$201	-3%	$211	$313	49%
Rhode Island	Providence	$261	$248	-5%	$207	$201	-3%	$54	$47	-13%
Tennessee	Nashville	$419	$507	21%	$207	$201	-3%	$212	$306	44%
Vermont	Burlington	$492	$491	0%	$207	$201	-3%	$285	$289	2%
Virginia	Richmond	$296	$394	33%	$207	$201	-3%	$89	$193	117%
Washington	Seattle	$238	$306	29%	$207	$201	-3%	$31	$105	239%

NOTES: *The 2018 premiums for MI and CA reflect the assumption that CSR payments will continue. **The 2018 premium for MN assumes no reinsurance. ***Empire has filed to offer on the individual market in New York in 2018 but has not made its rates public. SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Looking back to 2014, when changes to the individual insurance market under the ACA first took effect, reveals a wide range of premium changes. In many of these cities, average annual premium growth over the 2014-2018 period has been modest, and in two cites (Indianapolis and Providence), benchmark premiums have actually decreased. In other cities, premiums have risen rapidly over the period, though in some cases this rapid growth was because premiums were initially quite low (e.g., in Nashville and Minneapolis).

Table 2: Monthly Benchmark Silver Premiums for a 40 Year Old Non-Smoker, 2014–2018

State	Major City	2014	2015	2016	2017	2018	Average Annual % Change from 2014 to 2018	Average Annual % Change After Tax Credit, $30K Income
California	Los Angeles	$255	$257	$245	$258	$289	3%	-1%
Colorado	Denver	$250	$211	$278	$313	$352	9%	-1%
Connecticut	Hartford	$328	$312	$318	$369	$417	6%	-1%
DC	Washington	$242	$242	$244	$298	$324	8%	-1%
Delaware	Wilmington	$289	$301	$356	$423	$631	22%	-1%
Georgia	Atlanta	$250	$255	$254	$273	$308	5%	-1%
Idaho	Boise	$231	$210	$273	$348	$442	18%	-1%
Indiana	Indianapolis	$341	$329	$298	$286	$330	-1%	-1%
Maine	Portland	$295	$282	$288	$341	$397	8%	-1%
Maryland	Baltimore	$228	$235	$249	$313	$392	15%	-1%
Michigan*	Detroit	$224	$230	$226	$237	$250	3%	-1%
Minnesota**	Minneapolis	$162	$183	$235	$366	$383	24%	6%
New Mexico	Albuquerque	$194	$171	$186	$258	$395	19%	1%
New York***	New York City	$365	$372	$369	$456	$504	8%	-1%
Oregon	Portland	$213	$213	$261	$312	$343	13%	-1%
Pennsylvania	Philadelphia	$300	$268	$276	$418	$515	14%	-1%
Rhode Island	Providence	$293	$260	$263	$261	$248	-4%	-1%
Tennessee	Nashville	$188	$203	$281	$419	$507	28%	2%
Vermont	Burlington	$413	$436	$468	$492	$491	4%	-1%
Virginia	Richmond	$253	$260	$276	$296	$379	11%	-1%
Washington	Seattle	$281	$254	$227	$238	$306	2%	-1%

NOTES: *The 2018 premiums for MI and CA reflect the assumption that CSR payments will continue. **The 2018 premium for MN assumes no reinsurance. ***Empire has filed to offer on the individual market in New York in 2018 but has not made its rates public. SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Changes in Insurer Participation

Across these 20 states and DC, an average of 4.6 insurers have indicated they intend to participate in 2018, compared to an average of 5.1 insurers per state in 2017, 6.2 in 2016, 6.7 in 2015, and 5.7 in 2014. In states using Healthcare.gov, insurers have until September 27 to sign final contracts to participate in 2018. Insurers often do not serve an entire state, so the number of choices available to consumers in a particular area will typically be less than these figures.

Table 3: Total Number of Insurers by State, 2014 – 2018

State	Total Number of Issuers in the Marketplace				
	2014	2015	2016	2017	2018 (Preliminary)
California	11	10	12	11	11
Colorado	10	10	8	7	7
Connecticut	3	4	4	2	2
DC	3	3	2	2	2
Delaware	2	2	2	2	1 (Aetna exiting)
Georgia	5	9	8	5	4 (Humana exiting)
Idaho	4	5	5	5	4 (Cambia exiting)
Indiana	4	8	7	4	2 (Anthem and MDwise exiting)
Maine	2	3	3	3	3
Maryland	4	5	5	3	3 (Cigna exiting, Evergreen[1] filed to reenter)
Michigan	9	13	11	9	8 (Humana exiting)
Minnesota	5	4	4	4	4
New Mexico	4	5	4	4	4
New York	16	16	15	14	14
Oregon	11	10	10	6	5 (Atrio exiting)
Pennsylvania	7	8	7	5	5
Rhode Island	2	3	3	2	2
Tennessee	4	5	4	3	3 (Humana exiting, Oscar entering)
Vermont	2	2	2	2	2
Virginia	5	6	7	8	6 (UnitedHealthcare and Aetna exiting)
Washington	7	9	8	6	5 (Community Health Plan of WA exiting)
Average (20 states + DC)	5.7	6.7	6.2	5.1	4.6

NOTES: Insurers are grouped by parent company or group affiliation, which we obtained from HHS Medical Loss Ratio public use files and supplemented with additional research.
[1]The number of preliminary 2018 insurers in Maryland includes Evergreen, which submitted a filing but has been placed in receivership.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Uncertainty Surrounding ACA Provisions

Insurers in the individual market must submit filings with their premiums and service areas to states and/or the federal government for review well in advance of these rates going into effect. States vary in their deadlines and processes, but generally, insurers were required to submit their initial rate requests in May or June of 2017 for products that go into effect in January 2018. Once insurers set their premiums for 2018 and sign final contacts at the end of September, those premiums are locked in for the entire calendar year and insurers do not have an opportunity to revise their rates or service areas until the following year.

Meanwhile, over the course of this summer, the debate in Congress over repealing and replacing the Affordable Care Act has carried on as insurers set their rates for next year. Both the House and Senate bills included provisions that would have made significant changes to the law effective in 2018 or even retroactively, including repeal of the individual mandate penalty. Additionally, the Trump administration has sent mixed

signals over whether it would continue to enforce the individual mandate or make payments to insurers to reimburse them for the cost of providing legally required cost-sharing assistance to low-income enrollees.

Because this policy uncertainty is far outside the norm, insurers are making varying assumptions about how this uncertainty will play out and affect premiums. Some states have attempted to standardize the process by requesting rate submissions under multiple scenarios, while other states appear to have left the decision up to each individual company. There is no standard place in the filings where insurers across all states can explain this type of assumption, and some states do not post complete filings to allow the public to examine which assumptions insurers are making.

In the 20 states and DC with detailed rate filings included in the previous sections of this analysis, the vast majority of insurers cite policy uncertainty in their rate filings. Some insurers make an explicit assumption about the individual mandate not being enforced or cost-sharing subsidies not being paid and specify how much each assumption contributes to the overall rate increase. Other insurers state that if they do not get clarity by the time rates must be finalized – which is August 16 for the federal marketplace – they may either increase their premiums further or withdraw from the market.

Table 4 highlights examples of insurers that have explicitly factored into their premiums an assumption that either the individual mandate will not be enforced or cost-sharing subsidy payments will not be made *and* have specified the degree to which that assumption is influencing their initial rate request. As mentioned above, the vast majority of companies in states with detailed rate filings have included some language around the uncertainty, so it is likely that more companies will revise their premiums to reflect uncertainty in the absence of clear answers from Congress or the Administration.

Insurers assuming the individual mandate will not be enforced have factored in to their rate increases an additional 1.2% to 20%. Those assuming cost-sharing subsidy payments will not continue and factoring this into their initial rate requests have applied an additional rate increase ranging from 2% to 23%. Because cost-sharing reductions are only available in silver plans, insurers may seek to raise premiums just in those plans if the payments end. We estimate that silver premiums would have to increase by 19% on average to compensate for the loss of CSR payments, with the amount varying substantially by state.

Several insurers assumed in their initial rate filing that payment of the cost-sharing subsidies would continue, but indicated the degree to which rates would increase if they are discontinued. These insurers are *not* included in the Table 4. If CSR payments end or there is continued uncertainty, these insurers say they would raise their rates an additional 3% to 10% beyond their initial request – or ranging from 9% to 38% in cases when the rate increases would only apply to silver plans. Some states have instructed insurers to submit two sets of rates to account for the possibility of discontinued cost-sharing subsidies. In California, for example, a surcharge would be added to silver plans on the exchange, increasing proposed rates an additional 12.4% on average across all 11 carriers, ranging from 8% to 27%.

Table 4: Examples of Preliminary Insurer Assumptions Regarding Individual Mandate Enforcement

State	Insurer	Average Rate Increase Requested	Individual Mandate Assumption	CSR Payments Assumption	Requested Rate Increase Due to Mandate or CSR Uncertainty
CT	ConnectiCare	17.5%	Weakly enforced[1]	Not specified	Mandate: 2.4%
DE	Highmark BCBSD	33.6%	Not enforced	Not paid	Mandate and CSR: 12.8% combined impact
GA	Alliant Health Plans	34.5%	Not enforced	Not paid	Mandate: 5.0% CSR: Unspecified
ID	Mountain Health CO-OP	25.0%	Not specified	Not paid	CSR: 17.0%
ID	PacificSource Health Plans	45.6%	Not specified	Not paid	CSR: 23.2%
ID	SelectHealth	45.0%	Not specified	Not paid	CSR: 20.0%
MD	CareFirst BlueChoice	45.6%	Not enforced	Potentially not paid	Mandate: 20.0%
ME	Harvard PilgrimHealth Care	39.7%	Weakly enforced	Potentially not paid	Mandate: 15.9%
MI	BCBS of MI	26.9%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 5.0%
MI	Blue Care Network of MI	13.8%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 5.0%
MI	Molina Healthcare of MI	19.3%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 9.5%
NM	CHRISTUS Health Plan	49.2%	Not enforced	Potentially not paid	Mandate: 9.0%, combined impact of individual mandate non-enforcement and reduced advertising and outreach
NM	Molina Healthcare of NM	21.2%	Weakly enforced	Paid	Mandate: 11.0%
NM	New Mexico Health Connections	32.8%	Not enforced	Potentially not paid	Mandate: 20.0%
OR*	BridgeSpan	17.2%	Weakly enforced	Potentially not paid	Mandate: 11.0%
OR*	Moda Health	13.1%	Not enforced	Potentially not paid	Mandate: 1.2%
OR*	Providence Health Plan	20.7%	Not enforced	Potentially not paid	Mandate: 9.7%, largely due to individual mandate non-enforcement
TN	BCBS of TN	21.4%	Not enforced	Not paid	Mandate: 7.0% CSR: 14.0%
TN	Cigna	42.1%	Weakly enforced	Not paid	CSR: 14.1%
TN	Oscar Insurance	NA (New to state)	Not enforced	Not paid	Mandate: 0%, despite non-enforcement CSR: 17.0%, applied only to silver plans
VA	CareFirst BlueChoice	21.5%	Not enforced	Potentially not paid	Mandate: 20.0%
VA	CareFirst GHMSI	54.3%	Not enforced	Potentially not paid	Mandate: 20.0%
WA	LifeWise Health Plan of Washington	21.6%	Weakly enforced	Not paid	Mandate: 5.2% CSR: 2.3%
WA	Premera Blue Cross	27.7%	Weakly enforced	Not paid	Mandate: 4.0% CSR: 3.1%
WA	Molina Healthcare of WA	38.5%	Weakly enforced	Paid	Mandate: 5.4%

NOTES: The CSR assumption "Potentially not paid" refers to insurers that filed initial rates assuming CSR payments are made and indicated that uncertainty over CSR funding would change their initial rate requests. In Michigan, insurers were instructed to submit a second set of filings showing rate increases without CSR payments; the rates shown above assume continued CSR payments. *The Oregon Division of Financial Regulation reviewed insurer filings and advised adjustment of the impact of individual mandate uncertainty to between 2.4% and 5.1%. Although rates have since been finalized, the increases shown here are based on initial insurer requests. [1]Connecticare assumes a public perception that the mandate will not be enforced.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Discussion

A number of insurers have requested double-digit premium increases for 2018. Based on initial filings, the change in benchmark silver premiums will likely range from -5% to 49% across these 21 major cities. These rates are still being reviewed by regulators and may change.

In the past, requested premiums have been similar, if not equal to, the rates insurers ultimately charge. This year, because of the uncertainty insurers face over whether the individual mandate will be enforced or cost-sharing subsidy payments will be made, some companies have included an additional rate increase in their initial rate requests, while other companies have said they may revise their premiums late in the process. It is therefore quite possible that the requested rates in this analysis will change between now and open enrollment.

Insurers attempting to price their plans and determine which states and counties they will service next year face a great deal of uncertainty. They must soon sign contracts locking in their premiums for the entire year of 2018, yet Congress or the Administration could make significant changes in the coming months to the law – or its implementation – that could lead to significant losses if companies have not appropriately priced for these changes. Insurers vary in the assumptions they make regarding the individual mandate and cost-sharing subsidies and the degree to which they are factoring this uncertainty into their rate requests.

Because most enrollees on the exchange receive subsidies, they will generally be protected from premium increases. Ultimately, most of the burden of higher premiums on exchanges falls on taxpayers. Middle and upper-middle income people purchasing their own coverage off-exchange, however, are not protected by subsidies and will pay the full premium increase, switch to a lower level plan, or drop their coverage. Although the individual market on average has been stabilizing, the concern remains that another year of steep premium increases could cause healthy people (particularly those buying off-exchange) to drop their coverage, potentially leading to further rate hikes or insurer exits.

Methods

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Premium data are current as of August 7, 2017; however, filings in most states are still preliminary and will likely change before open enrollment. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes.

Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults

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ABSTRACT

ISSUE: Affordability of health coverage is a growing challenge for Americans facing rising premiums, deductibles, and copayments. The Affordable Care Act's tax credits make marketplace insurance more affordable for eligible lower-income individuals. However, individuals lose tax credits when their income exceeds 400 percent of the federal poverty level, creating a steep cliff.

GOALS: To analyze the effects of extending eligibility for tax credits to individuals with incomes above 400 percent of the federal poverty level.

METHODS: We used RAND's COMPARE microsimulation model to examine changes in insurance coverage and health care spending.

KEY FINDINGS AND CONCLUSIONS: Extending tax-credit eligibility increases insurance enrollment by 1.2 million, at a total federal cost of $6.0 billion. Those who would benefit from the tax-credit extension are mostly middle-income adults ages 50 to 64. These new enrollees would be healthier than current enrollees their age, which would improve the risk pool and lower premiums. Eliminating the cliff at 400 percent of the federal poverty level is one policy option that may be considered to increase affordability of insurance.

KEY TAKEAWAYS

‣ Middle-income people ages 50 to 64 would have more affordable coverage if the ACA's tax credits, which are currently available to lower-income people only, were extended to all income groups.

‣ The individual market risk pool would improve because premiums for the new enrollees would exceed the cost of their care.

‣ Eliminating the tax credit cliff would increase federal spending while lowering the ranks of the uninsured.

The Commonwealth Fund

BACKGROUND

The Affordable Care Act (ACA) has resulted in 20 million people gaining health insurance, but affordability of health coverage remains a problem for many people.[1] For example, the number of insured people who reported difficulty paying for insurance premiums increased from 27 percent to 37 percent between 2015 and 2017, according to a Kaiser Family Foundation tracking poll.[2] A majority of respondents identified "lowering the amount individuals pay for health care" as the top priority that President Donald Trump and Congress should focus on for health care.[3]

The ACA's tax credits for individuals purchasing health insurance via the federal and state marketplaces are designed to make insurance more affordable for those with incomes between 100 percent and 400 percent of the federal poverty level (FPL) and no other affordable source of insurance. For the 2018 coverage year, 400 percent of FPL is $48,240 for an individual and $98,400 for a family of four.[4] Eligible individuals who have incomes between 100 percent and 250 percent of FPL also can receive cost-sharing subsidies that help to lower out-of-pocket spending.

The tax-credit amount is the difference between the premium of a benchmark plan (the second-lowest-cost silver-tier plan available to the individual) and a required income contribution. In 2018, the income contributions will range from 2.01 percent of income for individuals earning between 100 percent and 133 percent of FPL to 9.56 percent for those between 300 percent and 400 percent of FPL.[5]

Thus, a single individual making $48,000 (just below 400% FPL) would have a required income contribution of $4,589 per year. For instance, if the benchmark plan had a $10,000 annual premium, then the maximum tax credit would be $5,411, which is the difference between the silver plan's premium and the individual's contribution (i.e., $10,000 – $4,589).

Current policy creates a steep cliff at 400 percent of FPL for some individuals because people with incomes above this threshold are ineligible for governmental financial assistance. Whether an individual faces a cliff and the size of that cliff depends on the cost of an individual's premium. For instance, many younger people face premiums that cost less than the highest required income contribution (9.56% of income in 2018). The cliff does not affect them because they would not receive ACA credits anyway. In contrast, older individuals often face significant cliffs because they can be charged high premiums, up to three times what younger adults pay.[6] These people might forfeit thousands in tax credits if their incomes rise a few hundred dollars above 400 percent of FPL. The small gain in income would be far outweighed by the large loss of tax credits.[7]

In this issue brief, we describe the effects of relaxing the ACA's tax-credit eligibility threshold to eliminate the cliff in 2020. We modeled a scenario in which eligibility for tax credits is extended to individuals with incomes above 400 percent of FPL if they have no other affordable source of coverage. These individuals would have the same required income contribution — an estimated 9.95 percent by the year 2020[8] — as those with incomes between 300 and 400 percent of FPL. Although everyone with incomes above 400 percent of FPL could be eligible, the tax-credit amount goes to zero when 9.95 percent of income exceeds the benchmark premium.[9]

We conducted the analysis using the RAND COMPARE microsimulation model, which uses economic theory and data to analyze the impact of health policy changes on insurance coverage and health care spending. The model and methods are described in more detail in Appendix A.

FINDINGS

Decreasing the Uninsured Rate

We found that relaxing the tax-credit eligibility threshold would increase the number of insured by approximately 1.2 million individuals in 2020 (Exhibit 1).[10] The newly insured include approximately 900,000 individuals with incomes above 400 percent of FPL. It also would draw 200,000 individuals with incomes up to 400 percent of FPL into the individual market because of improvements in the risk pool, which we estimate will reduce premiums by 2.6 percent. In addition, approximately 400,000 previously insured individuals with incomes above 400 percent of FPL would newly receive a tax credit.

Improving Affordability for Older, Middle-Income Adults

Older adults are the most likely to newly receive a tax credit (Exhibit 2). Specifically, 96 percent of those newly receiving a tax credit are ages 50 to 64.[11]

These individuals tend to be healthier and less expensive than other enrollees of the same age, which helps explains why the risk pool improves. On average, 50-to-64-year-olds who would newly enroll because of the tax-credit extension would spend $3,700 less each year than similarly aged, lower-income individuals who would enroll under current law (Exhibit 3).[12] Even though these individuals are older, their total premiums exceed the cost of their care, and they improve the individual market risk pool.

In addition, nearly all new tax-credit recipients would have incomes below 700 percent of FPL, with 61 percent falling in the above 400 percent to 500 percent of FPL range (Exhibit 4). Higher-income individuals are less likely to receive credits because, as income goes up, the required income contribution (9.95 percent of income) often exceeds the full cost of the premium. In Appendix B, we include case studies that illustrate the effect of the proposed tax-credit change for individuals at different age and income levels.

Exhibit 1. Estimated Change in Enrollment and Tax Credit Eligibility, 2020

Newly insured	**1,200,000**
More than 400 percent of the federal poverty level	900,000
Up to 400 percent of the federal poverty level	200,000
Previously insured, newly receiving tax credits	**400,000**

Exhibit 2. Age Distribution Among Individuals Newly Receiving Tax Credits, 2020
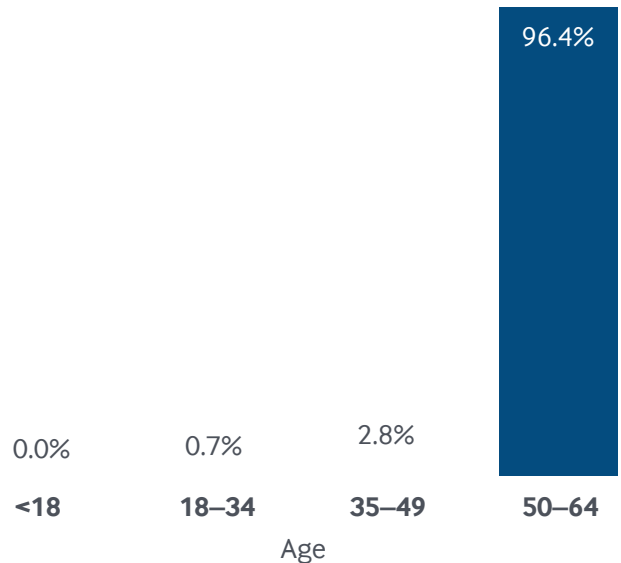
Note: Includes newly and previously enrolled.

Exhibit 3. Average Spending by Adults Ages 50 to 64, 2020

Enrolled in the individual market under the ACA	$10,700
Newly insured and newly eligible for tax credits under the proposed extension	$7,000

Note: Previously insured individuals who are newly receiving tax credits are included in the first line ($10,700 average spending).

Exhibit 4. Income Distribution Among Individuals Newly Receiving Tax Credits, 2020

61.0%	27.4%	10.5%	0.6%	0.5%
>400%–500% FPL	>500%–600% FPL	>600%–700% FPL	>700%–800% FPL	>800%–900% FPL
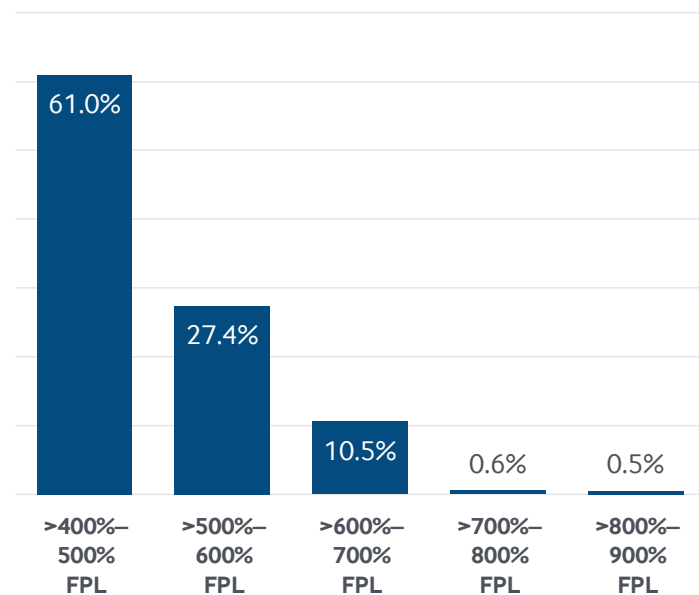
Notes: FPL = federal poverty level. Includes newly and previously enrolled. For the 2018 coverage year, 400% FPL is $48,240 for an individual and $64,960 for a couple; 700% FPL is $84,420 for an individual and $113,680 for a couple.

Exhibit 5. Net Deficit Effect, 2020

Net deficit effect (billions)	$6.0
Tax credits for newly insured	$3.6
Tax credits for previously insured	$3.2
Reduction in individual-mandate revenue	$1.7
Improvements to the risk pool	−$2.6

Increasing Federal Outlays

Extending tax credits to all incomes would cost the federal government $6.0 billion in 2020 (Exhibit 5). Of this, $3.6 billion would go toward tax credits for individuals who would have been uninsured if the tax credits were not extended. The average credit among people newly receiving the tax credit would be $3,030.

Tax credits for individuals who are insured under the ACA but were not previously receiving tax credits would cost $3.2 billion. The extension of tax credits for those already insured would provide some financial relief to individuals who are enrolled in marketplace plans but who may have difficulty paying their premiums and out-of-pocket costs.

The scenario would also reduce tax revenue. Because the expanded tax credits cause some people to become newly insured, they also lead to a $1.7 billion reduction in revenue from the ACA's individual mandate.

Finally, because this proposal would improve the individual market risk pool, it would reduce the cost of providing premium tax credits to people at or below 400 percent of FPL who were already receiving them, offsetting the gross costs of expanding tax credits by $2.6 billion.

