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ASPE
RESEARCH BRIEF

HEALTH INSURANCE MARKETPLACES 2016:
AVERAGE PREMIUMS AFTER ADVANCE PREMIUM TAX CREDITS IN THE 38 STATES USING THE HEALTHCARE.GOV ELIGIBILITY AND ENROLLMENT PLATFORM

For the period: November 1 – December 26, 2015

January 21, 2016

From November 1 through December 26, 2015, more than 8.5 million[1] consumers selected or were automatically enrolled in a 2016 plan through the Health Insurance Marketplaces ("the Marketplaces") in the 38 states using the HealthCare.gov eligibility and enrollment platform.[2] Eighty-three percent (approximately 7.1 million) of these consumers are receiving financial assistance to pay their premiums through the Marketplaces.

This report focuses on the health plan choices made by returning consumers and the premiums for the plans they selected. The analysis uses data on the number of reenrollees who actively reenrolled and/or changed plans; and data on several metrics related to the impact of the advance premium tax credit on net premium costs in the 38 states using the HealthCare.gov eligibility and enrollment platform. The appendix to this report also provides data on plan selections by premium amount and average premium savings at the state level for the 38 states using the HealthCare.gov eligibility and enrollment platform. The data in this report are preliminary, and will be updated after the end of the 2016 Open Enrollment Period.

[1] As of the publication date of this report, 8.8 million consumers selected or were automatically enrolled in a 2016 plan in states using the HealthCare.gov eligibility and enrollment platform. The Week 11 snapshot (November 1, 2015 through January 16, 2016) is available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-20.html.

[2] For more information about data on plan selections through the Marketplaces for the 2016 Open Enrollment Period (November 1 – December 26, 2015), see the "Health Insurance Marketplaces 2016 Open Enrollment Period: January Enrollment Report," available at: https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-january-enrollment-report.

Key Highlights

Based on analysis of consumers who selected or were automatically enrolled in a health plan through the Marketplaces in the 38 states using the HealthCare.gov eligibility and enrollment platform from November 1 through December 26, 2015:

- HealthCare.gov users are actively shopping and saving money. Active reenrollees who changed plans saved $43 per month ($516 a year) on average after advance premium tax credits (APTC).
- Among reenrollees, 3.6 million reenrollees actively selected a plan. Of those active reenrollees, 60 percent switched to a different plan than they had in 2015.
- More than 8 in 10 Marketplace consumers (83 percent) qualify for APTC with an average value of $294 per person per month.
- The average APTC covers about 72 percent of the gross premium for APTC qualified consumers.
- The average premium net of the APTC is $113 per month for APTC qualified consumers in the Marketplaces.
- Nearly 7 in 10 consumers have the option of selecting a health plan with a net premium after the APTC of less than $75 per month.
- Approximately 6 in 10 consumers have the option of selecting a health plan with a net premium after the APTC of less than $50 a month.

Reenrolling Marketplace Consumers Shop at a High Rate and Save on Premiums

Active reenrollees who switched plans have, on average, a monthly premium of $137 per month after applying APTC, compared to $179 per month if these consumers had remained in their 2015 plans. This type of shopping behavior results in average savings of 24 percent or $43 per month ($516 a year) after applying APTC for those active reenrollees who switch plans (see Table 1).

Within the 38 HealthCare.gov states, 3.6 million reenrollees actively selected a plan. Of those active reenrollees, 60 percent switched to a different plan than they had in 2015. Consumers in the Marketplace are more likely to shop and switch plans than consumers in other public and private programs.[3]

[3] The rate of plan switching in the Marketplace is high relative to that reported among employees of firms offering employer sponsored insurance (2.8% in 2010), among participants of the Federal Employees Health Benefits Program (FEHBP; 12% switched plans in 2001) and among elderly consumers enrolled in Medicare Prescription Drug Plans (13% across four enrollment periods). For more information, see, Cunningham, Peter, "Few Americans Switch Employer Health Plan for Better Quality, Lower Costs," National Institute for Health Care Reform, 2013.

Note that consumers' decisions related to changing health insurance plans may be influenced by a number of factors including a preference for a different premium, provider network, set of cost-sharing requirements, or issuer.

Table 1: Reduction in Average Monthly Premiums after APTC for Active Reenrollees in States Using the HealthCare.gov Eligibility and Enrollment Platform, November 1 through December 26, 2015

	Active Reenrollees with 2015 Plan Selections		
	Total	**Who Switched Plans**	**Who Remained in Same or Crosswalked Plan**
Total Consumer Plan Selections	3.64 million	2.18 million	1.45 million
Percent of Active Reenrollees	100%	60%	40%
Percent of Plan Selections with APTC	89%	88%	90%
Average Monthly Premium After APTC if Remained in Same or Crosswalked Plan from 2015 (1,2,3)	$162	$179	$145
Average Monthly Premium After APTC After Shopping (1,3)	$140	$137	N/A
Average Savings in Monthly Premium After APTC After Shopping (1,3)	$22	$43	N/A

Notes: Some numbers may not add to total due to rounding. (1) Based on consumer plan selections with valid crosswalked plans from 2015, which was defined as non-missing 2016 plan IDs and non-missing premiums in 2016 rating areas. The number of total consumer plan selections with valid crosswalked plans is 3.22 million, 1.76 million, and 1.45 million for total active reenrollees, active reenrollees who switched plans, and active reenrollees who remained in the same or crosswalked plan, respectively. (2) Average monthly premiums after APTC for reenrollees if they remained in same or crosswalked plan from 2015 are estimates based on applying an age adjustment to publicly-available data on premiums and also do not take into account the tobacco surcharge (where issuers may charge tobacco users more than those who do not use tobacco). (3) Based on all consumers, regardless of whether they do or do not qualify for APTC.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Reduction in Average Monthly Premiums from Advance Premium Tax Credits (APTC)

Across all 38 states using the HealthCare.gov eligibility and enrollment platform, approximately 7.1 million consumers (83 percent) who selected or were automatically enrolled in a 2016 plan

Hoadley, et al., "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money," Kaiser Family Foundation 2013. Aderly, Adam, Curtis Florence and Kenneth E. Thorpe, "Health Plan Switching Among Members of the Federal Employees Health Benefits Program," Inquiry, Vol. 42, No. 3 (Fall 2005).

through the Marketplaces qualify for APTC,[4] with an average value of $294 per person per month (see Table 2).[5]

The average APTC covers 72 percent of the gross premium for consumers who qualify for APTC, resulting in an average net premium after the APTC of $113 per month for APTC qualified consumers in states that use the HealthCare.gov eligibility and enrollment platform (see Table 2).

Table 2: Reduction in Average Monthly Premiums after APTC in States Using the HealthCare.gov Eligibility and Enrollment Platform, November 1 through December 26, 2015

	Total Consumers With 2016 Marketplace Plan Selections	Percent of Plan Selections with APTC	Average Monthly Premium before APTC (1)	Average Monthly APTC (1)	Average Monthly Premium After APTC (1)	Average Percent Reduction in Premium after APTC (1)
All HealthCare.gov States	8.52 million	83%	$408	$294	$113	72%

Notes: Some numbers may not add to total due to rounding. (1) Estimates are based on consumers who qualify for APTC. For purposes of this analysis, an individual qualifying for APTC was defined as any policy with APTC greater than $0. Additional individuals may qualify for APTC but may not elect to receive it in advance.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Availability of Marketplace Plans with Premiums of $100, $75, $50, or Less in States Using the HealthCare.Gov Eligibility and Enrollment Platform

More than 7 in 10 consumers[6] seeking health insurance coverage for 2016 through the Marketplaces had the option of selecting a plan with a monthly premium of $100 or less after applying the APTC. Through December 26, 2015, nearly half (48 percent) of consumers selected such a plan (see Table 3).

[4] For purposes of this analysis, an individual qualifying for APTC was defined as any policy with APTC greater than $0. Additional individuals may qualify for APTC but may not elect to receive it in advance.

[5] Averages in this brief refer to plan-selection-weighted averages across individuals with plan selections with tax credits in the 37 states using the HealthCare.gov enrollment and eligibility platform (prior to the addition of Hawaii in 2016).

[6] The estimates presented here are based on plan availability for all 2016 consumers (new consumers and reenrollees), which differ slightly from the plan availability estimates in "Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace", which examines 2016 plan availability for 2015 Marketplace enrollees. For more information, see the "Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace" Report, available at: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

Nearly 7 in 10 consumers seeking coverage through the Marketplaces could select a plan with a monthly premium of $75 or less after applying the APTC. Through December 26, 2015, nearly 4 in 10 (39 percent) consumers selected such a plan (see Table 3).

Approximately 6 in 10 consumers seeking coverage through the Marketplaces had a plan with a monthly premium of $50 or less available to them after applying the APTC. Nearly 3 in 10 (27 percent) consumers selected such a plan (see Table 3).

New consumers and active reenrollees who returned to the Marketplaces to shop for coverage were more likely to have a monthly premium of $75 or less after applying APTC than automatic reenrollees (44 percent of new consumers, 41 percent of active reenrollees, and 30 percent of automatic reenrollees, see Table 4).[7]

Table 3: Availability and Selection of Plans with Monthly Premiums of $100 or Less After APTC in States Using the HealthCare.gov Eligibility and Enrollment Platform, November 1 through December 26, 2015

	Monthly Premiums		
	$50 or Less after APTC	**$75 or Less after APTC**	**$100 or Less after APTC**
Percent Who Could Have Selected a Plan with a Monthly Premium of:	59%	66%	72%
Percent Who Selected or Were Automatically Reenrolled in a Plan With a Monthly Premium of:	27%	39%	48%

Notes: Some numbers may not add to total due to rounding. The estimates presented here are based on plan availability for all 2016 consumers (new consumers and reenrollees), which differ slightly from the plan availability estimates in "Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace," which examines 2016 plan availability for 2015 Marketplace enrollees.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

[7] To obtain percentages cited here, add percentages from the following two categories: (1) ≥$0 and ≤$50 and (2) >$50 and ≤$75. Some numbers may not add to total due to rounding.

Table 4: Plan Selections and Monthly Premium after APTC by Reenrollment Status in States Using the HealthCare.gov Eligibility and Enrollment Platform, November 1 through December 26, 2015

	Total Consumers With 2016 Marketplace Plan Selections	Reenrollment Status		
		New Consumers	Active Reenrollees	Automatic Reenrollees
Total Consumers with 2016 Marketplace Plan Selections	8.52 million	2.48 million	3.64 million	2.40 million
Plan Selections by Monthly Premium after Applicable APTC				
Less than or equal to $100	48%	53%	50%	40%
≥$0 and ≤$50	27%	33%	29%	20%
>$50 and ≤$75	11%	11%	12%	10%
>$75 and ≤$100	10%	9%	10%	9%
Greater than $100	52%	47%	50%	60%

Note: Some numbers may not add to total due to rounding.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Methodology and Limitations

Enrollment information is based on qualified health plan (QHP) selections in the Centers for Medicare & Medicaid Service's (CMS) Multidimensional Insurance Data Analytics Systems (MIDAS) for the 38 states using the HealthCare.gov eligibility and enrollment platform from November 1 through December 26, 2015.

The 38 states using the HealthCare.gov eligibility and enrollment platform for 2016 are as follows: Alaska, Alabama, Arkansas, Arizona, Delaware, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Louisiana, Maine, Michigan, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, and Wyoming.

Data in this report are based on plan selection and auto-reenrollments; as such, they do not reflect (a) any updated information for reenrollees that could change the premium or value of the advance premium tax credits (APTCs) that may have occurred after December 26, 2015; (b) any cancellation from a consumer or cancellation from an issuer after December 26, 2015; and (c) effectuated enrollment (the number of people who have paid monthly premiums to the issuer).

Average Premiums and Savings

For purposes of this analysis, an individual qualifying for APTC was defined as any policy with APTC greater than $0. Additional individuals may qualify for APTC but may not elect to receive it in advance. Averages in this brief refer to plan-selection-weighted averages across individuals with plan selections with tax credits in the 37 states using the HealthCare.gov enrollment and eligibility platform (prior to the addition of Hawaii in 2016).

Analysis for active reenrollees is based on consumer plan selections with valid crosswalked plans from 2015, which was defined as non-missing 2016 plan IDs and non-missing premiums in 2016 rating areas.

Average monthly premiums after APTC for reenrollees if they remained in same or crosswalked plan from 2015 are estimates based on applying an age adjustment to publicly-available data on premiums and also do not take into account the tobacco surcharge (where issuers may charge tobacco users more than those who do not use tobacco).

Savings for active reenrollees who switched plans is based on any plan switching, regardless of metal level. For example, this includes individuals who switched from bronze to silver or silver to bronze.

Premium Tax Credits (PTC)

The premium tax credit (PTC) is calculated as the difference between the cost of the adjusted monthly premium of the second-lowest cost silver plan with respect to the applicable taxpayer and the applicable contribution percentage that a person is statutorily required to pay determined

by household income and family size. An individual may choose to have all or a portion of the PTC paid in advance (i.e., APTC) to an issuer of a QHP in order to reduce the cost of monthly insurance premiums. APTCs are generally available for eligible individuals with a projected household income between 100 percent (133 percent in states that have chosen to expand their Medicaid programs) and 400 percent of the Federal Poverty Level (FPL). For 2016, the percentage of household income that a qualified individual or family will pay toward a health insurance premium ranges from 2.03 percent of household income at 100 percent of the FPL to 9.66 percent of income at 400 percent of the FPL. For more information on the required contribution percentage, see http://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

The healthcare.gov platform determines the APTC amount at a household-level. However, for the analyses in this brief, APTC is estimated for each consumer in the household using a member-level variable that's generated by the system when a plan is selected by the consumer. In rare cases, use of this variable can understate the APTC amount a consumer is receiving.

Appendix Table A1: Reduction in Average Monthly Premiums after APTC for *All Active Reenrollees*, for States Using the HealthCare.gov Eligibility and Enrollment Platform

All Active Reenrollees (November 1 through December 26, 2015)					
State	**Total**	**Percent of Plan Selections with APTC**	**Average Monthly Premium After APTC If they Remained in the Same Plan (1,2,3)**	**Average Monthly Premium After APTC After Shopping (1,3)**	**Average Savings in Monthly Premium After APTC After Shopping (1,3)**
All HealthCare.gov States	***3.64 million***	***89%***	***$162***	***$140***	***$22***
Alabama	71,496	93%	$148	$124	$24
Alaska	9,054	93%	$215	$173	$42
Arizona	84,861	80%	$201	$176	$25
Arkansas	22,905	91%	$161	$154	$8
Delaware	10,729	86%	$215	$196	$18
Florida	703,636	94%	$123	$108	$16
Georgia	195,983	91%	$155	$126	$29
Hawaii (4)	.	.	.	.	.
Illinois	144,679	81%	$229	$191	$38
Indiana	71,917	86%	$229	$189	$40
Iowa	20,310	88%	$166	$146	$21
Kansas	47,187	85%	$177	$158	$19
Louisiana	66,016	93%	$143	$124	$19
Maine	37,158	89%	$146	$142	$5
Michigan	134,391	88%	$200	$177	$24
Mississippi	25,391	95%	$137	$113	$23
Missouri	111,658	91%	$139	$123	$17
Montana	22,219	86%	$173	$157	$17
Nebraska	39,710	91%	$140	$129	$11
Nevada	34,835	91%	$141	$132	$9
New Hampshire	20,550	70%	$230	$219	$12
New Jersey	111,637	83%	$258	$221	$38
New Mexico	19,257	75%	$189	$163	$26
North Carolina	251,243	93%	$155	$128	$28
North Dakota	8,380	90%	$169	$162	$7
Ohio	91,422	86%	$227	$200	$27
Oklahoma	49,939	88%	$120	$111	$9
Oregon	61,301	78%	$209	$188	$21
Pennsylvania	190,204	82%	$199	$187	$11
South Carolina	95,174	91%	$150	$135	$16
South Dakota (5)	11,621	91%	$137	$138	-$1

All Active Reenrollees (November 1 through December 26, 2015)					
State	**Total**	**Percent of Plan Selections with APTC**	**Average Monthly Premium After APTC If they Remained in the Same Plan (1,2,3)**	**Average Monthly Premium After APTC After Shopping (1,3)**	**Average Savings in Monthly Premium After APTC After Shopping (1,3)**
Tennessee	99,017	88%	$171	$148	$23
Texas	413,514	89%	$144	$117	$27
Utah	75,686	90%	$129	$113	$17
Virginia	164,817	86%	$140	$130	$9
West Virginia	13,982	90%	$199	$191	$8
Wisconsin	96,088	89%	$194	$163	$31
Wyoming (5)	10,490	93%	$146	$150	-$4

Notes: Some numbers may not add to total due to rounding. (1) Based on consumer plan selections with valid crosswalked plans from 2015, which was defined as non-missing 2016 plan IDs and non-missing premiums in 2016 rating areas. The number of total consumer plan selections with valid crosswalked plans is 3.22 million, 1.76 million, and 1.45 million for total active reenrollees, active reenrollees who switched plans, and active reenrollees who remained in the same or crosswalked plan, respectively. (2) Average monthly premiums after APTC for reenrollees if they remained in same or crosswalked plan from 2015 are estimates based on applying an age adjustment to publicly-available data on premiums and also do not take into account the tobacco surcharge (where issuers may charge tobacco users more than those who do not use tobacco). (3) Based on all consumers, regardless of whether they do or do not qualify for APTC. (4) Hawaii is new to the HealthCare.gov eligibility and enrollment platform for 2016; therefore most plan selections are "new" to the platform. (5) Active reenrollees in South Dakota and Wyoming elected plans with an higher average monthly premium after shopping.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Appendix Table A2: Reduction in Average Monthly Premiums after APTC for *Active Reenrollees Who Switched Plans*, for States Using the HealthCare.gov Eligibility and Enrollment Platform

Active Reenrollees Who Switched Plans (November 1 through December 26, 2015)					
State	**Total**	**Percent of Plan Selections with APTC**	**Average Monthly Premium After APTC If they Remained in the Same Plan (1,2,3)**	**Average Monthly Premium After APTC After Shopping (1,3)**	**Average Savings in Monthly Premium After APTC After Shopping (1,3)**
All HealthCare.gov States	***2.18 million***	***88%***	***$179***	***$137***	***$43***
Alabama	44,661	92%	$153	$111	$42
Alaska	5,024	94%	$233	$156	$76
Arizona	72,870	80%	$208	$168	$40
Arkansas	9,030	91%	$160	$141	$19
Delaware	5,198	83%	$227	$185	$42
Florida	344,175	93%	$152	$114	$38
Georgia	125,418	92%	$155	$108	$47
Hawaii (4)	.	.	.	.	.
Illinois	110,518	80%	$237	$185	$52
Indiana	48,093	87%	$234	$170	$63
Iowa	9,656	88%	$201	$151	$49
Kansas	35,460	85%	$201	$150	$51
Louisiana	40,038	92%	$163	$124	$39
Maine	10,333	83%	$175	$158	$17
Michigan	75,704	89%	$204	$158	$46
Mississippi	16,541	96%	$137	$99	$38
Missouri	65,939	91%	$144	$112	$31
Montana	11,303	83%	$202	$164	$38
Nebraska	19,353	90%	$152	$124	$28
Nevada	23,629	91%	$151	$131	$20
New Hampshire	10,200	68%	$234	$207	$27
New Jersey	64,941	83%	$264	$200	$65
New Mexico	15,617	75%	$193	$151	$42
North Carolina	153,376	93%	$175	$127	$49
North Dakota	3,108	87%	$186	$160	$26
Ohio	49,462	86%	$246	$192	$54
Oklahoma	25,718	85%	$146	$120	$26
Oregon	36,425	76%	$219	$182	$37
Pennsylvania	135,056	82%	$196	$168	$28
South Carolina	73,555	91%	$156	$125	$31

Active Reenrollees Who Switched Plans (November 1 through December 26, 2015)					
State	**Total**	**Percent of Plan Selections with APTC**	**Average Monthly Premium After APTC If they Remained in the Same Plan (1,2,3)**	**Average Monthly Premium After APTC After Shopping (1,3)**	**Average Savings in Monthly Premium After APTC After Shopping (1,3)**
South Dakota	7,601	91%	$152	$140	$11
Tennessee	57,313	86%	$196	$143	$52
Texas	290,275	88%	$153	$113	$40
Utah	53,171	90%	$143	$113	$31
Virginia	68,092	82%	$166	$139	$28
West Virginia	5,951	86%	$234	$201	$33
Wisconsin	54,406	88%	$226	$166	$59
Wyoming	6,557	93%	$166	$162	$4

Notes: Some numbers may not add to total due to rounding. (1) Based on consumer plan selections with valid crosswalked plans from 2015, which was defined as non-missing 2016 plan IDs and non-missing premiums in 2016 rating areas. The number of total consumer plan selections with valid crosswalked plans is 3.22 million, 1.76 million, and 1.45 million for total active reenrollees, active reenrollees who switched plans, and active reenrollees who remained in the same or crosswalked plan, respectively. (2) Average monthly premiums after APTC for reenrollees if they remained in same or crosswalked plan from 2015 are estimates based on applying an age adjustment to publicly-available data on premiums and also do not take into account the tobacco surcharge (where issuers may charge tobacco users more than those who do not use tobacco). (3) Based on all consumers, regardless of whether they do or do not qualify for APTC. (4) Hawaii is new to the HealthCare.gov eligibility and enrollment platform for 2016; therefore most plan selections are "new" to the platform.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Appendix Table A3: Reduction in Average Monthly Premiums after APTC for *Active Reenrollees Who Remained in the Same or Crosswalked Plan*, for States Using the HealthCare.gov Eligibility and Enrollment Platform

Active Reenrollees Who Remained in the Same or Crosswalked Plan (November 1 through December 26, 2015)					
State	**Total**	**Percent of Plan Selections with APTC**	**Average Monthly Premium After APTC If they Remained in the Same Plan (1,2,3)**	**Average Monthly Premium After APTC After Shopping (1,3)**	**Average Savings in Monthly Premium After APTC After Shopping (1,3)**
All HealthCare.gov States	***1.45 million***	***90%***	***$145***	***N/A***	***N/A***
Alabama	26,835	94%	$143	N/A	N/A
Alaska	4,030	93%	$193	N/A	N/A
Arizona	11,991	80%	$189	N/A	N/A
Arkansas	13,875	91%	$162	N/A	N/A
Delaware	5,531	88%	$207	N/A	N/A
Florida	359,461	95%	$103	N/A	N/A
Georgia	70,565	89%	$158	N/A	N/A
Hawaii (4)	.	.	.	.	.
Illinois	34,161	84%	$208	N/A	N/A
Indiana	23,824	84%	$226	N/A	N/A
Iowa	10,654	89%	$141	N/A	N/A
Kansas	11,727	84%	$164	N/A	N/A
Louisiana	25,978	93%	$124	N/A	N/A
Maine	26,825	91%	$135	N/A	N/A
Michigan	58,687	88%	$199	N/A	N/A
Mississippi	8,850	93%	$139	N/A	N/A
Missouri	45,719	90%	$137	N/A	N/A
Montana	10,916	90%	$149	N/A	N/A
Nebraska	20,357	92%	$134	N/A	N/A
Nevada	11,206	92%	$134	N/A	N/A
New Hampshire	10,350	73%	$230	N/A	N/A
New Jersey	46,696	84%	$250	N/A	N/A
New Mexico	3,640	75%	$183	N/A	N/A
North Carolina	97,867	94%	$129	N/A	N/A
North Dakota	5,272	91%	$163	N/A	N/A
Ohio	41,960	86%	$210	N/A	N/A
Oklahoma	24,221	91%	$102	N/A	N/A
Oregon	24,876	80%	$197	N/A	N/A
Pennsylvania	55,148	81%	$205	N/A	N/A
South Carolina	21,619	91%	$147	N/A	N/A

Active Reenrollees Who Remained in the Same or Crosswalked Plan (November 1 through December 26, 2015)					
State	**Total**	**Percent of Plan Selections with APTC**	**Average Monthly Premium After APTC If they Remained in the Same Plan (1,2,3)**	**Average Monthly Premium After APTC After Shopping (1,3)**	**Average Savings in Monthly Premium After APTC After Shopping (1,3)**
South Dakota	4,020	91%	$137	N/A	N/A
Tennessee	41,704	91%	$153	N/A	N/A
Texas	123,239	89%	$126	N/A	N/A
Utah	22,515	91%	$113	N/A	N/A
Virginia	96,725	88%	$124	N/A	N/A
West Virginia	8,031	93%	$184	N/A	N/A
Wisconsin	41,682	90%	$159	N/A	N/A
Wyoming	3,933	93%	$144	N/A	N/A

Notes: Some numbers may not add to total due to rounding. (1) Based on consumer plan selections with valid crosswalked plans from 2015, which was defined as non-missing 2016 plan IDs and non-missing premiums in 2016 rating areas. The number of total consumer plan selections with valid crosswalked plans is 3.22 million, 1.76 million, and 1.45 million for total active reenrollees, active reenrollees who switched plans, and active reenrollees who remained in the same or crosswalked plan, respectively. (2) Average monthly premiums after APTC for reenrollees if they remained in same or crosswalked plan from 2015 are estimates based on applying an age adjustment to publicly-available data on premiums and also do not take into account the tobacco surcharge (where issuers may charge tobacco users more than those who do not use tobacco). (3) Based on all consumers, regardless of whether they do or do not qualify for APTC. (4) Hawaii is new to the HealthCare.gov eligibility and enrollment platform for 2016; therefore most plan selections are "new" to the platform.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Appendix Table A4: Reduction in Average Monthly Premiums from Advance Premium Tax Credits (APTC), for States Using the HealthCare.gov Eligibility and Enrollment Platform

All Plan Selections (November 1 through December 26, 2015)						
State	**Total Consumers With 2016 Marketplace Plan Selections**	**Percent of Plan Selections with APTC**	**Average Monthly Premium before APTC (1)**	**Average Monthly APTC (1)**	**Average Monthly Premium After APTC (1)**	**Average Percent Reduction in Premium after APTC (1)**
All HealthCare.gov States	***8.52 million***	***83%***	***$408***	***$294***	***$113***	***72%***
Alabama	174,708	87%	$419	$312	$107	75%
Alaska	21,682	83%	$871	$738	$133	85%
Arizona	169,110	73%	$336	$210	$126	62%
Arkansas	65,451	86%	$419	$292	$127	70%
Delaware	26,370	80%	$487	$333	$155	68%
Florida	1,556,561	89%	$396	$307	$89	77%
Georgia	511,826	85%	$397	$291	$106	73%
Hawaii	11,157	82%	$401	$274	$126	68%
Illinois	346,869	74%	$400	$236	$164	59%
Indiana	181,995	80%	$428	$264	$165	62%
Iowa	49,428	84%	$434	$309	$126	71%
Kansas	86,411	81%	$361	$250	$111	69%
Louisiana	185,215	86%	$461	$367	$94	80%
Maine	78,076	85%	$432	$325	$107	75%
Michigan	323,430	82%	$392	$243	$149	62%
Mississippi	93,999	88%	$404	$302	$102	75%
Missouri	257,228	85%	$417	$318	$100	76%
Montana	55,519	80%	$427	$310	$117	73%
Nebraska	78,927	87%	$406	$298	$108	73%
Nevada	75,367	86%	$382	$271	$111	71%
New Hampshire	50,737	64%	$405	$245	$159	61%
New Jersey	258,993	78%	$499	$328	$172	66%
New Mexico	46,816	67%	$344	$208	$136	61%
North Carolina	553,729	88%	$507	$403	$104	79%
North Dakota	19,729	84%	$410	$266	$144	65%
Ohio	224,139	79%	$417	$244	$173	59%

Oklahoma	128,758	82%	$385	$301	$84	78%
Oregon	132,393	70%	$402	$256	$146	64%
Pennsylvania	408,147	75%	$404	$254	$150	63%
South Carolina	194,982	88%	$416	$313	$102	75%
South Dakota	22,697	87%	$423	$310	$114	73%
Tennessee	232,623	83%	$412	$301	$112	73%
Texas	1,096,868	82%	$358	$262	$96	73%
Utah	148,814	85%	$276	$189	$87	68%
Virginia	384,147	80%	$372	$276	$96	74%
West Virginia	34,450	83%	$552	$391	$161	71%
Wisconsin	216,877	83%	$468	$336	$132	72%
Wyoming	20,707	89%	$578	$459	$119	79%

Notes: Some numbers may not add to total due to rounding. (1) Estimates are based on consumers who qualify for APTC. For purposes of this analysis, an individual qualifying for APTC was defined as any policy with APTC greater than $0. Additional individuals may qualify for APTC but may not elect to receive it in advance.

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

Appendix Table A5: Availability and Selection of Plans with Monthly Premiums of $100 or Less after the Advance Premium Tax Credit (APTC), for States Using the HealthCare.gov Eligibility and Enrollment Platform

All Plan Selections (November 1 through December 26, 2015)							
State	Total Consumers With 2016 Marketplace Plan Selections	Percent Who Could Have Selected a Plan with a Monthly Premium of			Percent Who Selected or Were Automatically Reenrolled in a Plan With a Monthly Premium of		
		$50 or Less after APTC	$75 or Less after APTC	$100 or Less after APTC	$50 or Less after APTC	$75 or Less after APTC	$100 or Less after APTC
All HealthCare.gov states	***8.52 million***	***59%***	***66%***	***72%***	***27%***	***39%***	***48%***
Alabama	174,708	63%	70%	74%	30%	42%	52%
Alaska	21,682	59%	64%	68%	30%	38%	45%
Arizona	169,110	49%	57%	68%	17%	29%	39%
Arkansas	65,451	51%	61%	68%	14%	28%	42%
Delaware	26,370	52%	60%	65%	13%	22%	32%
Florida	1,556,561	71%	76%	80%	42%	54%	63%
Georgia	511,826	63%	69%	74%	27%	40%	51%
Hawaii	11,157	57%	62%	70%	28%	35%	43%
Illinois	346,869	42%	51%	60%	10%	17%	25%
Indiana	181,995	45%	54%	61%	10%	19%	28%
Iowa	49,428	54%	62%	69%	20%	31%	41%
Kansas	86,411	53%	61%	67%	26%	37%	47%
Louisiana	185,215	74%	78%	80%	40%	49%	56%
Maine	78,076	52%	60%	67%	29%	41%	51%
Michigan	323,430	54%	62%	71%	14%	24%	34%
Mississippi	93,999	66%	73%	77%	28%	44%	56%
Missouri	257,228	64%	70%	74%	32%	44%	54%
Montana	55,519	52%	59%	65%	21%	33%	43%
Nebraska	78,927	59%	68%	74%	27%	40%	51%
Nevada	75,367	57%	67%	73%	22%	37%	50%
New Hampshire	50,737	37%	44%	56%	9%	15%	24%
New Jersey	258,993	40%	49%	55%	11%	19%	28%
New Mexico	46,816	38%	49%	58%	13%	22%	32%
North Carolina	553,729	69%	74%	78%	34%	45%	54%

All Plan Selections (November 1 through December 26, 2015)							
State	**Total Consumers With 2016 Marketplace Plan Selections**	**Percent Who Could Have Selected a Plan with a Monthly Premium of**			**Percent Who Selected or Were Automatically Reenrolled in a Plan With a Monthly Premium of**		
		$50 or Less after APTC	**$75 or Less after APTC**	**$100 or Less after APTC**	**$50 or Less after APTC**	**$75 or Less after APTC**	**$100 or Less after APTC**
North Dakota	19,729	49%	59%	67%	16%	26%	36%
Ohio	224,139	41%	51%	60%	9%	17%	26%
Oklahoma	128,758	69%	74%	79%	38%	48%	57%
Oregon	132,393	39%	46%	56%	12%	20%	29%
Pennsylvania	408,147	44%	51%	59%	12%	22%	32%
South Carolina	194,982	50%	60%	67%	34%	45%	55%
South Dakota	22,697	57%	66%	73%	25%	36%	47%
Tennessee	232,623	65%	71%	75%	27%	38%	47%
Texas	1,096,868	64%	70%	76%	31%	42%	53%
Utah	148,814	60%	70%	79%	32%	46%	58%
Virginia	384,147	60%	66%	71%	32%	43%	52%
West Virginia	34,450	49%	57%	63%	12%	23%	33%
Wisconsin	216,877	55%	62%	68%	23%	32%	41%
Wyoming	20,707	50%	58%	66%	27%	38%	47%

Source: ASPE computation of CMS data for the 38 states using the HealthCare.gov eligibility and enrollment platform.

National Health Interview Survey
Early Release Program

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2015

by Michael E. Martinez, M.P.H., M.H.S.A, Robin A. Cohen, Ph.D., and Emily P. Zammitti, M.P.H.,
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What's New?

- This report includes 2015 estimates for 37 selected states.

Highlights

- The number of uninsured persons has declined in the past 2 years. In the first 9 months of 2015, 28.8 million persons of all ages (9.1%) were uninsured at the time of interview—7.2 million fewer persons than in 2014 and 16.0 million fewer than in 2013.
- Among adults aged 18–64, the percentage uninsured decreased from 16.3% in 2014 to 12.9% in the first 9 months of 2015. A corresponding increase was seen in the percentage with private coverage, from 67.3% to 70.0%, respectively. In 2013, among adults aged 18–64, 20.4% were uninsured and 64.2% had private coverage.
- Among children under age 18 years, the percentage with private coverage increased from 52.6% in 2013 to 55.1% in the first 9 months of 2015.
- Among those under age 65, the percentage with private coverage through the Health Insurance Marketplace or state-based exchanges increased from 2.5% (6.7 million) in the fourth quarter of 2014 to 4.2% (11.3 million) in the third quarter of 2015 (July–September).

Introduction

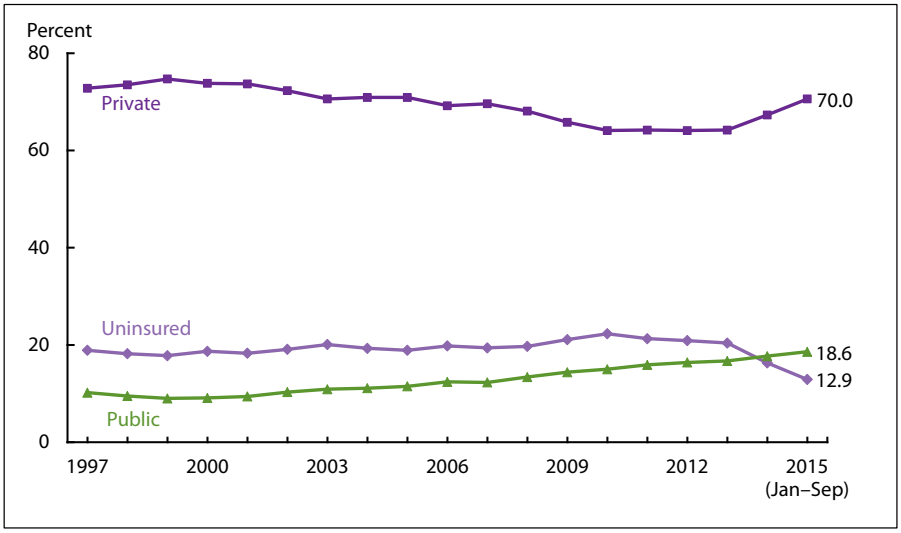
This report from the National Center for Health Statistics (NCHS) presents selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–September 2015 National Health Interview Survey (NHIS), along with comparable estimates from the 2010–2014 NHIS. Estimates for 2015 are based on data for 79,847 persons.

Three estimates of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. Estimates of public and private coverage, coverage through exchanges, and enrollment in high-deductible health plans (HDHPs) and consumer-directed health plans (CDHPs) are also presented. Detailed tables show estimates by selected demographics. Definitions are provided in the Technical Notes at the end of this report.

This report is updated quarterly and is part of the NHIS Early Release (ER) Program, which releases updated selected estimates that are available from the NHIS website at http://www.cdc.gov/nchs/nhis.htm.

Estimates for each calendar quarter, by selected demographics, are also available as a separate set of tables

Figure 1. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview: United States, 1997–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 1997–2015, Family Core component.

through the ER Program. For more information about NHIS and the ER Program, see the Technical Notes and the Additional Early Release Program Products sections at the end of this report.

Results

From January through September 2015, the percentage of persons uninsured at the time of interview was 9.1% (28.8 million), a decrease of 2.4 percentage points from the 2014 uninsured rate of 11.5% (36.0 million). More than 7 million fewer persons lacked health insurance coverage in the first 9 months of 2015 compared with 2014.

Long-term trends

In the first 9 months of 2015 among adults aged 18–64, 12.9% were uninsured at the time of interview, 18.6% had public coverage, and 70.0% had private health insurance coverage (Figure 1). From 1997 through 2010, the percentage of adults aged 18–64 who were uninsured at the time of interview generally increased. More recently, the percentage of uninsured decreased from 22.3% in 2010 to 12.9% in the first 9 months of 2015. During this 5-year period, corresponding increases were seen in both public and private coverage among adults aged 18–64.

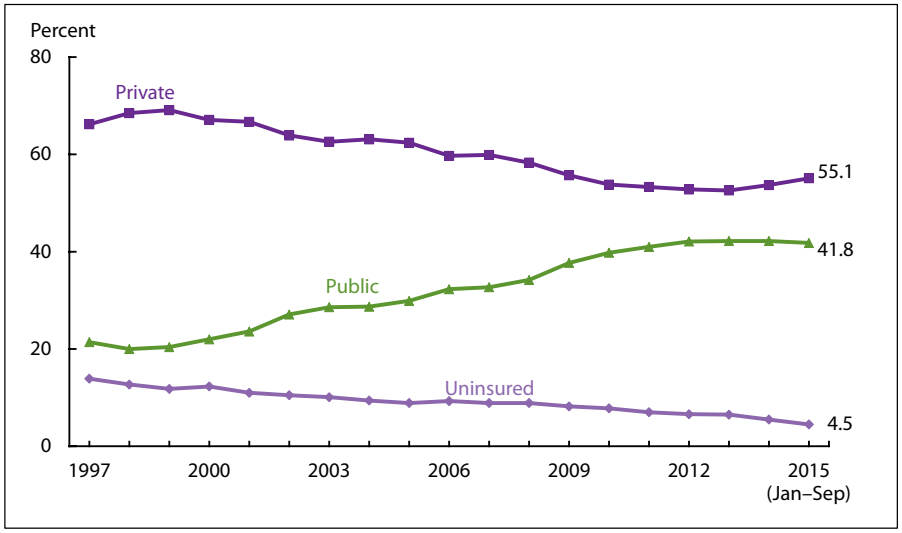
In the first 9 months of 2015 among children aged 0–17 years, 4.5% were uninsured, 41.8% had public coverage, and 55.1% had private coverage (Figure 2). The percentage of children who were uninsured decreased from 13.9% in 1997 to 4.5% in the first 9 months of 2015. From 1997 through 2010, the percentage of children with private coverage generally decreased and the percentage of children with public coverage generally increased. However, more recently, the percentage of children with public coverage has leveled off, and the percentage of children with private coverage has increased from 52.6% in 2013 to 55.1% in the first 9 months of 2015.

Short-term trends by age

In the first 9 months of 2015, adults aged 25–34 were more than twice as likely as adults aged 45–64 to lack health insurance coverage (17.9% compared with 8.9%) (Figure 3). Adults aged 18–24 and those aged 35–44 had similar rates of uninsurance, 14.5% and 14.7%, respectively.

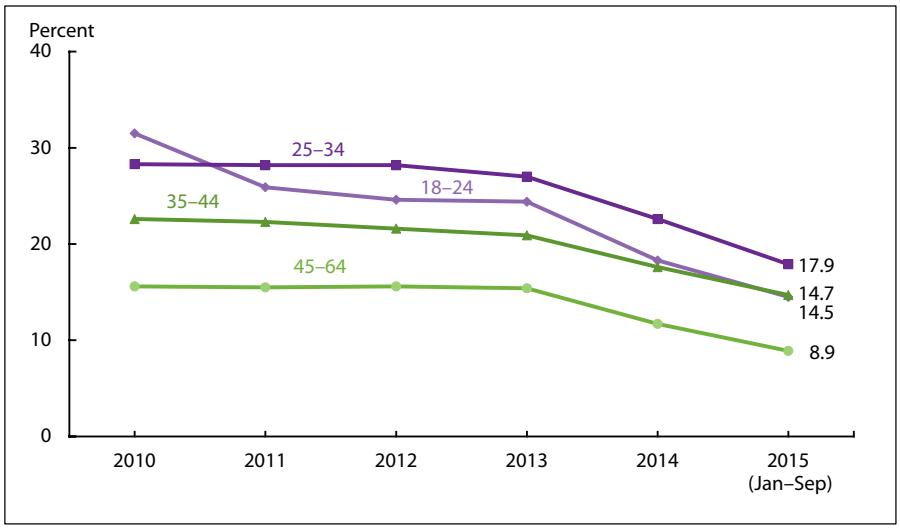
For all age groups shown in Figure 3, with the exception of adults aged 18–24, the rates of uninsurance at the time of interview remained relatively stable from 2010 through 2013. Among adults aged 18–24, the percentage uninsured decreased from 31.5% in 2010 to 25.9% in 2011 and then remained stable through 2013. For all age groups, from 2013 through the first 9 months of 2015, the percentage uninsured decreased significantly. The magnitude of the decreases ranged from 6.2 percentage points for adults aged 35–44 to 9.9 percentage points for adults aged 18–24.

Figure 2. Percentage of children aged 0–17 years who were uninsured or had private or public coverage at the time of interview: United States, 1997–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 1997–2015, Family Core component.

Figure 3. Percentage of adults aged 18–64 who were uninsured at the time of interview, by age group: United States, 2010–September 2015



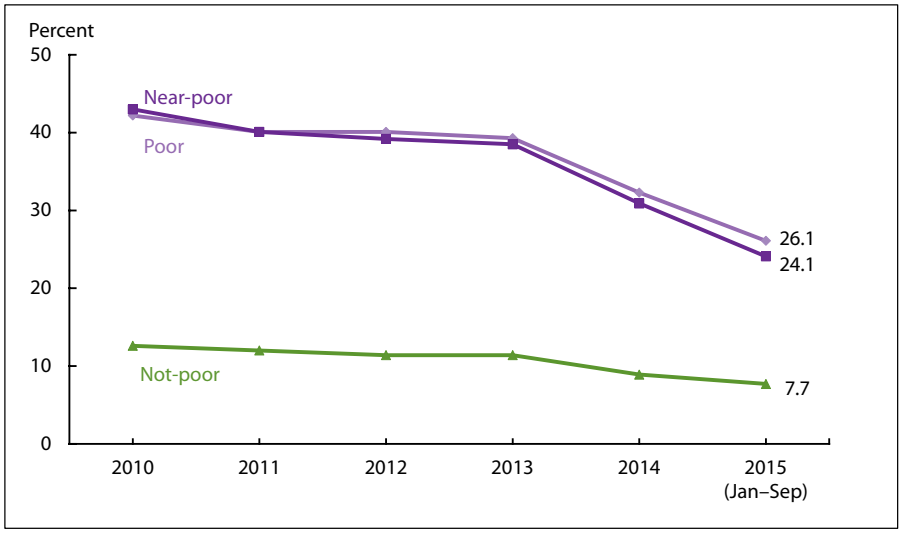
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Short-term trends by poverty status

In the first 9 months of 2015 among adults aged 18–64, 26.1% of poor, 24.1% of near-poor, and 7.7% of those who were not-poor lacked health insurance coverage at the time of interview (Figure 4). A decrease was noted in the percentage of uninsured adults from 2010 through the first 9 months of 2015 among all three poverty groups; however, the greatest decreases in the uninsured rate since 2013 were among adults who were poor or near-poor.

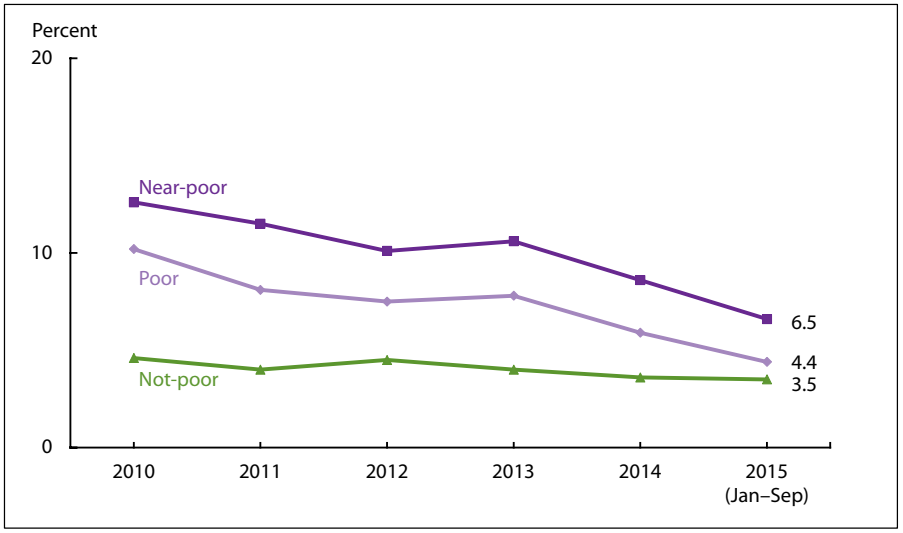
In the first 9 months of 2015 among children aged 0–17 years, 4.4% of poor, 6.5% of near-poor, and 3.5% of not-poor children lacked health insurance coverage at the time of interview (Figure 5). A decrease in the percentage of uninsured was observed for poor, near-poor, and not-poor children from 2010 through the first 9 months of 2015.

Figure 4. Percentage of adults aged 18–64 who were uninsured at the time of interview, by poverty status: United States, 2010–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Figure 5. Percentage of children aged 0–17 years who were uninsured at the time of interview, by poverty status: United States, 2010–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

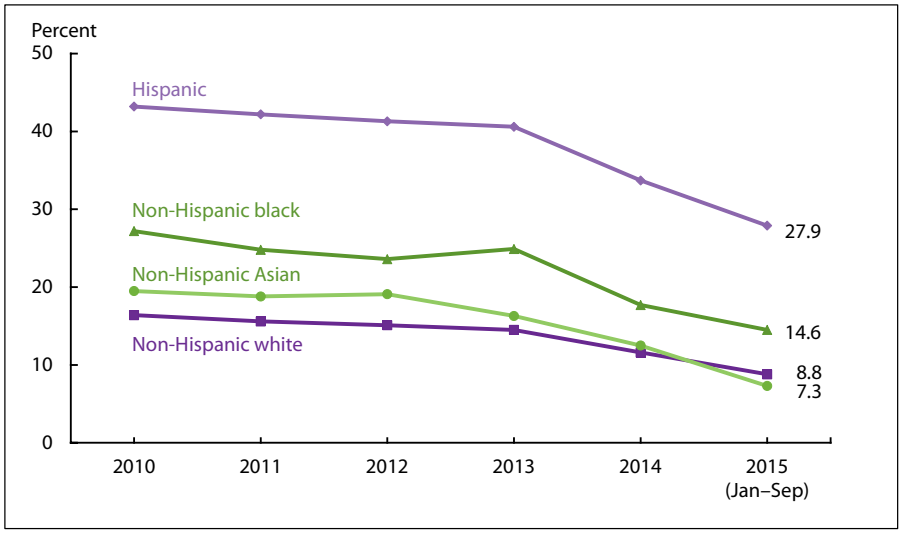
Short-term trends by race and ethnicity

In the first 9 months of 2015, 27.9% of Hispanic, 14.6% of non-Hispanic black, 8.8% of non-Hispanic white, and 7.3% of non-Hispanic Asian adults aged 18–64 lacked health insurance coverage at the time of interview (Figure 6). Significant decreases in the percentage of uninsured adults were observed between 2013 and the first 9 months of 2015 for Hispanic, non-Hispanic black, non-Hispanic white, and non-Hispanic Asian adults. Hispanic adults had the greatest percentage point decrease in the uninsured rate between 2013 (40.6%) and the first 9 months of 2015 (27.9%).

Periods of noncoverage

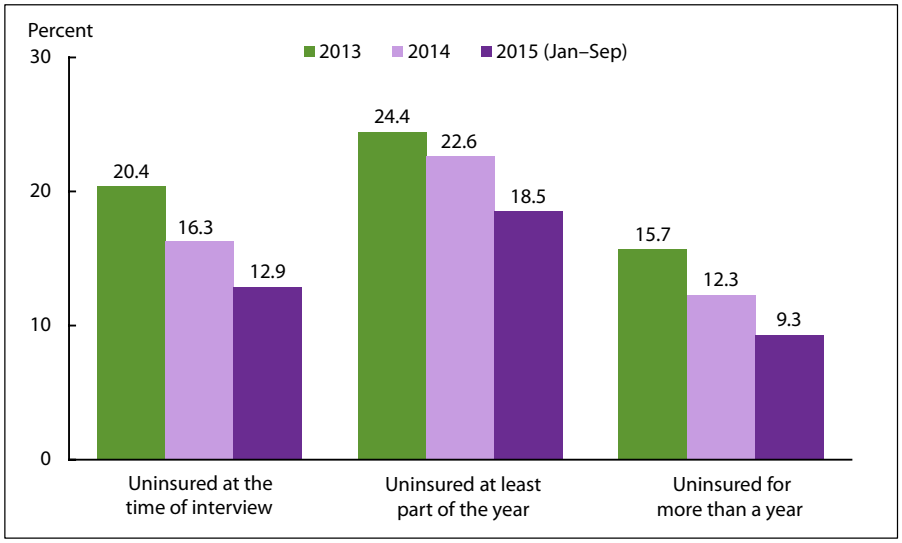
Among adults aged 18–64, the percentage who were uninsured at the time of interview decreased from 20.4% (39.6 million) in 2013 to 12.9% (25.3 million) in the first 9 months of 2015 (Figure 7). The percentage of adults who were uninsured for at least part of the past year decreased from 24.4% (47.4 million) in 2013 to 18.5% (36.2 million) in the first 9 months of 2015. The percentage of adults who were uninsured for more than a year decreased from 15.7% (30.5 million) in 2013 to 9.3% (18.1 million) in the first 9 months of 2015.

Figure 6. Percentage of adults aged 18–64 who were uninsured at the time of interview, by race and ethnicity: United States, 2010–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Figure 7. Percentage of adults aged 18–64 without health insurance, by time period: United States, 2013–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2013–2015, Family Core component.

Private exchange coverage

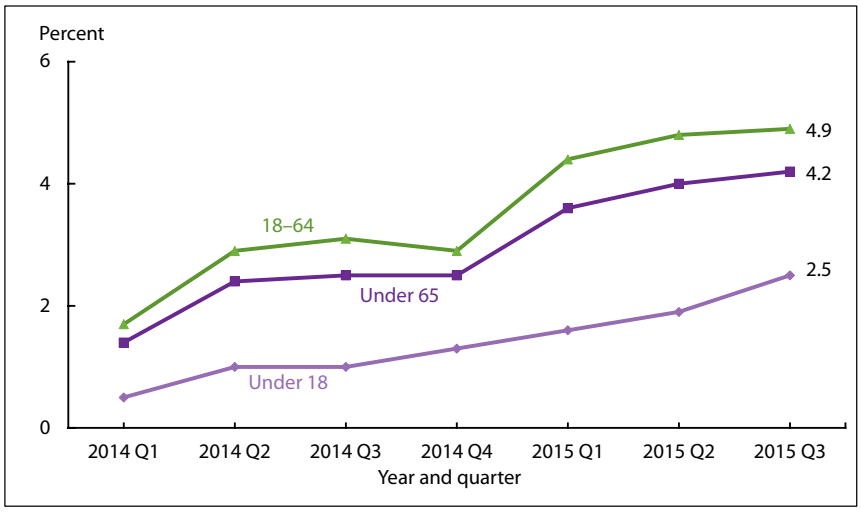
Among persons under age 65, 65.9% (177.5 million) were covered by private health insurance plans at the time of interview from January through September 2015. This includes 3.9% (10.6 million) covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. A significant increase was noted in the percentage of persons under age 65 covered by plans obtained through the Health Insurance Marketplace or state-based exchanges, from 2.5% (6.7 million) in the fourth quarter of 2014 (October through December) to 4.2% (11.3 million) in the third quarter of 2015 (July through September) (Figure 8).