CONCLUSION

Policymakers have a variety of options for increasing the affordability of health insurance and the number insured, and the resources policymakers have to achieve those goals are likely limited. For those reasons, policymakers should consider how the cost, coverage gains, and affordability improvements of this option compare to those achieved under other potential approaches, some of which we have analyzed previously.[13]

Our analysis demonstrates that the extension of the ACA's tax credits to all income levels is one option to provide some financial relief to middle- and upper-middle-income households. In particular, relaxing the eligibility threshold would increase affordability for older adults ages 50 to 64 who face high premiums.

NOTES

1   N. Uberoi, K. Finegold, and E. Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016* (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 3, 2016).

2   B. DiJulio, A. Kirzinger, B. Wu et al., *Data Note: Americans' Challenges with Health Care Costs* (Henry J. Kaiser Family Foundation, March 2, 2017).

3   Ibid.

4   *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs* (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, n.d.).

5   Internal Revenue Service, *26 CFR 601.105: Examination of Returns and Claims for Refund, Credit or Abatement; Determination of Correct Tax Liability* (IRS, 2017).

6   Under the ACA, older adults may be charged premiums up to three times the cost of premiums for younger adults. *HR 3590, Patient Protection and Affordable Care Act*.

7   See Appendix B for an example of how this circumstance might arise. Note that the steep cliff could be a work disincentive for individuals with income near 400 percent of FPL.

8   The required contribution percentage is adjusted each year based on the excess of per enrollee employer-sponsored insurance premium growth over per capita personal income growth between the preceding calendar year and 2013.

9   We assumed that, like with the ACA, individuals with access to other insurance (e.g., Medicaid, Medicare) that is affordable are not eligible for the tax credits.

10   See Appendix A for enrollment changes by insurance type. The number of individuals with employer-sponsored insurance decreases by 100,000 and the change to Medicaid enrollment is less than 100,000.

11   See Appendix C for a comparison of the tax-credit extension to alternative approaches analyzed in prior work.

12   See Appendix A for enrollment changes by insurance type. The number of individuals with employer-sponsored insurance decreases by 100,000 and the change to Medicaid enrollment is less than 100,000.

13   See Appendix C for a comparison of the tax-credit extension to alternative approaches analyzed in prior work.

ABOUT THE AUTHORS

Jodi Liu, Ph.D., is an associate policy researcher at the RAND Corporation. Liu has experience using simulation modeling to analyze the effects of health care financing and payment changes on health insurance coverage, household spending, government spending, and provider revenues. Her recent work has involved assessing proposals to repeal and replace the Affordable Care Act, alternative payment models, and policy options for single-payer health care. Liu received her Ph.D. in policy analysis from the Pardee RAND Graduate School, her master's degree in global disease epidemiology and control from the Johns Hopkins Bloomberg School of Public Health, and degrees in biomedical and chemical engineering from the University of Michigan.

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Editorial support was provided by Maggie Van Dyke.

APPENDIX A. TAX-CREDIT EXTENSION ANALYSIS

COMPARE Overview

COMPARE is a microsimulation model that uses economic theory, nationally representative data, and evidence from experience to estimate how consumers and business will respond to health policy changes.[1] The model creates a synthetic population of individuals, families, health expenditures, and firms using data from the 2008 Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the Kaiser Family Foundation Annual Survey of Employer Benefits.

We assign each individual in the SIPP a spending amount using the spending of a similar individual from the MEPS. We then augment spending imputations with data on high-cost claims from the Society of Actuaries. These adjustments account for the fact that the MEPS underrepresents individuals with high spending.

Individuals in COMPARE make health insurance enrollment decisions by weighing the costs and benefits of available options, an approach that is referred to by economists as "utility maximization." The utility-maximization framework accounts for the following:

- premium costs
- anticipated out-of-pocket health care spending
- the value of health care consumption
- the risk of incurring a financially devastating health care bill, and
- any penalties the individual would face by remaining uninsured, including the risk of facing denial or being charged higher premiums at a later date.

Premium costs are adjusted to account for tax credits, if such credits are available to the enrollee. All else being equal, higher premiums reduce an individual's probability of enrolling in health insurance. In contrast, several factors encourage enrollment, such as a lower risk of catastrophic spending, reduced out-of-pocket spending, the avoidance of penalties, and increases in health care utilization.

Businesses in the model make decisions by considering the value of health insurance to their workers. Tax credits for individual market coverage and Medicaid eligibility expansions may reduce the value of health insurance to workers, leading firms to drop insurance. However, mandates requiring individuals to enroll in insurance, as well as mandates requiring firms to offer coverage, tend to increase the likelihood that a firm will offer insurance.

We calibrate the model to ensure that it accurately predicts outcomes for years in which complete data exist.

The Approach to Modeling the ACA

To model individual and family health insurance enrollment decisions under the ACA, COMPARE uses a utility-maximization approach, in which decision-makers weigh the costs and benefits of available options. The utility-maximization framework accounts for the tax penalty for not purchasing insurance, the value of health care consumption, premium costs, expected out-of-pocket health care spending, and financial risk associated with out-of-pocket spending.

We scale each of these components of utility to dollars and assume that they are additively separable.[2] We further assume that individuals' utilities are separable in consumption and health. The health-related component of the utility function is modeled as follows:

$$U_{ijk} = u(H_{ij}) - E(OOP_{ij}) - p_{ij}^{(H)} - \frac{1}{2} rVAR(OOP_{ij}) - (0.8 * Penalty_j) + Calibration_{jk}$$

Within this equation:

- $u(H_{ij})$ is the utility associated with consuming health care services for individual i under insurance option j

- k represents an individual's demographic group based on age, health status, and income

- OOP_{ij} is the out-of-pocket spending expected

- $p^{(H)}$ is the individual's premium contribution (after adjusting for tax credits), and

- r is the coefficient of risk aversion.

Possible health insurance enrollment choices (j) under the ACA may include employer coverage, Medicaid or Children's Health Insurance Program (CHIP) coverage, an ACA-compliant individual-market plan (including plans available on and off the marketplaces), or another source of coverage.[3] Individuals can also choose to forgo insurance. Not all individuals will have access to all forms of coverage. For example, access to Medicaid is contingent on eligibility, and individuals will have access to employer coverage only if they (or their spouse or parent) work for a business that offers insurance.

The *Penalty* term represents the tax penalty associated with insurance status j, and it is 0 for all but the uninsured insurance status. We downweight the tax penalty by a factor of 0.8 to capture the fact that, on average, the Internal Revenue Service collects only about 80 percent of taxes owed.[4]

The term *Calibration_{jk}* is a factor that adjusts utilities to match enrollment patterns observed in pre-ACA data. The term accounts for nonpecuniary factors that may influence preferences for different types of insurance. Such factors include the convenience associated with enrolling in employer coverage and access constraints associated with Medicaid. Specific modeling strategies for each source of coverage j are described next.

Small-Group Employer Coverage. Small employers in the model choose whether to offer coverage based on worker preferences and a small set of other factors, including the employer's industry and whether workers are unionized. Under the ACA, all small firms are part of a single risk pool with guaranteed issue, three-to-one rate banding on age, and restrictions that preclude insurers from charging different premiums to different groups other than based on geography, family size, tobacco use, and plan generosity.

In the current version of the model, small-group market regulations apply to all firms with 50 or fewer employees, regardless of year. Earlier versions of the model expanded the small-group market to include firms with 100 or fewer workers after 2015, as originally intended by the ACA. We revised the definition because the Protecting Affordable Coverage for Employees Act, signed into law in late 2015, amended the ACA's definition of a *small employer* to include firms with one to 50 employees in perpetuity, unless states opt to extend the small-group market to firms with up to 100 workers.

Small firms in the model are permitted to purchase a 60 percent, 70 percent, 80 percent, or 90 percent actuarial value plan on the ACA's regulated small-group market, which includes the Small Business Health Options Program (SHOP) marketplaces. Small firms in the model may retain grandfathered status, which exempts them from the ACA's rating regulations, although we assume that a certain percentage of small firms will lose grandfathered status each year.

The ACA also offers a small-business tax credit to small firms with low-wage workers who obtain coverage through the SHOP marketplaces. Because firms can take advantage of these credits for only two years, we assume that all small firms will have exhausted their tax-credit eligibility by 2020 (the year modeled in this analysis).

Large-Group Employer Coverage. Like small employers, large employers choose whether to offer coverage based on worker preferences and several other characteristics, including union status and industry. We allow large firms that offer coverage to choose between four different plans, which are distinguished by plan generosity and rated based on enrollees' expected health expenditures. We estimate premiums for the large-group market based on a regression. The firm's decision to offer is modeled using structural econometric techniques.

Medicaid. We model state Medicaid expansion decisions as of January 1, 2017,[5] and include North Carolina as a Medicaid expansion state.[6] We assume that, under the ACA, states with Medicaid eligibility thresholds that exceeded 138 percent of the federal poverty level (FPL) before 2014 will roll back their eligibility thresholds to 138 percent because of federally funded tax credits and cost-sharing subsidies that become available to this group. In states that did not expand Medicaid, individuals who would have qualified for Medicaid expansion and have income above FPL can obtain tax credits on the market-

places. However, those with incomes below FPL are ineligible for tax credits. Through our calibration process, the model accounts for the fact that not all Medicaid-eligible individuals chose to enroll, perhaps because of stigma, lack of information, or transaction costs associated with enrolling. To account for the fact that the ACA increased Medicaid enrollment among the previously eligible population, we increase the calibration parameter by a factor of approximately $200 in the post-2014 period.

Individual Market. Under the ACA, the individual market consists of two components: 1) the insurance marketplaces where individuals can receive tax credits, and 2) off-marketplace plans that comply with the ACA's rating requirements. Because the ACA requires all plans in the individual market to be rated together, we model on- and off-marketplace plans that are ACA-compliant as a single risk pool. Hence, we do not distinguish between enrollment in on-marketplace plans and off-marketplace plans that comply with the ACA. In the ACA-compliant individual market, modeled individuals and families can purchase plans with a 60 percent, 70 percent, 80 percent, or 90 percent actuarial value, corresponding to bronze, silver, gold, and platinum plans on the marketplaces, respectively. We do not model catastrophic plans, which are available only to those under age 30 or who qualify for a hardship exemption from the individual mandate. According to a 2015 fact sheet published by the Centers for Medicare and Medicaid Services (CMS), less than 1 percent of all marketplace enrollees have selected catastrophic coverage.[7]

ACA-compliant individual market premiums are calculated endogenously in the model based on the health expenditure profile of those who choose to enroll. The total, unsubsidized premium is based on enrollees' age, smoking status, and market-rating reforms implemented under the ACA.[8] We model three-to-one rate-banding on age for adults ages 21 and older, with a separate age band for children and young adults under age 21. We also account for the ACA's risk-adjustment requirements, which transfer funds from plans with lower-than-average actuarial risk to plans with higher-than-average actuarial risk.

The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE) reports the average second-lowest-cost silver premium for a 27-year-old to be $296 per month in 2017.[9] This compares to our estimate of $348 per month for 2020, which reflects an average of 5.5 percent growth per year from the status quo. We do not account for possible changes to the individual market that may occur given uncertainties, such as possible funding cuts to cost-sharing reductions and not enforcing the individual mandate.

Under the ACA, the actual premium an enrollee pays is adjusted to account for tax credits available to qualifying individuals with incomes between 100 percent and 400 percent of FPL who do not have affordable offers of insurance from another source (e.g., employer coverage, Medicaid). We apply the ACA's subsidy formula using the benchmark silver premium and the individual's income. Eligible individuals who have incomes between 100 percent and 250 percent of FPL can also receive cost-sharing subsidies that help to lower out-of-pocket spending. As required by the ACA, individuals receiving cost-sharing subsidies in COMPARE must purchase a silver plan (70 percent actuarial value), and out-of-pocket spending is reduced to an equivalent of 94 percent, 87 percent, or 73 percent actuarial value plan if the individual's income is between 100 percent and 150 percent, 150 percent and 200 percent, or 200 percent and 250 percent of FPL, respectively. Note that out-of-pocket spending enters the individual's utility function; hence, individuals receiving cost-sharing subsidies are more likely to purchase coverage.

Comparison to Congressional Budget Office (CBO) Estimates. We also compared the current COMPARE insurance estimates for 2020 under current law with those of the CBO (Exhibit A1). We consider both CBO's March 2016 baseline,[10] which they used in their estimates of the potential effects of the American Health Care Act, and a subsequent update from January 2017.[11] The January update revised downward CBO's estimate of the number of enrollees in the individual market. Although the January update reported only individual market coverage and the number of uninsured individuals, the text stated that the reduction in estimated individual market enrollment was largely offset by revising upward the number of enrollees in employer-sponsored coverage.

After accounting for these changes, RAND's estimates are very similar to CBO's. One remaining difference is that CBO allows people to have more than one source of health insurance coverage, so the numbers in its 2016 baseline do not sum to population totals. RAND assigns everyone a primary insurance category, and does not account for multiple sources of coverage. This accounting difference may explain why CBO estimates more Medicaid enrollees than RAND.

Expanding the Tax Credits to Those with Incomes Above 400 Percent of FPL

To model the expansion of tax credits to individuals with incomes above 400 percent of FPL, we simply extend the tax credits to this population in our model. The change influences the chance of enrolling in the individual market by reducing the premium contribution that the enrollee faces (in the equation shown in the prior section). In addition, the tax credit reduces premium spending for eligible individuals who would have enrolled in the individual market without the tax credits, and increases government spending.

As under current law, we continue to assume that those with affordable employer coverage are ineligible for tax credits. Affordability is defined as having an employer premium contribution for single coverage that exceeds 9.95 percent of income. Further, we assume that those with incomes below 100 percent of FPL remain ineligible for tax credits, even if their states opted not to expand Medicaid.[12]

The proposed modification to extend the tax credit produces a number of changes in insurance coverage compared to the ACA (Exhibit A2). With the tax-credit extension above 400 percent of FPL, there is a 1.4 million increase in individual market coverage. This increase is offset by a small decrease of 300,000 enrollees in employer-sponsored insurance. In the tax-credit extension scenario, there are 2.8 million uninsured individuals with incomes above 400 percent of FPL. Many of these individuals are firewalled from receiving tax credits because they have an affordable offer from another source such as their employer.

Because the tax credit brings some new individuals into the individual insurance market, it has a small effect on the insurance risk pool. We estimate that it will decrease premiums by 2.6 percent because newly tax-credit-eligible enrollees tend to be healthier and less expensive given their age than other enrollees.

Exhibit A1. Insurance Enrollment by Source of Coverage Under the ACA, CBO and COMPARE, 2020

	CBO March 2016 (millions)	CBO January 2017 (millions)	COMPARE June 2017 (millions)
Total insured	249	—	252.8
Employer	152	—	155.7
Medicaid	68	—	62.0
Individual market	27	21	22.7
Other	14	—	12.5
Uninsured	27	28	25.2
Total population	276	—	278
Share uninsured	9.8%	—	9.1%

Note: Estimates reflect current law (the ACA), assuming the individual mandate is enforced and cost-sharing reductions are funded. CBO's numbers do not sum to population totals because they allow individuals to be assigned to more than one source of insurance coverage. CBO's January 2017 update reported estimates only for individual market coverage and the number uninsured.

Source: CBO estimates from 2016 and 2017.

Exhibit A2. Insurance Coverage, 2020

	ACA (millions under age 65)	Proposed tax credit extension (millions under age 65)	Difference (millions under age 65)
Total insured	252.8	254.0	1.2
Employer	155.7	155.5	−0.3
Medicaid	62.0	62.0	<0.1
Individual market	22.7	24.1	1.4
Other	12.5	12.5	0
Uninsured	25.2	24.0	−1.2
Up to 400% of FPL	21.5	21.3	−0.2
More than 400% of FPL	3.7	2.8	−0.9

APPENDIX B. CASE STUDIES

The ACA provides eligible individuals with a tax credit equal to the cost of the second-lowest-cost silver plan available to the enrollee minus a means-tested percentage contribution. The approach provides a "safety valve" that protects individuals from spending more than a specified percentage of income on premiums if they chose the second-lowest-cost silver plan or a less expensive plan. Under current law, the safety valve is only available for individuals with incomes between 100 percent and 400 percent of FPL. We estimate that, in 2020, the safety valve would prevent people with incomes between 300 percent and 400 percent of FPL from spending more than 9.95 percent of income on premiums, if they enrolled in the second-lowest-cost silver plan. The proposed change would extend the safety valve to individuals with incomes above 400 percent of FPL.

We provide example cases of individuals at different age and income levels (Exhibit A3). The tax credit is only paid if premiums exceed the required income contribution.

Thus, younger people at higher income levels are unlikely to receive a tax credit. (In fact, even under current law, many young people between 300% and 400% of FPL are not receiving tax credits.)

Extending tax credits has the biggest impact for older people who are just above the 400 percent of FPL threshold. The tax credit eliminates the steep cliff that exists for some age and income groups under current law. For example, we show the estimated second-lowest-cost silver premium for 2020 for a nationally representative population of individual market enrollees (Exhibit A3). Under current law, a 64-year-old whose income rises from $48,000 to $50,000 loses $6,424 in tax credits. That implies a marginal tax rate of more than 100 percent and means that the individual would be better off without the income increase. With the proposed change, this individual's tax credit declines by only about $200 as income rises from $48,000 to $50,000.

Exhibit A3. Example Cases of How the Proposed Change Would Work, 2020

Age	Income	Federal poverty level (%)	Second-lowest cost silver premium	Current law tax credit	Proposed tax credit
25	$48,000	398%	$4,200	$0	$0
	$50,000	415%	$4,200	$0	$0
	$75,000	622%	$4,200	$0	$0
40	$48,000	398%	$5,200	$424	$424
	$50,000	415%	$5,200	$0	$225
	$75,000	622%	$5,200	$0	$0
50	$48,000	398%	$7,600	$2,824	$2,824
	$50,000	415%	$7,600	$0	$2,625
	$75,000	622%	$7,600	$0	$138
64	$48,000	398%	$11,200	$6,424	$6,424
	$50,000	415%	$11,200	$0	$6,225
	$75,000	622%	$11,200	$0	$3,738

Note: The tax credit is equal to the second-lowest-cost silver premium minus 9.95 percent of income. Under current law, only those with incomes between 100 percent and 400 percent of the federal poverty level are eligible for tax credits. The proposed change would eliminate the upper limit on tax-credit eligibility.

APPENDIX C. COMPARISON TO OTHER PROPOSALS THAT MODIFY THE PREMIUM TAX CREDITS

Extending the ACA's premium tax credits to individuals with incomes above 400 percent of FPL is one possible modification to the tax credits. Exhibit A4 shows alternative modifications to the tax credits that RAND has previously analyzed compared to the current analysis. Each of these modifications would increase the number of insured but would require additional federal spending. Exhibit A4 focuses on coverage and spending but does not consider other metrics, such as how the policies might affect labor force participation.

Exhibit A4. Comparison to Prior RAND Analyses of Select Policy Options Modifying Premium Tax Credits

	Year	Number of insured (millions)	Federal deficit (billions)
Fix family glitch: allow an exception to the firewall for anyone in a family where the family employer-sponsored insurance premium contribution exceeds the required percent contribution of the worker's household income[a]	2017	+1.5	+$8.9
Reduce maximum premium contribution for benchmark plan in marketplace: 8.5 percent for individuals between 300 percent and 400 percent of the federal poverty level and proportional reductions for lower income levels[b]	2018	+1.7	+$3.5
Enhance tax credits for young adults: add $50 per month for eligible adults ages 19 to 30, and smaller amounts for individuals ages 31 to 34[c]	2018	+0.9	+$4.0
Extend tax credits to individuals with incomes above 400 percent of the federal poverty level	2020	+1.2	+$6.0

Note: The years analyzed vary in these analyses, and the model has been updated (e.g., to reflect more recent data) since some of the earlier results were published.

[a] S. Nowak, E. Saltzman, and A. Cordova, *Alternatives to the ACA's Affordability Firewall* (RAND Corporation, 2015).

[b] C. Eibner, S. Nowak, and J. Liu, *Hillary Clinton's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit* (The Commonwealth Fund, Sept. 2016).

[c] E. Saltzman, and C. Eibner, "Insuring Younger Adults Through the ACA's Marketplaces: Options to Expand Enrollment," *To the Point,* The Commonwealth Fund, Dec. 16, 2016.

APPENDIX NOTES

1   A. Cordova, F. Girosi, S. Nowak et al., "The COMPARE Microsimulation Model and the U.S. Affordable Care Act," *International Journal of Microsimulation,* 2013 6(3):78–117.

2   This approach follows D. P. Goldman, J. L. Buchanan, and E. B. Keeler, "Simulating the Impact of Medical Savings Accounts on Small Business," *Health Services Research,* April 2000 35(1 Pt. 1):53–75.

3   Other sources of coverage include Medicare for the nonelderly with qualifying conditions and military-related sources of coverage, such as TRICARE.

4   Internal Revenue Service, *Tax Gap Estimates for Tax Years 2008–2010* (IRS, April 2016).

5   Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (Henry J. Kaiser Family Foundation, Jan. 1, 2017).

6   North Carolina's governor announced plans to expand Medicaid, and — although there is uncertainty about whether the plans will move forward — we are assuming the state would expand by 2020. For a recent summary, see R. Craver, "U.S. House ACA Reform May Turn Up Heat on N.C. Medicaid Expansion," *Winston-Salem Journal,* March 8, 2017.

7   Centers for Medicare and Medicaid Services, *Fact Sheet: March 31, 2015 Effectuated Enrollment Snapshot* (CMS, June 2, 2015).

8   Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Federal Register 13405, Feb. 27, 2013.

9   *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Oct. 24, 2016).

10 Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (CBO, March 24, 2016).

11 Congressional Budget Office, *Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline* (CBO, 2017).

12 Arguably, it would make more sense to extend tax credits to lower-income individuals, rather than providing additional federal assistance to people with incomes above 400 percent of FPL. However, because extending tax credits to lower-income populations might cause some states to rescind Medicaid expansion, extending tax credits to lower-income individuals may be a less viable policy option than extending them to those with incomes above 400 percent of FPL.

U.S. Health Reform—Monitoring and Impact

Workers Gaining Health Insurance Coverage Under the ACA

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By Bowen Garrett, Anuj Gangopadhyaya, and Stan Dorn

Robert Wood Johnson Foundation

URBAN INSTITUTE

One major aim of the Patient Protection and Affordable Care Act (ACA) was to increase health insurance coverage. This brief highlights the ACA's impact on insurance coverage in working families, in light of the policy uncertainty surrounding ACA repeal and replace and the potential phase-out of Medicaid expansions and reductions in marketplace premium subsidies available to low-income people. Using data from the American Community Survey and the Current Population Survey, we examine changes in total coverage (i.e., all insurance types, including public insurance, employer-sponsored insurance, and individual plans) for workers and their family members from 2010 to 2015, by occupation type and state. Our main findings are as follows:

- Roughly 9.5 million workers under age 65 gained coverage from 2010 to 2015, along with 5.2 million family members. These 14.7 million Americans make up 77 percent of all those who gained coverage under the first six years of the ACA.

- Sorting workers by occupation, coverage gains appeared to target need well. Occupations that had lower rates of coverage and employer-sponsored insurance (ESI), lower wages, and lower earnings before the ACA saw greater gains.

  » In occupations where less than 70 percent of workers had health insurance in 2010, the median increase in coverage by 2015 was 13.4 percentage points. In occupations where 70–80 percent of workers had coverage in 2010, the median increase was 9.2 percentage points. Median increases were 6.1 and 2.3 percentage points, respectively, in occupations where

80–90 percent and more than 90 percent of workers had coverage in 2010.

  » Among occupations that paid average hourly wages of less than $15 in 2010, coverage increased at a median rate of 13.9 percentage points. For occupations with hourly wages of $15–20, $20–30, and more than $30, coverage increased by 7.1, 2.6, and 1.7 percentage points, respectively.

- Among the workers gaining coverage, 6.0 million (63 percent) lived in states that expanded their Medicaid programs under the ACA. The remaining 3.5 million (37 percent) lived in states that did not expand their programs. Coverage gains were larger in expansion states (7.2 percentage points) than nonexpansion states (6.4 percentage points). Hundreds of thousands of workers gained coverage in Florida (770,000) and Texas (915,000), even though neither state chose to expand Medicaid.

- State coverage expansions appeared well-targeted to need. Among Medicaid expansion and nonexpansion states, those with the lowest coverage levels in 2010—such as Florida and Texas—saw the greatest coverage increases among workers and their families.

By expanding health insurance coverage for workers, the ACA has helped counter the trends of increasingly unaffordable health care costs and steady erosion of employer-based health benefits. Repealing and replacing the ACA with either the Senate's Better Care Reconciliation Act (BCRA) or the House's American Health Care Act (AHCA) would reduce the coverage gains among low-wage workers and their families.