Among adults aged 18–64, 70.0% (137.1 million) were covered by private health insurance plans at the time of interview from January through September 2015. This includes 4.7% (9.1 million) covered by private health insurance plans obtained through the Health Insurance Marketplace or state-based exchanges. A significant increase was noted in the percentage of adults aged 18–64 covered by plans obtained through the Health Insurance Marketplace or state-based exchanges, from 2.9% (5.7 million) in October–December 2014 to 4.9% (9.5 million) in July–September 2015 (Figure 8).

Health insurance coverage by state Medicaid expansion status

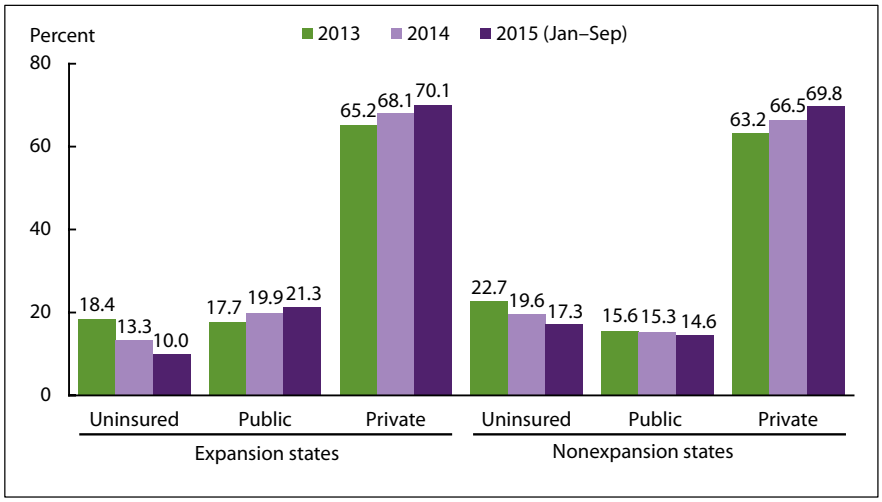
Under provisions of the Affordable Care Act (ACA) of 2010, states have the option to expand Medicaid coverage to those with low income. In the first 9 months of 2015, adults aged 18–64 residing in Medicaid expansion states were less likely to be uninsured than those residing in nonexpansion states (Figure 9). In Medicaid expansion states, the percentage of those uninsured decreased from 18.4% in 2013 to 10.0% in the first 9 months of 2015. In nonexpansion states, the percentage uninsured decreased from 22.7% in 2013 to 17.3% in the first 9 months of 2015.

Figure 8. Percentage of persons under age 65 with private health insurance obtained through the Health Insurance Marketplace or state-based exchanges, by age group and quarter: United States, January 2014–September 2015



NOTES: Data include persons who have purchased a private health insurance plan through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). All persons who have exchange-based coverage are considered to have private health insurance. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2014 and 2015, Family Core component.

Figure 9. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview, by year and state Medicaid expansion status: United States, 2013–September 2015



NOTES: For 2013 and 2014, there were 26 Medicaid expansion states, and for 2015, there were 29 Medicaid expansion states. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2013–2015, Family Core component.

Health insurance coverage by state Health Insurance Marketplace type

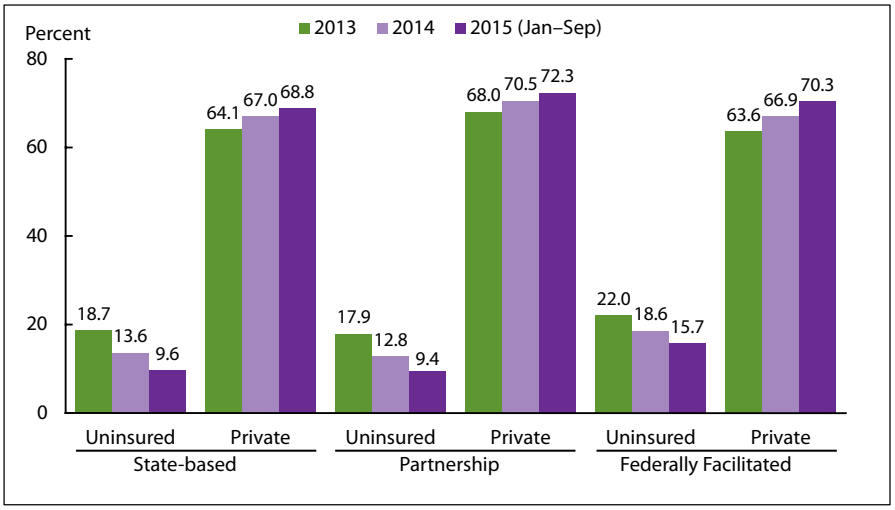
Under provisions of ACA, states have the option to set up and operate their own Health Insurance Marketplace, rely on a Federally Facilitated Marketplace operated solely by the federal government, or have a hybrid partnership Marketplace that is operated by the federal government but within which the state runs certain functions and makes key decisions. In the first 9 months of 2015, adults aged 18–64 in states with a Federally Facilitated Marketplace were more likely to be uninsured than those in states with a state-based Marketplace or states with a partnership Marketplace (Figure 10). In the first 9 months of 2015, adults aged 18–64 in states with a partnership Marketplace were more likely to have private coverage than those in states with a state-based Marketplace.

Among adults aged 18–64, decreases were seen in the uninsured rates between 2013 and the first 9 months of 2015 in states with a state-based Marketplace, a partnership Marketplace, and a Federally Facilitated Marketplace.

Estimates of enrollment in HDHPs and CDHPs

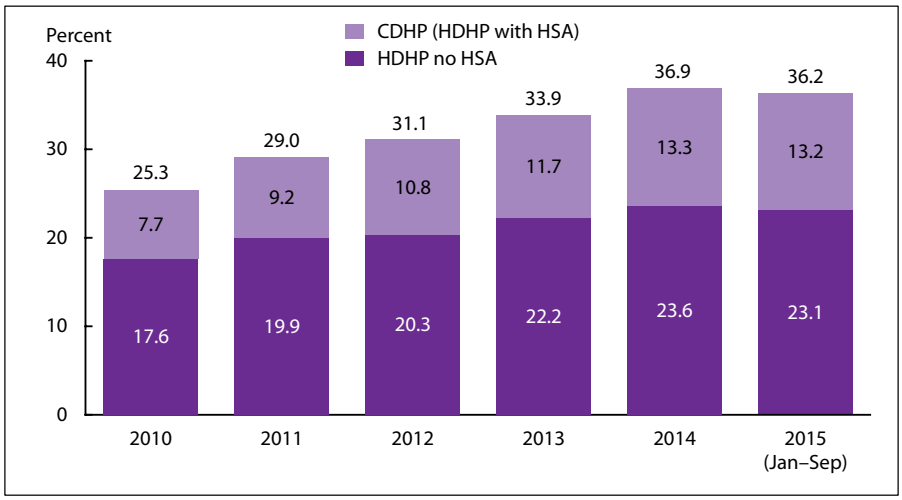
In the first 9 months of 2015, 36.2% of persons under age 65 with private health insurance were enrolled in an HDHP, including 13.2% who were enrolled in a CDHP (an HDHP with a health savings account [HSA]) and 23.1% who were enrolled in an HDHP without an HSA (Figure 11). (See Technical Notes for definitions of HDHP, CDHP, and HSA.) Among those with private insurance, enrollment in an HDHP has generally increased since 2010. However, the percentage who were enrolled in an HDHP did not change significantly between 2014 (36.9%) and the first 9 months of 2015 (36.2%).

Figure 10. Percentage of adults aged 18–64 who were uninsured or had private coverage at the time of interview, by year and state Health Insurance Marketplace type: United States, 2013–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2013–2015, Family Core component.

Figure 11. Percentage of persons under age 65 enrolled in a high-deductible health plan without a health savings account, or in a consumer-directed health plan, among those with private health insurance: United States, 2010–September 2015

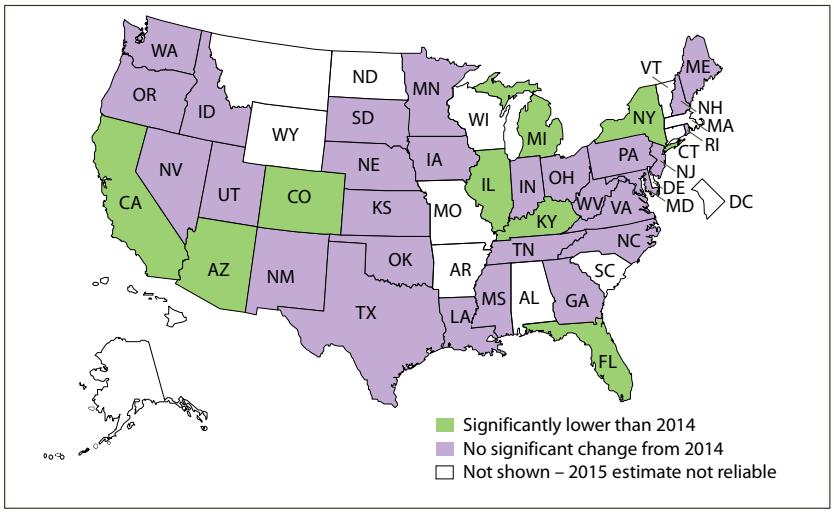


NOTES: CDHP is consumer-directed health plan, which is a high-deductible health plan (HDHP) with a health savings account (HSA). HDHP no HSA is a high-deductible health plan without an HSA. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Health insurance coverage in selected states

For the first 9 months of 2015, state-specific health insurance estimates are presented for 37 states for persons aged 18–64 (Figure 12). Among the 37 states presented for the first 9 months of 2015, Arizona, California, Colorado, Florida, Illinois, Kentucky, Michigan, and New York had a statistically significant lower percentage uninsured than in 2014. Several other states, such as Georgia, Idaho, Indiana, Louisiana, Mississippi, New Hampshire, New Mexico, North Carolina, Oklahoma, and Rhode Island, had declines of similar magnitude in the percentage of uninsured over this time period; however, these declines were not statistically significant.

Figure 12. Change in the percentage of adults aged 18–64 who were uninsured at the time of interview from 2014 to the first 9 months of 2015: United States, 2014–September 2015



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2014-2015, Family Core component.

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Technical Notes

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–September 2015 National Health Interview Survey (NHIS), along with comparable estimates from the 2010–2014 NHIS.

To reflect different policy-relevant perspectives, three measures of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which also includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. The three time frames are defined as:

- *Uninsured at the time of interview* provides an estimate of persons who at the given time may have experienced barriers to obtaining needed health care.
- *Uninsured at any time in the year prior to interview* provides an annual caseload of persons who may experience barriers to obtaining needed health care. This measure includes persons who have insurance at the time of interview but who had a period of noncoverage in the year prior to interview, as well as those who are currently uninsured and who may have been uninsured for a long period of time.
- *Uninsured for more than a year* provides an estimate of those with a persistent lack of coverage who may be at high risk of not obtaining preventive services or care for illness and injury.

These three measures are not mutually exclusive, and a given individual may be counted in more than one of the measures. Estimates of enrollment in public and private coverage are also provided.

This report also includes estimates for three types of consumer-directed private health care. Consumer-directed health care may enable individuals to have more control over when and how they access care, what types of care they use, and how much they spend on health care services. National attention to consumer-directed health care increased following enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108–173), which established tax-advantaged health savings accounts (HSAs) (1). In 2007, three new questions were added to the health insurance section of NHIS to monitor enrollment in consumer-directed health care among persons with private health insurance. Estimates are provided for enrollment in high-deductible health plans (HDHPs), plans with high deductibles coupled with HSAs (i.e., consumer-directed health plans or CDHPs), and being in a family with a flexible spending account (FSA) for medical expenses not otherwise covered. For a more complete description of consumer-directed health care, see "Definitions of selected terms" below.

The 2015 health insurance estimates are being released prior to final data editing and final weighting, to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. However, preliminary estimates of persons without health insurance coverage are generally 0.1–0.3 percentage points lower than the final estimates due to the editing procedures used for the final data files.

Estimates for 2015 are stratified by age group, sex, race and ethnicity, poverty status, marital status, employment status, region, and educational attainment.

Data source

NHIS is a multistage probability sample survey of the civilian noninstitutionalized population of the United States and is the source of data for this report. The survey is conducted continuously throughout the year by NCHS through an agreement with the U.S. Census Bureau.

NHIS is a comprehensive health survey that can be used to relate health insurance coverage to health outcomes and health care utilization. It has a low item nonresponse rate (about 1%) for the health insurance questions. Because NHIS is conducted throughout the year—yielding a nationally representative sample each month—data can be analyzed monthly or quarterly to monitor health insurance coverage trends.

The fundamental structure of the current NHIS oversamples Hispanic, black, and Asian populations. Visit the NCHS website at http://www.cdc.gov/nchs/nhis.htm for more information on the design, content, and use of NHIS.

The data for this report are derived from the Family Core component of the 2010–2015 NHIS, which collects information on all family members in each household. Data analyses for the January–September 2015 NHIS were based on 79,847 persons in the Family Core.

Data on health insurance status were edited using an automated system based on logic checks and keyword searches. Information from follow-up questions, such as plan name(s), were used to reassign insurance status and type of coverage to avoid misclassification. For comparability, the estimates for all years were created using these same procedures. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year).

Estimation procedures

NCHS creates survey weights for each calendar quarter of the NHIS sample. The NHIS data weighting procedure is described in more detail at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_165.pdf. Estimates were calculated using NHIS survey weights, which are calibrated to census totals for sex, age, and race and ethnicity of the U.S. civilian noninstitutionalized population. Weights for 2010–2011 were derived from 2000 census-based population estimates. Beginning with 2012 NHIS data, weights were derived from 2010 census-based population estimates.

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account

for the complex sample design of NHIS, taking into account stratum and primary sampling unit (PSU) identifiers. The Taylor series linearization method was chosen for variance estimation.

Trends in coverage were generally assessed using Joinpoint regression (2), which characterizes trends as joined linear segments. A Joinpoint is the year where two segments with different slopes meet. Joinpoint software uses statistical criteria to determine the fewest number of segments necessary to characterize a trend and the year(s) when segments begin and end. Trends from 2010 to 2015 were also evaluated using logistic regression analysis.

State-specific health insurance estimates are presented for 37 states for persons of all ages, persons under age 65, and adults aged 18–64. State-specific estimates are presented for 21 states for children aged 0–17 years. Estimates are not presented for all 50 states and the District of Columbia due to considerations of sample size and precision. States with fewer than 1,000 interviews for persons of all ages are excluded. In addition, estimates for children in states that did not have at least 300 children with completed interviews are not presented.

For the 10 states with the largest populations (California, Florida, Georgia, Illinois, Michigan, New York, North Carolina, Ohio, Pennsylvania, and Texas), standard errors (SEs) were calculated using SUDAAN. Because of small sample size and limitations of the NHIS design, similarly estimated SEs for other states could be statistically unstable or negatively biased; consequently, for states other than the largest 10 states, an estimated design effect was used to calculate SEs. For this report, the design effect, *deff*, of a percentage is the ratio of the sampling variance of the percentage (taking into account the complex NHIS sample design) to the sampling variance of the percentage from a simple random sample (SRS) based on the same observed number of persons.

Therefore, for each health insurance measure and domain, SEs for smaller states were calculated by multiplying the SRS SE by *A*, where *A* is the average value of the square root of *deff* over the 10 most populous states. Values of A ranged from 1.51 for children who were uninsured to 2.38 for persons of all ages and persons under 65 with private coverage.

Unless otherwise noted, all estimates shown meet the NCHS standard of having less than or equal to 30% relative standard error (RSE). Differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. All differences discussed are significant unless otherwise noted. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

Definitions of selected terms

Private health insurance coverage—Includes persons who had any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care.

Public health plan coverage—Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

Uninsured—A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

Directly purchased coverage—Private insurance that was originally obtained through direct purchase or other means not related to employment.

Employment-based coverage—Private insurance that was originally obtained through a present or former employer or union or a professional association.

Exchange-based coverage—A private health insurance plan purchased through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act (ACA) of 2010 (P.L. 111–148, P.L. 111–152). In response to the ACA, several new questions were added to NHIS to capture health care plans obtained through exchange-based coverage.

In general, if a family member is reported to have coverage through the exchange, that report is considered accurate unless there is other information (e.g., plan name or information about premiums) that clearly contradicts that report. Similarly, if a family member is not reported to have coverage through the exchange, that report is considered accurate unless there is other information that clearly contradicts that report. For a more complete discussion of the procedures used in classifying exchange-based coverage, see http://www.cdc.gov/nchs/nhis/insurance.htm.

Based on these classification procedures, an average of 3.9% (SE 0.15) of persons under age 65, 4.7% (SE 0.17) of adults aged 18–64, 2.0% (SE 0.19) of children under age 18, and 3.6% (SE 0.25) of adults aged 19–25 had exchange-based private health insurance coverage in the first 9 months of 2015. This equates to 10.6 million persons under age 65 and 9.1 million adults aged 18–64, 1.5 million children, and 1.0 million adults aged 19–25. If these procedures had not been used and reports of coverage through the exchanges (or lack thereof) had been taken at face value, the estimate would have been higher. For example, an average of 4.9% (13.4 million) of persons under age 65 would have been reported to have obtained their coverage through exchanges in the first three quarters of 2015.

High-deductible health plan (HDHP)—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. HDHP was defined in 2015 as a private health plan

with an annual deductible of at least $1,300 for self-only coverage or $2,600 for family coverage. The deductible is adjusted annually for inflation. For 2013 and 2014, the annual deductible for self-only coverage was $1,250 and for family coverage was $2,500. For 2010 through 2012, the annual deductible for self-only coverage was $1,200 and for family coverage was $2,400.

Consumer-directed health plan (CDHP)—Defined as an HDHP with a special account to pay for medical expenses. Unspent funds are carried over to subsequent years. For plans considered to be HDHPs, a follow-up question was asked regarding these special accounts. A person is considered to have a CDHP if there is a "yes" response to the following question: *With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.*

Health savings account (HSA)—A tax-advantaged account or fund that can be used to pay medical expenses. It must be coupled with an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike FSAs, HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual. Funds may be used to pay qualified medical expenses at any time without federal tax liability. HSAs may also be referred to as Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and the term "HSA" in this report includes accounts that use these alternative names.

Flexible spending account (FSA) for medical expenses—A person is considered to be in a family with an FSA if there is a "yes" response to the following question*: [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pretax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.*

The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive; a person may be counted in more than one measure.

Medicaid expansion status—Under provisions of ACA, states have the option to expand Medicaid eligibility to cover adults who have income up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of October 31, 2013, 26 states and the District of Columbia were moving forward with Medicaid expansion. As of January 1, 2015, 29 states and the District of Columbia were moving forward with Medicaid expansion.

Health Insurance Marketplace—A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on cost, benefits, and other important features; choose a plan; and enroll in coverage. The marketplace also provides information on programs that help people with low-to-moderate income and resources pay for coverage. There are three types of Health Insurance Marketplaces: (a) a state-based Marketplace set up and operated solely by the state; (b) a hybrid partnership Marketplace in which the state runs certain functions, makes key decisions, and may tailor the marketplace to local needs and market conditions, but which is operated by the federal government; and (c) the Federally Facilitated Marketplace operated solely by the federal government.

Education—The categories of education are based on the years of school completed or highest degree obtained for persons aged 18 and over.

Employment—Employment status is assessed at the time of interview and is obtained for persons aged 18 and over. In this release, it is presented only for persons aged 18–64.

Hispanic or Latino origin and race—Hispanic or Latino origin and race are two separate and distinct categories. Persons of Hispanic or Latino origin may be of any race or combination of races. Hispanic or Latino origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. Race is based on the family respondent's description of his or her own racial background, as well as the racial background of other family members. More than one race may be reported for a person. For conciseness, the text, tables, and figures in this report use shorter versions of the 1997 Office of Management and Budget (OMB) terms for race and Hispanic or Latino origin. For example, the category "Not Hispanic or Latino, black or African American, single race" is referred to as "non-Hispanic black, single race" in the text, tables, and figures. Estimates for non-Hispanic persons of races other than white only, black only, and Asian only, or of multiple races, are combined into the "Other races and multiple races" category.

Poverty status—Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children) as defined by the U.S. Census Bureau for that year (3–8). Persons categorized as "Poor" have a ratio less than 1.0 (i.e., their family income is below the poverty threshold); "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes that are 200% of the poverty threshold or greater. The remaining group of respondents is coded as "Unknown" with respect to poverty status. The percentage of respondents with unknown poverty status (12.2% in 2010, 11.5% in 2011, 11.4% in 2012, 10.2% in 2013, 8.8% in 2014, and 8.7% in the first three quarters of 2015) is disaggregated by age and insurance status in Tables IV, V, and VI.

For more information on unknown income and unknown poverty status, see the NHIS Survey Description document for 2010–2014 (available from: http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm).

NCHS imputes income for approximately 30% of NHIS records. The imputed income files are released a few months after the annual release of NHIS microdata and are not available for the

ER updates. Therefore, ER health insurance estimates stratified by poverty status are based on reported income only and may differ from similar estimates produced later (e.g., in *Health, United States* [9]) that are based on both reported and imputed income.

Region—In the geographic classification of the U.S. population, states are grouped into the following four regions used by the U.S. Census Bureau:

Region	*States included*
Northeast	Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, and Pennsylvania
Midwest	Ohio, Illinois, Indiana, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Kansas, and Nebraska
South	Delaware, Maryland, District of Columbia, West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Oklahoma, Arkansas, and Texas
West	Washington, Oregon, California, Nevada, New Mexico, Arizona, Idaho, Utah, Colorado, Montana, Wyoming, Alaska, and Hawaii

Expanded regions—Based on a subdivision of the four regions into nine divisions. For this report, the nine Census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (10).

Additional Early Release Program Products

Two additional periodical reports are published through the NHIS ER Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* (11) is published quarterly and provides estimates of 15 selected measures of health, including insurance coverage. Other measures of health include estimates of having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

Wireless Substitution: Early Release of Estimates From the National Health Interview Survey (12) is published semi-annually and provides selected estimates of telephone coverage in the United States.

Other ER reports and tabulations on special topics are released on an as-needed basis; see http://www.cdc.gov/nchs/nhis/releases.htm.

In addition to these reports, preliminary microdata files containing selected NHIS variables are produced as part of the ER Program. For each data collection year (January through December), these variables are made available four times approximately 5–6 months following the completion of data collection. NHIS data users can analyze these files through the NCHS Research Data Centers (http://www.cdc.gov/rdc/) without having to wait for the final annual NHIS microdata files to be released.

New measures and products may be added as work continues and in response to changing data needs. Feedback on these releases is welcome (nhislist@cdc.gov).

Announcements about ERs, other new data releases, and publications, as well as corrections related to NHIS, will be sent to members of the HISUSERS electronic mailing list. To join, visit the CDC website at: http://www.cdc.gov/nchs/products/nchs_listservs.htm and click on the "National Health Interview Survey (NHIS) researchers" button and follow the directions on the page.

Suggested Citation

Martinez ME, Cohen RA, Zammitti EP. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–September 2015. National Center for Health Statistics. February 2016. Available from: http://www.cdc.gov/nchs/nhis/releases.htm.

Table I. Percentages (and standard errors) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and year: United States, 2010–September 2015

Age group and year	Uninsured[1] at the time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than a year[2]
All ages			
2010	16.0 (0.27)	19.8 (0.29)	11.7 (0.22)
2011	15.1 (0.25)	19.2 (0.29)	11.2 (0.21)
2012	14.7 (0.23)	18.6 (0.27)	11.1 (0.22)
2013	14.4 (0.26)	17.8 (0.27)	10.7 (0.23)
2014	11.5 (0.23)	16.5 (0.25)	8.4 (0.19)
2015 (Jan–Sep)	9.1 (0.21)	13.5 (0.27)	6.3 (0.17)
Under 65 years			
2010	18.2 (0.30)	22.5 (0.33)	13.3 (0.24)
2011	17.3 (0.29)	21.8 (0.33)	12.7 (0.25)
2012	16.9 (0.27)	21.3 (0.31)	12.7 (0.24)
2013	16.6 (0.30)	20.4 (0.32)	12.4 (0.27)
2014	13.3 (0.26)	19.0 (0.29)	9.7 (0.22)
2015 (Jan–Sep)	10.6 (0.24)	15.6 (0.31)	7.4 (0.20)
0–17 years			
2010	7.8 (0.32)	11.6 (0.37)	4.5 (0.23)
2011	7.0 (0.27)	10.9 (0.36)	3.7 (0.19)
2012	6.6 (0.27)	10.4 (0.35)	3.7 (0.19)
2013	6.5 (0.26)	10.0 (0.33)	3.6 (0.20)
2014	5.5 (0.27)	9.4 (0.40)	3.0 (0.19)
2015 (Jan–Sep)	4.5 (0.29)	8.0 (0.39)	2.3 (0.19)
18–64 years			
2010	22.3 (0.35)	26.7 (0.37)	16.8 (0.30)
2011	21.3 (0.34)	26.0 (0.37)	16.3 (0.31)
2012	20.9 (0.31)	25.5 (0.34)	16.2 (0.29)
2013	20.4 (0.37)	24.4 (0.38)	15.7 (0.34)
2014	16.3 (0.31)	22.6 (0.34)	12.3 (0.27)
2015 (Jan–Sep)	12.9 (0.29)	18.5 (0.36)	9.3 (0.24)
19–25 years			
2010	33.9 (0.73)	41.7 (0.78)	24.1 (0.61)
2011	27.9 (0.71)	36.1 (0.77)	20.1 (0.61)
2012	26.4 (0.72)	33.0 (0.72)	19.6 (0.62)
2013	26.5 (0.71)	31.3 (0.79)	19.8 (0.61)
2014	20.0 (0.65)	26.9 (0.73)	14.2 (0.56)
2015 (Jan–Sep)	16.0 (0.63)	22.7 (0.75)	10.6 (0.51)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table II. Numbers (in millions) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and year: United States, 2010–September 2015

Age group and year	Uninsured[1] at the time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than a year[2]
All ages			
2010	48.6	60.3	35.7
2011	46.3	58.7	34.2
2012	45.5	57.5	34.1
2013	44.8	55.4	33.4
2014	36.0	51.6	26.3
2015 (Jan–Sep)	28.8	42.7	20.0
Under 65 years			
2010	48.2	59.6	35.4
2011	45.9	58.0	33.9
2012	45.2	56.8	33.9
2013	44.3	54.7	33.1
2014	35.7	50.8	26.1
2015 (Jan–Sep)	28.6	42.0	19.8
0–17 years			
2010	5.8	8.7	3.4
2011	5.2	8.1	2.7
2012	4.9	7.7	2.7
2013	4.8	7.3	2.6
2014	4.0	6.9	2.2
2015 (Jan–Sep)	3.3	5.9	1.7
18–64 years			
2010	42.5	51.0	32.0
2011	40.7	49.9	31.2
2012	40.3	49.2	31.2
2013	39.6	47.4	30.5
2014	31.7	44.0	23.9
2015 (Jan–Sep)	25.3	36.2	18.1
19–25 years			
2010	10.0	12.3	7.1
2011	8.4	10.8	6.0
2012	7.9	9.9	5.9
2013	8.0	9.5	6.0
2014	6.0	8.1	4.3
2015 (Jan–Sep)	4.8	6.8	3.2

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table III. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–September 2015

Age group and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
All ages			
1997	15.4 (0.21)	23.3 (0.27)	70.7 (0.32)
2005	14.2 (0.21)	26.4 (0.30)	67.3 (0.37)
2010	16.0 (0.27)	31.4 (0.39)	60.2 (0.48)
2011	15.1 (0.25)	32.4 (0.37)	60.1 (0.48)
2012	14.7 (0.23)	33.4 (0.35)	59.6 (0.43)
2013	14.4 (0.26)	33.8 (0.36)	59.5 (0.49)
2014	11.5 (0.23)	34.6 (0.37)	61.8 (0.45)
2015 (Jan–Sep)	9.1 (0.21)	35.3 (0.45)	63.5 (0.49)
Under 65 years			
1997	17.4 (0.24)	13.6 (0.25)	70.8 (0.35)
2005	16.0 (0.24)	16.8 (0.29)	68.4 (0.39)
2010	18.2 (0.30)	22.0 (0.38)	61.2 (0.50)
2011	17.3 (0.29)	23.0 (0.37)	61.2 (0.51)
2012	16.9 (0.27)	23.5 (0.37)	61.0 (0.47)
2013	16.6 (0.30)	23.8 (0.35)	61.0 (0.52)
2014	13.3 (0.26)	24.5 (0.36)	63.6 (0.46)
2015 (Jan–Sep)	10.6 (0.24)	25.0 (0.46)	65.9 (0.53)
0–17 years			
1997	13.9 (0.36)	21.4 (0.48)	66.2 (0.57)
2005	8.9 (0.29)	29.9 (0.56)	62.4 (0.60)
2010	7.8 (0.32)	39.8 (0.73)	53.8 (0.75)
2011	7.0 (0.27)	41.0 (0.74)	53.3 (0.76)
2012	6.6 (0.27)	42.1 (0.72)	52.8 (0.73)
2013	6.5 (0.26)	42.2 (0.70)	52.6 (0.76)
2014	5.5 (0.27)	42.2 (0.65)	53.7 (0.68)
2015 (Jan–Sep)	4.5 (0.29)	41.8 (0.85)	55.1 (0.86)
18–64 years			
1997	18.9 (0.23)	10.2 (0.20)	72.8 (0.30)
2005	18.9 (0.26)	11.5 (0.22)	70.9 (0.36)
2010	22.3 (0.35)	15.0 (0.30)	64.1 (0.46)
2011	21.3 (0.34)	15.9 (0.29)	64.2 (0.45)
2012	20.9 (0.31)	16.4 (0.29)	64.1 (0.42)
2013	20.4 (0.37)	16.7 (0.30)	64.2 (0.47)
2014	16.3 (0.31)	17.7 (0.32)	67.3 (0.43)
2015 (Jan–Sep)	12.9 (0.29)	18.6 (0.40)	70.0 (0.46)
19–25 years			
1997	31.4 (0.63)	11.2 (0.46)	58.4 (0.71)
2005	31.2 (0.65)	12.9 (0.51)	56.5 (0.79)
2010	33.9 (0.73)	15.7 (0.55)	51.0 (0.84)
2011	27.9 (0.71)	16.8 (0.60)	56.2 (0.85)
2012	26.4 (0.72)	17.5 (0.59)	57.2 (0.85)
2013	26.5 (0.71)	16.1 (0.54)	58.1 (0.84)
2014	20.0 (0.65)	19.1 (0.64)	61.9 (0.88)
2015 (Jan–Sep)	16.0 (0.63)	19.4 (0.77)	65.5 (0.87)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 1997, 2005, and 2010–2015, Family Core component.

Table IV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and year: United States, 2010–September 2015

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (<100% FPL)			
2010	29.5 (0.83)	56.0 (0.98)	15.5 (0.70)
2011	28.2 (0.66)	56.2 (0.82)	16.6 (0.77)
2012	28.3 (0.65)	57.1 (0.83)	16.1 (0.83)
2013	27.3 (0.68)	59.0 (0.81)	14.7 (0.72)
2014	22.3 (0.66)	62.1 (0.80)	16.6 (0.69)
2015 (Jan–Sep)	17.7 (0.67)	65.4 (0.99)	18.2 (0.84)
Near-poor (≥100% and <200% FPL)			
2010	32.3 (0.69)	36.2 (0.63)	33.2 (0.77)
2011	30.4 (0.58)	37.7 (0.73)	33.5 (0.75)
2012	29.5 (0.56)	37.1 (0.66)	35.2 (0.75)
2013	29.3 (0.70)	39.1 (0.77)	33.4 (0.79)
2014	23.5 (0.60)	41.1 (0.74)	37.3 (0.81)
2015 (Jan–Sep)	18.1 (0.58)	44.3 (0.91)	40.0 (0.91)
Not-poor (≥200% FPL)			
2010	10.7 (0.24)	9.7 (0.28)	81.0 (0.36)
2011	10.1 (0.25)	9.9 (0.26)	81.4 (0.36)
2012	9.8 (0.23)	10.3 (0.33)	81.3 (0.39)
2013	9.6 (0.24)	10.5 (0.29)	81.2 (0.39)
2014	7.6 (0.20)	9.9 (0.28)	83.7 (0.36)
2015 (Jan–Sep)	6.7 (0.21)	10.5 (0.35)	84.1 (0.42)
Unknown			
2010	22.7 (0.95)	21.0 (0.69)	57.3 (1.08)
2011	21.0 (0.64)	26.2 (0.95)	53.9 (1.09)
2012	20.4 (0.73)	28.8 (0.89)	52.1 (1.00)
2013	20.5 (0.76)	24.2 (0.94)	56.8 (1.24)
2014	15.0 (0.80)	22.2 (0.91)	64.1 (1.24)
2015 (Jan–Sep)	11.5 (0.93)	23.7 (1.24)	65.6 (1.30)

[1]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table V. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and year: United States, 2010–September 2015

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (<100% FPL)			
2010	42.2 (0.99)	38.8 (0.97)	19.6 (0.89)
2011	40.1 (0.92)	39.6 (0.93)	21.2 (1.02)
2012	40.1 (0.90)	40.8 (0.94)	20.2 (1.09)
2013	39.3 (1.00)	42.4 (0.95)	19.0 (0.97)
2014	32.3 (0.93)	46.6 (0.95)	21.9 (0.92)
2015 (Jan–Sep)	26.1 (0.96)	51.5 (1.22)	23.7 (1.10)
Near-poor (≥100% and <200% FPL)			
2010	43.0 (0.74)	23.7 (0.55)	34.7 (0.74)
2011	40.1 (0.72)	25.9 (0.69)	35.4 (0.75)
2012	39.2 (0.68)	25.2 (0.57)	37.2 (0.74)
2013	38.5 (0.84)	26.6 (0.78)	36.4 (0.78)
2014	30.9 (0.72)	29.6 (0.76)	41.2 (0.81)
2015 (Jan–Sep)	24.1 (0.69)	33.8 (0.94)	44.3 (0.90)
Not-poor (≥200% FPL)			
2010	12.6 (0.27)	8.1 (0.27)	80.8 (0.36)
2011	12.0 (0.28)	8.3 (0.23)	81.1 (0.35)
2012	11.4 (0.26)	8.7 (0.29)	81.3 (0.38)
2013	11.4 (0.27)	8.9 (0.26)	81.2 (0.37)
2014	8.9 (0.23)	8.5 (0.26)	83.9 (0.35)
2015 (Jan–Sep)	7.7 (0.24)	9.0 (0.29)	84.8 (0.36)
Unknown			
2010	27.1 (1.10)	15.6 (0.63)	58.4 (1.11)
2011	25.6 (0.77)	17.6 (0.73)	58.1 (0.96)
2012	25.7 (0.88)	18.9 (0.76)	56.9 (0.92)
2013	24.3 (0.87)	17.6 (0.77)	59.5 (1.11)
2014	17.2 (0.88)	17.2 (0.81)	67.0 (1.20)
2015 (Jan–Sep)	13.5 (0.91)	19.0 (1.03)	68.6 (1.18)

[1]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table VI. Percentages (and standard errors) of children aged 0–17 years who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and year: United States, 2010–September 2015

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (<100% FPL)			
2010	10.2 (0.96)	82.0 (1.22)	9.2 (0.70)
2011	8.1 (0.62)	84.4 (0.87)	8.9 (0.72)
2012	7.5 (0.58)	85.9 (0.80)	8.8 (0.78)
2013	7.8 (0.62)	86.1 (0.88)	7.7 (0.69)
2014	5.9 (0.52)	87.3 (0.72)	8.0 (0.62)
2015 (Jan–Sep)	4.4 (0.51)	87.3 (1.03)	9.6 (0.92)
Near-poor (≥100% and <200% FPL)			
2010	12.6 (0.73)	59.2 (1.16)	30.5 (1.18)
2011	11.5 (0.69)	60.8 (1.17)	29.9 (1.07)
2012	10.1 (0.70)	61.0 (1.30)	31.1 (1.18)
2013	10.6 (0.72)	64.4 (1.16)	27.3 (1.17)
2014	8.6 (0.65)	64.3 (1.23)	29.4 (1.19)
2015 (Jan–Sep)	6.5 (0.68)	65.0 (1.37)	31.4 (1.39)
Not-poor (≥200% FPL)			
2010	4.6 (0.29)	14.9 (0.57)	81.4 (0.61)
2011	4.0 (0.27)	15.0 (0.55)	82.1 (0.58)
2012	4.5 (0.31)	15.2 (0.62)	81.3 (0.64)
2013	4.0 (0.28)	15.6 (0.62)	81.2 (0.65)
2014	3.6 (0.28)	14.4 (0.56)	83.1 (0.58)
2015 (Jan–Sep)	3.5 (0.32)	15.7 (0.79)	81.7 (0.87)
Unknown			
2010	8.8 (0.89)	38.1 (1.71)	53.7 (1.74)
2011	10.4 (0.76)	45.9 (1.70)	44.5 (1.66)
2012	8.2 (0.77)	51.8 (1.50)	41.2 (1.49)
2013	9.2 (1.00)	43.7 (2.16)	48.6 (2.20)
2014	8.0 (1.41)	37.9 (2.01)	54.8 (2.05)
2015 (Jan–Sep)	5.9 (1.55)	36.9 (2.53)	57.4 (2.43)

[1]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not-poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table VII. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and sex: United States, January–September 2015

Age group and sex	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Age group (years)			
All ages	9.1 (0.21)	35.3 (0.45)	63.5 (0.49)
Under age 65	10.6 (0.24)	25.0 (0.46)	65.9 (0.53)
0–17	4.5 (0.29)	41.8 (0.85)	55.1 (0.86)
18–64	12.9 (0.29)	18.6 (0.40)	70.0 (0.46)
18–24	14.5 (0.61)	21.4 (0.78)	65.1 (0.86)
25–34	17.9 (0.59)	17.3 (0.57)	65.7 (0.82)
35–44	14.7 (0.51)	15.5 (0.59)	70.4 (0.72)
45–64	8.9 (0.26)	19.8 (0.46)	73.7 (0.52)
65 and over	0.6 (0.08)	95.3 (0.27)	49.5 (0.89)
19–25	16.0 (0.63)	19.4 (0.77)	65.5 (0.87)
Sex			
Male:			
All ages	10.5 (0.25)	33.1 (0.46)	63.6 (0.53)
Under age 65	12.1 (0.28)	23.5 (0.46)	65.8 (0.55)
0–17	4.3 (0.32)	42.3 (0.96)	54.8 (0.98)
18–64	15.1 (0.34)	16.1 (0.41)	70.2 (0.51)
18–24	16.5 (0.80)	17.7 (0.86)	66.7 (1.05)
25–34	21.8 (0.83)	13.2 (0.65)	65.9 (1.06)
35–44	17.5 (0.65)	12.4 (0.61)	70.6 (0.81)
45–64	9.9 (0.35)	18.9 (0.56)	73.5 (0.59)
65 and over	0.6 (0.12)	94.7 (0.39)	49.1 (1.11)
19–25	18.1 (0.82)	15.4 (0.85)	67.4 (1.10)
Female:			
All ages	7.8 (0.23)	37.5 (0.50)	63.4 (0.51)
Under age 65	9.2 (0.27)	26.4 (0.52)	66.0 (0.56)
0–17	4.8 (0.37)	41.2 (0.98)	55.4 (0.99)
18–64	10.8 (0.31)	21.0 (0.46)	69.8 (0.50)
18–24	12.5 (0.78)	25.1 (1.06)	63.5 (1.11)
25–34	14.0 (0.58)	21.2 (0.73)	65.5 (0.83)
35–44	11.9 (0.58)	18.5 (0.75)	70.2 (0.88)
45–64	8.0 (0.31)	20.7 (0.53)	74.0 (0.58)
65 and over	0.5 (0.09)	95.8 (0.29)	49.8 (0.88)
19–25	13.9 (0.77)	23.5 (1.07)	63.6 (1.10)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2015, Family Core component.

Table VIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–September 2015

Race and ethnicity and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	31.9 (0.72)	32.0 (0.78)	36.6 (0.81)
2011	31.1 (0.68)	33.6 (0.74)	36.1 (0.82)
2012	30.4 (0.71)	34.0 (0.71)	36.4 (0.74)
2013	30.3 (0.66)	33.4 (0.62)	37.0 (0.76)
2014	25.2 (0.59)	34.6 (0.78)	41.2 (0.89)
2015 (Jan–Sep)	21.0 (0.61)	35.7 (0.82)	44.1 (0.84)
Non-Hispanic white, single race			
2010	13.7 (0.30)	16.4 (0.42)	71.4 (0.57)
2011	13.0 (0.32)	17.1 (0.39)	71.4 (0.55)
2012	12.7 (0.28)	17.3 (0.39)	71.5 (0.51)
2013	12.1 (0.29)	17.9 (0.38)	71.6 (0.53)
2014	9.8 (0.25)	18.1 (0.41)	73.6 (0.50)
2015 (Jan–Sep)	7.5 (0.25)	18.7 (0.49)	75.5 (0.54)
Non-Hispanic black, single race			
2010	20.8 (0.63)	36.3 (0.79)	44.6 (0.84)
2011	19.0 (0.51)	36.9 (0.83)	45.6 (0.85)
2012	17.9 (0.50)	38.2 (0.77)	45.4 (0.79)
2013	18.9 (0.51)	37.5 (0.92)	44.9 (1.01)
2014	13.5 (0.49)	40.3 (0.76)	47.7 (0.86)
2015 (Jan–Sep)	11.3 (0.55)	38.5 (1.01)	52.0 (1.02)
Non-Hispanic Asian, single race			
2010	16.8 (0.76)	14.9 (0.98)	69.1 (1.17)
2011	16.0 (0.89)	17.6 (1.14)	67.0 (1.40)
2012	16.4 (0.93)	16.6 (0.85)	67.5 (1.24)
2013	13.8 (0.81)	17.5 (1.00)	69.4 (1.27)
2014	10.6 (0.61)	16.7 (0.86)	73.4 (1.01)
2015 (Jan–Sep)	6.2 (0.51)	18.4 (1.43)	76.0 (1.56)
Non-Hispanic other races and multiple races			
2010	22.4 (4.83)	30.3 (2.14)	48.7 (3.83)
2011	19.1 (1.78)	32.5 (1.60)	50.6 (1.89)
2012	16.4 (1.33)	35.8 (1.77)	50.8 (2.16)
2013	16.0 (1.17)	35.9 (1.75)	50.1 (1.97)
2014	12.8 (1.30)	36.2 (1.69)	52.7 (2.01)
2015 (Jan–Sep)	10.4 (1.02)	36.3 (2.23)	54.4 (2.23)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table IX. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–September 2015

Race and ethnicity and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	43.2 (0.91)	16.3 (0.64)	41.1 (0.85)
2011	42.2 (0.89)	18.1 (0.63)	40.3 (0.82)
2012	41.3 (0.89)	19.0 (0.64)	40.4 (0.73)
2013	40.6 (0.88)	18.0 (0.62)	42.1 (0.70)
2014	33.7 (0.76)	20.6 (0.73)	46.4 (0.86)
2015 (Jan–Sep)	27.9 (0.75)	22.4 (0.84)	50.4 (0.88)
Non-Hispanic white, single race			
2010	16.4 (0.35)	12.8 (0.34)	72.2 (0.52)
2011	15.6 (0.35)	13.4 (0.31)	72.5 (0.48)
2012	15.1 (0.31)	13.7 (0.33)	72.7 (0.46)
2013	14.5 (0.34)	14.4 (0.32)	72.7 (0.49)
2014	11.6 (0.29)	14.6 (0.36)	75.3 (0.47)
2015 (Jan–Sep)	8.8 (0.27)	15.5 (0.44)	77.4 (0.48)
Non-Hispanic black, single race			
2010	27.2 (0.75)	25.3 (0.70)	49.3 (0.81)
2011	24.8 (0.65)	26.2 (0.75)	50.5 (0.79)
2012	23.6 (0.61)	27.0 (0.68)	50.8 (0.75)
2013	24.9 (0.62)	26.6 (0.80)	50.0 (0.91)
2014	17.7 (0.60)	30.5 (0.73)	53.4 (0.84)
2015 (Jan–Sep)	14.6 (0.62)	29.1 (0.83)	58.3 (0.91)
Non-Hispanic Asian, single race			
2010	19.5 (0.92)	11.2 (0.72)	70.2 (1.05)
2011	18.8 (0.96)	13.6 (0.87)	68.0 (1.27)
2012	19.1 (0.92)	13.2 (0.83)	68.2 (1.15)
2013	16.3 (0.88)	14.1 (0.91)	70.4 (1.28)
2014	12.5 (0.65)	13.7 (0.84)	74.5 (1.01)
2015 (Jan–Sep)	7.3 (0.55)	15.7 (1.24)	77.5 (1.39)
Non-Hispanic other races and multiple races			
2010	32.8 (5.76)	20.6 (1.94)	48.5 (4.77)
2011	27.1 (2.01)	23.6 (1.53)	52.1 (2.17)
2012	24.9 (1.78)	26.1 (1.62)	52.0 (2.24)
2013	23.8 (1.66)	26.8 (1.84)	51.6 (2.26)
2014	19.5 (1.65)	25.2 (1.51)	56.9 (2.06)
2015 (Jan–Sep)	15.7 (1.59)	27.5 (2.13)	58.4 (2.09)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table X. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by selected demographic characteristics: United States, January–September 2015

Selected characteristic	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Race and ethnicity			
Hispanic or Latino	27.9 (0.75)	22.4 (0.84)	50.4 (0.88)
Non-Hispanic:			
White, single race	8.8 (0.27)	15.5 (0.44)	77.4 (0.48)
Black, single race	14.6 (0.62)	29.1 (0.83)	58.3 (0.91)
Asian, single race	7.3 (0.55)	15.7 (1.24)	77.5 (1.39)
Other races and multiple races	15.7 (1.59)	27.5 (2.13)	58.4 (2.09)
Region			
Northeast	8.6 (0.50)	20.0 (0.79)	73.0 (0.84)
Midwest	10.1 (0.55)	16.8 (0.78)	74.5 (0.90)
South	17.1 (0.58)	16.4 (0.54)	68.3 (0.76)
West	12.0 (0.51)	22.9 (1.10)	66.3 (1.15)
Education			
Less than high school	30.5 (0.89)	34.4 (0.96)	36.7 (0.93)
High school diploma or GED[4]	17.3 (0.56)	24.3 (0.65)	60.2 (0.74)
More than high school	7.6 (0.25)	13.3 (0.37)	80.4 (0.42)
Employment status			
Employed	11.9 (0.31)	10.2 (0.28)	78.7 (0.41)
Unemployed	29.7 (1.19)	36.2 (1.18)	34.8 (1.25)
Not in workforce	12.5 (0.46)	42.3 (0.80)	49.2 (0.77)
Poverty status[5]			
<100% FPL	26.1 (0.96)	51.5 (1.22)	23.7 (1.10)
≥100% and ≤138% FPL	24.7 (1.11)	41.5 (1.39)	36.1 (1.36)
>138% and ≤250% FPL	20.8 (0.66)	24.1 (0.73)	57.0 (0.84)
>250% and ≤400% FPL	11.2 (0.48)	11.8 (0.54)	78.7 (0.64)
>400% FPL	3.9 (0.21)	5.6 (0.33)	91.8 (0.36)
Unknown	11.9 (0.81)	16.6 (0.88)	72.4 (1.06)
Marital status			
Married	9.4 (0.32)	13.5 (0.39)	78.7 (0.48)
Widowed	12.6 (1.49)	35.8 (2.04)	55.8 (2.16)
Divorced or separated	15.6 (0.75)	27.5 (0.81)	58.9 (1.04)
Living with partner	21.7 (0.88)	23.5 (0.98)	55.9 (1.11)
Never married	16.2 (0.48)	23.4 (0.63)	61.6 (0.72)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]GED is General Educational Development high school equivalency diploma.

[5]FPL is federal poverty level. Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. The percentage of respondents with "Unknown" poverty status for this five-level categorization is 9.6%. This value is greater than the corresponding value for the three-level poverty categorization because of greater uncertainty when assigning individuals to more detailed poverty groups. For more information on poverty status, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2015, Family Core component.

Table XI. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, in a high-deductible health plan without a health savings account, and in a consumer-directed health plan, and who were in a family with a flexible spending account for medical expenses, by year: United States, 2010–September 2015

Year	Enrolled in high-deductible health plan (HDHP)[1]	Enrolled in HDHP without health savings account (HSA)[2]	Enrolled in consumer-directed health plan (CDHP)[3]	In family with flexible spending account (FSA) for medical expenses
2010	25.3 (0.54)	17.6 (0.46)	7.7 (0.33)	20.4 (0.50)
2011	29.0 (0.54)	19.9 (0.41)	9.2 (0.35)	21.4 (0.53)
2012	31.1 (0.57)	20.3 (0.42)	10.8 (0.34)	21.6 (0.45)
2013	33.9 (0.68)	22.2 (0.48)	11.7 (0.43)	21.6 (0.48)
2014	36.9 (0.77)	23.6 (0.52)	13.3 (0.47)	21.2 (0.49)
2015 (Jan–Sep)	36.2 (0.72)	23.1 (0.54)	13.2 (0.48)	21.8 (0.54)

[1]HDHP was defined in 2015 as a health plan with an annual deductible of at least $1,250 for self-only coverage and $2,500 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in Technical Notes.

[2]HSA is a tax-advantaged account or fund that can be used to pay for medical expenses. It must be coupled with an HDHP.

[3]CDHP is an HDHP coupled with an HSA.

NOTES: The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive. Therefore, a person may be counted in more than one measure. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table XII. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, by year and source of coverage: United States, 2010–September 2015

Year	Employment-based[1]	Directly purchased[2]
2010	23.3 (0.54)	48.0 (1.48)
2011	26.9 (0.53)	52.4 (1.49)
2012	29.2 (0.60)	54.7 (1.61)
2013	32.0 (0.67)	56.4 (1.50)
2014	36.2 (0.73)	54.1 (1.43)
2015 (Jan–Sep)	36.0 (0.75)	51.1 (1.67)

[1]Private insurance that was originally obtained through a present or former employer or union, or through a professional association.

[2]Private insurance that was originally obtained through direct purchase or other means not related to employment.