INTRODUCTION

Most working-age Americans with health insurance get it through an employer—either their own or a family member's. But employer-sponsored insurance rates had been declining for decades, especially for low-wage workers and workers in small firms,[1] before Congress passed the Patient Protection and Affordable Care Act in 2010. Publicly assisted coverage was unavailable to most workers who did not receive health coverage on the job. In the median state, working parents were ineligible for Medicaid if their income exceeded 64 percent of the federal poverty level (FPL).[2] Workers with incomes above Medicaid thresholds were generally ineligible for any help, and Medicaid in all but a few states did not cover workers without dependent children, no matter how low their income.

The ACA provided new ways for workers to obtain coverage, reduced coverage costs for many workers, and gave employers new incentives to offer health insurance. Health insurance marketplaces, combined with subsidies for premium assistance offered to workers with incomes between 100 and 400 percent of FPL, provided new ways for workers to buy coverage and, in many cases, to reduce its cost. Medicaid coverage became available to workers with incomes below 138 percent of FPL, including childless adults, who lived in expansion states. The ACA's employer mandate requires firms with 50 or more full-time-equivalent employees to provide ESI for their full-time workers (the employer mandate had not gone into full effect in 2015 and applied only to firms with 100 or more full-time-equivalent employees). And, the ACA's individual mandate, which imposed a penalty for going without health insurance coverage, provided an additional incentive for previously uninsured workers to seek coverage or take offers of employer-sponsored coverage.

The large increases in health insurance coverage attributable to the ACA have been well documented.[3] According to the latest estimates from government sources, 20.0 million Americans have gained coverage under the ACA as of 2016.[4] Studies have examined how the gains vary by income, family structure, geography, age, race/ethnicity, and parental status, but few have focused on the broad coverage gains for workers and their families.[5] This brief examines health insurance coverage among workers and their family members from 2010 to 2015 under the ACA, focusing on changes by occupation and state. We find that workers of all occupation types experienced increases in their insurance coverage, but the increases were greatest among occupations that, in 2010, had lower hourly wages, weekly earnings, health insurance coverage rates, and ESI coverage rates. We also find that the number of uninsured workers declined in all states, but the greatest coverage gains occurred in states that expanded Medicaid under the ACA. Across all states, those with lower coverage levels in 2010 experienced larger coverage gains. Put simply, the ACA's coverage gains appear well-targeted to need among workers and their families.

As Congress deliberates repealing the ACA and replacing it with a bill that resembles the Better Care Reconciliation Act (BCRA) or the American Health Care Act (AHCA), we note that ACA provisions are associated with large increases in insurance coverage for working families. The House version of the AHCA phases out the Medicaid expansions and lowers marketplace premium subsidies for those who are older, lower-income, or living in high-premium areas.[6] The BCRA also phases out the Medicaid expansions and lowers marketplace premium subsidies for low-income individuals (eligibility ends at 351 percent of FPL instead of 400 percent, and the premium cap as a share of income is higher).[7] We find that coverage gains for workers were higher among low-wage workers and among workers in states that expanded their Medicaid programs. These findings suggest that repealing and replacing the ACA with either the AHCA or the BCRA would reduce the coverage gains among low-wage workers and their families that occurred under the ACA.[8]

FINDINGS

We use data from the American Community Survey (ACS) to compute overall coverage rates from all sources and ESI rates by occupation and state. We calculate these rates for 2010 and 2015 as well as 2010 uninsured and ESI rates adjusted for demographic changes in the population between these periods (see the Data and Methods box for details). Similarly, we use the monthly Current Population Survey (CPS) to calculate hourly wage rates and earnings by occupation type in 2010, also adjusted for demographic changes. We calculate the change in the number of people gaining coverage by using the difference between the 2015 actual rate and the 2010 adjusted rate multiplied by the estimated 2015 population.

Coverage Gains in Working Families by Occupation

Table 1 reports the number of workers gaining coverage from 2010 to 2015 by occupation. It also reports the number of workers' family members gaining coverage. Occupations are listed in order of increasing insurance coverage rates as measured in 2010.

Table 1: Change in Insurance Coverage from 2010 to 2015 by Occupation

Occupation	Number of workers, 2015	Coverage rate, 2015	Adjusted 2010 coverage rate	Change, 2010–15 (% pt.)	Number Gaining Coverage in Working Families		
					Workers	Family members	Total
All occupations	**139,484,000**	**88.5%**	**81.6%**	**6.8**	**9,533,000**	**5,187,000**	**14,720,000**
< 70% insured in 2010	**21,172,000**	**71.9%**	**58.5%**	**13.4**	**2,834,000**	**1,325,000**	**4,159,000**
Farming, fishing, and forestry	998,000	63.7%	49.5%	14.2	142,000	91,000	233,000
Food preparation and serving	7,629,000	74.0%	56.5%	17.5	1,338,000	374,000	1,712,000
Construction and extraction	7,211,000	69.9%	60.3%	9.5	688,000	497,000	1,185,000
Building and grounds cleaning and maintenance	5,333,000	73.1%	60.6%	12.5	666,000	370,000	1,036,000
70–80% insured in 2010	**36,109,000**	**86.2%**	**76.6%**	**9.6**	**3,466,000**	**1,702,000**	**5,168,000**
Personal care and service	5,125,000	84.8%	70.8%	13.9	713,000	243,000	956,000
Transportation and material moving	8,668,000	83.2%	73.2%	10.0	863,000	476,000	1,339,000
Health care support	3,438,000	87.9%	77.1%	10.9	373,000	171,000	544,000
Extraction workers	206,000	86.0%	79.4%	6.5	13,000	20,000	33,000
Installation, maintenance, and repair	4,524,000	86.8%	79.5%	7.2	327,000	217,000	544,000
Sales and related	14,149,000	88.1%	79.7%	8.3	1,177,000	590,000	1,767,000
80–90% insured in 2010	**32,333,000**	**90.7%**	**84.8%**	**5.9**	**1,908,000**	**1,133,000**	**3,041,000**
Production	8,542,000	86.9%	80.0%	6.9	593,000	424,000	1,017,000
Arts, design, entertainment, sports, and media	2,741,000	91.0%	83.7%	7.3	199,000	60,000	259,000
Office and administrative support	18,070,000	91.9%	86.5%	5.4	982,000	585,000	1,567,000
Protective service	2,981,000	93.6%	89.1%	4.5	134,000	69,000	203,000
> 90% insured in 2010	**49,870,000**	**95.7%**	**93.0%**	**2.7**	**1,323,000**	**997,000**	**2,320,000**
Management, business, science, and arts	14,495,000	94.1%	91.0%	3.1	447,000	362,000	809,000
Community and social services	2,355,000	95.1%	92.4%	2.7	64,000	64,000	128,000
Education, training, and library	8,330,000	96.0%	92.5%	3.5	290,000	145,000	435,000
Business operations specialists	3,679,000	95.9%	93.5%	2.4	90,000	53,000	143,000
Legal	1,544,000	96.6%	93.5%	3.1	48,000	25,000	73,000
Health care practitioners and technicians	8,374,000	96.2%	94.1%	2.1	175,000	180,000	355,000
Financial specialists	3,127,000	97.0%	94.8%	2.2	70,000	59,000	129,000
Life, physical, and social science	1,239,000	97.0%	94.9%	2.1	26,000	18,000	44,000
Computer and mathematical	4,163,000	97.1%	95.4%	1.7	73,000	59,000	132,000
Architecture and engineering	2,565,000	97.2%	95.6%	1.6	40,000	34,000	74,000

Source: Urban Institute analysis of 2010 and 2015 American Community Survey data (IPUMS-USA, University of Minnesota, www.ipums.org).

Notes: Cells may not sum to totals because of rounding. The adjusted 2010 coverage rate reflects the demographic and geographic composition of the 2015 population.

In total, 139.5 million workers were age 18 to 64 in 2015, of whom 88.5 percent had some form of health coverage. In 2010, 81.6 percent of workers had health insurance after adjusting for compositional changes in the worker population over the period. This 6.8 percentage-point increase translates to 9.5 million newly insured workers, along with 5.2 million of their family members, totaling 14.7 million people in working families gaining coverage under the ACA. An estimated 19.2 million nonelderly people gained coverage between 2010 and 2015,[9] so approximately 77 percent of them were workers and their family members.

Coverage expansion in working families was widespread, benefiting workers in all occupations. For example, 1.3 million workers in food preparation and serving occupations gained coverage along with 374,000 family members. Nearly 1.2 million workers in sales and related occupations and 590,000 family members became insured. And 982,000 office and

administrative support workers gained coverage from 2010 to 2015, along with 585,000 family members.

Coverage gains from 2010 to 2015 tended to be higher for workers with lower coverage rates in 2010 (Table 1 and Figure 1). In the several higher-wage occupations with 2010 coverage rates above 90 percent, coverage gains through 2015 averaged 2.7 percentage points, ranging from 1.6 percentage points for architecture and engineering to 3.5 percentage points for education, training, and library occupations. By contrast, among the lower-wage occupations with baseline coverage rates below 70 percent, coverage gains averaged 13.4 percentage points, ranging from 9.5 percentage points for construction and extraction to 17.5 percentage points for food preparation and serving. Because coverage gains under the ACA were generally larger in occupations with lower baseline rates, variation across occupations narrowed between 2010 and 2015.

Figure 1: Change in Occupation-level Insurance Coverage from 2010 to 2015 and 2010 Insurance Coverage Rate
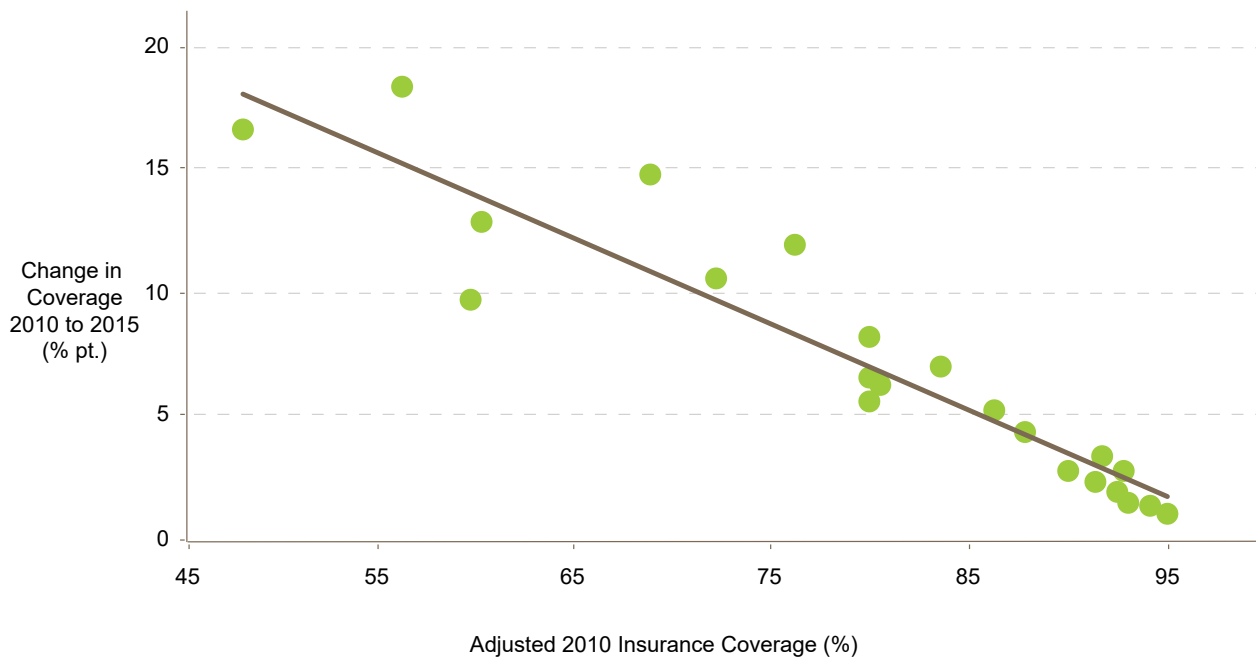
Source: Urban Institute analysis of 2010 and 2015 American Community Survey data (IPUMS-USA, University of Minnesota, www.ipums.org).
Note: The adjusted 2010 coverage rate reflects the demographic and geographic composition of the 2015 population.

Table 2 reports coverage gains between 2010 and 2015 along with three other characteristics of occupations measured in 2010: ESI coverage rates, average hourly wages, and average weekly earnings. Occupations are listed in order of increasing average wage. Rates of workers covered by employers (their own or a family member's) varied substantially across occupations. Higher-wage occupations tended to have higher

ESI coverage rates in 2010 than lower-wage occupations. For example, 48.2 percent of workers in personal care and service occupations (with hourly wages averaging $12.74) had coverage through an employer in 2010, compared with 84.0 percent of workers in education, training, and library occupations (with hourly wages averaging $22.35).

Table 2: Change in Insurance Coverage Rates from 2010 to 2015 and 2010 Employment Measures by Occupation

Occupation	Change in coverage rate, 2010–15 (% pt.)	Adjusted 2010 ESI rate	Adjusted 2010 hourly wage	Adjusted 2010 weekly earnings
All occupations	**6.8**	**70.1%**	**$20.38**	**$860**
Hourly wage < $15 in 2010	**14.3**	**45.9%**	**$11.71**	**$442**
Food preparation and serving	17.5	39.3%	$10.10	$390
Farming, fishing, and forestry	14.2	34.0%	$10.37	$449
Building and grounds cleaning and maintenance	12.5	45.8%	$12.22	$459
Personal care and service	13.9	48.2%	$12.74	$465
Health care support	10.9	60.9%	$13.15	$492
Hourly wage $15–20 in 2010	**7.4**	**67.8%**	**$16.98**	**$719**
Transportation and material moving	10.0	62.1%	$15.12	$678
Production	6.9	71.5%	$15.81	$669
Office and administrative support	5.4	76.0%	$16.41	$645
Sales and related	8.3	64.6%	$17.03	$739
Construction and extraction	9.5	49.0%	$18.92	$789
Extraction workers	6.5	74.9%	$19.26	$1,133
Protective service	4.5	81.2%	$19.42	$891
Installation, maintenance, and repair	7.2	70.3%	$19.53	$839
Hourly wage $20–30 in 2010	**3.1**	**82.3%**	**$26.77**	**$1,155**
Community and social services	2.7	82.6%	$20.92	$850
Education, training, and library	3.5	84.0%	$22.35	$888
Arts, design, entertainment, sports, and media	7.3	66.2%	$25.43	$1,037
Business operations specialists	2.4	84.6%	$27.09	$1,181
Health care practitioners and technicians	2.1	85.2%	$27.37	$1,095
Life, physical, and social science	2.1	87.1%	$28.01	$1,197
Financial specialists	2.2	86.4%	$29.10	$1,266
Management, business, science, and arts	3.1	80.6%	$29.31	$1,365
Hourly wage > $30 in 2010	**1.9**	**87.9%**	**$32.62**	**$1,431**
Architecture and engineering	1.6	90.3%	$31.70	$1,378
Computer and mathematical	1.7	89.0%	$33.02	$1,418
Legal occupations	3.1	81.0%	$33.12	$1,556

Source: Urban Institute analysis of 2010 and 2015 American Community Survey and Current Population Survey data (IPUMS-USA and IPUMS-CPS, University of Minnesota, www.ipums.org).

Notes: Coverage change and employer-sponsored insurance (ESI) coverage rates are estimated using American Community Survey data. Weekly earnings and hourly wages are estimated using monthly Current Population Survey data. The adjusted 2010 employment measures reflect the demographic and geographic composition of the 2015 population.

Occupations with lower rates of employer-sponsored coverage in 2010 tended to have larger gains in total insurance coverage by 2015. Only 39.3 percent of workers in food preparation and serving occupations had ESI in 2010, and their rate for all coverage types increased 17.5 percentage points under the ACA. Sales and related occupations, which had a 64.6 percent ESI rate in 2010, experienced a gain in insurance coverage under the ACA of 8.3 percentage points. Workers in occupations with 2010 ESI coverage rates in the 80 to 90 percent range experienced modest gains in total coverage by 2015, ranging from 1.7 to 4.5 percentage points. These findings indicate that coverage gains under the ACA were well-targeted to workers who did not previously receive health insurance coverage through an employer.

Workers earning lower wages had larger percentage-point gains in coverage from 2010 to 2015, compared to those earning higher wages (Table 2 and Figure 2). In occupations with hourly wages of less than $15 in 2010, coverage gains ranged from 10.9 percentage points for health care support

to 17.5 percentage points for food preparation and serving. In occupations with hourly wages of more than $30, gains from 2010 to 2015 ranged from 1.6 percentage points for architecture and engineering to 3.1 percentage points for legal occupations. The data points in Figure 2 and the line of best fit show a close inverse relationship between wage rates in 2010 and coverage gains from 2010 to 2015.

Gains in coverage from 2010 to 2015 across occupations were also strongly associated with average weekly earnings, which combines wage rates and hours worked (Table 2). In occupations with average weekly earnings of less than $500, coverage gains ranged from 10.9 to 17.5 percentage points. Coverage gains tended to be smaller for workers with higher earnings (Table 2), similar to the results for wage levels (Figure 2). These findings suggest that coverage gains were well-targeted to workers who were less able to afford health insurance premiums, whether buying individual coverage or paying the worker's share of employer-based coverage.

Figure 2: Change in Occupation-level Insurance Coverage from 2010 to 2015 and 2010 Hourly Wage

Source: Urban Institute analysis of 2010 and 2015 American Community Survey and Current Population Survey data (IPUMS-USA and IPUMS-CPS, University of Minnesota, www.ipums.org).
Note: The adjusted 2010 hourly wage reflects the demographic and geographic composition of the 2015 population.

Table 3 summarizes the findings on how coverage gains for workers from 2010 to 2015 vary by the baseline characteristics of occupations. Among occupations that, in 2010, had coverage rates below 70 percent, the median increase by 2015 was 13.4 percentage points. For occupations with baseline coverage between 70 and 80 percent, the median increase was 9.2 percentage points. Median increases were 6.1 and 2.3 percentage points for occupations with baseline coverage rates of 80–90 percent and above 90 percent, respectively. Similarly, coverage gains were largest for occupations with lower levels of ESI coverage in 2010.

Among occupations that paid average hourly wages less than $15 in 2010, coverage increased at a median rate of 13.9 percentage points. For occupations with wages of $15–20, $20–30, and more than $30, coverage increased by 7.1, 2.6, and 1.7 percentage points, respectively. A similar pattern emerges when occupations are grouped by weekly earnings in 2010. Across all baseline measures, coverage gains for workers under the ACA were well-targeted to need.

Table 3: Change in Insurance Coverage Rates from 2010 to 2015 by Occupation Characteristics in 2010

2010 characteristics		Median coverage increase (% pt.)	Range of coverage increases (% pt.)	Occupational categories
Coverage rate	< 70%	13.4	9.5–17.5	4
	70–80%	9.2	6.5–13.9	6
	80–90%	6.1	4.5–7.3	4
	> 90%	2.3	1.6–3.5	10
Employer-sponsored insurance rate	< 60%	13.9	9.5–14.2	5
	60–75%	7.3	6.5–10.9	7
	75–85%	3.1	2.4–5.4	7
	> 85%	2.1	1.6–2.2	5
Hourly wages	< $15	13.9	10.9–17.5	5
	$15–20	7.1	4.5–10.0	8
	$20–30	2.6	2.1–7.3	8
	> $30	1.7	1.6–3.1	3
Weekly earnings	< $500	13.9	10.9–17.5	5
	$500–800	8.3	5.4–10.0	5
	$800–1,200	3.5	2.1–7.3	9
	> $1,200	2.2	1.6–3.1	5

Source: Urban Institute analysis of 2010 and 2015 American Community Survey and Current Population Survey data (IPUMS-USA and IPUMS-CPS, University of Minnesota, www.ipums.org).

Coverage Gains in Working Families by State

Table 4 shows the number of workers and their family members gaining coverage in each state. States are grouped by whether they had expanded Medicaid as provided under the ACA by mid-2015. The largest percentage-point gains (from 10.6 to 12.2) in worker coverage were in California, New Mexico, Oregon, and West Virginia, all four of which expanded Medicaid coverage under the ACA. The smallest percentage-point gains (from 1.3 to 3.4) were in Hawaii, Maine, Massachusetts, South Dakota, Vermont, and Wisconsin. Hawaii, Massachusetts, and Vermont had already expanded coverage before the ACA; by 2010, their worker coverage rates were above 90 percent. Maine, South Dakota, and Wisconsin also had relatively high 2010 coverage rates, from 86.0 to 89.3 percent; Maine and Wisconsin had significantly expanded eligibility for Medicaid before the ACA.

Table 4: State Change in Insurance Coverage for Workers and their Family Members from 2010 to 2015 by Medicaid Expansion Status

	Number of workers, 2015	Coverage rate, 2015	Adjusted 2010 coverage rate	Change, 2010–15 (% pt.)	Number Gaining Coverage in Working Families		
					Workers	Family members	Total
All states	**139,484,000**	**88.5%**	**81.6%**	**6.8**	**9,533,000**	**5,187,000**	**14,720,000**
Expansion states							
Arizona	2,726,000	86.2%	79.6%	6.6	180,000	123,000	303,000
Arkansas	1,171,000	88.1%	78.8%	9.4	110,000	45,000	155,000
California	16,965,000	88.8%	77.8%	11.0	1,866,000	1,264,000	3,130,000
Colorado	2,569,000	89.8%	81.7%	8.2	210,000	119,000	329,000
Connecticut	1,655,000	92.8%	88.7%	4.2	69,000	8,000	77,000
Delaware	412,000	93.2%	86.1%	7.0	29,000	NP	NP
District of Columbia	346,000	96.2%	91.1%	5.2	18,000	NP	NP
Hawaii	620,000	95.8%	93.4%	2.3	14,000	15,000	29,000
Illinois	5,758,000	91.0%	83.7%	7.3	422,000	211,000	633,000
Indiana	2,871,000	88.6%	83.1%	5.5	158,000	70,000	228,000
Iowa	1,452,000	94.3%	88.9%	5.4	79,000	26,000	105,000
Kentucky	1,781,000	92.2%	82.8%	9.4	168,000	72,000	240,000
Maryland	2,808,000	92.3%	86.8%	5.5	154,000	64,000	218,000
Massachusetts	3,223,000	96.6%	94.4%	2.1	69,000	32,000	101,000
Michigan	4,181,000	92.2%	85.0%	7.2	302,000	105,000	407,000
Minnesota	2,677,000	95.0%	89.5%	5.5	146,000	65,000	211,000
Nevada	1,237,000	85.0%	77.3%	7.7	96,000	101,000	197,000
New Hampshire	653,000	91.2%	87.0%	4.2	28,000	13,000	41,000
New Jersey	4,057,000	88.6%	84.2%	4.4	179,000	100,000	279,000
New Mexico	805,000	84.8%	74.1%	10.7	86,000	47,000	133,000
New York	8,831,000	90.6%	84.9%	5.7	503,000	240,000	743,000
North Dakota	366,000	91.9%	88.3%	3.6	13,000	NP	NP
Ohio	5,049,000	92.2%	86.2%	6.0	305,000	129,000	434,000
Oregon	1,751,000	90.8%	80.2%	10.6	185,000	83,000	268,000
Pennsylvania	5,575,000	92.7%	88.0%	4.6	258,000	112,000	370,000
Rhode Island	486,000	93.7%	86.4%	7.2	35,000	NP	NP
Vermont	299,000	93.3%	90.1%	3.2	10,000	NP	NP
Washington	3,176,000	91.7%	83.9%	7.8	247,000	131,000	378,000
West Virginia	689,000	92.4%	80.2%	12.2	84,000	32,000	116,000
Expansion state total	**84,189,000**	**90.8%**	**83.7%**	**7.2**	**6,023,000**	**3,207,000**	**9,230,000**

Table 4: Continued

	Number of workers, 2015	Coverage rate, 2015	Adjusted 2010 coverage rate	Change, 2010–15 (% pt.)	Number Gaining Coverage in Working Families		
					Workers	Family members	Total
All states	**139,484,000**	**88.5%**	**81.6%**	**6.8**	**9,533,000**	**5,187,000**	**14,720,000**
Nonexpansion states							
Alaska	325,000	83.5%	77.8%	5.7	19,000	8,000	27,000
Alabama	1,901,000	87.4%	83.5%	4.0	75,000	53,000	128,000
Florida	8,300,000	82.6%	73.4%	9.3	770,000	443,000	1,213,000
Georgia	4,315,000	83.9%	77.6%	6.3	272,000	129,000	401,000
Idaho	690,000	84.3%	77.6%	6.8	47,000	40,000	87,000
Kansas	1,301,000	89.1%	84.4%	4.7	61,000	24,000	85,000
Louisiana	1,893,000	85.0%	77.0%	7.9	150,000	41,000	191,000
Maine	591,000	89.4%	86.0%	3.4	20,000	NP	NP
Mississippi	1,120,000	84.7%	79.7%	4.9	55,000	45,000	100,000
Missouri	2,655,000	88.6%	84.6%	4.0	107,000	32,000	139,000
Montana	450,000	85.3%	79.4%	6.0	27,000	9,000	36,000
Nebraska	892,000	90.8%	85.0%	5.8	52,000	10,000	62,000
North Carolina	4,235,000	85.8%	80.4%	5.4	228,000	151,000	379,000
Oklahoma	1,601,000	82.8%	75.1%	7.7	123,000	48,000	171,000
South Carolina	1,989,000	86.7%	80.4%	6.3	126,000	83,000	209,000
South Dakota	388,000	88.1%	86.9%	1.3	5,000	NP	NP
Tennessee	2,767,000	87.3%	82.7%	4.6	126,000	47,000	173,000
Texas	11,813,000	79.8%	72.1%	7.7	915,000	614,000	1,529,000
Utah	1,298,000	87.5%	82.4%	5.0	65,000	42,000	107,000
Virginia	3,764,000	89.3%	85.1%	4.2	157,000	63,000	220,000
Wisconsin	2,738,000	92.7%	89.3%	3.3	91,000	46,000	137,000
Wyoming	267,000	87.5%	80.9%	6.7	18,000	12,000	30,000
Nonexpansion state total	**55,293,000**	**84.9%**	**78.5%**	**6.4**	**3,509,000**	**1,940,000**	**5,449,000**

Source: Urban Institute analysis of 2010 and 2015 American Community Survey data (IPUMS-USA, University of Minnesota, www.ipums.org).