NOTES: For persons under age 65, approximately 8% of private health plans were directly purchased from 2010 through 2013. In 2014 and the first two quarters of 2015, 10% of private plans were directly purchased. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table XIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Medicaid expansion status, and year: United States, 2010–September 2015

Age group, state Medicaid expansion status, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
Medicaid expansion states[4]:			
2010	16.4 (0.42)	21.8 (0.54)	63.1 (0.70)
2011	15.3 (0.35)	23.1 (0.56)	62.9 (0.72)
2012	15.0 (0.34)	23.1 (0.50)	63.3 (0.63)
2013	14.9 (0.40)	24.1 (0.48)	62.3 (0.68)
2014	10.9 (0.29)	25.6 (0.49)	64.9 (0.59)
2015 (Jan–Sep)	8.4 (0.26)	26.3 (0.59)	66.7 (0.66)
Non-Medicaid expansion states[5]:			
2010	20.3 (0.48)	22.1 (0.51)	59.0 (0.76)
2011	19.6 (0.50)	22.7 (0.50)	59.1 (0.78)
2012	19.2 (0.45)	24.0 (0.55)	58.3 (0.75)
2013	18.4 (0.48)	23.4 (0.51)	59.6 (0.80)
2014	16.0 (0.44)	23.2 (0.52)	62.1 (0.76)
2015 (Jan–Sep)	13.9 (0.46)	22.9 (0.66)	64.7 (0.86)
0–17 years			
Medicaid expansion states[4]:			
2010	6.7 (0.46)	38.2 (1.05)	56.5 (1.06)
2011	5.9 (0.33)	40.2 (1.11)	55.4 (1.09)
2012	5.3 (0.32)	40.4 (1.00)	55.9 (1.07)
2013	5.6 (0.33)	41.3 (0.86)	54.5 (0.95)
2014	4.3 (0.33)	41.0 (0.84)	56.2 (0.88)
2015 (Jan–Sep)	3.9 (0.33)	40.4 (1.05)	57.3 (1.08)
Non-Medicaid expansion states[5]:			
2010	9.0 (0.47)	41.7 (0.99)	50.7 (1.08)
2011	8.3 (0.46)	42.0 (1.02)	50.9 (1.11)
2012	8.0 (0.46)	43.9 (1.11)	49.4 (1.07)
2013	7.5 (0.40)	43.1 (1.12)	50.5 (1.23)
2014	6.7 (0.43)	43.5 (1.06)	51.0 (1.11)
2015 (Jan–Sep)	5.4 (0.52)	43.6 (1.38)	52.2 (1.40)
18–64 years			
Medicaid expansion states[4]:			
2010	20.1 (0.47)	15.5 (0.40)	65.6 (0.62)
2011	18.9 (0.41)	16.6 (0.41)	65.8 (0.61)
2012	18.5 (0.39)	16.7 (0.38)	66.0 (0.53)
2013	18.4 (0.49)	17.7 (0.44)	65.2 (0.65)
2014	13.3 (0.34)	19.9 (0.46)	68.1 (0.56)
2015 (Jan–Sep)	10.0 (0.31)	21.3 (0.52)	70.1 (0.58)
Non-Medicaid expansion states[5]:			
2010	24.8 (0.58)	14.4 (0.45)	62.2 (0.70)
2011	24.1 (0.60)	15.1 (0.42)	62.3 (0.71)
2012	23.7 (0.54)	16.1 (0.44)	61.8 (0.69)
2013	22.7 (0.59)	15.6 (0.41)	63.2 (0.69)
2014	19.6 (0.54)	15.3 (0.41)	66.5 (0.69)
2015 (Jan–Sep)	17.3 (0.56)	14.6 (0.50)	69.8 (0.74)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]For 2010 through 2014, states moving forward with Medicaid expansion include AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV (as of October 31, 2013). Beginning with 2015, three additional states are included as expansion states: IN, NH, and PA.

[5]For 2010 through 2014, states not moving forward with Medicaid expansion include AL, AK, FL, GA, ID, IN, KS, LA, ME, MS, MO, MT, NE, NH, NC, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013). Beginning with 2015, three states have been removed from this grouping: IN, NH, and PA.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Health Insurance Marketplace type, and year: United States, 2010–September 2015

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
State-based Marketplace states[4]:			
2010	16.3 (0.46)	21.6 (0.66)	63.2 (0.80)
2011	15.9 (0.46)	23.6 (0.70)	61.8 (0.88)
2012	15.2 (0.43)	24.2 (0.66)	61.8 (0.83)
2013	15.2 (0.48)	25.0 (0.56)	61.0 (0.83)
2014	11.1 (0.38)	26.4 (0.63)	63.7 (0.78)
2015 (Jan–Sep)	8.0 (0.34)	27.8 (0.89)	65.5 (1.02)
Partnership Marketplace states[5]:			
2010	14.7 (0.87)	22.5 (1.15)	64.8 (1.73)
2011	14.3 (0.71)	22.7 (1.28)	64.5 (1.72)
2012	14.1 (0.70)	20.8 (1.12)	66.7 (1.53)
2013	14.2 (0.83)	21.8 (1.07)	65.6 (1.42)
2014	10.2 (0.57)	24.4 (1.06)	67.2 (1.28)
2015 (Jan–Sep)	7.8 (0.60)	25.5 (1.03)	68.7 (1.17)
Federally Facilitated Marketplace states[6]:			
2010	20.1 (0.48)	22.1 (0.50)	59.1 (0.70)
2011	18.8 (0.45)	22.6 (0.47)	60.0 (0.71)
2012	18.6 (0.41)	23.6 (0.50)	59.3 (0.67)
2013	17.9 (0.44)	23.3 (0.49)	60.2 (0.74)
2014	15.3 (0.40)	23.3 (0.50)	62.8 (0.69)
2015 (Jan–Sep)	12.8 (0.37)	23.1 (0.59)	65.7 (0.71)
0–17 years			
State-based Marketplace states[4]:			
2010	6.7 (0.50)	38.0 (1.32)	56.4 (1.31)
2011	6.4 (0.47)	40.9 (1.43)	54.2 (1.39)
2012	5.4 (0.43)	42.2 (1.37)	53.9 (1.46)
2013	5.7 (0.37)	42.8 (1.05)	52.6 (1.18)
2014	4.2 (0.40)	42.0 (1.11)	54.9 (1.13)
2015 (Jan–Sep)	3.3 (0.43)	41.8 (1.55)	56.2 (1.64)
Partnership Marketplace states[5]:			
2010	4.1 (0.78)	40.7 (2.21)	57.9 (2.31)
2011	4.2 (0.53)	39.6 (2.44)	58.0 (2.39)
2012	3.6 (0.69)	38.5 (2.20)	59.9 (2.26)
2013	4.2 (0.53)	38.4 (1.95)	59.2 (2.08)
2014	3.2 (0.51)	40.8 (1.88)	58.4 (1.99)
2015 (Jan–Sep)	3.4 (0.59)	40.2 (2.35)	58.8 (2.26)
Federally Facilitated Marketplace states[6]:			
2010	9.2 (0.48)	40.7 (0.91)	51.3 (0.97)
2011	8.0 (0.40)	41.4 (0.93)	51.8 (1.01)
2012	7.9 (0.41)	42.7 (1.00)	50.8 (0.98)
2013	7.5 (0.39)	42.6 (1.02)	51.3 (1.11)
2014	6.6 (0.41)	42.6 (0.94)	52.0 (1.00)
2015 (Jan–Sep)	5.5 (0.43)	42.0 (1.15)	53.8 (1.15)

See footnotes at end of table.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age, state Health Insurance Marketplace type, and year: United States, 2010–September 2015—*Continued*

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
18–64 years			
State-based Marketplace states[4]:			
2010	19.9 (0.52)	15.3 (0.48)	65.9 (0.68)
2011	19.5 (0.53)	17.1 (0.52)	64.7 (0.75)
2012	18.8 (0.50)	17.7 (0.49)	64.7 (0.69)
2013	18.7 (0.60)	18.4 (0.52)	64.1 (0.80)
2014	13.6 (0.45)	20.6 (0.57)	67.0 (0.75)
2015 (Jan–Sep)	9.6 (0.41)	22.8 (0.78)	68.8 (0.89)
Partnership Marketplace states[5]:			
2010	18.9 (1.12)	15.3 (0.90)	67.6 (1.59)
2011	18.4 (0.92)	15.9 (0.87)	67.1 (1.52)
2012	18.1 (0.85)	13.9 (0.79)	69.3 (1.36)
2013	17.9 (0.98)	15.7 (0.91)	68.0 (1.29)
2014	12.8 (0.68)	18.2 (0.98)	70.5 (1.22)
2015 (Jan–Sep)	9.4 (0.76)	20.0 (0.93)	72.3 (1.12)
Federally Facilitated Marketplace states[6]:			
2010	24.5 (0.56)	14.7 (0.43)	62.2 (0.66)
2011	23.0 (0.54)	15.1 (0.39)	63.3 (0.64)
2012	22.8 (0.48)	16.1 (0.41)	62.7 (0.61)
2013	22.0 (0.54)	15.9 (0.41)	63.6 (0.64)
2014	18.6 (0.49)	15.8 (0.41)	66.9 (0.63)
2015 (Jan–Sep)	15.7 (0.45)	15.7 (0.48)	70.3 (0.62)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]State-based Marketplace states are CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, VT, and WA (as of October 31, 2013).

[5]Partnership Marketplace states are AR, DE, IL, IA, MI, NH, and WV (as of October 31, 2013).

[6]Federally Facilitated Marketplace states are AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013).

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2010–2015, Family Core component.

Table XV. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and expanded region: United States, January–September 2015

Age group and expanded region[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All regions	9.1 (0.21)	35.3 (0.45)	63.5 (0.49)
New England	4.3 (0.50)	34.8 (1.71)	70.0 (2.09)
Middle Atlantic	6.8 (0.44)	35.8 (1.00)	66.4 (0.98)
East North Central	6.7 (0.46)	35.0 (0.87)	68.2 (1.09)
West North Central	7.7 (0.70)	29.8 (1.53)	72.7 (1.27)
South Atlantic	11.2 (0.61)	36.4 (1.08)	60.2 (1.31)
East South Central	8.4 (0.78)	41.5 (1.76)	58.8 (2.16)
West South Central	15.4 (0.67)	30.6 (1.18)	59.7 (1.41)
Mountain	9.8 (0.85)	35.3 (2.20)	62.0 (2.23)
Pacific	8.3 (0.43)	38.2 (1.31)	59.6 (1.37)
Under 65 years			
All regions	10.6 (0.24)	25.0 (0.46)	65.9 (0.53)
New England	5.0 (0.58)	23.8 (2.12)	72.4 (2.31)
Middle Atlantic	8.0 (0.49)	24.4 (0.91)	69.1 (1.01)
East North Central	7.8 (0.54)	24.4 (0.98)	69.6 (1.12)
West North Central	9.1 (0.82)	17.6 (1.28)	74.8 (1.45)
South Atlantic	13.3 (0.72)	25.0 (1.01)	63.6 (1.30)
East South Central	9.8 (0.93)	31.4 (2.08)	60.5 (2.34)
West South Central	17.4 (0.75)	21.4 (1.12)	62.3 (1.51)
Mountain	11.2 (1.02)	25.8 (2.03)	64.2 (2.47)
Pacific	9.4 (0.47)	29.5 (1.41)	62.3 (1.56)
0–17 years			
All regions	4.5 (0.29)	41.8 (0.85)	55.1 (0.86)
New England	†	36.1 (3.30)	63.0 (3.45)
Middle Atlantic	3.7 (0.84)	37.5 (1.72)	60.1 (1.79)
East North Central	3.3 (0.57)	37.7 (2.05)	61.4 (1.95)
West North Central	3.2 (0.62)	33.7 (2.85)	65.0 (2.68)
South Atlantic	4.1 (0.62)	47.4 (1.81)	49.7 (1.92)
East South Central	1.8 (0.52)	51.3 (4.14)	47.6 (4.39)
West South Central	9.0 (1.17)	43.5 (2.55)	48.5 (2.36)
Mountain	6.6 (1.21)	40.1 (2.91)	54.3 (3.66)
Pacific	3.9 (0.55)	44.1 (2.32)	53.4 (2.47)
18–64 years			
All regions	12.9 (0.29)	18.6 (0.40)	70.0 (0.46)
New England	5.9 (0.68)	19.6 (1.89)	75.6 (2.02)
Middle Atlantic	9.4 (0.55)	20.1 (0.78)	72.1 (0.86)
East North Central	9.5 (0.65)	19.3 (0.80)	72.6 (1.00)
West North Central	11.5 (1.01)	10.9 (0.98)	78.9 (1.38)
South Atlantic	16.5 (0.88)	16.9 (0.87)	68.5 (1.14)
East South Central	12.9 (1.16)	23.7 (1.73)	65.5 (2.16)
West South Central	21.2 (1.00)	11.6 (0.61)	68.4 (1.28)
Mountain	13.2 (1.07)	19.6 (1.98)	68.4 (2.21)
Pacific	11.5 (0.59)	24.2 (1.29)	65.5 (1.36)

†Estimate has a relative standard error (RSE) greater than 50% and is not shown.

[1]The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK, and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR, and WA.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2015, Family Core component.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2015

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All states[5]	9.1 (0.21)	35.3 (0.45)	63.5 (0.49)
Arizona	11.6 (1.56)	39.3 (2.99)	55.5 (3.43)
California	8.3 (0.49)	38.2 (1.65)	58.4 (1.62)
Colorado	6.1 (1.20)	29.6 (2.86)	70.7 (3.21)
Florida	11.8 (1.11)	38.9 (1.84)	55.7 (2.08)
Georgia	10.9 (1.67)	32.5 (1.74)	62.2 (2.73)
Idaho	11.0 (1.61)	35.1 (3.07)	63.3 (3.50)
Illinois	7.3 (0.98)	32.6 (1.30)	69.5 (1.71)
Indiana	10.0 (1.49)	29.9 (2.84)	69.3 (3.22)
Iowa	5.1 (1.06)	33.9 (2.84)	72.1 (3.03)
Kansas	9.2 (1.34)	33.5 (2.75)	71.9 (2.95)
Kentucky	6.2 (1.14)	47.8 (2.95)	53.5 (3.33)
Louisiana	9.1 (1.47)	37.4 (3.10)	60.8 (3.52)
Maine	9.9 (1.54)	41.9 (3.18)	60.0 (3.56)
Maryland	7.3 (1.39)	36.7 (3.22)	65.2 (3.59)
Massachusetts	3.2 (0.92)	34.2 (3.13)	71.7 (3.35)
Michigan	6.0 (0.82)	38.9 (1.80)	67.5 (2.22)
Minnesota	4.3 (0.99)	25.7 (2.68)	79.4 (2.80)
Mississippi	12.1 (1.71)	42.8 (3.25)	56.1 (3.67)
Nebraska	11.7 (1.67)	29.7 (2.98)	70.6 (3.35)
Nevada	13.9 (1.63)	39.4 (2.88)	55.3 (3.30)
New Hampshire	5.2 (1.17)	27.2 (2.94)	77.7 (3.10)
New Jersey	7.8 (1.17)	30.1 (2.50)	71.7 (2.77)
New Mexico	8.8 (1.38)	54.8 (3.03)	47.5 (3.42)
New York	5.2 (0.56)	38.6 (1.58)	64.2 (1.81)
North Carolina	12.1 (1.06)	36.5 (2.75)	59.6 (3.32)
Ohio	6.2 (0.77)	37.6 (2.32)	64.1 (2.36)
Oklahoma	14.5 (1.74)	37.7 (3.00)	53.7 (3.48)
Oregon	7.5 (1.38)	39.1 (3.21)	65.8 (3.52)
Pennsylvania	8.4 (0.96)	35.8 (2.21)	65.7 (1.84)
Rhode Island	3.4 (0.94)	34.9 (3.09)	71.6 (3.29)
South Dakota	7.7 (1.42)	31.3 (3.08)	74.0 (3.29)
Tennessee	8.3 (1.39)	36.9 (3.05)	62.0 (3.46)
Texas	16.9 (0.78)	28.1 (1.39)	60.3 (1.74)
Utah	8.5 (1.23)	21.9 (2.28)	74.0 (2.73)
Virginia	9.3 (1.29)	31.6 (2.58)	68.3 (2.92)
Washington	8.3 (1.32)	37.8 (2.90)	62.9 (3.25)
West Virginia	6.0 (1.21)	48.3 (3.18)	56.9 (3.56)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2015—*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Under 65 years			
All states[5]	10.6 (0.24)	25.0 (0.46)	65.9 (0.53)
Arizona	13.5 (1.78)	29.4 (3.02)	57.6 (3.67)
California	9.4 (0.53)	30.2 (1.71)	61.3 (1.85)
Colorado	6.8 (1.32)	21.0 (2.71)	72.8 (3.32)
Florida	14.6 (1.31)	25.1 (1.63)	61.1 (1.79)
Georgia	12.5 (1.96)	23.1 (1.61)	65.5 (3.09)
Idaho	12.8 (1.86)	24.3 (3.03)	64.4 (3.78)
Illinois	8.4 (1.11)	22.5 (1.09)	70.1 (1.83)
Indiana	11.6 (1.70)	18.1 (2.60)	72.1 (3.39)
Iowa	6.1 (1.26)	21.1 (2.72)	73.8 (3.28)
Kansas	11.1 (1.60)	19.5 (2.57)	71.3 (3.29)
Kentucky	7.2 (1.31)	40.3 (3.15)	54.4 (3.58)
Louisiana	10.9 (1.74)	25.8 (3.09)	65.3 (3.77)
Maine	12.2 (1.88)	29.1 (3.31)	59.3 (4.01)
Maryland	8.5 (1.60)	26.4 (3.21)	66.0 (3.86)
Massachusetts	3.6 (1.04)	23.2 (3.01)	73.9 (3.51)
Michigan	7.0 (0.97)	28.8 (2.43)	67.1 (2.37)
Minnesota	4.9 (1.12)	14.9 (2.35)	81.6 (2.87)
Mississippi	14.6 (2.04)	31.0 (3.39)	56.0 (4.08)
Nebraska	14.2 (2.05)	15.9 (2.73)	71.3 (3.78)
Nevada	16.4 (1.91)	28.1 (2.94)	58.2 (3.62)
New Hampshire	5.9 (1.35)	17.3 (2.74)	78.6 (3.33)
New Jersey	9.1 (1.34)	18.3 (2.29)	74.2 (2.91)
New Mexico	10.9 (1.68)	44.6 (3.40)	46.2 (3.82)
New York	6.1 (0.64)	27.4 (1.35)	68.0 (1.77)
North Carolina	14.4 (1.15)	25.3 (2.83)	62.5 (3.53)
Ohio	7.2 (0.93)	27.5 (2.54)	66.4 (2.45)
Oklahoma	16.7 (1.99)	27.6 (3.02)	57.1 (3.75)
Oregon	9.0 (1.65)	25.5 (3.19)	67.4 (3.84)
Pennsylvania	10.1 (1.08)	23.9 (2.08)	67.9 (2.32)
Rhode Island	4.0 (1.10)	22.7 (2.99)	76.4 (3.39)
South Dakota	9.5 (1.71)	16.8 (2.78)	74.5 (3.63)
Tennessee	9.5 (1.58)	27.0 (3.03)	64.9 (3.66)
Texas	18.8 (0.87)	19.6 (1.27)	62.5 (1.81)
Utah	9.2 (1.33)	15.9 (2.14)	76.1 (2.79)
Virginia	10.7 (1.45)	22.1 (2.47)	69.4 (3.07)
Washington	9.7 (1.50)	28.5 (2.92)	64.6 (3.46)
West Virginia	7.2 (1.43)	39.0 (3.43)	57.3 (3.89)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2015—*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
18–64 years			
All states[5]	12.9 (0.29)	18.6 (0.40)	70.0 (0.46)
Arizona	13.6 (1.19)	24.1 (2.57)	63.1 (3.37)
California	11.6 (0.66)	24.7 (1.52)	64.6 (1.62)
Colorado	8.4 (1.48)	16.7 (2.15)	75.5 (2.88)
Florida	17.8 (1.56)	16.8 (1.51)	66.4 (1.54)
Georgia	16.1 (2.49)	12.7 (1.54)	72.5 (2.87)
Idaho	17.2 (1.91)	15.2 (2.29)	69.6 (3.42)
Illinois	10.6 (1.50)	17.4 (0.62)	73.2 (1.73)
Indiana	14.2 (2.17)	11.8 (1.94)	74.9 (3.04)
Iowa	7.7 (1.64)	12.0 (1.88)	80.9 (2.64)
Kansas	14.4 (2.05)	10.3 (1.77)	77.0 (2.85)
Kentucky	9.1 (2.09)	33.6 (2.67)	59.7 (3.22)
Louisiana	14.4 (2.50)	16.4 (2.27)	71.1 (3.24)
Maine	14.8 (1.54)	22.4 (2.59)	63.0 (3.49)
Maryland	10.0 (2.43)	20.8 (2.59)	70.4 (3.39)
Massachusetts	†	20.6 (2.48)	76.5 (3.02)
Michigan	7.7 (1.01)	24.5 (2.13)	69.8 (2.23)
Minnesota	6.4 (1.32)	10.8 (1.85)	83.5 (2.58)
Mississippi	18.2 (1.81)	19.1 (2.54)	64.8 (3.59)
Nebraska	17.1 (2.34)	8.1 (1.76)	76.0 (3.20)
Nevada	18.0 (2.14)	22.3 (2.41)	62.3 (3.27)
New Hampshire	7.7 (2.30)	13.1 (2.07)	80.9 (2.81)
New Jersey	11.3 (1.43)	13.4 (1.74)	77.1 (2.50)
New Mexico	13.9 (2.43)	35.5 (2.87)	52.8 (3.48)
New York	7.3 (0.83)	23.5 (0.92)	70.7 (1.35)
North Carolina	18.0 (1.51)	16.3 (2.10)	68.0 (3.09)
Ohio	8.9 (1.16)	21.8 (2.30)	70.3 (2.32)
Oklahoma	21.8 (1.96)	15.5 (2.18)	64.0 (3.36)
Oregon	10.8 (1.88)	21.8 (2.57)	69.1 (3.34)
Pennsylvania	11.3 (1.09)	20.1 (1.54)	70.5 (2.12)
Rhode Island	*4.7 (1.72)	20.7 (2.48)	77.5 (2.98)
South Dakota	12.0 (1.84)	12.6 (2.17)	75.9 (3.26)
Tennessee	13.3 (2.22)	21.6 (2.49)	66.6 (3.32)
Texas	22.6 (1.23)	9.9 (0.54)	68.4 (1.46)
Utah	12.8 (1.95)	8.5 (1.49)	79.1 (2.52)
Virginia	13.7 (1.72)	16.1 (1.89)	73.0 (2.66)
Washington	11.1 (2.01)	23.7 (2.36)	67.6 (3.02)
West Virginia	8.8 (2.38)	34.4 (2.86)	60.5 (3.42)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–September 2015—*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
0–17 years			
All states[5]	4.5 (0.29)	41.8 (0.85)	55.1 (0.86)
Arizona	13.2 (2.74)	41.6 (5.40)	45.0 (5.33)
California	3.7 (0.48)	44.7 (2.71)	52.6 (2.84)
Florida	4.8 (0.88)	50.5 (3.39)	45.0 (3.37)
Georgia	*4.0 (1.33)	47.4 (3.28)	49.3 (4.15)
Idaho	*3.6 (1.60)	43.4 (5.78)	53.6 (5.69)
Illinois	2.5 (0.71)	36.4 (3.92)	61.8 (3.71)
Indiana	*5.4 (1.93)	33.0 (5.44)	65.2 (5.39)
Kansas	*3.3 (1.43)	41.4 (5.39)	57.8 (5.29)
Kentucky	†	57.6 (5.61)	40.7 (5.45)
Michigan	5.3 (1.44)	40.1 (4.35)	59.9 (3.89)
Minnesota	†	24.1 (4.69)	77.1 (4.51)
Nevada	11.5 (2.67)	46.4 (5.68)	45.1 (5.54)
New Jersey	†	33.0 (5.21)	65.4 (5.15)
New York	*2.2 (1.04)	39.9 (3.20)	59.3 (3.36)
North Carolina	*5.2 (1.71)	48.2 (4.58)	48.5 (4.34)
Ohio	*2.3 (0.89)	44.6 (4.50)	54.9 (4.03)
Oklahoma	*5.3 (1.92)	54.8 (5.77)	41.7 (5.59)
Pennsylvania	*6.5 (1.99)	35.4 (4.20)	60.0 (3.87)
Texas	10.6 (1.40)	40.8 (3.06)	49.5 (2.91)
Utah	*3.3 (1.26)	27.9 (4.28)	71.4 (4.22)
Virginia	†	39.1 (5.30)	59.2 (5.22)

†Estimate has a relative standard error (RSE) greater than 50% and is not shown.

*Estimate has an RSE greater than 30% and less than or equal to 50% and should be used with caution because it does not meet standards of reliability or precision.

[1]Estimates are presented for fewer than 50 states and the District of Columbia due to considerations of sample size and precision.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, or purchased through local or community programs. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[5]Includes all 50 states and the District of Columbia.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2015, Family Core component.

Table XVII. Change in percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage at the time of interview, by selected states: United States, 2014 and 2015 (January–September)

Selected states[1]	2014	2015 (Jan–Sep)	Difference (percentage points)
All states[2]	16.3 (0.26)	12.9 (0.29)	†–3.4
Arizona	19.5 (1.01)	13.6 (1.19)	†–5.9
California	16.7 (0.67)	11.6 (0.66)	†–5.1
Colorado	13.3 (1.43)	8.4 (1.48)	†–4.9
Florida	23.0 (1.34)	17.8 (1.56)	†–5.2
Georgia	20.2 (2.21)	16.1 (2.49)	–4.1
Idaho	21.9 (1.81)	17.2 (1.91)	–4.7
Illinois	15.0 (1.26)	10.6 (1.50)	†–4.4
Indiana	18.3 (2.09)	14.2 (2.17)	–4.1
Iowa	8.4 (1.51)	7.7 (1.64)	–0.7
Kansas	13.9 (1.87)	14.4 (2.05)	0.5
Kentucky	15.6 (2.00)	9.1 (2.09)	†–6.5
Louisiana	18.9 (2.16)	14.4 (2.50)	–4.5
Maine	16.9 (0.95)	14.8 (1.54)	–2.1
Maryland	12.3 (2.13)	10.0 (2.43)	–2.3
Michigan	11.6 (1.30)	7.7 (1.01)	†–3.9
Minnesota	8.0 (1.52)	6.4 (1.32)	–1.6
Mississippi	22.4 (1.57)	18.2 (1.81)	–4.2
Nebraska	16.9 (2.14)	17.1 (2.34)	0.2
Nevada	20.4 (1.86)	18.0 (2.14)	–2.4
New Hampshire	11.6 (2.07)	7.7 (2.30)	–3.9
New Jersey	12.9 (1.44)	11.3 (1.43)	–1.6
New Mexico	18.7 (2.36)	13.9 (2.43)	–4.8
New York	12.9 (0.90)	7.3 (0.83)	†–5.6
North Carolina	22.5 (1.84)	18.0 (1.51)	–4.5
Ohio	10.9 (0.91)	8.9 (1.16)	–2.0
Oklahoma	26.6 (1.78)	21.8 (1.96)	–4.8
Oregon	13.3 (2.00)	10.8 (1.88)	–2.5
Pennsylvania	11.9 (1.20)	11.3 (1.09)	–0.6
Rhode Island	9.0 (1.75)	*4.7 (1.72)	–4.3
South Dakota	13.4 (1.32)	12.0 (1.84)	–1.4
Tennessee	14.8 (2.10)	13.3 (2.22)	–1.5
Texas	25.7 (1.03)	22.6 (1.23)	–3.1
Utah	16.2 (1.78)	12.8 (1.95)	–3.4
Virginia	15.2 (1.66)	13.7 (1.72)	–1.5
Washington	13.3 (1.77)	11.1 (2.01)	–2.2
West Virginia	12.2 (2.05)	8.8 (2.38)	–3.4

†Significant difference between 2014 and 2015 (Jan–Sep) ($p < 0.05$).

*Estimate has a relative standard error (RSE) greater than 30% and less than or equal to 50% and should be used with caution because it does not meet standards of reliability or precision.

[1]Estimates are presented for fewer than 50 states and the District of Columbia due to considerations of sample size and precision.

[2]Includes all 50 states and the District of Columbia.

NOTES: A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state–sponsored or other government–sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. These health insurance estimates are being released prior to final data editing and final weighting to provide access to the most recent information from the National Health Interview Survey. The resulting estimates for persons without health insurance are generally 0.1–0.3 percentage points lower than those based on the editing procedures used for the final data files. Occasionally, due to decisions made for the final data editing and weighting, estimates based on preliminary editing procedures may differ by more than 0.3 percentage points from estimates based on final files. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2014–2015, Family Core component.

CONGRESS OF THE UNITED STATES
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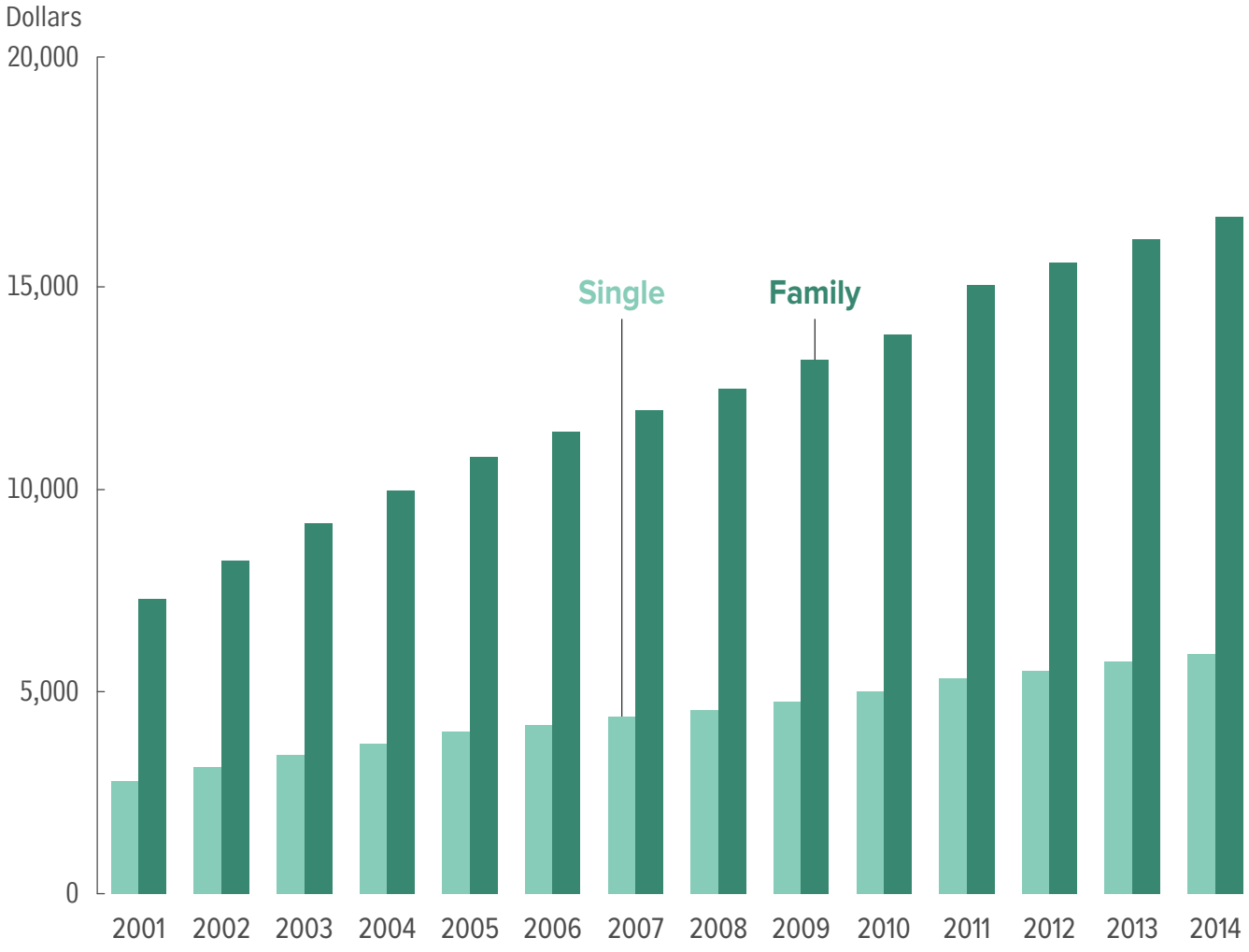
CBO

Private Health Insurance Premiums and Federal Policy



Average Premiums for Employment-Based Plans

FEBRUARY 2016

Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

The Congressional Budget Office's projections of health insurance enrollment and premiums for years after 2016 have not been updated since March 2015, except to incorporate the effects of enacted legislation. The agency will revise its projections for its next baseline, to be published in March 2016.

Unless otherwise indicated, all years referred to in this report are calendar years, not fiscal years.

Numbers in the tables and figures may not add up to totals because of rounding.

Key terms are defined in a glossary at the end of the report.

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Private Health Insurance Premiums and Federal Policy

Summary

Most Americans are covered by private health insurance, which they either obtain through employment or purchase individually. Insurance premiums—the payments made to buy that coverage by enrollees or by other parties on their behalf—are high and rising. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project that in 2016, the average premium for an employment-based insurance plan will be about $6,400 for single coverage and about $15,500 for family coverage.[1] Average premiums for coverage purchased individually (in what is called the nongroup market) are also high—but not quite as high as average employment-based premiums, mostly because nongroup coverage is less extensive and thus requires enrollees to make higher out-of-pocket payments when they receive care.

Although premiums for private insurance have grown relatively slowly in recent years, they have usually grown faster than the economy as a whole and thus faster than average income. Over the period from 2005 to 2014, premiums for employment-based insurance grew by 48 percent for single coverage and by 55 percent for family coverage. CBO and JCT expect them to grow at similar rates over the next decade—by about 5 percent per year, on average, or about 2 percentage points faster than income per capita. As a result of that growth, average premiums for employment-based coverage are projected to be about $10,000 for single coverage and about $24,500 for family coverage in 2025, nearly 60 percent higher than they were in 2016.

High and rising premiums for private health insurance are a matter of concern for enrollees. They also affect the federal budget, because the federal government subsidizes most premiums—directly or indirectly—at a cost of roughly $300 billion in fiscal year 2016. Lawmakers have therefore expressed interest in examining the factors that affect premiums. This report reviews the available evidence about premium levels and growth; analyzes the major federal subsidies, taxes, fees, and regulations that affect premiums; and examines how insurers' own actions affect premiums.

How Do Federal Subsidies, Taxes, and Fees Affect Premiums?

The federal government subsidizes health insurance premiums in two main ways. First, nearly all premiums for employment-based insurance are excluded from federal income and payroll taxes. That tax exclusion, estimated to cost more than $250 billion in fiscal year 2016, subsidizes roughly 30 percent of the average premium for employment-based coverage. Second, under the Affordable Care Act (ACA), the federal government offers tax credits to people who buy nongroup coverage through a health insurance exchange and meet various other criteria. Those premium tax credits are projected to cost about $40 billion in fiscal year 2016.

Not only do the subsidies reduce the portion of the total premium that enrollees must pay; they also affect the total amount of the premium. Both subsidies encourage relatively healthy people to enroll, which reduces insurers' average spending for enrollees' health care and thus helps to reduce premiums. However, the tax exclusion also provides an incentive for employers to offer, and for employees to select, more extensive coverage than they otherwise would—which raises total premiums. (The tax credits do not have that effect because their value, unlike the value of the tax exclusion, does not increase when people purchase more extensive coverage.) On balance, CBO estimates, the tax exclusion increases average premiums for employment-based coverage by 10 percent to 15 percent.

1. Those projections are lower than the estimates reported in some recent surveys; as this report explains below, different estimates may vary somewhat in the types of insurance policy that they encompass.

Various federal taxes and fees also affect premiums. Starting in 2020, a new excise tax on employment-based plans with relatively high premiums is scheduled to take effect; for people who buy those plans, the tax will roughly offset the incentive to obtain more extensive coverage that the federal tax exclusion provides. Consequently, employers and employees affected by the tax are expected to choose less expensive coverage than they would have otherwise—and as a result, the tax is expected to reduce average premiums. Other federal taxes and fees imposed on insurers, by contrast, tend to raise average premiums, because the insurers generally pass the costs on to all purchasers.

How Do Federal Regulations Affect Premiums?

Before the ACA was enacted, many federal and state regulations already affected private health insurance premiums, particularly for employment-based coverage. But the ACA significantly expanded the scope of federal regulations, especially in the nongroup market. This report focuses on regulations resulting from the ACA, because proposals designed to affect premiums often involve changing those regulations rather than the earlier ones.

One key regulation is the individual mandate, which took effect in 2014 and requires most people to obtain health insurance or pay a penalty. Like the subsidies just mentioned, the individual mandate reduces premiums by encouraging relatively healthy people to get coverage. The ACA also imposes an employer mandate, which requires larger employers to offer coverage that meets specified standards to their full-time workers or face a penalty. That regulation, which took effect in 2015, is not expected to change average premiums very much, but it will discourage employers from dropping coverage and thus will keep some workers from shifting to nongroup coverage.

Other ACA regulations apply only to insurance policies newly sold in the nongroup and small-group markets. (Employment-based coverage is sold in two markets: the small-group, which generally covers employers with up to 50 employees, and the large-group, which covers larger employers.) Many of the regulations tend to increase average premiums, particularly in the nongroup market. For example, when they sell those policies, insurers must now accept all applicants during specified open-enrollment periods, may not vary people's premiums on the basis of their health, may vary premiums by age only to a limited extent, and may not restrict coverage of enrollees' preexisting health conditions. Insurers must also cover specified categories of health care services, and they generally must pay at least 60 percent of the costs of those covered services, on average.

Together, the ACA's regulations increase premiums noticeably in the nongroup market and have more limited effects in the other markets. However, the nongroup market represents a relatively small fraction of the total private insurance market, and according to CBO's projections, it will continue to do so—accounting for about 15 percent in 2025. As a result, CBO expects that premium increases stemming from the ACA's regulations will have a relatively small effect on the overall average of private health insurance premiums.

How Do Actions by Insurers Affect Premiums?

Insurance premiums depend partly on actions that insurers themselves take. Above all, insurers generally try to control their costs by restraining spending on health care—spending that accounts for about 88 percent of their premium revenues, on average. That restraint tends to reduce premiums. In order to limit spending on health care, insurers use various strategies, such as negotiating lower payment rates for services provided within their networks of doctors and hospitals; managing enrollees' use of care more closely; and increasing the amounts that enrollees pay out of pocket. Insurers may also try to attract relatively healthy enrollees and avoid less healthy ones, though federal and state regulations limit or prohibit such practices or reduce insurers' incentives to engage in them.

Competition also affects premiums. On average, premiums are lower in markets with more insurers. The reason is that those insurers have a stronger incentive to keep premiums low, because otherwise they might lose enrollees to their competitors. Premiums are also lower in markets with more hospitals and physicians, because insurers there have an easier time negotiating lower payment rates or excluding high-cost providers from their networks. The available evidence, however, indicates that many insurance markets are quite concentrated; that is, a small number of insurers account for the bulk of enrollment. Many markets for hospital care and some markets for physicians' services are concentrated as well. As a result, efforts to increase competition among insurers, like other efforts to reduce insurance premiums, may have complex effects.

Premium Levels and Growth Rates

Most nonelderly people have a private health insurance plan as their primary source of coverage.[2] CBO and JCT estimate that in 2015, about 153 million nonelderly people had employment-based coverage, nearly all of which was private.[3] An additional 17 million nonelderly people were covered by a private insurance policy purchased individually in the nongroup market. All told, employment-based and nongroup plans covered roughly two-thirds of the nonelderly population and just over half of the total U.S. population. Over the next several years, the number of people with private health insurance is expected to rise, mostly because continued implementation of the ACA will expand the nongroup market.

An insurance premium is simply the price that is paid to obtain coverage; it is usually expressed on a monthly or annual basis. In general, this report examines the total premiums paid for insurance coverage—or in certain cases, the equivalent costs of obtaining that coverage—regardless of whether the costs are paid by enrollees, employers, or the federal government. People with employment-based coverage usually pay only a portion of the total premium directly, and their employer covers the remaining costs. But in CBO's view, the costs of premiums for employment-based coverage are ultimately borne by enrollees, so examining total premium payments for that coverage is a good way to understand the financial pressures that those premiums create.

Premiums for private insurance represent a considerable expense, averaging more than $5,000 per enrollee per year. In 2015, they were expected to total about $1.1 trillion, accounting for one-third of all spending on health care and nearly 6 percent of gross domestic product (GDP).[4] Average premiums have generally risen faster than the economy as a whole, though their growth has slowed in recent years. CBO and JCT project that they will grow by about 5 percent per year, on average, over the next 10 years—about 2 percentage points faster than per capita GDP.

Premium Levels

Because payments of premiums are private transactions, obtaining precise and timely data about them can be difficult. Data about premiums for employment-based insurance are available primarily from surveys of employers. Although reliable data about premiums for nongroup coverage have been harder to obtain, some better data have recently become available. Different sources of data generally yield different estimates and cover different periods, but all of the data indicate that premiums for employment-based insurance are higher than premiums for nongroup insurance, on average—largely because employment-based insurance tends to provide more extensive coverage.

Premiums for Employment-Based Insurance. The most recent nationally representative data about premiums for employment-based insurance come from a survey of employers conducted by the Kaiser Family Foundation.[5] In 2015, according to that survey, annual premiums averaged about $6,250 for single coverage and about $17,550 for family coverage.

The Kaiser survey also found that premiums varied substantially. Among workers with single coverage, 22 percent had a premium of less than $5,000, and

2. Many other people obtain insurance through a public program, such as Medicare or Medicaid. Of those people, millions receive their benefits through a plan that is run by a private company, such as a Medicare Advantage plan or a Medicaid managed care plan. However, those plans differ in many ways from employment-based and nongroup plans—for example, in the populations that they cover and the regulations that govern them—so they were not included in this analysis. Also, when responding to surveys, many people report having more than one source of insurance coverage, which can generate higher estimates of the number of people with private insurance; in its analyses, CBO assigns such people a primary source of coverage.

3. In CBO and JCT's projections, employment-based coverage includes not only insurance provided by private and public employers but also insurance obtained through labor unions and multiemployer plans (often called Taft-Hartley plans), as well as insurance obtained by retirees from their former employers. A small share of that employment-based coverage (such as coverage provided through the military) is not provided by a private insurance plan. Also, a small number of people have coverage that is neither employment based nor nongroup, such as health plans established through churches or other groups; such people are difficult to identify in the surveys that CBO uses in its analyses.

4. See Andrea M. Sisko and others, "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage and Improving Economy," *Health Affairs*, vol. 33, no. 10 (October 2014), pp. 1841–1850, http://dx.doi.org/10.1377/hlthaff.2014.0560. Those figures include premiums for private supplemental insurance coverage (often called Medigap plans) that Medicare enrollees buy individually or obtain through their former employers; such premiums constitute a relatively small share of the total.

5. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), http://tinyurl.com/oj7dhwp.

Box 1.

Major Determinants of Private Health Insurance Premiums

The factors that determine health insurance premiums can usefully be grouped into four major categories:

- The **costs of health care generally,** which themselves are determined by the quantity and kind of services that people use and the prices that are paid for those services. Those components, in turn, are a function of the population's health and need for services, the state of medical technology and treatment options, physicians' patterns of practice, and various other considerations. Prices in particular can vary substantially among markets and within them.
- The **mix of enrollees** in a given plan or in the overall insurance pool, relative to the population as a whole. A group of enrollees that is older or sicker will tend to use more health care and thus will generate higher premiums, if other factors are held equal.
- The **extent of the coverage** provided by an insurance plan, which reflects both the scope of health benefits covered by the plan and the share of costs for those covered benefits that the plan pays. Plans that cover more services or pay a larger share of their costs will tend to have higher premiums.
- The **administrative costs and profits** that insurers generate.

The extent of competition among insurers and among health care providers, as well as actions taken by insurers and others, can affect premiums by influencing those four factors directly or indirectly. Insurers operating in more competitive insurance markets have stronger incentives to control costs and to limit profits, which would reduce premiums. For example, insurers may establish limited networks of providers or steer enrollees toward providers who tend to order fewer or less complex services—thus reducing the costs of care for their enrollees, which can yield lower premiums. In areas with limited competition among doctors and hospitals, by contrast, insurers may have more difficulty negotiating lower prices for those providers' services, which could result in higher premiums.

State or federal subsidies and regulations may change premiums by affecting the mix of people who enter or remain in the insurance pool; by encouraging people to purchase more extensive or less extensive coverage; or by changing the benefits that insurers offer, the administrative costs that they incur, or the profits that they retain.

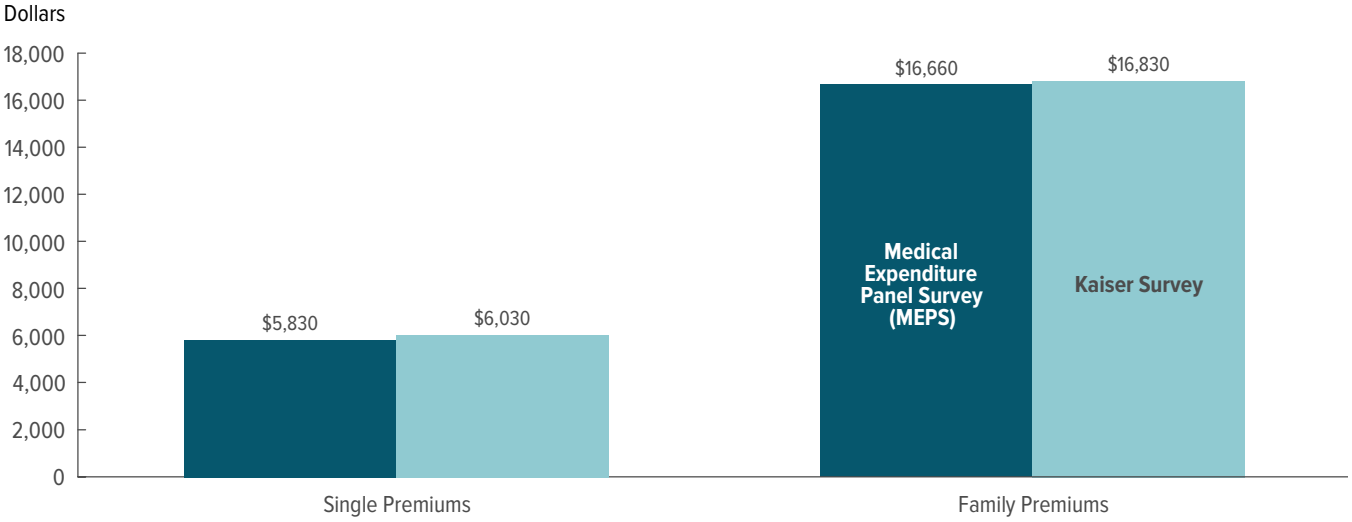
13 percent had a premium of $8,000 or more. Among workers with family coverage, 22 percent had a premium of less than $14,000, and 15 percent had a premium of $22,000 or more. The reasons for that variation are not fully understood, but they are probably related to the ways in which the major determinants of premiums vary among insurers and employers (see Box 1). The variation suggests that average premiums, though often a useful measure, mask substantial differences in the extent and characteristics of the coverage that different employers provide.

Another source of nationally representative data about premiums for employment-based coverage is the Medical Expenditure Panel Survey (MEPS), which is conducted by the Agency for Healthcare Research and Quality. According to the most recent MEPS data, which cover 2014, those premiums averaged about $5,830 for single coverage and $16,660 for family coverage. The results from the Kaiser survey in that year were only slightly higher (see Figure 1).

The two surveys differ in several respects. For example, the MEPS separately asks employers about premiums for "self plus one" policies—which, as the name suggests, cover an employee and one spouse or dependent. The MEPS found that the average premium for those policies was about $11,500 in 2014; if it had included them among family premiums, the average family premium that it found would have been reduced to about $14,680. By contrast, the Kaiser survey does not ask employers about self plus one policies. Also, the MEPS may provide

Figure 1.

Average Premiums for Employment-Based Plans in 2014, According to Two Surveys



Source: Congressional Budget Office, using data from the *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust) and from the insurance component of the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality).

In both surveys, employment-based coverage is defined as health insurance obtained through a worker's employment or a retiree's former employment, including coverage provided by private firms but excluding coverage provided by federal employers. The Kaiser survey includes coverage provided by state and local governments; the data from the Medical Expenditure Panel Survey used here do not.

the more accurate estimates, because it uses a much larger sample of employers than the Kaiser survey does; however, the Kaiser survey's results are available sooner.

According to the 2015 Kaiser survey, about three-fifths of all workers with employment-based health insurance got it through a self-insured firm. A self-insured firm essentially acts as its own insurer and bears most or all of the financial risk of providing coverage to its workers.[6] (Alternatively, a firm can buy a plan from an insurance company that bears the risk; that approach is called fully insured coverage.) A firm that is self-insured generally contracts with an insurance company or a similar entity to administer its plan but pays for employees' health care costs directly. A resulting complication for measuring premiums is that self-insured employers do not make a premium payment to an insurer. Therefore, the Kaiser survey and the MEPS instead measure self-insured employers' premium equivalent—their average costs for covered health care claims and administrative expenses, costs that would have been included in premiums if those employers had opted for a fully insured plan.

Premiums for Nongroup Insurance. The ACA requires nongroup plans to report annually to the Centers for Medicare & Medicaid Services (CMS) on their premium revenues and enrollment. According to CBO's analysis of those administrative data, nongroup premiums per enrollee averaged about $2,780 in 2012.[7]

That finding differs in an important respect from the findings described above for employment-based plans: It is reported in terms of the average premium per enrollee. That is, it was calculated by dividing one component of the data (total premium revenues) by another (total enrollment). Unfortunately, those data do not allow analysts to calculate premium levels separately for single policies and family policies, which would allow clearer comparisons with the employment-based plans discussed above. However, insurers are also required to report data about fully insured employment-based plans, and those data furnish a basis for comparison. Premiums per enrollee for those plans averaged about $4,360 in 2012—57 percent higher than nongroup premiums.

6. Self-insured employers may buy coverage (often called stop-loss coverage or reinsurance) to protect them from very high costs for medical claims.

7. CBO analyzed data derived from 2012 filings of the Medical Loss Ratio Annual Reporting Form, which insurers must file with CMS. The data were compiled for CBO by Milliman, Inc., an actuarial firm.

Another limitation of the administrative data is that they take longer than the survey data to become available for analysis. However, the administrative data have two advantages over the survey data: They cover all plans, not just a sample, and they are probably more accurate.

Average premiums have been lower for nongroup plans than for employment-based plans primarily because nongroup plans have offered more limited coverage. In 2010, according to one recent study, the actuarial value of the average nongroup plan was 60 percent; in other words, that plan paid 60 percent of enrollees' health care claims. The average for employment-based plans was 83 percent.[8] Reflecting that difference in estimated actuarial values, average out-of-pocket spending was $4,127 for nongroup enrollees in family plans but $1,765 for families with employment-based coverage. The study accounted for the fact that, by definition, plans with lower actuarial values require enrollees to pay a larger share of costs out of pocket. It did not, however, account for the fact that by paying a smaller share of claims, such plans encourage enrollees to use fewer services. If the study had accounted for that effect, the difference in out-of-pocket spending between nongroup and employment-based plans would have been smaller.