Notes: Expansion states are those that expanded their Medicaid programs on or before July 1, 2015. The District of Columbia is classified as a state. The adjusted 2010 coverage rate reflects the demographic and geographic composition of the 2015 population.

NP = nonprecise estimate. We do not report estimates for which the margin of error (two times the standard error) exceeds 30 percent of the average coverage rates.

Between 2010 and 2015, 6.02 million workers and 3.21 million family members gained coverage in states that expanded Medicaid under the ACA; 3.51 million workers and 1.94 million family members gained coverage in states that did not expand Medicaid. The coverage gains for workers were higher in Medicaid expansion states (7.2 percentage points) than in nonexpansion states (6.4 percentage points). If we exclude the states that had already expanded Medicaid coverage to levels similar to the ACA's by 2010 (Delaware, Massachusetts, New York, Vermont, and Washington, D.C.), we find an even larger difference between expansion states and nonexpansion states: 7.6 percentage points versus 6.4 percentage points. Despite not expanding Medicaid, Florida and Texas had very large coverage gains among working families under the ACA: 770,000 workers and 443,000 family members in Florida, and 915,000 workers and 614,000 family members in Texas. Among all nonexpansion states, these two had the highest shares and numbers of uninsured workers in 2010.

Figure 3 plots the state-level changes in coverage between 2010 and 2015 against 2010 coverage rates for expansion and nonexpansion states. This figure illustrates two main points. First, Medicaid expansion states (green dots and brown trend line) generally show larger coverage changes than nonexpansion states (blue dots and orange trend line), even when they had similar baseline coverage rates. Second, both trend lines show a sharp inverse relationship between baseline coverage levels and increased coverage under the ACA. Put simply, among both expansion and nonexpansion states, the ACA improved coverage the most in states with the highest baseline levels of uninsured workers. Coverage gains were thus well-targeted by state as well as occupation.

Figure 3: Change in State-level Insurance Coverage for Workers from 2010 to 2015 and 2010 Insurance Coverage Rate, by Medicaid Expansion Status
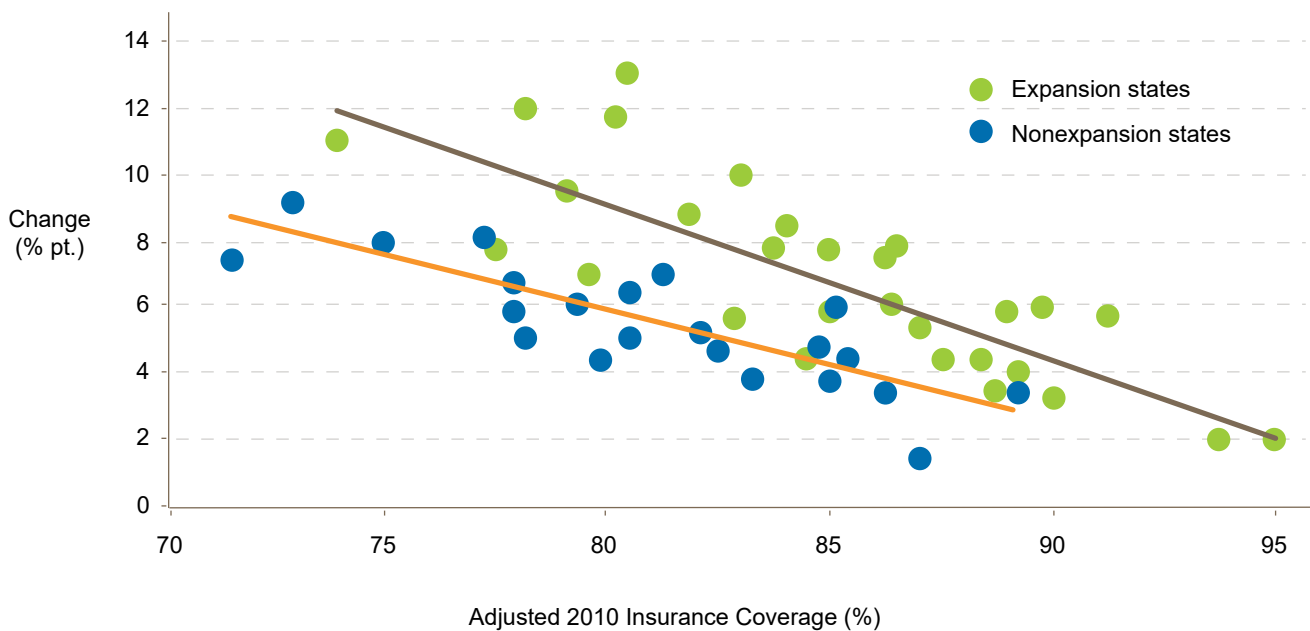
Source: Urban Institute analysis of 2010 and 2015 American Community Survey data (IPUMS-USA, University of Minnesota, www.ipums.org).
Note: The adjusted 2010 coverage rate reflects the demographic and geographic composition of the 2015 population.

To summarize the data in Table 4 and Figure 3, Table 5 reports the median percentage-point coverage increase within groups of states classified by their coverage rate in 2010 and their Medicaid expansion status. Among states with coverage rates for workers below 80 percent in 2010, the median expansion state experienced a 9.4 percentage-point increase in coverage by 2015, whereas the median nonexpansion state experienced a 6.8 percentage-point increase. States with higher 2010 coverage rates had smaller gains. Median percentage-point gains in coverage were higher in Medicaid expansion states than nonexpansion states, apart from states with 2010 worker coverage rates above 90 percent (because no nonexpansion states had a baseline rate that high). These findings suggest that Medicaid expansion under the ACA helped cover workers, especially in states that had the lowest coverage rates for workers before the main provisions of the ACA took effect.

Table 5: State-Level Changes in Insurance Coverage from 2010 to 2015 by 2010 Coverage Rate and Medicaid Expansion Status

Coverage rate, 2010	Medicaid expansion status	Median coverage increase (% pt.)	Range of coverage increases (% pt.)	Number of states
< 80%	Expansion	9.4	6.6–10.7	5
	Nonexpansion	6.8	4.9–9.3	9
80–85%	Expansion	7.8	4.4–12.2	9
	Nonexpansion	4.9	4.0–6.7	8
85–90%	Expansion	5.5	3.6–7.2	11
	Nonexpansion	3.4	1.3–5.8	5
> 90%	Expansion	2.8	2.1–5.2	4
	Nonexpansion	n/a	n/a	0

Source: Urban Institute analysis of 2010 and 2015 American Community Survey data (IPUMS-USA, University of Minnesota, www.ipums.org).
Notes: Expansion states are those that expanded their Medicaid programs on or before July 1, 2015. The District of Columbia is classified as a state.
n/a = not applicable

DISCUSSION

Employer-sponsored health insurance has been, and remains, the largest source of health insurance for nonelderly adults in the United States. Yet many workers are uninsured. For some employers, particularly small firms and those with predominately low-wage workers, paying for ESI makes little economic sense. In 2010, annual ESI premiums averaged $5,049 for a single adult and $13,770 for a family. By 2016, those costs had risen to $6,435 and $18,142.[10] The cost for family coverage exceeds the annual $15,080 income of a full-time, year-round worker paid the federal minimum wage of $7.25 an hour.

In 2010, 70.1 percent of workers had employer-sponsored coverage from their own or a family member's employer, and 81.6 percent of workers had some form of health insurance. The ACA included many provisions designed to increase health insurance coverage for workers and nonworkers alike. From 2010 to 2015, we estimate that 9.5 million workers gained health insurance coverage under the ACA, increasing their coverage rate from 81.6 in 2010 to 88.5 percent in 2015. In addition, 5.2 million family members of workers gained health insurance under the ACA. Assuming that 19.2 million people gained coverage from 2010 to 2015,[11] our findings suggest that most people gaining coverage under the ACA were workers and their family members. These findings run contrary to the concerns of some observers that the ACA primarily benefits nonworking populations that are "freeloading" and "undeserving" of public assistance.[12]

Workers across all occupation groups saw gains in coverage from 2010 to 2015, but the size of the gains varied greatly. Workers in occupations with lower average wages and lower average earnings (accounting for hours worked) had larger gains in coverage. The occupations with the largest coverage gains also tended to be those with the least insurance coverage, as well as those with the least employer-sponsored coverage, in 2010. Thus, the coverage gains were largest among workers more likely to be missed by employer coverage.

Coverage gains for workers from 2010 to 2015 were larger in states that expanded Medicaid (7.2 percentage points) than those that did not (6.4 percentage points). For workers in occupations with average hourly wages below $15, insurance coverage increased 12.9 percentage points in states that expanded Medicaid and 10.7 percentage points in states that did not. Thus, the ACA's Medicaid expansion appears to have helped provide health insurance coverage to workers and their dependents.

Labor markets over recent decades have produced stagnant wages, declines in employer-sponsored coverage, and a hollowing out of well-paying middle class jobs. From 1979 to 2013, wages remained stagnant for middle-wage workers and fell for low-wage workers.[13] ESI coverage of the nonelderly population fell 11 percentage points (16 percent) from 1999 to 2013.[14] By expanding health insurance coverage for workers, the ACA helped counter the trends of increasingly unaffordable health insurance costs and steady erosion of employer-based health benefits.

DATA AND METHODS

The primary data source for this brief is the American Community Survey (ACS). Starting in 2005, the ACS provides demographic, employment, and health insurance information for more than 2 million Americans each year. Using 2010 and 2015 ACS data for nonelderly adults (ages 19–64) from the Integrated Public Use Microdata Series (IPUMS), we estimate health insurance coverage rates for workers, including employer-based coverage, by workers' occupation type.

We also use data from the Current Population Survey (CPS), which provides monthly updates on the status of labor markets. We use CPS information on workers' wages, number of hours worked per week, and earnings per week. Questions on these topics are asked of approximately a quarter of CPS respondents each month. We pool all months in 2010 and all months in 2015 to establish an annual average of these outcomes by occupation. Hourly wage rates in the CPS are only assessed for workers who reported working for an hourly wage; we calculate the hourly wage rate for all other workers by dividing their reported weekly earnings by the number of hours worked.

In both the ACS and CPS, we use the IPUMS-harmonized 2010 Census Bureau occupation classification system to group workers into broad occupation categories. Observation counts within detailed occupation categories are too small to provide precise estimates, so we aggregate occupations into 24 predefined categories. We then estimate occupation-specific uninsured and ESI rates (from the ACS) as well as industry-specific wages, hours worked, and weekly earnings (from the CPS). All estimates use individual-level survey weights.

Between 2010 and 2015, factors other than the ACA may have affected workers' coverage status, wages, and earnings (i.e., macroeconomic improvements or decreased labor supply from an aging population). To help separate these factors from the ACA, we compare our 2015 coverage and labor measures with a "counterfactual" 2010 estimate that is adjusted to reflect the demographic and occupational composition of 2015. Specifically, we calculate the weighted average for each outcome measure by crossing all combinations of age groups, gender, education, race and ethnicity, occupation classifications, industrial classifications, and state. We then match the 2010 outcome by cell to the corresponding cell in 2015. We refer to this as the "adjusted" 2010 estimate. The maximum deviation between the actual and adjusted 2010 measures are small: 1.2 percentage points for uninsured rates, 1.4 percentage points for ESI rates, 7.5 percent for earnings, and 5.0 percent for hourly wage rates.

We also estimate the number of workers' family members that gained coverage from 2010 to 2015. To make this estimate, we identified family units in the ACS. All individuals under age 65 within families that include a single worker with a listed occupation are included as family members of workers in that occupation. For individuals in families that include two workers with listed occupations, we allocate them with equal probability randomly as family members of one of the two workers. For the small number of families that have more than two workers, we allocate nonworkers with equal probability randomly to one of the two working family members in occupations with the highest wages.

In analyzing coverage changes by state, we separate expansion and nonexpansion states based on their Medicaid expansion status for most of 2015. Therefore, we classify Indiana (expansion effective February 1, 2015), Michigan (April 1, 2014), New Hampshire (August 15, 2014), and Pennsylvania (January 1, 2015) as expansion states; and Alaska (September 1, 2015), Montana (January 1, 2016), and Louisiana (July 1, 2016) as nonexpansion states.[15]

ENDNOTES

1. See Figures 1.A and 2.A in: Blavin F, Holahan J, Kenney G, Chen V. *A Decade of Coverage Losses: Implications for the Affordable Care Act*. Washington: Urban Institute and the Robert Wood Johnson Foundation; 2012. http://www.urban.org/research/publication/decade-coverage-losses-implications-affordable-care-act.

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3. See: Garrett B, Gangopadhyaya A. *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?* Washington: Urban Institute; 2016. http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf. Kaestner R, Garrett B, Chen J, Gangopadhyaya A, Fleming C. Effects of ACA Medicaid expansions on health insurance coverage and labor supply. *Journal of Policy Analysis and Management.* 2017;36(3):608–642. doi:10.1002/pam.21993. Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D. Early impacts of the Affordable Care Act on health insurance coverage in Medicaid expansion and non-expansion states. *Journal of Policy Analysis and Management.* 2017;36(1):178–210.

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5. See: Williamson A, Antonisse L, Tolbert J, Garfield R, Damico A. *ACA Coverage Expansions and Low-Income Workers*. Menlo Park, CA: Kaiser Family Foundation; 2016. http://files.kff.org/attachment/ACA-Coverage-Expansions-and-Low-Income-Workers. The authors document that low-income workers have lower access to full-time, full-year jobs with benefit packages and that coverage expansions under the ACA resulted in coverage gains for these workers, especially in Medicaid expansion states.

6. Cox C, Claxton G, Levitt L. *How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits*. Menlo Park, CA: Kaiser Family Foundation; 2017. http://files.kff.org/attachment/Issue-Brief-How-Affordable-Care-Act-Repeal-and-Replace-Plans-Might-Shift-Health-Insurance-Tax-Credits.

7. For a summary of the BCRA, see: Kliff S. The Better Care Reconciliation Act: the Senate's bill to repeal and replace Obamacare, explained. Vox. June 26, 2017. https://www.vox.com/policy-and-politics/2017/6/22/15846728/senate-plan-better-care-reconciliation-act.

8. For state-level estimates of coverage changes under the AHCA, see: Blumberg LJ, Buettgens M, Holahan J, Garrett B, Wang R. *State-by-State Coverage and Government Spending Implications of the American Health Care Act*. Washington: Urban Institute; 2017. http://www.urban.org/research/publication/state-state-coverage-and-government-spending-implications-american-health-care-act. For state-level estimates of coverage changes under the BCRA, see Blumberg LJ, Buettgens M, Holahan J, Garrett B, Wang R. *State-by-State Coverage and Government Spending Implications of the Better Care Reconciliation Act*. Washington: Urban Institute; 2017. http://www.urban.org/research/publication/state-state-coverage-and-government-spending-implications-better-care-reconciliation-act.

9. See our earlier report, which used the same data source: Garrett B, Gangopadhyaya A. *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?* Washington: Urban Institute; 2016. http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf.

10. Premiums and worker contributions among workers covered by employer-sponsored coverage, 1999–2016. Kaiser Family Foundation website. http://kff.org/interactive/premiums-and-worker-contributions/. Published September 14, 2016.

11. Federal estimates including 2016 data indicate that around 20 million Americans gained coverage under the ACA. See: Uberoi N, Finegold K, Gee E. *Health Insurance Coverage and the Affordable Care Act, 2010–2016*. Washington: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; 2016. https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf. Garrett B, Gangopadhyaya A. *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?* Washington: Urban Institute; 2016. http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf.

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Individual Insurance Market Performance in Early 2017

Cynthia Cox and Larry Levitt

Concerns about the stability of the individual insurance market under the Affordable Care Act (ACA) have been raised in the past year following exits of several insurers from the exchange markets, and again with renewed intensity in recent months as debate over repeal of the health law has picked up. Our earlier analysis of premium and claims data from 2011 – 2016 found that insurer financial performance indeed worsened in 2014 and 2015 with the opening of the exchange markets, but showed signs of improving in 2016. A similar analysis by S&P looking at a subset of Blue Cross Blue Shield plans found a comparable pattern.

In this brief, we look at recently-released first quarter financial data from 2017 to examine whether recent premium increases were sufficient to bring insurer performance back to pre-ACA levels. These new data offer more evidence that the individual market has been stabilizing and insurers are regaining profitability.

We use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at the average premiums, claims, medical loss ratios, gross margins, and enrollee utilization from first quarter 2011 through first quarter 2017 in the individual insurance market.[1] These figures include coverage purchased through the ACA's exchange marketplaces and ACA-compliant plans purchased directly from insurers outside the marketplaces (which are part of the same risk pool), as well as individual plans originally purchased before the ACA went into effect.

Medical Loss Ratios

As we found in our previous analysis, insurer financial performance as measured by loss ratios (the share of health premiums paid out as claims) worsened in the earliest years of the Affordable Care Act, but began in improve more recently. This is to be expected, as the market had just undergone significant regulatory changes in 2014 and insurers had very little information to work with in setting their premiums, even going into the second year of the exchange markets.

Loss ratios began to decline in 2016, suggesting improved financial performance. In 2017, following relatively large premium increases, individual market insurers saw significant improvement in loss ratios, averaging 75% in the first quarter. First quarter loss ratios tend to follow the same pattern as annual loss ratios, but in recent years have been 10 to 15 percentage points lower than annual loss ratios.[2] Though 2017 annual loss ratios are therefore likely to end up higher than 75%, this is nevertheless a sign that individual market insurers on average are on a path toward regaining profitability in 2017.

Figure 1

Average First Quarter Individual Market Medical Loss Ratios, 2011 - 2017
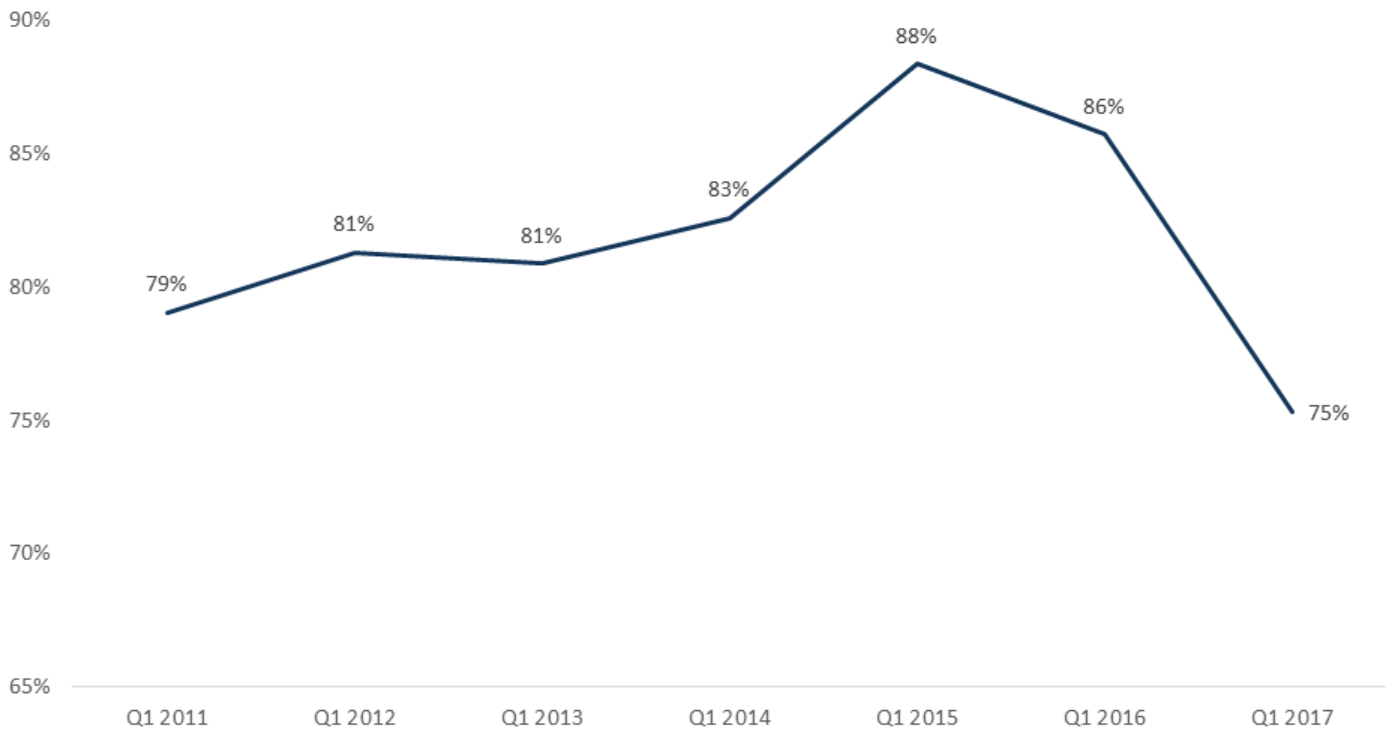
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM. Note: Figures above represent simple loss ratios and differ from the definition of MLR in the Affordable Care Act

Margins

Another way to look at individual market financial performance is to examine average gross margins per member per month, or the average amount by which premium income exceeds claims costs per enrollee in a given month. Gross margins are an indicator of performance, but positive margins do not necessarily translate into profitability since they do not account for administrative expenses. As with medical loss ratios, first quarter margins tend to follow a similar pattern to annual margins, but generally look more favorable as enrollees are still paying toward their deductibles in the early part of the year, lowering claims costs for insurers.

Figure 2

Average First Quarter Individual Market Gross Margins Per Member Per Month, 2011 - 2017
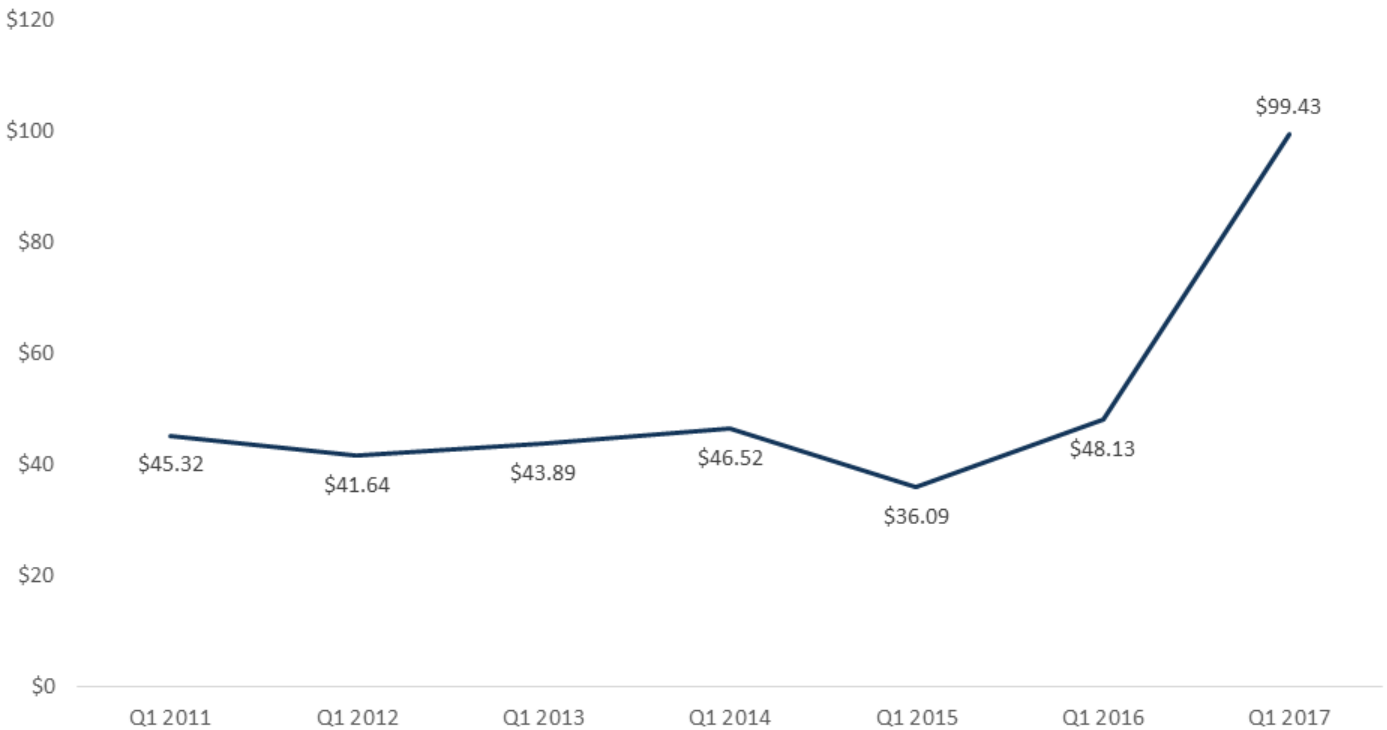
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

Looking at gross margins, we see a similar pattern as we did looking at loss ratios, where insurer financial performance improved dramatically in the first quarter of 2017 (increasing to $99 per enrollee, from a recent first quarter low of $36 in 2015). Again, first quarter data tend to indicate the general direction of the annual trend, and while annual 2017 margins are unlikely to end as high as they are in the first quarter, these data suggest that insurers in this market are on track to reach pre-ACA individual market performance levels.

Underlying Trends

Driving recent improvements in individual market insurer financial performance are the premium increases in 2017 and simultaneous slow growth in claims for medical expenses. On average, premiums per enrollee grew 20% from first quarter 2016 to first quarter 2017, while per person claims grew only 5%.

Figure 3

Average First Quarter Individual Market Monthly Premiums and Claims Per Person, 2011 - 2017
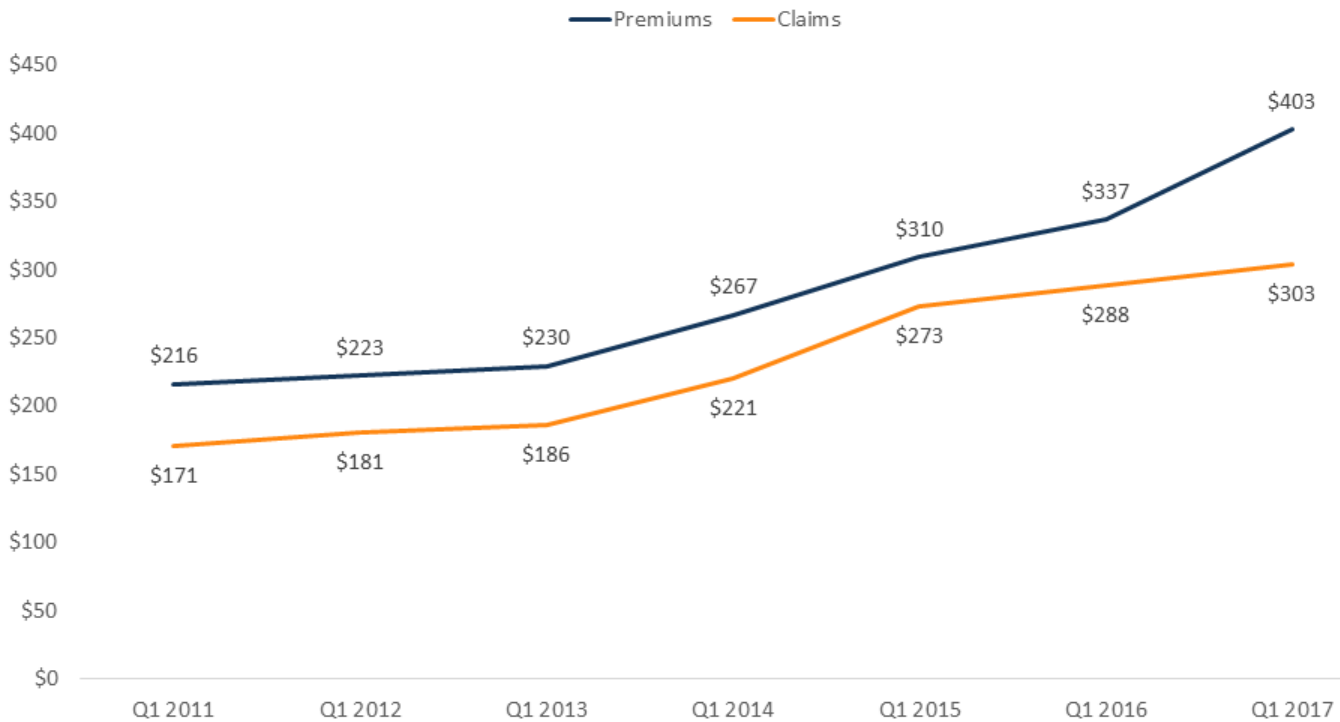
Premiums — Claims

Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

One concern about rising premiums in the individual market was whether healthy enrollees would drop out of the market in large numbers rather than pay higher rates. While the vast majority of exchange enrollees are subsidized and sheltered from paying premium increases, those enrolling off-exchange would have to pay the full increase. As average claims costs grew very slowly in the first quarter of 2017, it does not appear that the enrollees today are noticeably sicker than it was last year.

On average, the number of days individual market enrollees spent in a hospital in first quarter of 2017 was similar to first quarter inpatient days in the previous two years. (The first quarter of 2014 is not necessarily representative of the full year because open enrollment was longer that year and a number of exchange enrollees did not begin their coverage until mid-year 2014).

Figure 4

Average First Quarter Individual Market Monthly Hospital Patient Days Per 1,000 Enrollees, 2011 - 2017
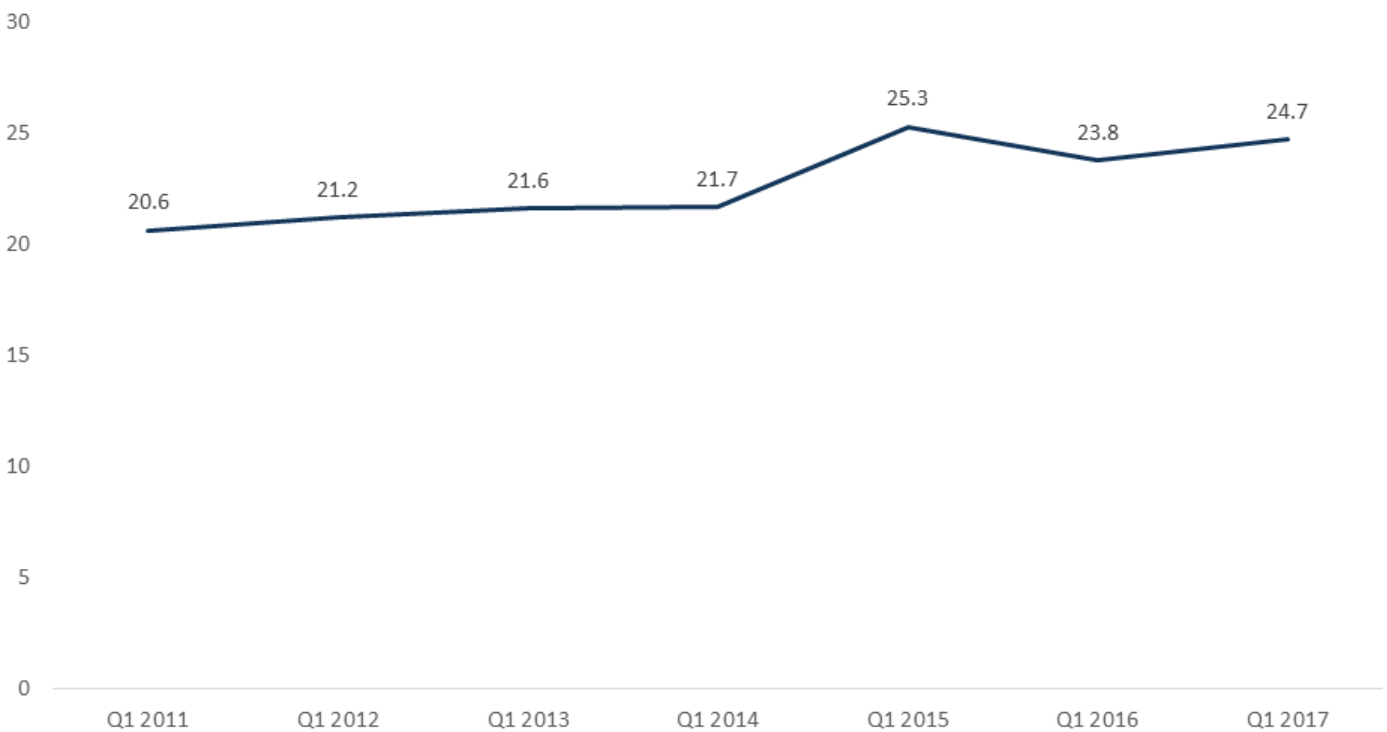
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

Taken together, these data on claims and utilization suggest that the individual market risk pool is relatively stable, though sicker on average than the pre-ACA market, which is to be expected since people with pre-existing conditions have guaranteed access to coverage under the ACA.

Discussion

Early results from 2017 suggest the individual market is stabilizing and insurers in this market are regaining profitability. Insurer financial results show no sign of a market collapse. First quarter premium and claims data from 2017 support the notion that 2017 premium increases were necessary as a one-time market correction to adjust for a sicker-than-expected risk pool. Although individual market enrollees appear on average to be sicker than the market pre-ACA, data on hospitalizations in this market suggest that the risk pool is stable on average and not getting progressively sicker as of early 2017. Some insurers have exited the market in recent years, but others have been successful and expanded their footprints, as would be expected in a competitive marketplace.

While the market on average is stabilizing, there remain some areas of the country that are more fragile. In addition, policy uncertainty has the potential to destabilize the individual market generally. Mixed signals from

the Administration and Congress as to whether cost sharing subsidy payments will continue or whether the individual mandate will be enforced have led to some insurers to leave the market or request larger premium increases than they would otherwise. A few parts of the country may now be at risk of having no insurer on exchange, though new entrants or expanding insurers have moved in to cover most areas previously thought to be at risk of being bare.

Methods

We analyzed insurer-reported financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California HMOs regulated by California's Department of Managed Health Care; in total, the plans in this dataset represent at least 75% of the individual market. All figures in this data note are for the individual health insurance market as a whole, which includes major medical insurance plans sold both on and off exchange. We excluded some UnitedHealth plans that filed negative enrollment in 2017 and corrected for a Centene plan that did not file "member months" in first quarter 2016 but did file first quarter membership.

To calculate the weighted average loss ratio across the individual market, we divided the market-wide sum of total incurred claims by the sum of all health premiums earned. Medical loss ratios in this analysis are simple loss ratios and do not adjust for quality improvement expenses, taxes, or risk program payments. Gross margins were calculated by subtracting the sum of total incurred claims from the sum of health premiums earned and dividing by the total number of member months (average monthly enrollment) in the individual insurance market.

Endnotes

[1] The loss ratios shown in this data note differ from the definition of MLR in the ACA, which makes some adjustments for quality improvement and taxes, and do not account for reinsurance, risk corridors, or risk adjustment payments. Reinsurance payments, in particular, helped offset some losses insurers would have otherwise experienced. However, the ACA's reinsurance program was temporary, ending in 2016, so loss ratio calculations excluding reinsurance payments are a good indicator of financial stability going forward.

[2] Although first quarter loss ratios and margins generally follow a similar pattern as annual data, starting in 2014 with the move to an annual open enrollment that corresponds to the calendar year, first quarter MLRs have been 10 – 15 percentage points lower than annual loss ratios in the same year. This is because renewing existing customers, as well as new enrollees, are starting to pay toward their deductibles in January, whereas pre-ACA, renewals would occur throughout the calendar year.

By Kevin Griffith, Leigh Evans, and Jacob Bor

The Affordable Care Act Reduced Socioeconomic Disparities In Health Care Access

ABSTRACT The United States has the largest socioeconomic disparities in health care access of any wealthy country. We assessed changes in these disparities in the United States under the Affordable Care Act (ACA). We used survey data for the period 2011–15 from the Behavioral Risk Factor Surveillance System to assess trends in insurance coverage, having a personal doctor, and avoiding medical care due to cost. All analyses were stratified by household income, education level, employment status, and home ownership status. Health care access for people in lower socioeconomic strata improved in both states that did expand eligibility for Medicaid under the ACA and states that did not. However, gains were larger in expansion states. The absolute gap in insurance coverage between people in households with annual incomes below $25,000 and those in households with incomes above $75,000 fell from 31 percent to 17 percent (a relative reduction of 46 percent) in expansion states and from 36 percent to 28 percent in nonexpansion states (a 23 percent reduction). This serves as evidence that socioeconomic disparities in health care access narrowed significantly under the ACA.

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Access to health care among nonelderly Americans is strongly associated with socioeconomic characteristics, including income, education, employment, and wealth.[1–5] Compared to Americans who are better off, those in lower socioeconomic strata are less likely to be insured,[6,7] are more likely to avoid medical care due to cost[8] and to enter hospitals through emergency departments,[9] and have twice as many avoidable hospitalizations.[10] The poor use less health care in spite of having greater medical need.[11] These health care access gaps are compounded by—and may contribute to—the large and widening socioeconomic disparities in health and longevity in the United States.[6,12–14]

The Affordable Care Act (ACA) was designed to improve access to health care by expanding insurance coverage. Although some aspects of the ACA applied to people of all socioeconomic strata—such as eliminating exclusions due to preexisting conditions—key features of the law sought to increase coverage among lower-income people specifically. These features included federal subsidies to expand eligibility for Medicaid to all Americans with incomes of up to 138 percent of the federal poverty level[15] and large premium subsidies for people with incomes of 100–400 percent of poverty who purchase insurance on the newly created exchanges. In January 2014 twenty-four states and the District of Columbia expanded Medicaid, and residents of all states gained access to subsidized premiums. Twenty-six states chose not to expand Medicaid at the time, though nonpoor residents of these states gained access to subsidized coverage on the exchanges. President Donald Trump and the Republicans in Congress have proposed repealing the ACA and eliminating many of these subsidies to lower-income people.

In this article we assess the extent to which the ACA—and its Medicaid expansion, in particular—reduced socioeconomic gaps in access to health care. Previous studies on the effects of Medicaid expansion suggest that health coverage increased, particularly for members of racial and ethnic minority groups,[16,17] the poor,[18–22] and younger adults,[23] with gains concentrated in Medicaid expansion states.[24] Furthermore, there is some evidence of increased use of preventive and primary care services in expansion states[23,25,26] and a higher proportion of citizens reporting excellent health.[21] However, many existing studies have relied on surveys with very low (5–10 percent) response rates, used data from just a few states, assessed just the first year of full ACA implementation, or have not accounted for preexisting trajectories in outcomes. The effect of the ACA on socioeconomic disparities in access has not previously been reported.

Using nationally representative data for 2011–15 from the Behavioral Risk Factor Surveillance System (BRFSS), we assessed changes in health insurance coverage and access associated with the ACA for people in different socioeconomic strata, comparing changes between Medicaid expansion and nonexpansion states. We quantified changes in socioeconomic access gaps, defined as differences in access between low and high socioeconomic groups, in the two groups of states.

Study Data And Methods

DATA Data were extracted for all nonelderly adults (people ages 18–64) who responded to the 2011–15 BRFSS. For a description of the data, see the online Appendix.[27]

Several states (Arizona, Delaware, Hawaii, New York, and Vermont) and the District of Columbia provided health coverage to households with incomes at or above 100 percent of poverty before the ACA's Medicaid expansion and were excluded from this analysis.[28] We also excluded Massachusetts and Maryland because they had statewide programs covering adults who had no dependent children and whose household incomes were up to 150 percent[29] and 116 percent[30,31] of poverty, respectively. We did not exclude California because its pre-2014 Medicaid expansion was not statewide and did not always cover people with household incomes of at least 100 percent of poverty. Our final data set contained a total of 1,089,940 respondents from the remaining forty-three states. Summary statistics are presented in Appendix Exhibit S1, and a map of states by expansion status is presented in Appendix Exhibit S12.[27]

MEASURES We assessed changes in three measures of health care access. Insurance coverage was measured by asking, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs [health maintenance organizations], or government plans such as Medicare, or Indian Health Service?" Whether or not respondents had a primary care provider was measured by asking, "Do you have one person you think of as your personal doctor or health care provider?" Lastly, whether or not a respondent avoided care due to cost was measured by asking, "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" These three measures have been found to have high levels of validity and test-retest reliability.[32]

Analyses were stratified by respondents' socioeconomic characteristics: self-reported household income, educational attainment, employment status, and home ownership status. The BRFSS reports annual household income in eight categories: less than $10,000, $10,000 to less than $15,000, $15,000 to less than $20,000, $20,000 to less than $25,000, $25,000 to less than $35,000, $35,000 to less than $50,000, $50,000 to less than $75,000, and more than $75,000. Because of small sample sizes at lower incomes, we also stratified using a binary indicator for household poverty (household income of less than $25,000 per year), which allowed us to identify households most likely to have incomes below the federal poverty level (the poverty level for a family of four in 2014 was $23,850). In describing income-related access gaps, we compared people in households with higher incomes (more than $75,000) to those in households with lower incomes (less than $25,000). These categories each represented about 30 percent of the respondents.

Education was treated as binary characteristic: whether or not the respondent had graduated from college. Employment status was defined as employed, unemployed, or not in the labor force. Home ownership was a binary characteristic: whether the respondent's household owned or rented its home.

To be considered an expansion state in this analysis, a state had to have implemented the ACA Medicaid expansion by mid-2015 (Pennsylvania and Indiana were considered expansion states; Alaska was not). Of the forty-three states included in the analysis, twenty-one were categorized as expansion states. In sensitivity analyses, we excluded all states that had expanded Medicaid after January 1, 2014: Michigan (which expanded on April 1, 2014), New Hampshire (August 15, 2014), Pennsylvania (January 1, 2015), Indiana (February 1, 2015), Alaska (Sep-

tember 1, 2015), and Montana (January 1, 2016).

ANALYTIC APPROACH Our analysis proceeded in four steps. First, we assessed how each of our outcomes (having insurance coverage, having a primary care provider, and avoiding care due to cost) varied with socioeconomic characteristics, thus illuminating disparities in access. We assessed these relationships in 2013 (before implementation of Medicaid expansion and the new health insurance exchanges) and 2015 (up to two years post-implementation), stratifying by whether each state had expanded Medicaid.

Second, we estimated pre/post "first differences" regression models to assess temporal changes in health care access associated with the ACA rollout. We estimated both crude changes (from 2013 to 2015) and adjusted changes (controlling for state-level time trends for the period 2011–15 and the following respondent characteristics: race/ethnicity, sex, age category, pregnancy status, veteran status, education level, home ownership status, household size, household income, presence of children in the household, and state). Models were stratified by socioeconomic characteristics and by residence in an expansion versus a nonexpansion state.

Third, to identify changes in outcomes associated with Medicaid expansion, we estimated difference-in-differences models, adjusting for national time-varying factors—including the rollout of other aspects of the ACA that were implemented in all states. We estimated both crude and adjusted difference-in-differences models, controlling for state-level trends for the period 2011–15 and the covariates listed above. Crude models included data just for 2013–15; adjusted models used data for 2011–15 to better capture pre-reform trends. The difference-in-differences models were stratified by socioeconomic characteristics. All regression models were estimated as linear probability models with BRFSS sampling weights[33] and standard errors clustered at the state level to account for intrastate correlation.[34] Regression equations are presented in the Appendix.[27]

Fourth, we assessed changes in health care access gaps between 2013 and 2015, defined as absolute and relative changes over time in the percentage-point difference in access between people in high and low socioeconomic strata for each socioeconomic characteristic. Our analysis of access gaps was stratified by whether the state expanded Medicaid. Absolute changes in access gaps were assessed in regression models, interacting the socioeconomic strata with the post-reform indicator. All analyses were conducted using R, version 3.24.

LIMITATIONS Our study had several limitations. First, as with all nonexperimental studies, certain assumptions are required to interpret the estimates as causal. Our adjusted first-differences models could be interpreted this way if all secular changes between 2013 and 2015 were attributable to the ACA, after adjustment for linear time trends and changes in observed covariates. Our difference-in-differences models relied on the assumption that expansion states would have experienced changes similar to those in nonexpansion states had they not expanded Medicaid, after adjustment for state trends and covariates. In interpreting our difference-in-differences models, we note that if Medicaid expansion states differentially implemented other aspects of the ACA—such as more or less advertising and outreach[35]—then our effect estimates could reflect these differences in addition to the direct effect of Medicaid itself.

A second limitation is that survey nonresponse could also be a source of bias. The BRFSS response rates are about 40–50 percent, which is high for telephone surveys but still indicates substantial nonparticipation.[36] Although responses were reweighted to reflect state demographics, the data may be nonrepresentative in other ways. We adjusted for observed characteristics in our models to reduce the influence of variation in survey participation.

Third, the analysis included data from only the first two years of the ACA Medicaid expansion and exchanges. More distal outcomes, including health outcomes, might need more time to respond to this policy intervention.[17,37–41]

Finally, the persistence of the observed changes is uncertain, given the changing policy environment.

Study Results

The study sample was weighted to reflect the noninstitutionalized US resident population ages 18–64 years. Compared to Medicaid nonexpansion states, expansion states had smaller proportions of black residents and a somewhat higher average household income, but similar levels of employment and homeownership (for sample characteristics, see Appendix Exhibit S1).[27]

In 2013 there was a steep gradient in coverage across income groups: Over 90 percent of Americans in households with annual incomes of more than $75,000 were insured (Exhibit 1), compared to only about 60 percent of Americans in households with annual incomes of less than $25,000 per year (63.2 percent in expansion states and 55.0 percent in nonexpansion states) (for more detailed results on insurance coverage by income group, see Appendix Exhibits S2 and
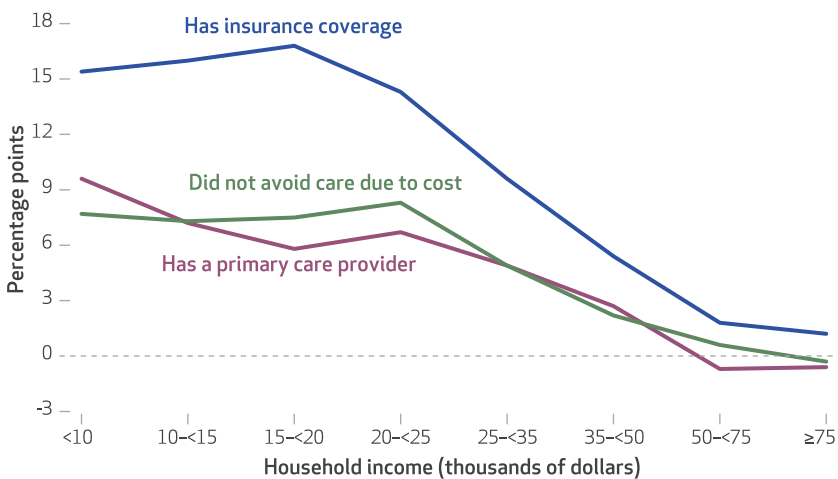
EXHIBIT 1

Insurance coverage in 2013 and 2015, by household income and state Medicaid expansion status
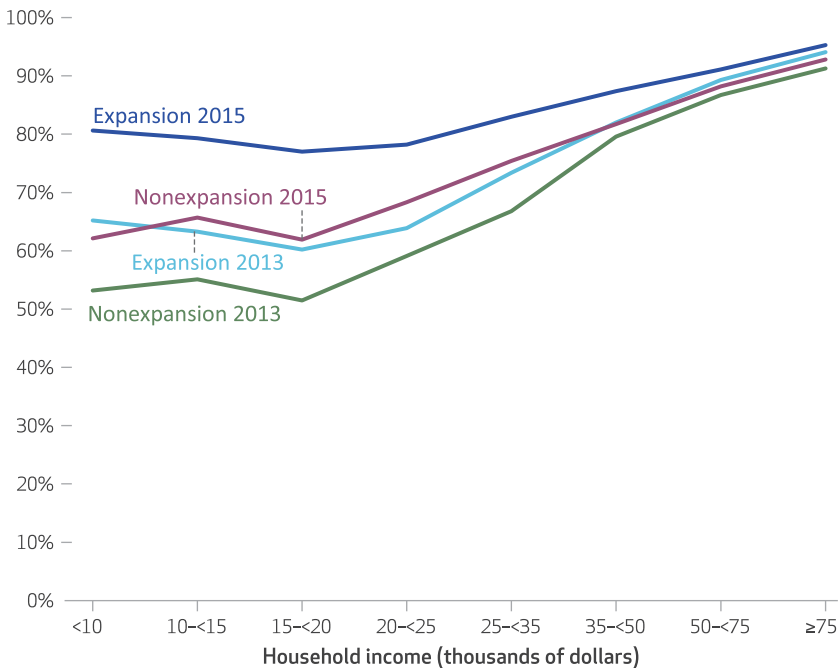
SOURCE Authors' analysis of data for 2013 and 2015 from the Behavioral Risk Factor Surveillance System (BRFSS). NOTES The exhibit displays the percentage of noninstitutionalized US adults ages 18–64 who reported that they had insurance coverage, by BRFSS household income category. As explained in more detail in the text, to be considered an expansion state, a state must have expanded eligibility for Medicaid through the Affordable Care Act by mid-2015.