Another likely reason for nongroup plans' lower average premiums is that in most states, before 2014, insurers in the nongroup market could generally deny coverage to applicants who had high expected costs for health care. The insurers could also generally limit their coverage of any preexisting health conditions for people who did enroll. By contrast, federal and state laws significantly restricted both practices in the employment-based markets. The precise effect of those practices on past nongroup premiums is difficult to estimate, however.[9]

Premium Growth Rates

Private health insurance premiums have generally grown faster than the economy as a whole. The Office of the Actuary at CMS estimates that the average premium per enrollee in all private markets grew from about $2,320 in 2000 to about $5,080 in 2013, indicating an average annual growth rate of 6.2 percent.[10] However, private insurance premiums grew more slowly from 2005 to 2013 (4.5 percent per year, on average) than they did from 2000 to 2005 (9 percent per year). By comparison, the growth rate of per capita GDP from 2000 to 2013 was about 3 percent per year, on average.

Because enrollees in employment-based plans constitute the great majority of total enrollment in private health insurance, the growth of employment-based premiums accounts for most of the total growth in premiums. Tracking growth in premiums for nongroup plans alone is difficult, but over the longer term, they probably changed in a broadly similar fashion.

When premiums grow faster than the economy does, households have to use a larger share of their income to pay those premiums, on average. Another consequence of rising premiums has been a gradual decline in the share of the population that has private health insurance.

Growth in Premiums for Employment-Based Insurance. Premiums for employment-based insurance grew sharply between 2000 and 2005 but more slowly thereafter (see Figure 2). Premium data reported in the MEPS and in the Kaiser survey are generally similar, and together those data indicate that average premiums for

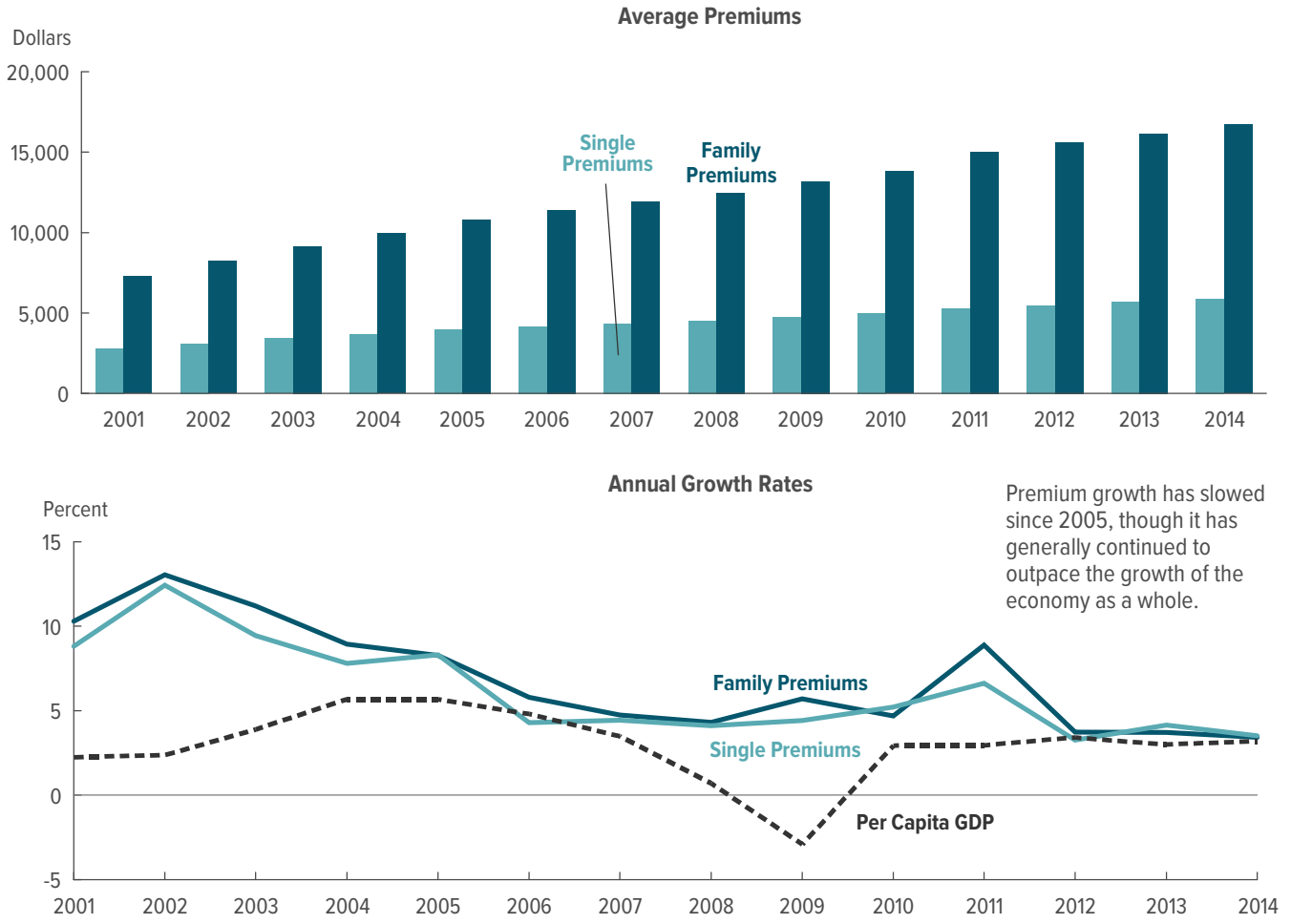
8. Jon R. Gabel and others, "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs*, vol. 31, no. 6 (June 2012), pp. 1339–1348, http://dx.doi.org/10.1377/hlthaff.2011.1082. The authors estimated actuarial values using a database of medical claims for enrollees in large employment-based plans, which generally cover a wide range of services. For nongroup plans that "did not cover a category, such as maternity and newborn services," the authors "classified all related charges for that plan as out-of-pocket expenses" (p. 1341). CBO reached similar conclusions about the actuarial values of employment-based and nongroup plans in an earlier study; see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), p. 63, www.cbo.gov/publication/41746.

9. For one analysis of the effects that those practices had on nongroup premiums, see Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs*, vol. 26, no. 3 (May 2007), pp. 770–779, http://dx.doi.org/10.1377/hlthaff.26.3.770.

10. See Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts—Historical" (December 3, 2015), Tables 1, 3, and 22, http://go.usa.gov/3WGtP. To arrive at those figures, CMS defined total private health insurance premiums as total health consumption expenditures for private health insurance. The figures include spending by some forms of private insurance that are outside the scope of this report, such as dental insurance and Medigap plans.

Figure 2.

Annual Premium Levels and Growth Rates for Employment-Based Plans, According to Survey Data



Source: Congressional Budget Office, using data from the *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust) and from the insurance component of the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality).

This figure shows premium levels and growth rates calculated by averaging the premiums reported in two surveys. Because the Medical Expenditure Panel Survey did not collect data about premiums in 2007, CBO used the average of that survey's 2006 and 2008 results instead.

In both surveys, employment-based coverage is defined as health insurance obtained through a worker's employment or a retiree's former employment, including coverage provided by private firms but excluding coverage provided by federal employers. The Kaiser survey includes coverage provided by state and local governments; the data from the Medical Expenditure Panel Survey used here do not.

GDP = gross domestic product.

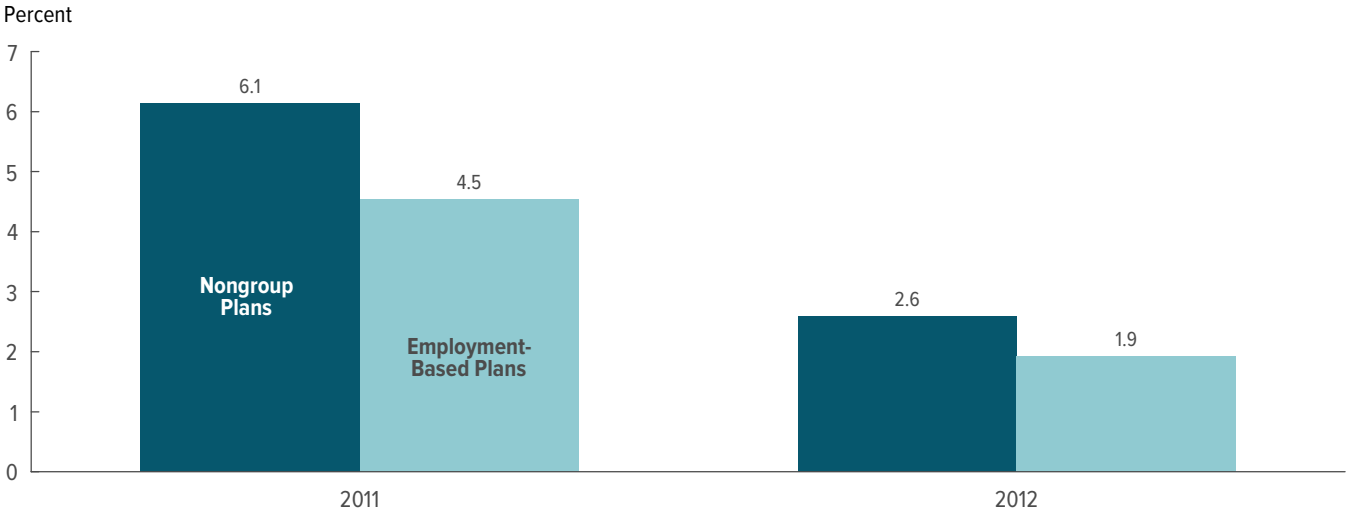
single or family coverage grew by more than 7 percent in every year between 2001 and 2005. The annual rate of growth has exceeded 7 percent only once since then, however—for family premiums in 2011—and has stood at roughly 4 percent since 2012.

The growth of premiums for employment-based insurance has generally exceeded growth in per capita GDP, but the difference has been smaller in recent years than in the early 2000s. Indeed, there was very little difference in 2006 and between 2012 and 2014. And the unusually large gap in 2009, when premiums grew more than 6 percentage points faster than per capita GDP did, was caused not by the rapid growth of the former but by a decline in the latter during the deep economic recession.

Growth in Premiums for Nongroup Insurance. According to CBO's analysis of data from insurers, the average premium per enrollee in nongroup coverage grew by 6.1 percent between 2010 and 2011 and by

Figure 3.

Annual Growth in Premiums for Fully Insured Plans, According to Data From Insurers



Source: Congressional Budget Office, using 2010 filings of the Supplemental Health Care Exhibit (National Association of Insurance Commissioners) and 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form (Centers for Medicare & Medicaid Services).

The growth shown is of the average premium per enrollee, calculated by dividing total premium revenues for each year by total enrollment for the year (which equals the reported number of member-months divided by 12).

Nongroup coverage is insurance that an enrollee purchases directly from an insurer, rather than through an employer. Here, employment-based plans include not only insurance provided by employers but also insurance obtained through labor unions and multiemployer plans (often called Taft-Hartley plans), insurance obtained by retirees from their former employers, and insurance obtained through churches and other groups.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

2.6 percent between 2011 and 2012 (see Figure 3).[11] Those rates of growth were somewhat higher than the rates for fully insured employment-based plans that CBO derived from the same data.

Analyzing the growth of nongroup premiums over a longer period is difficult, because consistent and representative data about those premiums are hard to come by. One recent study used the rate filings and enrollment data that insurers had submitted to 30 state insurance departments since 2008. Although that study's scope was limited by "a lack of publicly available data and often inconsistent, inadequate quality of data," the authors concluded that premium growth in the nongroup market averaged about 10 percent per year between 2008 and 2011.[12]

Other sources of data indicate that nongroup premiums have grown more slowly than that, but whether those data are representative of the entire nongroup market is not clear. For example, according to the company eHealth, which sells insurance online, premiums for the nongroup policies that it sold grew by an average of 4.8 percent per year for single plans and 3.9 percent per year for family plans over the 2008–2011 period.[13] Perhaps those growth rates are lower because the people

11. CBO analyzed administrative data derived from two sources: insurers' 2010 filings of the Supplemental Health Care Exhibit with the National Association of Insurance Commissioners, and insurers' 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form with CMS. The data were compiled for CBO by Milliman, Inc. The two sources include enrollment and premium data for all fully insured plans in the United States and report those data in the same way.

12. Jon R. Gabel, *Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011* (submitted by NORC to the Department of Health and Human Services, November 2012), p. 9, http://go.usa.gov/3k7Nx. In calculating those aggregate results, the analysts weighted the premium change for each policy according to the number of enrollees in that policy. As a result, the findings reflect the fact that some people shifted to less expensive policies when their premiums rose. If the study had not taken that step, the average rate of premium growth that it showed would have been higher.

13. eHealth, *Cost and Benefits of Individual and Family Health Insurance* (December 2013), http://tinyurl.com/k66fkgy (PDF, 1 MB). Over the 2005–2013 period, according to that report, nongroup premiums grew at an average rate of about 4 percent per year for single plans and about 3.5 percent per year for family plans.

purchasing coverage online differ from those purchasing coverage in other ways, or perhaps the plans sold through eHealth differ from plans sold elsewhere.

Effects of Premium Growth on Coverage Rates. Rising premiums have contributed to a gradual decline in the share of the population that has private insurance coverage. According to one nationally representative survey, the share of people younger than 65 with private health insurance dropped from 77 percent in 1984 to 72 percent in 2000 and then to 62 percent in 2013.[14] A study of private insurance coverage rates found that most of the decline that had occurred during the 1990s could be attributed to increases in premiums.[15]

Increases in premiums may reduce insurance coverage for several reasons. As premiums rise, some people may decide that coverage is not affordable. Others may forgo insurance because they expect that the health care services that they use will cost less than a premium will. Still others may expect or hope to receive charity care if they incur significant and unanticipated health care costs. Although people may reduce their expected costs by being uninsured, they also increase their financial risk.

Projections of Future Premiums

CBO and JCT's projections of future premiums for private insurance plans depend greatly on the past trends in premium growth that were just described; the projections factor in both the slow growth of recent years and the faster growth of earlier years. They also take into account other considerations. In particular, they were updated in March 2015 to incorporate recent data indicating that insurers' costs rose even more slowly in 2013 (the latest year for which data were available) than they had previously, and much more slowly than the agencies had expected.[16] The projections also take into account projected growth in personal income, which affects people's ability to buy health insurance.

On the basis of those factors alone, CBO and JCT estimate that premiums for private plans will increase by an average of about 4 percent per year from 2014 through 2018 and by between 5 percent and 6 percent per year from 2019 through 2025. However, the agencies have adjusted those projections to account for effects of the ACA, which increases projected nongroup premiums over the next few years but reduces projected employment-based premiums in the longer term.

Projections of Premiums for Employment-Based Insurance. For employment-based health plans, the agencies' projections of premiums largely reflect projected growth in insurers' costs over the next few years. In 2016, CBO and JCT expect that the average premium for an employment-based insurance plan will be about $6,400 for single coverage and about $15,500 for family coverage. When calculating that estimate of the average family premium, the agencies included premiums for self plus one policies among family premiums. Because self plus one policies are typically much less expensive, an estimate of family premiums that includes such policies will be lower than estimates that exclude them, such as those in the Kaiser survey. CBO and JCT estimate that average premiums have grown by between 3 percent and 4 percent per year from 2014 through 2016.

Over the longer term, the agencies have reduced their projections of premiums to reflect the net effects of an excise tax that is scheduled to take effect in 2020. As this report discusses in more detail below, that tax will apply to employment-based plans with relatively high premiums, effectively increasing those premiums. However, employers and workers affected by it are likely to respond by seeking plans with lower premiums—a response that would outweigh the first effect and thus reduce average premiums. Further complicating that analysis is the fact that the costs of various tax-preferred accounts through which employees may pay for health care also count in determining whether the excise tax applies. As a result, affected employers and workers might respond to the tax by seeking plans with lower premiums or by reducing their use of those accounts. Predicting the extent to which they will do one or the other is difficult.

14. Those findings are from the National Health Interview Survey as reported in National Center for Health Statistics, *Health, United States, 2014*, DHHS Publication 2015-1232 (Department of Health and Human Services, May 2015), Table 111, www.cdc.gov/nchs/data/hus/hus14.pdf (15 MB).

15. Michael Chernew, David M. Cutler, and Patricia Seliger Keenan, "Increasing Health Insurance Costs and the Decline in Insurance Coverage," *Health Services Research*, vol. 40, no. 4 (August 2005), pp. 1021–1039, http://dx.doi.org/10.1111/j.1475-6773.2005.00409.x. Over a longer period, another contributing factor has been various expansions of public insurance coverage, such as the establishment of the Children's Health Insurance Program in 1997 and expansions of the Medicaid program. A third factor has been the recent recession, in which many people who became unemployed lost their insurance or shifted from private to public coverage.

16. See Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), Appendix, www.cbo.gov/publication/49973.

The effects of the excise tax will increase over time. CBO and JCT project that in 2020, between 5 percent and 10 percent of enrollees in employment-based plans would be subject to the tax if their employers did not make any changes in response; in 2025, that share would be between 15 percent and 20 percent. The agencies also expect that many affected employers and workers will respond by adopting plans with premiums that are lower than they would have been otherwise. Taking into account both the premium increases stemming from the tax and the premium reductions stemming from responses to it, the agencies expect that average premiums among affected enrollees will be about 10 percent lower in 2020, and between 10 percent and 15 percent lower in 2025, than they would have been otherwise. All told, the agencies project that in 2025, the average premium among all employment-based plans will probably be about $10,000 for single coverage and about $24,500 for family coverage.

Projections of Premiums for Nongroup Insurance. Although premium growth for nongroup plans is expected to reflect the same trends that underlie premium growth for employment-based plans, nongroup premiums are projected to grow somewhat more quickly over the next few years because of factors related to the ACA (including a phaseout of the reinsurance program discussed below). The agencies' analysis focuses on premium growth for a certain set of nongroup plans that are offered in the health insurance exchanges—known as reference plans—because federal subsidies are tied to those premiums and budget projections are based on them. The ACA defines a person's reference plan as the second-lowest-cost silver plan offered to that person through an exchange. (Silver plans are those that pay about 70 percent of the costs of covered health care services for a broadly representative group of enrollees; other levels of coverage, such as bronze and gold, pay different percentages.)

Between 2016 and 2018, CBO and JCT project, premiums for reference plans will increase at an average rate of about 8 percent per year. After 2018, they are projected to rise roughly in line with premiums for employment-based plans—that is, between 5 percent and 6 percent per year, on average. For the 2016–2025 period as a whole, premiums for reference plans are projected to grow by about 6 percent per year, on average. Of course, premiums for some plans or areas will grow more quickly or slowly than the nationwide average.

Translating those growth rates into projected premiums is complicated, because in most states, nongroup premiums depend in a complex way on the number of people covered by a policy and the ages of the enrollees. For example, in most states, a given plan's premium for someone who is 64 years old is exactly three times the premium for someone 21 to 24 years old; the premium for a 46-year-old is 1.5 times the premium for a 21- to 24-year-old; and the premium for someone younger than 21 is 0.635 times the premium for a 21- to 24-year-old.[17] For a family policy, the total premium is usually the sum of the premiums that would be charged for each enrollee—but no more than three children younger than 21 count toward the total.

Analysts often focus on premiums for 21- to 24-year-olds because they are used as the basis for calculating premiums for other ages. CBO and JCT currently project that the average premium for a reference plan for a 21- to 24-year-old will increase from about $2,800 in 2016 to about $5,000 in 2025. A 46-year-old buying single coverage would face a premium that was 1.5 times that amount—that is, about $4,200 in 2016 and about $7,500 in 2025. For a family consisting of two 46-year-old parents and one child younger than 21, the average premium for a reference plan is projected to be about $10,200 in 2016, which is twice the premium for a 46-year-old plus about $1,800 for one child. That family premium will rise to about $18,200 in 2025, according to CBO and JCT's projections.

Projections of premiums for private health insurance are highly uncertain, however. At present, a particular source of uncertainty is that the causes of the pronounced slowdown in spending of the past several years are not well understood. It is therefore difficult to determine whether that slowdown will persist or whether spending might accelerate instead. Projections of premium growth for plans sold in health insurance exchanges are even more

17. Vermont and New York do not allow premiums to vary by age, and a few other states use different systems of varying premiums by age in the nongroup market. For more information, see Centers for Medicare & Medicaid Services, "Market Rating Reforms: State Specific Rating Variations" (accessed November 23, 2015), http://go.usa.gov/c2Fnd.

Table 1.

Major Federal Subsidies, Taxes, and Fees Affecting Premiums

	Relevant Health Insurance Market				
	Large-Group		Small-Group		
	Fully Insured	Self-Insured	Fully Insured	Self-Insured	Nongroup
Tax Exclusion for Premiums	X	X	X	X	
Excise Tax on High-Premium Health Plans[a]	X	X	X	X	
Tax Preferences for Out-of-Pocket Spending	X	X	X	X	X
Premium Tax Credits (For exchange plans)					X
Cost-Sharing Subsidies (For exchange plans)					X
Transitional Reinsurance Subsidies[b]					X
Transitional Reinsurance Fees[b]	X	X	X	X	X
Health Insurer Tax	X		X		X

Source: Congressional Budget Office.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected. A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

The small-group market generally serves employers with up to 50 employees.

This table omits several smaller fees, including a user fee for health insurance exchanges, an assessment to cover the administrative costs of operating a system of risk adjustment, and an assessment to fund the Patient-Centered Outcomes Research Institute.

a. The excise tax is scheduled to take effect in 2020.

b. The system of reinsurance subsidies and fees affects only plans offered in 2014, 2015, or 2016.

uncertain, because the exchanges are so new. In CBO and JCT's view, the agencies' projections show the most likely outcome in what is nevertheless a wide distribution of possible outcomes.

Federal Subsidies, Taxes, and Fees That Affect Premiums

One important way in which the federal government affects premiums is by subsidizing the purchase of private health insurance. The two main subsidies operate through the tax code: a tax exclusion that subsidizes premiums for employment-based coverage, and tax credits for nongroup coverage purchased through health insurance exchanges (see Table 1). CBO estimates that the combined cost of those two subsidies in fiscal year 2016 will be roughly $300 billion.

The two subsidies are structured differently and therefore have different effects on premiums. A particularly significant difference is that the tax exclusion, by providing an open-ended subsidy, encourages people to select more extensive coverage through their employer—raising premiums for employment-based plans. The tax credit does not have that effect, because its value does not increase when people choose a nongroup plan that provides more extensive coverage.

Two smaller federal subsidies affect enrollees' out-of-pocket costs. First, tax provisions subsidize some out-of-pocket spending on health care by enrollees, mostly those in employment-based plans. Second, certain enrollees in exchange plans may receive subsidies to reduce their cost-sharing requirements (that is, their out-of-pocket expenses). Those subsidies affect premiums in various ways.

Finally, the federal government imposes various taxes and fees on private insurance plans. Most of them raise premiums to a modest degree.

Tax Exclusion for Premiums

The largest federal subsidy for private health insurance stems from a feature of the tax code: Most premium payments for employment-based insurance are excluded from income and payroll taxes. Employers typically cover part of their employees' premiums, and those contributions—like other forms of compensation, such as wages—are deducted as expenses when employers calculate their income taxes. Unlike wages, however, the employers' contributions are

also exempt from the individual income and payroll taxes that employees pay; furthermore, the share of premiums that employees pay is usually exempt from income and payroll taxes as well. CBO has estimated that the subsidy cost about $250 billion in fiscal year 2013 and expects it to cost more in 2016 because of growth in premiums.[18]

Employers typically cover the majority of their employees' premiums—on average, 71 percent of the premium for family coverage and 82 percent for single coverage, according to the Kaiser survey for 2015. Nevertheless, the subsidy resulting from the tax exclusion ultimately accrues to the employees, because the employers' contributions are simply another form of compensation. Most economists agree that an employer that pays for health insurance generally pays less in wages and other forms of compensation than it otherwise would, leaving total compensation about the same. As a result, the employers' costs are ultimately borne by their employees as a group. Buttressing that point, several recent studies indicate that rising premiums have been an important cause of slow growth in workers' wages and income.[19]

The size of the subsidy for any particular worker depends on two things: the amount of that worker's premium and the subsidy rate (that is, the percentage of the premium being subsidized). The subsidy is open-ended; that is, it increases as premiums rise. And because the subsidy results from excluding premium payments from taxation, the subsidy rate equals the tax rate that workers would otherwise have faced on those payments—specifically, the workers' marginal tax rate, which is the rate that applies to their last dollar of income. The subsidy rate therefore tends to be higher for people with higher income, because those people usually face higher marginal tax rates. CBO estimates that the federal subsidy averages about 30 percent of the premium and that it ranges from roughly 20 percent to 40 percent of the premium for most workers. Workers in states with individual income taxes receive an additional subsidy because those states also exclude premiums for employment-based coverage from taxable income.

The tax exclusion exerts both upward and downward pressure on premiums for employment-based coverage—but on balance, CBO estimates, it increases them. On the one hand, the subsidy encourages relatively healthy workers to obtain coverage. (People with lower expected costs for health care would be less likely to obtain coverage without the subsidy; by contrast, people with higher expected costs would be more likely to purchase coverage regardless of the subsidy.) That reduces insurers' average spending for enrollees' health care and thus lowers average premiums. On the other hand, the open-ended nature of the subsidy gives employers and employees an incentive to select more extensive coverage than they otherwise would. Because premiums are paid with before-tax dollars whereas wages are subject to taxes, health insurance effectively costs less than other goods and services—so workers will tend to purchase more of it, up to a point. In CBO's judgment, the available evidence indicates that the second effect is stronger and that the tax exclusion increases average premiums for employment-based plans by 10 percent to 15 percent.

Excise Tax on High-Premium Health Plans

Starting in 2020, an excise tax will be levied on employment-based health plans with premiums that exceed certain thresholds. (The tax was originally scheduled to start in 2018, but legislation enacted in December 2015 delayed its implementation.) For those plans, the excise tax will largely counteract the incentives created by the federal tax exclusion—thus encouraging the affected firms and workers to seek less expensive coverage.