EXHIBIT 2

Changes from 2013 to 2015 in health care access among states that expanded eligibility for Medicaid, by household income

SOURCE Authors' analysis of data for 2013 and 2015 from the Behavioral Risk Factor Surveillance System (BRFSS). NOTES The exhibit displays changes in the percentage of noninstitutionalized US adults ages 18–64 who reported that they had insurance coverage, had a primary care provider, and did not avoid care due to cost, by BRFSS household income category. As explained in more detail in the text, to be considered an expansion state, a state must have expanded eligibility for Medicaid through the Affordable Care Act by mid-2015.

S3).[27] Steep income gradients were also observed in 2013 for access to a primary care doctor and avoiding care due to cost (for detailed results, see Appendix Exhibits S4–S7).[27] Large pre-reform access gaps were also observed between education, employment, and home ownership strata (for results, see Appendix Exhibits S2–S7).[27] By 2015 the income-access gradient had flattened substantially in Medicaid expansion states, with smaller changes observed in nonexpansion states (Exhibit 1).

Changes in access from 2013 to 2015 differed by household income category. In Medicaid expansion states, there were large increases in insurance coverage for the poor under the ACA, but little change at higher incomes (Exhibit 2). Gains in access to a primary care provider and reductions in avoiding care due to cost were also strongly concentrated among the poor and were about half the size of the gains in insurance coverage. (Changes for nonexpansion states are shown in Appendix Exhibits S2–S7.)[27]

Similar estimates were obtained after we adjusted for state trends and observed covariates. In Medicaid expansion states, the poor gained 15.0 percentage points in insurance coverage and 7.7 percentage points in having a primary care provider. The percentage of poor respondents avoiding care due to cost fell by 7.5 percentage points (Exhibit 3). Households with annual incomes above $75,000 experienced much smaller changes: a 1.9-percentage-point increase in insurance coverage, a 1.9-percentage-point increase in having a primary care provider, and no change in avoiding care due to cost. Gains in access were substantially larger among people who were not college graduates, compared to those who were; renters, compared to homeowners; and the unemployed, compared to the employed.

In general, residents of nonexpansion states also had increased access. However, compared to people in expansion states, residents of nonexpansion states had smaller gains, and the distribution of benefits was less concentrated in lower socioeconomic groups. (For a comparison of crude and adjusted estimates, see Appendix Exhibits S2, S4, and S6.)[27]

To what extent were changes in access attributable to Medicaid expansion? In adjusted difference-in-differences models, Medicaid expansion was associated with a 2.2-percentage-point increase in insurance coverage in the full sample, after adjustment for covariates (Exhibit 3) (95% confidence interval: 0.8, 3.6). The benefits of expansion were particularly large among respondents in poor households (6.3 percentage points; 95% CI: 3.2, 9.4) the unemployed (11.0 percentage points; 95% CI: 5.2, 16.8), those who

EXHIBIT 3

Changes from 2013 to 2015 in health care access for different socioeconomic groups under the ACA

	Has insurance coverage			Has a primary care provider			Avoided care due to cost		
	Expansion state			Expansion state			Expansion state		
	Yes	**No**	**Difference[a]**	**Yes**	**No**	**Difference[a]**	**Yes**	**No**	**Difference[a]**
Whole sample	7.4****	5.3****	2.2***	4.8****	3.4****	1.6**	−3.1****	−2.0****	−1.2*
HOUSEHOLD IN POVERTY[b]									
Yes	15.0****	8.8****	6.3****	7.7****	4.1****	3.6**	−7.5****	−4.0****	−3.5**
No	4.1****	3.4****	0.8	3.7****	3.1****	0.8	−1.1***	−0.9	−0.4
HOUSEHOLD INCOME[c]									
<$10k	13.0****	7.3***	5.8*	9.8****	6.6***	3.0	−7.8****	−6.2**	−1.2
$10k to <$15k	15.0****	7.1***	8.1**	7.1***	3.7	3.3	−7.7***	−6.1**	−1.3
$15k to <$20k	18.0****	10.0****	7.0**	6.5***	3.5	2.6	−7.4****	−3.6	−3.7
$20k to <$25k	14.0****	9.5****	4.7	7.1****	3.3	4.0	−7.0****	−1.0	−6.1**
$25k to <$35k	10.0****	9.3****	1.0	9.1****	5.4***	3.9	−3.3**	−0.7	−3.0
$35k to <$50k	5.5****	0.1	5.2***	5.6****	2.5	3.3	−2.1*	−0.5	−1.5
$50k to <$75k	3.6****	3.0**	0.8	1.8	2.6*	−0.5	−1.1	0.9	−2.1
$75k or more	1.9****	2.1***	0.0	1.9***	2.2**	0.0	0.2	−1.3*	1.3
COLLEGE GRADUATE									
No	9.4****	6.3****	3.2****	6.0****	3.6****	2.5***	−4.1****	−2.5****	−1.6*
Yes	3.2****	3.4****	−0.3	2.5****	3.8****	−1.2	−1.5***	−1.4**	−0.1
EMPLOYMENT STATUS									
Unemployed	17.0****	6.8***	11.0****	9.0****	4.9**	4.5	−7.4****	−3.9	−3.5
Employed	6.9****	6.7****	0.1	4.8****	4.0****	0.9	−3.1****	−2.7****	−0.5
HOME OWNERSHIP STATUS									
Rent	11.0****	8.4****	2.8**	7.4****	5.9****	1.6	−5.4****	−3.6****	−1.8
Own	5.5****	3.8****	1.5*	3.8****	2.3****	1.3	−2.0****	−1.2*	−0.8

SOURCE Authors' analysis of data for 2011–15 from the Behavioral Risk Factor Surveillance System (BRFSS). **NOTES** The exhibit displays regression-adjusted percentage-point changes in outcomes associated with the Affordable Care Act (ACA) rollout. All columns show regression estimates adjusted for state time trends and covariates described in the text. "Expansion states" are those that expanded eligibility for Medicaid by mid-2015; "nonexpansion states" are those that did not. Standard errors are adjusted for clustering at the state level and are shown in online Appendix Exhibits S2, S4, and S6 (see Note 27 in text). [a]Difference between expansion and nonexpansion states in changes over time, adjusted for covariates. [b]Households in poverty are those whose annual incomes are less than $25,000 (in 2014 the federal poverty level for a family of four was $23,850). [c]BRFSS categories. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

were not college graduates (3.2 percentage points; 95% CI: 1.4, 5.0), and renters (2.8 percentage points; 95% CI: 0.2, 5.4). By contrast, Medicaid expansion was associated with near-zero changes in coverage among nonpoor respondents, college graduates, and the employed.

Changes in access to a primary care provider and avoiding care due to cost followed patterns similar to those for insurance coverage, although the changes were smaller. Among poor Americans, Medicaid expansion reduced the percentage without a primary care provider by 3.6 percentage points (95% CI: 0.4, 6.8) and the percentage who avoided medical care due to cost by 3.5 percentage points (95% CI: 0.4, 6.6) (Exhibit 3). (For a comparison of crude and adjusted difference-in-differences estimates and coefficient standard errors, see Appendix Exhibits S2, S4, and S6.)[27] A sensitivity analysis excluding states that expanded after January 1, 2014, had similar results. (For results of the sensitivity analyses, see Appendix Exhibits S8 and S9.)[27]

What was the impact of the ACA on socioeconomic disparities in access? In expansion states, the gap in insurance coverage between residents of poor households (with incomes less than $25,000) and higher-income households (incomes more than $75,000) fell by 46 percent between 2013 and 2015, from 31 percentage points to 17 percentage points, while in nonexpansion states the coverage gap fell by 23 percent, from 36 percentage points to 28 percentage points (Exhibit 4). Income-related gaps in access to a primary care provider and avoiding care due to cost also declined more in expansion states than in nonexpansion states (Exhibit 4). There were also greater reductions in health care access disparities based on education level and employment status in expansion versus nonexpansion states. (For data on both relative and absolute changes in access gaps based on different socioeconomic characteristics, as well as confidence intervals, see Appendix Exhibits S10 and S11.)[27]

Not only did access disparities fall in greater absolute terms in expansion states compared to

EXHIBIT 4

Percent changes in health care access gaps between low- and high-income US adults, 2013 to 2015
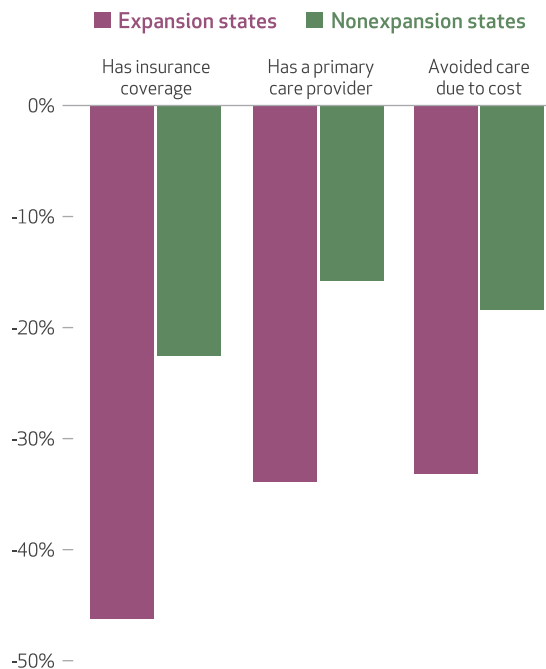
■ Expansion states   ■ Nonexpansion states

SOURCE Authors' analysis of data for 2011–15 from the Behavioral Risk Factor Surveillance System. NOTES The exhibit displays percent changes from 2013 to 2015 in health care access gaps between low- and high-income noninstitutionalized US adults ages 18–64. The data are stratified by whether the state expanded Medicaid. Percent changes were calculated as the access gap in 2015 divided by the access gap in 2013, minus one. All changes in access gaps were statistically significant ($p < 0.05$). Low income means household income of less than $25,000. High income means household income of more than $75,000. As explained in more detail in the text, to be considered an expansion state, a state must have expanded eligibility for Medicaid through the Affordable Care Act by mid-2015. Changes in access gaps by educational attainment, employment status, and homeownership are shown in online Appendix Exhibit S8 (see Note 27 in text).

nonexpansion states, but disparities were also smaller in expansion states in the first place (see Appendix Exhibits S2 and S11). States' opting out of the ACA Medicaid expansion thus compounded preexisting access barriers for their poorer residents, leading to a geographic divergence in access for poor Americans. In 2013, poor residents of nonexpansion states were 22 percent (8.2 percentage points) more likely to be uninsured than poor residents of expansion states. After the ACA's passage, this geographic disparity increased: By 2015, poor Americans were 66 percent (14.0 percentage points) more likely to be uninsured if they lived in a nonexpansion state than if they lived in an expansion state (see Appendix Exhibit S2).[27]

Discussion

We examined the extent to which the ACA reduced disparities in health care access across socioeconomic groups and assessed the contribution of Medicaid expansion to these trends. Americans in groups with lower socioeconomic status made substantial gains in access during the first two years of full implementation of the ACA. Medicaid expansion was responsible for about half of these gains, with the rest likely attributable to other aspects of the ACA implemented in all states in 2014, such as the insurance exchanges, federal subsidies for the purchase of insurance for people with incomes of 100–400 percent of poverty, and the individual mandate. Disparities in access narrowed significantly under the ACA, with the gap in coverage between higher- and lower-income households falling by 46 percent in Medicaid expansion states and 23 percent in nonexpansion states.

In spite of the substantial reduction in access gaps under the ACA, many Americans with household incomes under $25,000 were still without coverage in 2015: 35 percent in nonexpansion states and 21 percent in expansion states. Additionally, in 2015, many low- and middle-income Americans still reported avoiding care due to cost and said that they did not have a primary care provider. Incomplete insurance uptake might be due to factors such as unawareness of coverage options,[42] complicated enrollment processes,[43] political attitudes toward the ACA,[44] lack of Medicaid expansion, and the cost and low perceived value of existing plans. Understanding people's reasons for not taking up insurance under the ACA will be important in designing policies to further reduce access gaps.

Health care access disparities in the United States far exceed those observed in other wealthy countries, which by and large guarantee some basic level of health coverage[45] (for cross-national comparisons, see Appendix Exhibit S13).[27] Reducing these disparities has been a subject of national debate since President Harry Truman proposed universal coverage in 1945. As we have shown in this analysis, the ACA substantially improved health insurance coverage and access to care for the poor and significantly reduced socioeconomic gaps in health care access in just two years. The ACA was a highly redistributive law, directing public resources, financed primarily through taxes on high-income people, to improve health care access among lower-income Americans. Those who benefited most from the ACA were those most likely to be excluded by an employer-based insurance system: the unemployed, those without a college degree, and those earning a low income. With significant numbers of Americans out of work and an in-

creasing share of jobs not offering employer-based health coverage, there is a growing need for a robust, publicly funded insurance safety net.

President Trump and Republicans in Congress have promised to repeal and replace the ACA, with plans to reduce federal subsidies for Medicaid expansion and for low-income (but not Medicaid-eligible) insurance plans purchased on the exchanges. Such an approach is likely to widen gaps in health care access between lower-income and better-off Americans, reversing gains observed under the ACA.

Conclusion

In its first two years of full implementation, the ACA improved health care access for Americans in low-income households, people who were not college graduates, and the unemployed. The law's Medicaid expansion was responsible for about half of these gains. The ACA was associated with a substantial (but incomplete) narrowing of socioeconomic disparities in access, particularly in states that expanded Medicaid. More research is needed to determine whether existing access gains will translate into improved health outcomes and reductions in health disparities more broadly, and to monitor future trends in access disparities in a changing policy environment. ■

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Would States Eliminate Key Benefits if AHCA Waivers are Enacted?

Gary Claxton, Karen Pollitz, Ashley Semanskee, Larry Levitt

As the debate over amending health insurance market rules continues, proponents of changing the law have proposed reducing the health benefits provided by non-group plans as a potential way to lower premiums in the market. The Affordable Care Act (ACA) prescribes 10 categories of essential health benefits that non-group and small-group policies must cover, and provides in most cases that the scope of these benefits should be similar to those in employer group health plans, which cover most non-elderly Americans. The American Health Care Act (AHCA), which passed the House of Representatives on May 5, would permit states to seek waivers to amend the required benefits if doing so would achieve one of several purposes, including lowering premiums.[1] We look below at the benefits covered by non-group plans before the ACA as a possible indication of how states could respond to the waiver authority under the AHCA.

Background

The lack of coverage for benefits such as maternity and mental health care in many nongroup plans, which was a frequent point of criticism when the ACA was debated, was one (but not the only) reason why non-group coverage was less expensive before the ACA was enacted. In the pre-ACA market, certain benefits were excluded to make coverage more affordable and to guard against potential adverse selection by applicants with more predictable, chronic health care needs. Even with the ability to medically screen applicants for non-group policies, some insurers excluded coverage for conditions such as mental health and substance abuse care unless states required that they be covered.

States determined coverage requirements for health insurance policies prior to the ACA. A few states defined a standard benefit package to be offered by insurers in the nongroup market. Most states adopted some mandates to cover or offer specific benefits or benefit categories – such as requirements for policies to cover maternity benefits or mental health treatments. In addition to deciding which categories of benefits must be included or offered, states might also specify a minimum level or scope of coverage; for example, a few states required that mental health benefits have similar cost sharing and limits as other outpatient services (sometimes called parity).

Pre-ACA non-group plans varied considerably in scope and comprehensiveness of coverage, with some plans limiting benefit categories or putting caps on benefits, while others offered more comprehensive options. For example, some plans did not cover prescriptions, others covered only generic medications or covered a broader range of medications subject to an annual cap, while still others covered a more complete range of medications. This diversity was possible because insurers generally were able to decline applicants with pre-existing conditions, and could require their existing customers to pass screening if they wanted to upgrade to more

comprehensive benefits. This prevented applicants from selecting the level of coverage they wanted based on their known health conditions, but also prevented many people from being able to obtain non-group coverage at all.

To look more closely at the benefits provided in pre-ACA non-group plans, we analyzed data submitted by insurers for display on HealthCare.gov for the last quarter of 2013. Beginning in 2010, insurers submitted information about their non-group plans to be displayed on HealthCare.gov; the data includes information on benefits, coverage levels for each benefit, benefit limits, premiums and cost sharing parameters, and enrollment. We focus here on the benefits and benefit limits. We use data from 2013 because it is the most current year prior to when the ACA's major insurance market changes went into effect, provides more benefit categories than some earlier years, and has more information about benefit limits for each category. We note, however, that the ACA prohibition on annual dollar limits took effect shortly after enactment and was phased in between 2010 and 2013, so these types of limits would likely not be reflected often in data we received. This means that our analysis likely misses some of the limits (for example, dollar limits on prescriptions) that existed in nongroup policies before the ACA was enacted. We limit the analysis to plans where insurers report enrollment in the product upon which the plan is based. Our methods are described in more detail in the appendix.

Results

The data include 8,343 unique plans across 50 states and the District of Columbia. We looked at the percentage of plans that included coverage for major benefit categories. Not surprisingly, all of the plans covered basic benefits such as inpatient hospital services, inpatient physician and surgical services, emergency room services, and imaging services, while virtually all (99%) covered outpatient physician/surgical services, primary care visits, home health care services, and inpatient and outpatient rehabilitation services.

Certain other benefits, however, were covered much less often (Figure 1). Large shares of plans did not provide coverage for inpatient or outpatient mental/behavioral health care services (38% each), inpatient or outpatient substance abuse disorder services (45% each), and delivery and inpatient care for maternity care (75%).[2] In addition, 6% of plans did not provide coverage for generic drugs, 11% did not provide coverage for preferred brand drugs, 17% did not provide coverage for non-preferred brand drugs, and 13% did not provide coverage for specialty drugs.

Figure 1

Coverage of Benefits in 2013 Non-Group Plans

Benefit	Covered	Not Covered
Delivery and Inpatient Care for Maternity Care	25%	75%
Outpatient Substance Abuse Disorder Services	55%	45%
Inpatient Substance Abuse Disorder Services	55%	45%
Outpatient Mental/Behavioral Health Services	62%	38%
Inpatient Mental/Behavioral Health Services	62%	38%
Non-Preferred Brand Drugs	83%	17%
Specialty Drugs	87%	13%
Preferred Brand Drugs	89%	11%
Generic Drugs	94%	6%

Percent of Plans with Benefit

■ Covered ■ Not Covered

Source: Kaiser Family Foundation analysis of Centers for Medicare and Medicaid Services (CMS) data:
https://www.cms.gov/cciio/resources/data-resources/health_plan_finder_data.html.

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Even when coverage was provided, some policies had meaningful limits or restrictions for certain benefits. Mental/behavioral health care is a case in point. Among plans with coverage for outpatient mental/behavioral health services, 23% limited benefits for some or all mental/behavioral services to fewer than 30 visits or sessions over a defined period (often a year) and 12% limited it to 12 or fewer. A small share (about 5%) of plans providing coverage for outpatient mental/behavioral health services provided benefits only for conditions defined as severe mental disorders or biologically-based illnesses or applied limits (such as visit limits) if the illness was not defined as severe or biologically based. The definitions of these terms varied by state.[3]

Similarly, for plans covering outpatient substance abuse disorder services, 22% limited the benefit to fewer than 30 visits or sessions; 12% limited it to 12 or fewer. In many of these plans, visits for either mental health or substance abuse care were combined to apply toward the same limit.

Among the relatively few plans that provided coverage for delivery and inpatient maternity care, a small share (3%) applied separate deductibles of at least $5,000 for maternity services and some plans (6%) applied a separate waiting period of at least year before benefits were available. A few plans restricted benefits to enrollees enrolled in family coverage or required that the enrollee's spouse also be enrolled.

Discussion

The ACA raised the range of benefits provided by non-group policies such that the benefits now offered by non-group plans are comparable to those offered in employer group plans. The desire to lower non-group premiums, however, has led policymakers to consider allowing states to roll back the essential health benefits prescribed by the ACA.

Among the pre-ACA policies we reviewed, virtually all included benefits for certain services: hospital, physician, surgical, emergencies, imaging, and rehabilitation. Other services were covered less often, including prescription drugs, mental/behavioral health care, substance abuse disorder care, and coverage for pregnancy and delivery. This latter group of services all have some element of predictability or persistency that make them more subject to adverse selection. For example, many people use drug therapies over long periods and would be much more likely to select policies covering prescriptions than people who do not regularly use prescription drugs. If states were to drop any of these services from the list of essential health benefits for non-group plans, access to them could be significantly reduced.

The difficulty is that insurers would be very reluctant to offer some of these services unless they were required in all policies because people who need these benefits would disproportionately select policies covering them. In the pre-ACA market, insurers were able to offer products with different levels of benefits because they generally were able to control who could purchase them by medically screening new applicants. Even existing customers faced medical screening if they wanted to change to a more comprehensive policy at renewal. Through these practices, insurers were able to avoid the situation where people could choose cheaper policies when they were healthy and upgrade to better benefits when their health worsened. The proposed AHCA market rules, however, would not guard against this type of adverse selection, because people with pre-existing health conditions would be able to select any policy offered at a standard premium rate, and change their selection annually without incurring a penalty, as long as they maintained continuous coverage. This means that the range of benefits provided by insurers in states with essential health benefit waivers would likely be more limited than what insurers offered in the pre-ACA non-group market. Benefit choice might be particularly limited in states that specify only a few benefits as essential.

It is hard to imagine that insurers would cover certain benefits if they were not required. For example, some insurers before the ACA did not offer mental health benefits unless required by a state, even when they could medically screen all of the applicants. And given the current problems with substance abuse in many communities, insurers would be reluctant to include coverage to treat them unless required. Offering these benefits as an option (for example, including them in some policies but not in others), would result in very high premiums for optional benefits because people who know they need them would be much more likely to choose them.

The AHCA presents state policymakers with a dilemma: they can reduce the essential health benefits to allow less expensive insurance options for their residents, but doing so may eliminate access to certain benefits for people who want and need them.

Methods

The data we used in our analysis were obtained from the Centers for Medicare and Medicaid Services (CMS) through a Freedom of Information Act Request, submitted January 10, 2017, with data supplied April 11, 2017. The data are now available here: https://www.cms.gov/cciio/resources/data-resources/health_plan_finder_data.html. Insurers submitted the data to CMS to be displayed on the Health Plan Finder on HealthCare.gov. Data were submitted periodically and updated periodically by CMS. We received data for three quarters in 2011, and for four quarters in 2012 and 2013. The data fields changed over the period; we used data from the fourth quarter of 2013, the last available, for our analysis. The 2013 data have more benefit categories than the 2011 data and more information about limits on benefits than the 2012 data. Our discussion with CMS staff suggested that the data became more complete as they were updated through the year, so we chose to use the fourth quarter.

The analysis is limited to plans for which the insurer reported that there were enrollees in the underlying product upon which the plan was based. Results are not enrollment weighted. Enrollment was reported only by product, so we do not know if there were actually enrollees in each of the plans associated with that product. A plan was assumed not to offer coverage for a benefit category if the dataset left the coverage description blank for that category. The analysis of benefit limits was conducted among plans that offered coverage for the benefit category analyzed, for example outpatient mental/behavioral health services.

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[1] In its application for a waiver, the state must show that the waiver would reduce average premiums for health insurance, increase enrollment in health insurance, stabilize the market for insurance coverage, stabilize premiums for applicants with pre-existing conditions, or increase choice of health plans. AHCA, section 136.

[2] Plans generally paid for complications from pregnancy, but not for the costs associated with a normal delivery.

[3] Roach, J., "Discrimination and Mental Illness, Codified in Federal Law and Continued by Agency Practice," 2016 Mich. St. Law Review 269, at 285:288.

The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums Under the ACA

Linda J. Blumberg and John Holahan

Timely Analysis of Immediate Health Policy Issues   *JULY 2017*

In Brief

The essential health benefit requirements for private nongroup insurance continue to be hotly debated amid the ongoing congressional effort to repeal and replace the Affordable Care Act (ACA). We use data from the Medical Expenditure Panel Survey Household Component (MEPS-HC) to estimate the share of nongroup insurance premiums attributable to the health service categories in the requirements. We find that the largest shares of ACA-compliant nongroup insurance premiums can be attributed to the costs of office-based care (30%), prescription drugs (22%), outpatient facility care (17%), and inpatient care (15%). Coverage for these services is generally seen as fundamental to insurance. The benefit requirements targeted for cuts account for much smaller shares of premiums: Maternity and newborn care accounts for just 6 percent of total premium dollars, habilitative/rehabilitative care for 2 percent, and pediatric dental and vision care for 1 percent. But eliminating these benefits from insurance packages would lead to very high increases in costs for people who need those types of care.

The ACA has a reasonably comprehensive list of essential health benefit requirements, but it also addresses coverage richness through policies on cost-sharing requirements, tying marketplace premium assistance to plans with reasonably high deductibles but with lower requirements for low-income people. This approach reduces coverage comprehensiveness by an alternate route. Health insurance is, at its core, a mechanism for pooling health care risk across a population. As this analysis shows, the per-person costs of insuring essential benefits are reasonably low when the costs are spread broadly across a large population with diverse health care risks. Placing the costs fully on the users of health care can make those services unaffordable for those who need them.

Essential Health Benefits as a Share of Total Nongroup Premiums, 2017
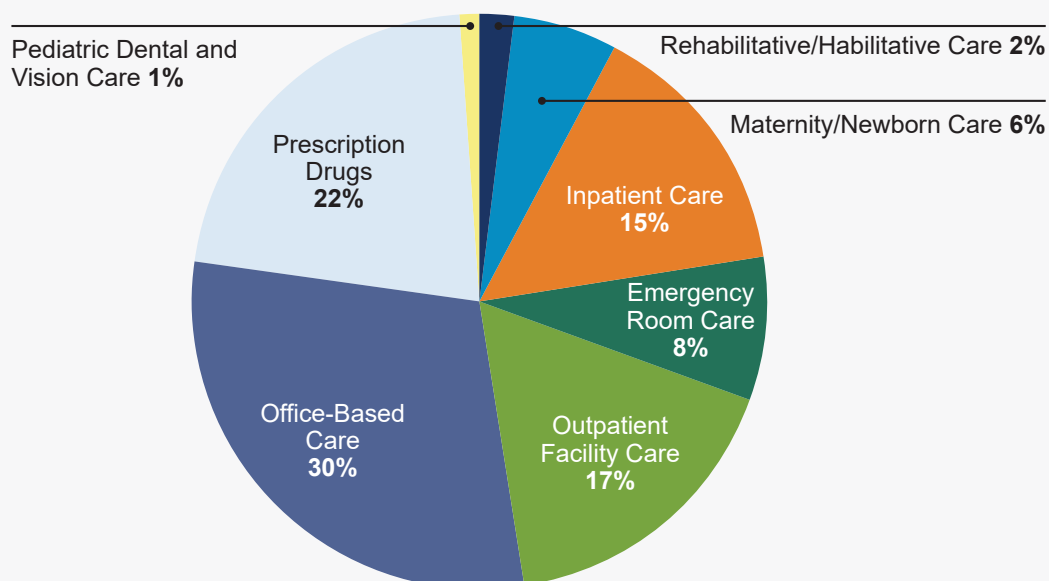
Introduction

The American Health Care Act (AHCA), passed by the U.S. House of Representatives on May 4, 2017 and the Better Care Reconciliation Act (BCRA) being debated in the Senate have heightened the debate over essential health benefit (EHB) requirements for nongroup (i.e., individually purchased) health insurance. Currently the Affordable Care Act (ACA) requires all nongroup and fully insured small group insurers to include each of 10 EHBs defined in the law: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder (MH/SUD) services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Some insurers and ACA critics blame the EHB requirements for high unsubsidized premiums and have proposed eliminating some or all of the prescribed benefi categories.[1] Maternity care, substance use disorder treatment, and rehabilitative/habilitative care are the most frequent targets of benefit cuts [2]

We analyze a typical silver level (70% actuarial value[3]) marketplace plan, breaking out the share of premiums associated with various EHBs. We rely on data from the Medical Expenditure Panel Survey Household Component (MEPS-HC), which allows us to divide claims into the following categories of care: rehabilitative/habilitative care; maternity/newborn care; inpatient care (facility and provider costs separately); emergency room care (facility and provider costs separately); care provided in an outpatient facility (facility and provider costs separately); office-based care (physician preventive care, physician primary care, physician specialty care, other provider care separately); prescription drugs (generic, brand name/nonspecialty, and specialty separately); and pediatric dental and vision care.

We estimate the average share of premiums associated with each of these categories of care and estimate the share

of nongroup insurance enrollees who use care of that type. This analysis allows us to compare the average premium cost associated with each service type and how that cost would change if only people using that type of care financed the portion currently covered by ACA-compliant insurance coverage. Data from other sources also provide some indication of the share of outpatient claims attributable to mental health and substance use disorder care; we provide that information separately.

Data and Methods

This analysis is based largely upon data from the 2014 Medical Expenditure Panel Survey Household Component (MEPS-HC), using both the full-year consolidated file (HC-171) and event-level file [4] when needed. The data were parsed to identify people covered by nonemployer private plans, which include coverage through the ACA marketplaces and other private health insurance; we refer to these two groups as having nongroup health insurance.

We examined health care spending and use for these covered people, partitioned into services that map to the EHB services as closely as possible. For inpatient and outpatient hospital and emergency room care, costs associated with facility fees were separated from those for providers. Physician costs and use for preventive, primary, and specialty care were partitioned based on data in the event files. Although specific identifiers for generic, brand name, and specialty drugs were not available in the MEPS-HC or in the prescription drug event file, we used simplifying assumption that mapped drugs costing less than $50 per prescription to the generic category and those costing $1,000 or more to the specialty category; the remainder were considered brand name, nonspecialty drugs.

Once we had average cost and use by service, we computed the approximate share of benefits paid for the covered services and then adjusted this total benefit amount up to the average silver marketplace premium in 2017, approximately $4,700. This adjustment allowed for inflation and benchmarking, as well as an applicable premium load

to benefit costs, to reach actual 2017 per capita spending on premiums.

Spending and use for mental health and substance use disorders could not be easily identified separately in the MEPS-HC, and the data in the event files were sparse. To estimate the share of total nongroup premiums attributable to these services, we used the Center for Consumer Information and Insurance Oversight (CCIIO) Actuarial Value Calculator[5] (AVC) and Health Care Cost Institute (HCCI) data[6] on employer-sponsored insurance plans. Both showed that approximately 1 percent of premium costs are associated with these outpatient services. Inpatient and prescription drug costs associated with MH/SUD care are indistinguishable in the data from other costs associated with inpatient and drug care. If inpatient care and prescription drugs for MH/SUD care could be separated from general medical care, MH/SUD treatment would account for more than 1 percent of premium costs. However, it would be difficult to exclude such care from general inpatient and prescription drug coverage.

Our analysis differs from a recent, related one by Milliman[7] in the following ways:

- We rely on publicly available health care spending data for the private nongroup market specifically. The Milliman analysis uses the 2017 Milliman Commercial Health Cost Guidelines, a proprietary data set of employer-based insurance data.

- The Milliman data provide specific quantitative estimates for only two categories of services (pediatric dental care and maternity care). We provide estimates for an array of additional services—all those that could be credibly analyzed using the MEPS-HC. The Milliman analysis includes a pie chart that breaks out relative costs for the eight other ACA essential health benefits but does not show their actual quantities.

Our analysis uses data for the population most likely to be directly affected by changes to essential health benefi requirements under the AHCA or the BCRA: people with private nongroup

insurance. In addition, we provide much more detail on the share of premium costs attributable to specific benefits and services. Still, both analyses reach the same general conclusions.

Results

In 2017, the average nongroup marketplace premium is approximately $4,700 (Table 1). This includes both claims paid (as benefits) and administrative costs. We divide that premium proportionately based on the share of total claims paid for each category of service. The largest shares of ACA-compliant nongroup insurance premiums can be attributed to the costs of office-based care (30%), prescription drugs (22%), outpatient facility care (17%), and inpatient care (15%). Maternity and newborn care accounts for just 6 percent of total premium dollars, habilitative/rehabilitative care for 2 percent, and pediatric dental and vision care for 1 percent. A separate analysis of data from the HCCI and the CCIIO AVC indicates that outpatient care for mental health and substance use disorders account for approximately 1 percent of outpatient care (not shown). Preventive care and primary care delivered in physician offices accounts for 9 percent and 4 percent of premiums, respectively. Approximately 8 percent of premiums pays for physician offic specialty care, and 9 percent pays for care delivered by other health professionals in physician offices. The largest share of prescription drug costs is attributable to brand name, nonspecialty drugs (12% of premium costs, 56% of covered drug costs); generic drugs account for only 2% of total premium costs.

Although prescription drugs account for 22 percent of ACA-compliant premium dollars, 56 percent of enrollees use at least one prescription a year. Office based care, which accounts for 30 percent of premium dollars, is used by more than 71 percent of enrollees in the nongroup market. But inpatient care, which accounts for 15 percent of premium dollars, is used by just 4 percent of the insured population in a year.

The far right column of the table shows the average cost that users of each service would have to pay if the costs associated with that service were averaged only over users, instead of over all those insured in the market. These costs should be compared with the cost per insured person when all those covered in the ACA-compliant nongroup insurance market share in the costs equally, whether or not they use that type of care (the first column of numbers in the table). For example, maternity and newborn care accounts for $278 (or 6%) of the typical ACA-compliant silver premium, but each person using that type of care would have to pay $13,888 on average if they were financing those costs separately from the rest of the insurance pool. Emergency room care adds $376 to the premium, but those using it would have to pay $4,251 to cover those costs separately. Rehabilitative and habilitative care adds $96 to the premium, but financing that care separately would cost $2,247 per user on average. Non-maternity-related inpatient care adds approximately $720 to the average premium, but users of this care would pay more than $19,000 to cover it separately. Pediatric dental and vision care adds $43 to the average premium but would cost $453 per child user if financed separatel .

People use different types of services every year, so their needs in the coming year cannot be accurately predicted at the start of a plan year. Thus, it is unrealistic to expect people to purchase specifi additional coverage with other users alone. Before the nongroup insurance market reforms of the ACA, only a small fraction of nongroup insurance policies covered maternity care, for example, but the additional cost of that coverage often exceeded the costs associated with a typical birth. Likewise, policies that offered more generous coverage for prescription drugs charged much higher premiums, expecting that those purchasing the policy would be substantial users of that benefit

But in practice, eliminating a benefit from the essential health benefit requirements would likely eliminate coverage for that benefit in the nongroup insurance market. Any single insurer would be averse to offering a benefit on their own because doing so would attract users of that care, increasing the insurer's costs relative to its competitors. Users would not be able to average their costs even with other users, leaving those with the greatest needs with the highest health care costs.

Discussion

Health insurance affordability is a focal issue in assessments of the ACA and in debates over potential replacements such as the AHCA or BCRA. Premiums are an important component but not the sole determinant of affordability. Eliminating benefits from a plan's coverage can reduce premiums, but it increases the cost of using that type of care for people who need it. The benefits that usually account for large shares of an ACA-compliant nongroup insurance premium are those considered fundamental to health insurance, including office-based care, inpatient hospital care, and outpatient facility care. Prescription drugs, which were either excluded from or very limited in pre-ACA nongroup insurance policies, account for approximately 22 percent of premium costs by our estimates. But eliminating prescription drug coverage from benefit packages could limit access to drugs for most people insured through the nongroup insurance market in any given year, reduce access to lifesaving treatments, and it could lead to higher physician and hospital care costs. Maternity/newborn care, rehabilitative/ habilitative care, and outpatient care for mental health and substance use disorder treatment are also potentially on the chopping block and account for small percentages of the overall premium, but their removal would lead to extremely large cost increases for people who need those types of care. Limited access to such services could lead to higher inpatient or office-based care costs because of later complications.

The ACA has a reasonably comprehensive list of essential health benefit requirements, but it also addresses coverage richness through policies on cost-sharing requirements. For example, the ACA individual mandate is satisfied by bronze (60% actuarial value) nongroup coverage. These policies have an average deductible of over $6,000 in

2017. This approach reduces coverage comprehensiveness by an alternate route.

Health insurance is a mechanism for pooling health care risk across a population. The per-person costs of insuring essential benefits are reasonably low when the costs are spread broadly across a large population with diverse health care risks. But placing those costs fully on the users of care can make those services unaffordable for those who need them. Because people cannot predict which services they will need and when, health insurance spreads those costs across users and non-users, such that benefits are affordable and therefore accessible to enrollees when and if the need should arise. Peeling back covered benefits erodes the financial protection that health insurance is designed to provide.

Essential Health Benefits as a Share of Total Nongroup Premiums, 2017

Type of Service	Incremental Premium Cost per Year, 2017	Share of Premium	Share of Nongroup Enrollees Who Use the Service	Additional Premium Cost if Only Users Finance Costs Now Covered by Insurance
Rehabilitative/Habilitative Care	$96	2%	4%	$2,247
Maternity/Newborn Care	$278	6%	2%	$13,888
Inpatient Care	$720	15%	4%	$19,071
Facility	$609	13%	4%	$16,121
Provider	$111	2%	3%	$3,647
Emergency Room Care	$376	8%	9%	$4,251
Facility	$317	7%	9%	$3,588
Provider	$59	1%	7%	$794
Outpatient Facility Care	$776	17%	13%	$5,755
Facility	$696	15%	13%	$5,162
Provider	$80	2%	8%	$942
Office-Based Care	$1,389	30%	71%	$1,947
Physician Preventive Care	$422	9%	40%	$1,066
Physician Primary Care	$195	4%	32%	$607
Physician Specialty Care	$369	8%	29%	$1,251
Other Provider Care	$402	9%	39%	$1,038
Prescription Drugs	$1,023	22%	56%	$1,836
Generic (Rx < $50)	$114	2%	n.a.	n.a.
Brand Name, Nonspecialty	$576	12%	n.a.	n.a.
Specialty (Rx >= $1,000)	$333	7%	n.a.	n.a.
Pediatric Dental and Vision Care	$43	1%	10%	$453
Total Cost of EHBs	$4,700	100%		

Source: Authors' analysis of 2014 Medical Expenditure Panel Survey Household Component, aged to 2017.

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

1 See, for example: Fox M. What are 'essential benefits in GOP health care bill debate? *NBC News*. March 24, 2017. http://www.nbcnews.com/health/health-care/gop-health-care-debate-what-are-essential-benefits-n737646.

2 Alonso-Zaldivar R. Trump health pick Seema Verma says maternity coverage should be optional. *Chicago Tribune*. February 16, 2017. http://www.chicagotribune.com/lifestyles/health/ct-trump-health-pick-says-maternity-coverage-should-be-optional-20170216-story.html. Luhby T. Essential health benefits and why they matter. *CNN*. Updated March 24, 2017. http://www.cnn.com/2017/03/22/politics/essential-health-benefits-obamacare-freedom-caucus/index.html. Sullivan P. What the GOP's plan to kill essential health benefits means. *The Hill*. March 23, 2017. http://thehill.com/policy/healthcare/325381-what-the-gops-plan-to-kill-essential-health-benefits-means. Andrews M. GOP considers trimming health law's 10 essential benefits. *NPR Shots*. February 22, 2017. http://www.npr.org/sections/health-shots/2017/02/22/516465156/gop-seeks-reduction-in-health-law-s-10-essential-benefits.

3 Actuarial value (AV) is the proportion of claims paid by an insurance plan over a standard population. A 70 percent AV plan pays, on average, 70 percent of claims submitted, leaving the policyholder responsible for the remaining 30 percent.

4 Event-level files were the 2014 office-based medical provider visit file (MEPS HC-168G) and the 2014 prescribed medicines file (MEPS HC-H16

5 The CCIIO Actuarial Value Calculator allows users to value the metal tier of a specific health insurance plan and includes data on the underlying distributions of service by metal tier. Centers for Medicare & Medicaid Services. Center for Consumer Information & Insurance Oversight website. https://www.cms.gov/cciio/resources/regulations-and-guidance/.

6 Health Care Cost Institute. Health Care Cost Reports website. http://www.healthcostinstitute.org/report/.

7 Bayram R, Dewey B. *Are Essential Health Benefits Here to Stay?* Seattle: Milliman; 2017. http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf.

State Efforts to Lower Cost-Sharing Barriers to Health Care for the Privately Insured

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Introduction

Consumer cost-sharing for covered health plan services has been growing over time and is likely to increase under proposals to repeal and replace the Affordable Care Act (ACA), many of which would encourage enrollment in high-deductible health plans.[1] High deductibles can help lower premiums, in part by reducing the use of health care services, but they can also encourage consumers to delay or forgo necessary care.[2] This can lead to poorer health outcomes and greater financial liability for policyholders. As a result, some health care experts have called for more nuanced health benefit plan designs that cover certain services, such as primary care and generic drugs, before the deductible.[3] This is sometimes called value-based insurance design (VBID).

States have historically been, and are likely to remain, the primary regulators of health insurance in the individual and small-group markets. As such they have authority to require insurers to cover certain benefits or to adjust cost-sharing to lower financial barriers to care. We find, however, that very few states currently use their authority to establish cost-sharing standards for specific services. Only six states and the District of Columbia do so, largely through standardized plan designs that insurers must offer. However, other state and federal policymakers may wish to learn from the experiences of these six states and DC as consumers increasingly enroll in high-deductible health plans and face higher out-of-pocket costs to obtain needed health care services. This paper discusses findings from our review of laws and policies in 50 states and the District of Columbia that regulate cost-sharing for consumers in individual and small-group health plans, as well as from interviews with officials and health care stakeholders about the development and implementation of these policies.

Background

Cost-sharing is a common feature in private health insurance and refers to the amount that a consumer is responsible for paying when accessing covered services. Cost-sharing generally includes deductibles, copayments, and coinsurance.[4]

- **deductible:** a fixed dollar amount that a consumer must pay before the health plan provides its share of payment for covered services under the health plan

- **copayment:** a fixed dollar amount that a consumer must pay at the point of service

- **coinsurance:** a percentage of the cost of services that a consumer must pay at the point of service

Cost-sharing allows insurers to keep monthly premiums low by shifting costs to consumers when they use health care services. Increased cost-sharing has also been shown to lower consumers' use of covered services and overall health care spending.[5] Although more people have private health insurance now than ever before, the share of costs that privately insured individuals shoulder, via deductibles, copayments, and coinsurance, has risen steadily. In particular, health plans with high deductibles—amounts that consumers must meet before services are covered—have become increasingly popular among insurers and plan sponsors.[6] However, several surveys of consumer satisfaction with high-deductible health plans indicate lower satisfaction compared with consumers enrolled in plans without high deductibles.[7]

Enrollment in high-deductible plans is growing. For the estimated 155 million people enrolled in coverage through their employer, the percentage of people with a deductible of $1,000 or more has grown from 10 percent in 2006 to 51 percent in 2016.[8] For 43 percent of those enrolled in an individual market plan without reduced cost-sharing through the ACA's Marketplaces, the average deductible for the most popular level of coverage was $3,064 in 2016, an increase of 17 percent from the previous year. However, more than half of Marketplace enrollees receive subsidies to reduce their cost-sharing.[9] Approximately half of consumers enrolled in the Marketplaces report increased dissatisfaction with higher deductibles under their coverage.[10]

Cost-sharing obligations can be a barrier to accessing health care services. According to one survey, one-third of Americans with private health insurance report postponing medical treatment because of cost.[11] This number jumps to more than half for families with chronic conditions and those with low incomes.[12] Delayed or postponed care often leads to worse health outcomes. Many who receive care struggle to pay their cost-sharing charges, leading to financial insecurity and medical debt, particularly for those enrolled in high-deductible health plans.[13]

Under the ACA, consumers in individual and employer group health plans have several protections that limit enrollees' cost-sharing liability. First, insurers and plan sponsors must cover preventive services and screenings without cost-sharing. Second, the law places an annual limit on the out-of-pocket cost-sharing an individual or family must pay for covered items and services. In 2017, that

amount is $7,150 for an individual and $14,300 for a family.[14] Third, health plans are no longer allowed to impose annual or lifetime dollar limits on benefits. Fourth, individual and small-group market health plan designs, both on and off the health insurance Marketplaces, must fit within five specified levels of coverage: catastrophic, bronze, silver, gold, and platinum. Each of these actuarial value (AV) levels corresponds to the percentage of costs an insurer must pay for covered services versus the percentage in cost-sharing a consumer must pay. Bronze level plans cover, on average, 60 percent of enrollees' costs for covered services. On the other end are platinum level plans, which cover, on average, 90 percent of enrollees' costs. Within each AV level, insurers have flexibility to set deductibles, copayments and coinsurance for covered services, but they must stay within the parameters for each AV level.[15]

VBID is a more nuanced approach to cost-sharing that policymakers and plan sponsors have encouraged in recent years as part of efforts to simultaneously lower health care costs and cost-sharing for consumers. Under a VBID health plan, a consumer may have access to certain "high-value" services predeductible, meaning the consumer does not need to exhaust his or her deductible before a health plan pays for the service or drug. High-value services are those known to promote or maintain good health. A VBID health plan may also eliminate or lower copayment or coinsurance amounts to encourage consumers to obtain these high-value services. For example, lowering cost-sharing for blood pressure or diabetes medication has been shown to increase patient compliance with treatment regimens that help manage chronic conditions, which then may save insurers money on more costly and preventable health care services in the future.[16] Other versions of VBID also work to lower health care spending by imposing higher enrollee cost-sharing for services whose benefits do not justify the cost, based on available evidence.[17] Policymakers critical of the negative incentives under a VBID approach often cite the challenges of determining which services are "low-value" and designing appropriate plans accordingly. They also cite the lack of reliable data as a challenge to applying VBID to low-value services, particularly because affected populations may have varying characteristics that make comparison difficult.[18]

The use of VBID has gained traction among insurers and plan sponsors. In one survey of large employers in 2014, 59 percent indicated interest in adopting VBID for medical benefits and 57 percent for prescription drug benefits in the next three to five years.[19] Medicare is also piloting a VBID initiative for its Medicare Advantage health plans for specific chronic conditions.[20] In the individual market, as many as one-third of policies sold on the federally facilitated Marketplaces (FFM) have gone beyond the law's requirement to cover preventive services without cost-sharing and voluntarily cover commonly needed health care services, such as primary care visits and generic drugs, before the deductible.[21]

Methodology

To determine whether states have policies to lower consumers' financial barriers to services through cost-sharing standards in the individual and small-group market, we conducted a survey of laws and policies in 50 states and DC. We excluded from our review state policies that mandated coverage or parity of coverage for certain goods or services, even if they include cost-sharing limits. For example, we

excluded state-mandated cost-sharing limits or parity for oral chemotherapy compared with intravenous chemotherapy. We also excluded state policies that limit cost-sharing for out-of-network providers—for example, capping coinsurance at a certain percentage for nonpreferred providers.[22] In our analysis, we focused on policies directed at the individual insurance market; however, standards for individual and small-group plans were similar if not identical in most of these states.

We supplemented our research with in-depth interviews of stakeholders in four study states (California, Connecticut, DC, Massachusetts) about their respective state policies. Stakeholders included state-based Marketplace (SBM) officials, state regulators, insurance company representatives, and consumer advocates. We conducted 10 interviews between November 2016 and December 2016.

Findings

50-State Analysis: Results

We find that six states have policies aimed at lowering cost-sharing for specified health care services in the individual and small-group markets through state-prescribed standardized plan designs: California, Connecticut, Massachusetts,[23] New York, Oregon, and Vermont. In most cases, standardized plans for the individual and small-group markets are similar, if not identical. The District of Columbia has pursued a similar policy through standardized plan designs but applies it only to the individual market; DC is considering extending standardized plans to the small-group market in the future (see figure 1). It is no coincidence that all of these states also established their own health insurance Marketplaces under the ACA. Decisions to standardize benefit designs in these states were largely driven by Marketplace officials, even though insurers are required to offer these plans inside and outside the Marketplaces. And except in California, insurers can offer nonstandardized plans on their Marketplaces. [24] New Jersey also has standard plans, but these plans predate the ACA and explicitly waive the deductible for immunizations and lead screening for children, preventive care, maternity care, and second surgical opinions. New Jersey's approach reflects legislated state benefit mandates rather than an intentional, government-led effort to develop standardized cost-sharing that reflects VBID principles.[25] The federally facilitated market (FFM) also developed standardized benefit plans for 2017 but does not require insurers to offer them.[26]

FIGURE 1

States That Have Lowered Cost-Sharing for Health Services
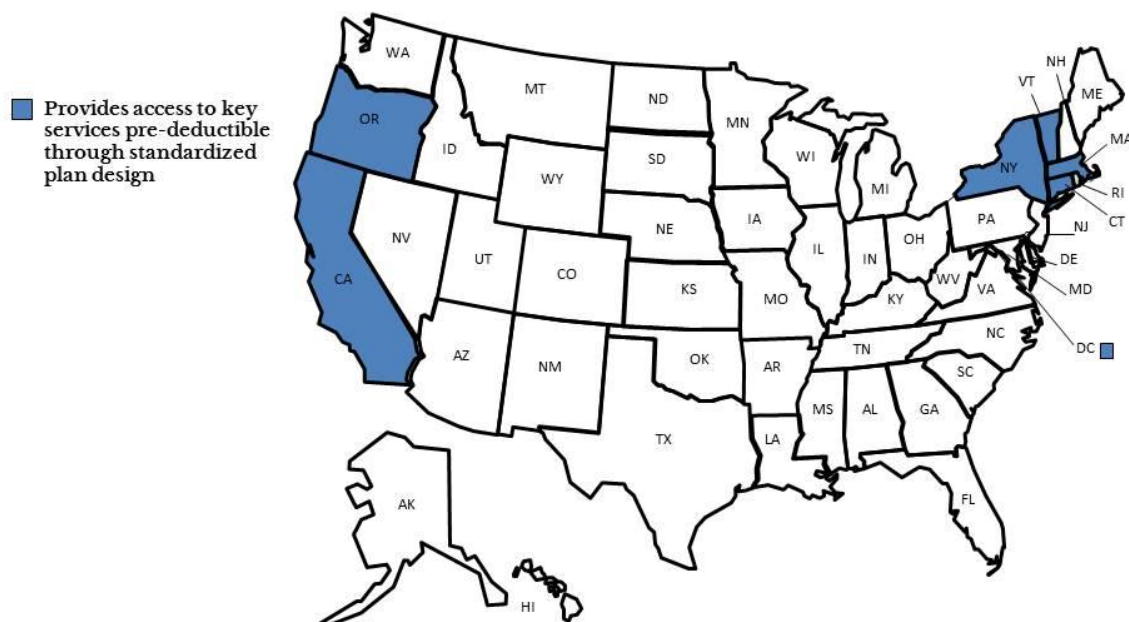
Source: Authors' analysis of state law and guidance, based on data as of November 2016.

In all these states except New York, standardized benefit plans include the following predeductible services with low to moderate copayment amounts: doctor's visits for nonpreventive primary care, specialty care, mental health and substance use disorder (MH/SUD) treatment, and urgent care, as well as generic prescription drugs in the popular metal categories of silver and bronze (table 1). Other predeductible services or services available without any cost-sharing include outpatient habilitative and rehabilitative services, home health services, and hospice care. Routine pediatric care such as eye exams and dental exams are available predeductible with little or no copayments in California, Connecticut, DC, and Vermont. California, Connecticut, DC, and Oregon also ensure easier access to laboratory and diagnostic testing by including them as predeductible services. New York's standardized plan design differs from the other states' because it only provides access to prescription drugs (generic and brand-name) predeductible and does not require coverage of any medical services predeductible. New York, however, allows insurers to offer a version of its standardized plan design that provides three nonpreventive primary care visits predeductible in the silver and gold levels.[27] Massachusetts's

ConnectorCare program, available to people with incomes below 300 percent of the federal poverty level, eliminated cost-sharing for opioid addiction treatments in its standardized plans.[28]

Partly because of the constraints on the federally prescribed metal plan levels, more services are available predeductible in silver level plans than bronze level plans. Though fewer services are available predeductible at the bronze level, nonpreventive primary care visits and urgent care must be covered predeductible by standard plans in California, Connecticut, DC, and Oregon. In California, however, enrollees are limited to three visits before the deductible apples. Only DC and Oregon provide access to generic drugs in the standard bronze plan without meeting a deductible.

TABLE 1

Required Predeductible Services in 2017 Individual Silver Standard Plans, with State-Prescribed Copayments*

State	Deductible	Primary Care	Specialist	Mental Health/Substance Use Disorder	Urgent Care	Generic Drugs
California	$2,500	$35	$75	$35	$35	$15
Connecticut	$4,000	$35	$50	$35	$50	$5
DC	$2,000	$25	$50	$25	$90	$15
Massachusetts**	$2,000	$30	$50	$30	$50	$20
New York***	$2,000	None	None	None	None	$10
Oregon	$2,500	$35	$70	$35	$70	$15
Vermont	$2,150	$25	$65	$25	$60	$15

Sources: *2017 Patient-Centered Benefit Designs and Medical Costs*. Covered California. http://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf. *2017 Standard Benefit Plan Designs Redline*. California Health Benefit Exchange, Board Meeting, June 16, 2016. http://board.coveredca.com/meetings/2016/6-16/index%20-%20Copy.shtml. *Plan Designs, 2017 Standard Silver Plan—70%*, Health Access CT, http://agency.accesshealthct.com/wp-content/uploads/2016/10/Health-Plans-2017-Ind-Standard_Silver_Plan70.pdf. *Standard Plans Advisory Working Group Report 4-4-16*. DC Health Benefit Exchange Authority, Executive Board Meeting April 6, 2016, Meeting Materials. https://hbx.dc.gov/event/executive-board-meeting-54. *All Assister Conference Call: Health Connector 2017 Seal of Approval Process and Results*. Massachusetts Health Connector. Sept. 21, 2016. http://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review_FINAL.pdf. *2017 Invitation for Participation in NY State of Health*. New York State of Health. April 11, 2016. https://info.nystateofhealth.ny.gov/resource/2017-invitation-participation-ny-state-health. *Recommendations for NY State of Health 2017 Plan Invitation*. Health Care for All New York. March 8, 2016. http://hcfany.org/wp/wp-content/uploads/2016/03/HCFANY-comments-on-plan-invitation-1.pdf. Accessed Jan. 2017. Oregon standardized health plans: Summary of Coverage. Oregon Div. of Financial Regulation of the Dept. of Consumer and Business Services, June 2016. http://dfr.oregon.gov/healthrates/Documents/plan_summary.pdf. Summaries of Benefits and Coverage, Silver BCBSVT and MVP. Vermont Health Connect. http://info.healthconnect.vermont.gov/healthplans#PCB.
*Although these services are available predeductible, copays are required at the time of service
** The information shown here refers to the Massachusetts Health Connector, available for individuals with income above 300 percent of the federal poverty level. The deductible is a combined medical and prescription drug deductible ($4,000 for family coverage).
***New York gives insurers an option to provide a standardized benefit design that includes 3 non-preventive primary care visits predeductible, but the required standardized benefit design that insurers must offer on the silver level does not include any predeductible services except for prescription drugs, see table 2.

California, Connecticut, DC, and Vermont have mandated separate prescription drug deductibles, but Massachusetts limits prescription drug deductibles if they are present. In Massachusetts, all three tiers of prescription drugs are available predeductible with copayments of $20, $60, and $90. Similarly, Connecticut makes the first three tiers of prescription drugs available predeductible with copayments of $5, $35, and $60, and places out-of-pocket limits on the fourth tier. There are no deductibles applicable in New York and Oregon for prescription drugs in their silver standard plans. In New York, copayments of $10, $35, and $70 correspond to the first three tiers; the state does not allow a fourth tier. In Oregon, copayments are $15 for tier 1, $50 for tier 3, and 50 percent coinsurance for the last two tiers.

TABLE 2

Prescription Drugs Available Predeductible in 2017 Individual Silver Standard Plan

State	Deductible	Tier 1/ Generic	Tier 2	Tier 3	Tier 4
California	$250	Yes	No	No	No
Connecticut*	$150	Yes	Yes	Yes	No
DC	$250	Yes	No	No	No
Massachusetts**	$250	Yes	Yes	Yes	N/A
New York	N/A	Yes	Yes	Yes	N/A
Oregon***	N/A	Yes	Yes	Yes	Yes
Vermont	$150	Yes	No	No	No

Sources: *2017 Patient-Centered Benefit Designs and Medical Costs*. Covered California. http://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf. *2017 Standard Benefit Plan Designs Redline*. California Health Benefit Exchange, Board Meeting, June 16, 2016. http://board.coveredca.com/meetings/2016/6-16/index%20-%20Copy.shtml. *Plan Designs, 2017 Standard Silver Plan— 70%*, Health Access CT, http://agency.accesshealthct.com/wp-content/uploads/2016/10/Health-Plans-2017-Ind-Standard_Silver_Plan70.pdf. *Standard Plans Advisory Working Group Report 4-4-16*. DC Health Benefit Exchange Authority, Executive Board Meeting April 6, 2016, Meeting Materials. https://hbx.dc.gov/event/executive-board-meeting-54. *All Assister Conference Call: Health Connector 2017 Seal of Approval Process and Results*. Massachusetts Health Connector. Sept. 21, 2016. https://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review_FINAL.pdf. *2017 Invitation for Participation in NY State of Health*. New York State of Health. April 11, 2016. https://info.nystateofhealth.ny.gov/resource/2017-invitation-participation-ny-state-health. *Recommendations for NY State of Health 2017 Plan Invitation*. Health Care for All New York. March 8, 2016. Accessed Feb. 2017. Oregon standardized health plans: Summary of Coverage. Oregon Div. of Financial Regulation of the Dept. of Consumer and Business Services, June 2016. http://dfr.oregon.gov/healthrates/Documents/plan_summary.pdf. Summaries of Benefits and Coverage, Silver BCBSVT and MVP. Vermont Health Connect. http://info.healthconnect.vermont.gov/healthplans#PCB.
*In Connecticut's 2017 standardized silver plan, Tier 4 drugs are subject to the deductible and then a 20% coinsurance is required, but the out-of-pocket cost is limited to $200 per prescription.
**The information shown here refers to Massachusetts Health Connector, available to individuals with income above 300 percent of the federal poverty level. The deductible is a combined medical and prescription drug deductible ($4,000 for family coverage).
***Oregon has no deductible for prescriptions under its standardized silver plan.

Stakeholder Observations

In the four study states, Marketplace officials and stakeholders alike viewed the ACA's Marketplaces and insurance reforms as opportunities to deliver a better shopping experience and greater value to health insurance consumers. Despite numerous initial challenges in standing up their Marketplaces and

operationalizing key functions, they continued to pursue this goal through benefit design standardization and the principles of VBID. Their efforts to implement these policies highlight the importance of policy transparency and public input. States had to be willing to create "winners" and "losers" depending on which services receive lowered cost-sharing. But although California, Connecticut, and Massachusetts have had standardized plans for several years, none of the study states had yet reviewed data to help them assess the effectiveness of these policies, particularly with regard to consumers' access to services, customer satisfaction, and enrollee retention.

CREATING VALUE FOR THE CONSUMER:
MAKING SERVICES AVAILABLE PREDEDUCTIBLE

Several state officials noted that although the original policy objective of adopting standardized plan designs was to promote a simplified, streamlined consumer shopping experience, they quickly realized they could use their authority over benefit design to improve the value of coverage available to Marketplace consumers. For example, one Marketplace official noted, "While the policy wasn't implemented per se to make plans better, it is also a vehicle to do that." The official added that such standardized plans "create a consumer-centric baseline with a good balance of coverage richness and simplicity of design." Another official said that the standard plans were about "apples-to-apples comparison, but in doing so, we really did try to create the best value for consumers and try to design our plans to at least help people get services."

Indeed, state Marketplace officials in California and Connecticut assert that creating better value for their customers was the primary reason they decided to require standardized plan designs.[29] In particular, they hoped the designs would appeal to healthy consumers, many of whom may only see a primary care clinician or fill a prescription once or twice a year. Because these healthy enrollees are more likely to stop paying their plan premiums midyear if they are required to pay the full cost of these services out-of-pocket, Marketplace officials believe that providing some predeductible coverage is an important enrollment retention tactic. Insurer respondents shared similar views, but not all supported the Marketplace's control over plan design. One respondent said insurers "have to convince [consumers] that they want this" by "putting some services before the deductible."

Some consumer advocates view standardized plan designs not only as a way to generate better value for consumers, but also as a "policy vehicle" to reduce out-of-pocket costs for vulnerable enrollees, particularly those with chronic conditions. One respondent stated, "The goal of the policy was minimizing the liability people are faced with when they need coverage." One consumer advocate said that coverage of drugs and primary care services predeductible was important for patients with chronic conditions, who may need multiple prescriptions and a few physician visits to control their condition. Consumer advocates also noted that lowering cost-sharing or providing predeductible coverage specifically for drugs would improve medication adherence for consumers with chronic conditions, thereby improving health outcomes over the long term.

Consumer advocates in Massachusetts see VBID as the next logical step to lower out-of-pocket costs for consumers. In particular, Massachusetts Marketplace officials noted that they were exploring

ways to expand VBID use in the future, citing their experience eliminating cost-sharing for opioid addiction treatment under ConnectorCare plans.

At the same time, some stakeholders in California and Connecticut indicated reluctance to use standardized designs to impose higher cost-sharing on services deemed to have low or uncertain value. They cited concerns about the lack of effectiveness data specific to their Marketplace population and disagreement over what services should be considered high- versus low-value. One insurer respondent said, "No one has ever come up with a list of what the low-value things that we're going to charge more for are. The people who get and provide those services think they're high-value." District of Columbia stakeholders also noted that they lacked the expertise and resources to conduct the kind of medical evidence review needed to make value judgments about which services should be subjected to higher cost-sharing.

POLICY DEVELOPMENT AND IMPLEMENTATION:
AN OPEN PROCESS WITH STAKEHOLDER INPUT

The study states developed standardized plan designs for their Marketplaces with significant input from insurers and consumer advocates. One Marketplace official noted, "Everything we do here, by and large, with respect to policy decisions [is] driven by stakeholder input." In California, Connecticut, and DC, an advisory group develops the standardized plan designs. Advisory groups meet in public before making their recommendations to the Marketplace board of directors. In all three states, consumer or health care advocates are members of these advisory groups. Consumer advocates generally agreed that the benefit design development process has been open, although one consumer advocate in Connecticut observed that the Marketplace is not as "vigorous about consumer and community input as [Marketplace officials] were." The Massachusetts Marketplace does not have a benefit design advisory committee, but designs are developed by staff who receive input from insurers and consumer advocates. Their recommendations are submitted to and voted on by the board of directors. Massachusetts consumer advocates applauded the process, noting that it is "mostly driven by a lot of research and conversations of staff with insurers and the community."

Insurers we interviewed also agreed that the process of developing standardized plan designs is open. One insurer said, "There's always an open door policy." However, some insurer respondents raised concerns that some advocacy groups pushing for coverage of certain items and services in the standardized benefit designs were funded to engage in that advocacy by special interests, such as pharmaceutical companies. One insurer noted that there is little transparency around the funding of patient advocacy groups, noting that financial disclosure "by and large does not happen." But another insurer shrugged off these concerns, noting that in the relatively small world of state policy advocacy, "we generally know where [a policy] is coming from and which group is advocating for it."

Insurers also use the process to voice concerns about the costs of implementing standardized benefit plans that incorporate VBID, particularly because costs for services and drugs differ in markets around the state. "They [costs] can be big; this is a tight Marketplace with very thin margins." Insurers

also expressed reservations about these benefit designs leading to higher use among enrollees; this could increase their costs and, ultimately, their premiums.

IMPLEMENTATION CHALLENGES:

DEVELOPING APPROPRIATE BENEFIT DESIGNS WITHIN FEDERAL LIMITS

Under the ACA, the cost-sharing associated with specific covered services must apply within the context of the federally set AV levels. As a result, many respondents described the process of deciding what to provide predeductible as a series of trade-offs. One official said, "We do a bit of push and pull, raise the deductible here and lower the copay there, and then look at the impact... It's definitely a trade-off." For some respondents, keeping deductibles as low as possible was important to help consumers feel they were getting value out of their monthly premium payments, but doing so often meant that cost-sharing was higher in other parts of the benefit package.

Some respondents described predeductible coverage as cost-shifting, noting that "it's a zero-sum game" and "somebody else is going to pay more" when some services are made available predeductible. One insurer pointed out that because most consumers don't incur large costs, the burden shifts to those who use services the most—usually people in the worst health: "I'm not sure we are helping the right people." One insurer respondent asserted that costs had gone up as a result of their state's requirement to provide standardized plans, citing the operational cost of implementing the new plans as well as higher use. However, the insurer conceded that it is difficult to isolate the effect of plan standardization because there were "a lot of interactions between benefits and changes every year."

Providing coverage predeductible in the bronze level was particularly challenging, largely because enrollees must cover such a high percentage (40 percent) of the cost of covered services. One DC consumer advocate respondent said, "There's no good decision within the bronze level." Advocates in New York noted that Marketplace officials cited the constraints of the federal AV levels as a reason not to make this predeductible coverage mandatory.

EVALUATION CHALLENGES:

OBTAINING TIMELY DATA TO ASSESS IMPACT OF PREDEDUCTIBLE COVERAGE

Although one insurer asserted that their state's requirement of predeductible coverage had prompted higher use of health care services, most insurer respondents and state officials did not have data on enrollees' use of services covered predeductible. Most think it is too early to determine whether patient access to these services has improved, or whether there has been any effect on health outcomes or overall spending. In general, state officials noted that they must rely on participating insurers to report the data. One Marketplace official said, "Utilization data tends to trail behind." Some said that even if insurers regularly provided state regulators with data on service use, they would have difficulty analyzing it because reports are not uniform and staff resources are insufficient. In addition, many consumers in the individual market switch health plans and insurers year to year, making data on utilization trends less useful. One insurer said that for smaller populations, it's difficult to substantiate "any positive population health [trend] down the road."

Discussion

The uninsured rate is at a historic low, but consumers' out-of-pocket costs for accessing services have been climbing, largely because of higher deductibles, coinsurance, and copayments. Opponents of the ACA have pointed to high cost-sharing in the individual market as one reason to repeal the ACA. However, proposals to repeal and replace the ACA would encourage enrollment in plans with even higher deductibles and potentially less comprehensive coverage, thereby increasing the amount consumers must pay to access high-value services such as primary care or specialist visits and prescription drugs.

At the same time, federal policymakers have called for states to have increased authority and flexibility to regulate their insurance markets. Some states may choose to use that authority to help reduce the financial barriers that could prevent consumers from obtaining needed, high-value health care services or prescription drugs. In doing so, states may be able to learn from the experiences of the six states and DC which have enacted standardized benefit designs that include coverage of key services predeductible.

Our review of the policies in these states and interviews with insurers, consumer advocates, and Marketplace officials finds that although data on consumer use of services or health outcomes of plans with predeductible coverage are not yet available, most stakeholders believe that these plans offer consumers a better value than plans that do not cover any services predeductible. The study states have also generated stakeholder buy-in and, in some cases, the support of participating insurers, thanks to design and implementation processes that incorporated public input and stakeholder views.

State officials and advocates also noted that providing predeductible coverage involves a series of trade-offs, resulting in winners and losers among enrollees. The actuarial value targets prescribed by the ACA mean that lowering cost-sharing for one set of goods or services necessarily means increasing cost-sharing for another set of goods or services. Choosing among these, and thinking through the impact on different patient populations as well as the enrollee population as a whole, is a significant challenge for state officials and the stakeholder advisory committees. This challenge is compounded by the lack of timely access to data about how these benefit designs are affecting service use over time. Nor do state officials yet have a quantifiable method to demonstrate whether they are meeting their policy goal of delivering greater plan value and improving enrollee retention.

How health insurance will be regulated after an ACA repeal is uncertain, but lowering financial barriers to needed care remains an important policy goal. As policymakers call for greater state autonomy to establish standards for health insurance coverage, states may wish to consider requiring coverage of services predeductible or establishing cost-sharing limits for specific services in order to improve consumers' access to necessary care.

About the Authors

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Acknowledgments

Notes

[1] *See,* for example, American Health Care Act of 2017, H.R. 1628, 115th Cong, (1st Sess., 2017).

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[8] Altman, D. *Health-Care Deductibles Climbing Out of Reach*. Menlo Park: Kaiser Family Foundation, March 11, 2015; Herman, B. "Most Americans gain health coverage, but their cost-sharing keeps rising." *Modern Healthcare*, Sept. 17, 2016. http://www.modernhealthcare.com/article/20160917/MAGAZINE/309179964. Accessed February. 2017. *Health Insurance Coverage of the Total Population, State Health Facts, 2015*. Menlo Park: Kaiser Family Foundation. http://kff.org/other/state-indicator/total-population/?currentTimeframe=0. Accessed February 2017. Claxton, G et. al. *2016 Employer Health Benefits Survey*. Menlo Park: Kaiser Family Foundation, Sept. 14, 2016.

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[22] See, for example, Utah Code. Ann. § 31A-22-641 requires that if a health plan covers both types of chemotherapy, cost-sharing for oral chemotherapy is no more restrictive than for intravenous therapy or if the cost-sharing is more restrictive, cannot apply cost-sharing that exceeds $300 per prescription; Vernon's Texas Code Ann. § 1301.0046 limits coinsurance to 50 percent of the total covered amount for non-preferred providers with preferred provider organizations.

[23] Massachusetts, which passed its states' health reform law in 2006, established minimum credible coverage standards that limit deductibles. 956 Code of Mass. Reg. 5.03, Massachusetts Health Connector, Admin. Bulletin 01-03, May 6, 2013 and Admin. Bulletin 02-13, Oct. 2, 2013. In general, in order to meet minimum creditable coverage (MCC) standards, individual health plans must limit deductibles to $2,000 for individuals and $4,000 for families. However, the Massachusetts Health Connector has the authority to grant MCC status to health plans that deviate from MCC standards as long as they meet certain guidelines including an actuarial value equal or greater to the bronze plan offered through the Massachusetts Health Connector.

[24] In 2014 and 2015, Vermont required all individual and small group plans to be sold on its Marketplace. In DC, all individual and small group plans must be sold on its Marketplace.

[25] N.J. Admin. Code § 11:22-5.3 (limiting deductibles to $2,500 for individual coverage and $5,000 for family coverage in the individual and small group markets); N.J. Admin. Code § 11:22-5.3 (limiting coinsurance percentages to 50 percent); N.J. Admin. Code § 11:22-5:4 (prescribing copayment limits for specific services) and N.J. Ins. Bul. No. 2015-4, May 4, 2015 (increasing the individual deductible to $3,000 in bronze level plans). Under New Jersey's standardized plans, the copayments for emergency room visits cannot be more than $100, which is payable in addition to the deductible and any coinsurance, but is waived if the consumer is admitted within 24 hours of the visit. There are also coinsurance limits to covered services for each type of standardized plan. In addition, pre-natal visits and second surgical opinions must be provided predeductible. *See* New Jersey IHC Program Forms. http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html. Accessed February 2017. N.J. Rev. Stat. §§ 17:48-6c, 17:48A-7c, 17B:26-2.1k, 17B:27-46.1k; N.J. Rev. Stat. §§ 17:48E-33, 17B:27-46.2.

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[29] See *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability Discussion DRAFT – Options and Recommendations.* California Health Benefit Exchange. July 16, 2012. http://board.coveredca.com/meetings/2012/06%20Jun-19%20Bay%20Area%20Meeting%20Materials/PDFs/CHBE-QHP_Discussion_Draft_7162012.pdf. Accessed April 2017.

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