The excise tax will equal 40 percent of the amount by which annual premiums exceed the thresholds, which are projected to be about $10,800 for single plans and

18. See Congressional Budget Office, *Health-Related Options for Reducing the Deficit: 2014 to 2023* (December 2013), p. 64, www.cbo.gov/publication/44906. The exclusion is a tax expenditure—a provision in the tax code that resembles federal spending by providing financial assistance to specific activities, entities, or groups of people. Its estimated cost here consists of reductions in income and payroll taxes. Such an estimate, however, may differ from a cost estimate for a proposal to eliminate the exclusion. That is because CBO's and JCT's estimates of tax expenditures, unlike their cost estimates, do not incorporate any behavioral responses of taxpayers or changes in the timing of tax payments. For a general discussion of tax expenditures, see Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2014–2018*, JCX-97-14 (August 2014), http://go.usa.gov/cBPJ5.

19. Gary Burtless and Pavel Svaton, "Health Care, Health Insurance, and the Distribution of American Incomes," *Forum for Health Economics and Policy*, vol. 13, no. 1 (February 2010), http://dx.doi.org/10.2202/1558-9544.1194; Paul Ginsburg, *Alternative Health Spending Scenarios: Implications for Employers and Working Households* (Brookings Institution, April 2014), http://tinyurl.com/ksh9p47; and Katherine Baicker and Amitabh Chandra, "The Veiled Economics of Employee Cost Sharing," *JAMA Internal Medicine*, vol. 175, no. 7 (July 2015), pp. 1081–1082, http://dx.doi.org/10.1001/jamainternmed.2015.1109.

$29,100 for family plans in 2020. The thresholds are scheduled to rise at the rate of overall price inflation in later years.[20] Because prices are projected to grow more slowly than health insurance premiums, CBO and JCT expect the tax to affect more health plans and more people over time.

Although the tax is levied on insurers, plan administrators, and employers that self-insure, economic theory and empirical evidence indicate that they will pass on the cost of the tax to employers and workers in the form of higher premiums. However, CBO and JCT expect that many of those employers will seek to avoid the tax by offering their workers coverage with premiums that are below the thresholds; in fact, some evidence indicates that employers have already started to take steps in that direction.[21] Because of that response, the projected result of the excise tax is lower average premiums, although premiums for most plans will not be affected within the next decade.

The excise tax will increase federal revenues, CBO and JCT expect, even though some employers will take steps to keep premiums below the thresholds. The reason is that, in order to attract and retain workers, employers offering less expensive coverage are expected to increase workers' wages correspondingly to hold total compensation about the same. Because those wages will be taxable, total tax revenues will increase. (If employers did not increase workers' wages or other forms of compensation, their profits would increase—and those profits too would generally be taxable.) Overall, the agencies project that revenues resulting from the excise tax will rise from $2 billion in fiscal year 2020 to $20 billion in fiscal year 2025; over fiscal years 2016 through 2025, those revenues are projected to total $70 billion.[22] Of that sum, between 20 percent and 25 percent will represent excise tax receipts, CBO and JCT estimate; the remainder will come from the projected changes in employees' taxable compensation.

Tax Preferences for Out-of-Pocket Spending

The tax code allows people who establish accounts of certain types to pay out-of-pocket costs for health care with before-tax dollars. For example, people with employment-based coverage may direct a predetermined part of their pay into flexible spending accounts (FSAs) for medical care. That money is excluded from income and payroll taxes, and the employees may use it to pay for health care expenses not covered by their insurance plan—though they may forfeit some of the money if they do not spend it by the end of the year.[23] Contributions to FSAs are limited to $2,550 in 2016, and that limit is indexed to general inflation for later years.

Another tax preference for out-of-pocket spending is available to people enrolled in certain high-deductible health plans (HDHPs). If those enrollees have employment-based coverage, and if they establish and contribute to an associated health savings account (HSA), those contributions are excluded from income and payroll taxes.[24] The money may be used to pay for the enrollees' deductible—that is, the amount that an enrollee must pay out of pocket each year before the insurer begins to pay—and other medical expenses. Unspent contributions to an HSA may be rolled over from year to year, and if they are ultimately used to pay for health care, they are never taxed as income.[25]

20. The thresholds are also subject to various adjustments and are higher for certain retirees and for workers in certain professions.

21. See Towers Watson and the National Business Group on Health, *The New Health Care Imperative: Driving Performance, Connecting to Value* (May 2014), p. 6, http://tinyurl.com/olnnjo8.

22. The excise tax will also affect federal revenues and outlays by changing people's sources of insurance coverage. Therefore, a recent estimate by CBO and JCT of the cost of repealing the excise tax by itself was somewhat larger than the figures shown here. For more information, see Congressional Budget Office, cost estimate for reconciliation recommendations of the House Committee on Ways and Means (October 2, 2015), www.cbo.gov/publication/50869. Because subsequent legislation delayed the implementation of the excise tax, the net cost of repealing it over the 2016–2025 period would be somewhat lower than that cost estimate indicated.

23. Employers may treat funds that remain in an FSA at the end of the year in one of two ways: They may allow employees to transfer up to $500 into their FSA for the new year; or they may provide a grace period of two and a half months at the start of the new year, during which employees may use the remaining funds. See Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans*, Publication 969 (March 2015), www.irs.gov/publications/p969.

24. People purchasing a qualifying HDHP in the nongroup market are also allowed to establish and use an HSA; their contributions (up to the annual limit) are deductible from their income taxes but not from their payroll taxes.

25. HDHPs coupled with HSAs are sometimes called consumer-directed health plans, although that term also includes similar plans known as health reimbursement arrangements and medical savings accounts. For more information, see Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006), www.cbo.gov/publication/18261.

To contribute tax-preferred funds to an HSA in 2016, people must be enrolled in a plan with an annual deductible of at least $1,300 for single policies or $2,600 for family policies, and the plan's annual limit on out-of-pocket costs cannot exceed $6,550 for single policies or $13,100 for families. Enrollees and their employers are generally allowed to contribute as much as $3,350 for single coverage or $6,750 for family coverage in 2016. All of those thresholds and limits increase each year at the rate of general inflation.

The tax exclusions for out-of-pocket spending have complex effects on premiums. Subsidizing people's out-of-pocket costs effectively reduces the price of their health care services, which encourages them to use more care—and greater use of care usually translates into higher premiums. But for HSAs, two factors work in the opposite direction. First, in order to take advantage of the tax exclusion, people must enroll in a qualifying HDHP. The exclusion thus encourages enrollment in HDHPs—which have relatively low premiums, because they have relatively high deductibles—and that helps bring down average premiums. Second, allowing employees to pay out-of-pocket costs with pretax dollars, just as they do for insurance premiums, increases their incentive to select HDHPs with higher out-of-pocket costs and lower premiums.

Two considerations tend to limit the effects that HSAs have on premiums. First, analyses have found that many of the enrollees in HDHPs who could have established an HSA have not done so.[26] Second, the value of tax-excluded contributions to HSAs (and to accounts of other types) will be added to plans' premiums for the purpose of determining whether the coverage is subject to the high-premium excise tax—so in effect, for some people, those contributions could be subject to the tax. That taxation will further restrain the use of HSAs.

Premium Tax Credits

Before 2014, few subsidies were available for nongroup coverage.[27] Now, however, some people who buy nongroup coverage in health insurance exchanges qualify for tax credits that cover at least part of their premium. To qualify, they must meet four conditions: They must be U.S. citizens or otherwise lawfully present in the country; they must not be eligible for Medicare, Medicaid, or certain other sources of coverage; they must not have an offer of coverage from their employer or from a family member's employer that is considered affordable under federal law; and their income must generally be between 100 percent and 400 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL).[28] The tax credit is refundable; that is, its value may exceed the income tax liability of the recipient.

Eligibility for the credits varies by state, because it depends on Medicaid eligibility, which also varies by state. For example, states may now expand Medicaid so that adults with income up to 138 percent of the FPL are eligible, but they are not required to do so. In states that have adopted that expansion, eligibility for the premium tax credits is generally limited to people whose income is between 138 percent and 400 percent of the FPL. In states that have not expanded Medicaid, people whose income is between 100 percent and 138 percent of the FPL may be eligible for tax credits as well—but people whose income is below 100 percent of the FPL are generally ineligible, even if they do not qualify for Medicaid. As of 2015, CBO estimates, about half of the people who met the new eligibility criteria for Medicaid lived in states that had expanded coverage. CBO expects that share to grow substantially over time.

The tax credit equals the difference between the premium for a person's reference plan and a specified share of that person's income (see Table 2). For example, in 2015, the share of income for a person whose income equaled 150 percent of the FPL was set at 4.02 percent; the credit therefore equaled the difference between that amount and the reference plan's premium. The specified percentages

26. See Robin A. Cohen and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2014* (National Center for Health Statistics, September 2014), Figure 6, http://go.usa.gov/crckQ; and Paul Fronstin, *HSA Balances, Contributions, Distributions, and Other Vital Statistics*, Issue Brief 400 (Employee Benefit Research Institute, June 2014), http://tinyurl.com/o26ht74.

27. Then as now, self-employed people could deduct their premium payments for nongroup insurance from their taxable income, and all tax filers could deduct medical expenses (including premiums) that exceeded a specified share of their income. For more information, see Matthew Rae and others, *Tax Subsidies for Private Health Insurance* (Kaiser Family Foundation, October 2014), Part III, http://tinyurl.com/ofqjkwh.

28. For more information, see Internal Revenue Service, "Questions and Answers on the Premium Tax Credit" (accessed November 24, 2015), http://go.usa.gov/craZQ.

Table 2.

Premium Tax Credits and Premium Payments for Two Hypothetical Families in 2015

	Lower-Income Family of Four	Middle-Income Family of Four
	Calculation of Family's Premium Tax Credit	
Family's Annual Income		
Percentage of FPL[a]	150	300
Dollar amount	35,775	71,550
Total Premium for a Reference Plan (Dollars)	10,000	10,000
What the Family Would Have to Pay for a Reference Plan		
Percentage of annual income	4.02	9.56
Dollar amount	1,438	6,840
Family's Premium Tax Credit (Dollars)	8,562	3,160
	Calculation of Family's Payment for Various Plans (Dollars)	
Plan With Lower Premium		
Total premium	9,500	9,500
Family's premium tax credit	8,562	3,160
Family's Payment	**938**	**6,340**
Reference Plan		
Total premium	10,000	10,000
Family's premium tax credit	8,562	3,160
Family's Payment	**1,438**	**6,840**
Plan With Higher Premium		
Total premium	10,500	10,500
Family's premium tax credit	8,562	3,160
Family's Payment	**1,938**	**7,340**

Source: Congressional Budget Office.

The Affordable Care Act defines a person's reference plan as the second-lowest-cost silver plan available to that person through a health insurance exchange. Silver plans are those that cover about 70 percent of the costs of covered health care services for a broadly representative group of enrollees. The actual cost of a reference plan's premium may vary for several reasons; the $10,000 shown here is merely illustrative.

FPL = federal poverty level.

a. Premium tax credits in 2015 were calculated on the basis of the 2014 FPL, which was $23,850 for a family of four.

increase with income. For example, people with an income equaling 200 percent of the FPL paid 6.34 percent of their income for the reference plan in 2015, and people with an income between 300 percent and 400 percent of the FPL paid 9.56 percent. Those percentages of income are indexed to rise over time.[29]

Lower-income families thus receive a larger tax credit than middle-income families do, but the value of the credit generally does not depend on which plan any given family chooses. People receiving the credit can buy a more expensive plan and pay the additional premium, or they can buy a less expensive one and reduce their premium. (They may not receive a rebate if the premium is less than the amount of the credit, however.) Unlike the tax exclusion for employment-based premiums, therefore, the tax credits are not structured in a way that encourages people to buy more extensive coverage, and consequently they do not put the same kind of upward pressure on nongroup premiums.

In other respects, however, the tax credits and the tax exclusion have similar effects. Like the exclusion, the

29. For a discussion of the indexing provisions, see Congressional Budget Office, *Additional Information About CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges* (May 2011), www.cbo.gov/publication/41464.

credits encourage people with lower expected costs for health care—who may not value insurance as highly as people with higher expected costs do—to buy insurance. That helps keep premiums down. (It also helps offset the effects on premiums of new regulations, described below, that have made it easier for people with higher expected costs to purchase nongroup coverage.) At the same time, the tax credits effectively increase recipients' net income, just as the exclusion does—putting slight upward pressure on premiums, because recipients are likely to spend some of that increase on more extensive health insurance.

CBO and JCT estimate that in fiscal year 2016, the tax credits will cost the federal government about $37 billion. The cost will grow in later years because of projected increases in premiums for exchange plans, even though the number of subsidized enrollees is projected to decline slightly. From fiscal years 2016 through 2025, the credits are projected to cost $691 billion.[30]

Cost-Sharing Subsidies

Some people who buy nongroup coverage through an exchange are also eligible for cost-sharing subsidies, which the federal government pays to their insurer to reduce their out-of-pocket expenses. To be eligible, people must generally have income that is between 100 percent and 250 percent of the FPL, be eligible for premium tax credits, and buy a silver plan.

The subsidies are designed to increase the percentage of covered health care costs that a silver plan pays (that is, the plan's actuarial value) for an average enrollee in various income groups. Specifically, the subsidies increase a plan's actuarial value from 70 percent to 94 percent for enrollees with income between 100 percent and 150 percent of the FPL; to 87 percent for enrollees with income between 150 percent and 200 percent of the FPL; and to 73 percent for enrollees with income between 200 percent and 250 percent of the FPL. The subsidies tend to increase average premiums in two ways: by making exchange plans more attractive to people with health problems (who would expect to gain more from the subsidies than other people would); and by lowering the cost of health care, thus encouraging people to use more of it.

CBO and JCT estimate that in fiscal year 2016, the cost-sharing subsidies will cost the federal government about $8 billion. Those costs, like the costs of the premium tax credits, will grow in later years. From fiscal years 2016 through 2025, the subsidies are projected to cost $132 billion.

Transitional Reinsurance

A temporary federal program known as transitional reinsurance makes payments to insurers in the nongroup market whose enrollees, in plans sold between 2014 and 2016, incur particularly high costs.[31] Any nongroup plan may receive payments, whether it is sold in the exchanges or not, as long as it complies with the new market and benefit standards that went into effect in 2014 (which are discussed further below).

The funding for the payments comes from a fee per enrollee that is levied on most insurers in the nongroup, small-group, and large-group markets and on employers providing self-insured coverage. The Department of Health and Human Services (HHS) set the fee at $63 per enrollee for plans operating in 2014, $44 per enrollee for 2015, and $27 for 2016.

Qualifying nongroup insurers must pay the fee, but on average, the reinsurance payments that they receive will be greater than the fees that they pay. The reinsurance program therefore operates as a subsidy for those insurers—and by covering costs that would otherwise have to be financed by premiums, it reduces nongroup premiums. By law, the subsidy was supposed to total $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016. According to CMS, however, insurers' requests for 2014 payments were somewhat lower, totaling about $8 billion.

Another way to measure the size of the subsidy is to examine its effect on premiums. Specifically, CBO and JCT have estimated that the reinsurance payments for 2014 made premiums for nongroup exchange plans approximately 10 percent lower than they would have been otherwise. That percentage is expected to decrease

30. A separate tax credit is available for certain employers that purchase small-group coverage: Employers with fewer than 25 full-time-equivalent employees may qualify for a credit covering a portion of the premium if the annual wages of their employees average less than $50,000. CBO and JCT project that the subsidy will cost the federal government $11 billion from fiscal years 2016 through 2025.

31. For the 2014 benefit year, CMS paid qualifying insurers 100 percent of their costs between $45,000 and $250,000; for 2015, it will pay 50 percent of those costs; and for 2016, it will pay 50 percent of their costs between $90,000 and $250,000.

in 2015 and 2016—both because the total payments will be smaller and because, as more people enroll in qualifying plans in those years, the payments will represent a smaller percentage of insurers' costs. After 2016, transitional reinsurance is expected to have no direct effect on nongroup premiums.

Insurers and employers operating in the small-group and large-group markets, by contrast, are ineligible to receive payments, so CBO expects that they will charge higher premiums in order to pay the fees. Because payments out and payments in are supposed to be equal, the effect of the program on average premiums overall—that is, in the nongroup, small-group, and large-group markets together—is expected to be negligible.

Other Taxes and Fees Imposed on Private Insurers

The ACA imposed several taxes and fees on insurers in addition to those mentioned above. One of them, usually called the health insurer tax, is allocated among insurers on the basis of their market share for fully insured plans, so it is effectively a tax on premiums for those plans. By law, it started at $8.0 billion in 2014 and increased to $11.3 billion in 2015 and 2016. Although recent legislation suspended the tax in 2017, it is scheduled to total $14.3 billion in 2018 and will increase at the rate of premium growth thereafter.

Another is a user fee paid by insurers that participate in health insurance exchanges. The fee was set at 3.5 percent of premiums in 2014 for federally run exchanges and at various rates for state-run exchanges. Insurers offering plans in the federally run exchanges paid about $400 million in user fees in fiscal year 2014 and about $900 million in 2015; CMS expects them to pay about $1.4 billion in 2016.[32]

Two smaller fees are an assessment that primarily finances the Patient-Centered Outcomes Research Institute (PCORI), which was established by the ACA, and another to cover the administrative costs of operating a system of risk adjustment, which is described later in this report. All plans (including self-insured plans) pay the PCORI assessment, which is about $2 per enrollee in 2016 and is set to increase at the rate of growth for national health expenditures thereafter. CBO estimates that health plans' payments for that assessment will total about $400 million in fiscal year 2016. The risk-adjustment assessment is $1 per enrollee per year, but it applies only to fully insured plans in the nongroup and small-group markets in states that use the federal risk-adjustment system. CMS expects those payments to total about $20 million in 2016.

CBO and JCT anticipate that insurers will generally pass the fees on to consumers in the form of higher premiums; for example, JCT has estimated that the health insurer tax will increase premiums for the affected plans by between 2.0 percent and 2.5 percent.[33] In some cases, however, the premium increases may not be as large as the fees—for example, if some of the money that insurers pay in user fees for health insurance exchanges substitutes for expenses that the insurers had to incur on their own before the exchange system existed.

Federal Regulations That Affect Premiums

A number of federal regulations related to health insurance affected premiums even before the ACA was enacted, but the ACA expanded the scope of federal regulations considerably, especially in the nongroup market. This report focuses on regulations resulting from the ACA, because proposals designed to affect premiums often involve changing those regulations rather than the ones that were previously in place.[34]

The regulations resulting from the ACA include requirements for most people to have insurance and for larger employers to offer it. Together, those two requirements, which are called the individual mandate and the employer mandate, are expected to increase enrollment in private insurance plans. The individual mandate is also expected to reduce average premiums in the nongroup market by encouraging relatively healthy people to enroll.

32. Centers for Medicare & Medicaid Services, *Fiscal Year 2016 Justification of Estimates for Appropriations Committees* (February 2015), p. 14, http://go.usa.gov/cn7MJ.

33. For additional discussion, see Thomas A. Barthold, Joint Committee on Taxation, letter to the Honorable Jon Kyl, United States Senate (June 3, 2011), http://tinyurl.com/oyrydvj (PDF, 371 KB).

34. The regulations discussed here include provisions of law as well as the regulations issued to implement them. Two of the regulations—the individual mandate and the employer mandate—involve penalties that are essentially taxes and could alternatively have been listed above in the discussion of subsidies, taxes, and fees. Some federal regulations affect competition among insurers and among health care providers, thus affecting premiums, but this report does not mention them, because it focuses on regulations resulting from the ACA.

Table 3.

Major Federal Regulations Affecting Premiums

	Relevant Health Insurance Market				
	Large-Group		Small-Group		
	Fully Insured	Self-Insured	Fully Insured	Self-Insured	Nongroup
Individual Mandate	X	X	X	X	X
Employer Mandate	X	X			
Regulations Governing Insurance Benefits					
Requirement to cover "essential health benefits"			X		X
Prohibition on excluding preexisting conditions	X	X	X	X	X
Minimum actuarial value (Generally 60 percent)[a]	X	X	X		X
Regulations Governing Insurance Offers and Pricing					
Guaranteed issue and guaranteed renewability[b]			X		X
Modified community rating[c]			X		X
Requirements for review of proposed premium increases			X		X
Risk Adjustment			X		X
Minimum Medical Loss Ratios	X		X		X

Source: Congressional Budget Office.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected. A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

The small-group market generally serves employers with up to 50 employees.

In each market, plans that are "grandfathered" and certain other plans are exempt from many regulations.

a. Large employers may be penalized under the employer mandate if they offer coverage that has an actuarial value of less than 60 percent.

b. For the fully insured large-group market, guaranteed renewability applies; guaranteed issue does not.

c. For large employers and for small ones that self-insure, the total premium or cost per enrollee may vary because of differences in the average health of each firm's enrollees. However, an individual employee's eligibility to enroll in a plan and that employee's required premium payment generally cannot vary on the basis of health.

Other regulations govern the benefits that insurers must cover and the prices that they may charge. Those regulations tend to increase average premiums, primarily in the nongroup market. They do that by requiring more extensive coverage than was typically purchased in the nongroup market under prior law and by making it easier for people with high health care costs to obtain coverage in that market.

Another regulation establishes a program of risk adjustment, which takes money from insurance plans with healthier enrollees and gives it to insurance plans with sicker ones. Still another regulation establishes a minimum medical loss ratio (MLR), which is the share of premiums that may go toward insurers' administrative costs and profits. CBO and JCT estimate that those two regulations do not substantially affect average premiums but that they do affect the distribution of premiums among plans.

One complication that arises in assessing the effects of regulations on insurance premiums is that they differ by market, and those markets differ substantially in size (see Table 3). Of the roughly 180 million nonelderly people who will have employment-based or nongroup coverage in 2025, CBO and JCT project, about 75 percent will be covered through employers with more than 50 workers; those people will generally have coverage through the large-group market. An additional 10 percent will be covered in the small-group market, and the remaining 15 percent will be covered in the nongroup market. Another complication that arises in assessing the regulations' effects on premiums is that some parts of each market are exempt from certain regulations.

The Individual Mandate

Since 2014, an individual mandate has required most people to obtain health insurance. It is closely related to two other ACA regulations (discussed below), which

require insurers to offer coverage to all applicants and prohibit insurers from charging higher premiums to people with health problems. On their own, those other two regulations make it easier for people to wait until they develop health problems to sign up for coverage; the individual mandate discourages such delays.

People who do not comply with the individual mandate (and do not obtain an exemption) must pay a penalty. The penalty equals the greater of two amounts, each of which is subject to a cap: a fixed dollar amount assessed for each uninsured person in a household; and a share of the difference between the household's adjusted gross income and its income threshold for tax filing.[35] The fixed dollar amount per uninsured adult rises from $95 in 2014 to $695 in 2016 and will rise at the rate of general inflation thereafter; the penalty per child is half as large; and a household's total penalty may be no larger than three times the penalty per adult. The income-based penalty rises from 1 percent in 2014 to 2.5 percent in 2016 and later, but it may be no larger than the national average premium for a bronze plan sold in the exchanges. For people who are uninsured for only part of the year, the penalty is reduced.

Although most legal residents are subject to the individual mandate, a number of exemptions apply. For example, people who would have to pay more than a certain share of their income to acquire health insurance do not face a penalty; that share was 8.05 percent in 2015. People with income below the tax-filing threshold are also exempt. CBO and JCT expect that a substantial majority of the people who remain uninsured will receive an exemption. All told, the agencies expect that, on average, about 4 million people will pay the penalty during any given month in 2017 (including dependents who have the penalty paid on their behalf). Because some people will be insured in some months and uninsured in others, the total number of people who pay a penalty during that year will be greater.[36]

Notwithstanding the exemptions, the mandate significantly reduces average premiums, CBO and JCT estimate. It does so by encouraging healthier people to obtain insurance, which lowers average spending on health care among the insured population. Although the penalty may be smaller than the premium that a person would have to pay for coverage, it nevertheless increases the cost of remaining uninsured and thus means that more people will gain financially by obtaining coverage. That financial analysis takes into account the benefits of having insurance—including a reduced risk of facing large medical bills—and the fact that people who pay the penalty receive no benefits in return. CBO also expects that some people will obtain coverage not for financial reasons but simply because the mandate exists. That expectation is based on an analysis of people's responses to other mandates and their tendency to comply with laws even when the expected costs of noncompliance are low.[37]

A recent CBO estimate of the effects of repealing the individual mandate illustrates its impact on premiums. Specifically, CBO estimated in 2015 that repealing that mandate while maintaining all other provisions of current law would increase average premiums in the nongroup market by roughly 20 percent.[38]

The Employer Mandate

The ACA also established an employer mandate, which requires larger employers to offer coverage to

35. The tax-filing thresholds depend on a person's age and filing status and increase annually. In 2015, the thresholds for people younger than 65 were $10,300 for single filers and $20,600 for married couples. For more information, see Internal Revenue Service, "Individual Shared Responsibility Provision—Reporting and Calculating the Payment" (accessed January 15, 2016), http://go.usa.gov/crReY.

36. For additional discussion about the penalty, see Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update* (June 2014), www.cbo.gov/publication/45397, and cost estimate for H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (October 20, 2015), pp. 10–12, www.cbo.gov/publication/50918.

37. See David Auerbach and others, *Will Health Insurance Mandates Increase Coverage? Synthesizing Perspectives From the Literature in Health Economics, Tax Compliance, and Behavioral Economics*, Working Paper 2010-05 (Congressional Budget Office, August 2010), www.cbo.gov/publication/21600; and Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 48–54, www.cbo.gov/publication/41746.

38. Repeal would also increase the number of people without health insurance by about 14 million in 2025, CBO and JCT estimated, and would reduce federal deficits by $305 billion over 10 years. See Congressional Budget Office, preliminary estimate of the budgetary effect of eliminating the requirement that individuals purchase health insurance and associated penalties (September 15, 2015), www.cbo.gov/publication/50821.

their full-time workers or face a penalty.[39] In 2016, an employer is liable for the penalty if it has 50 or more full-time-equivalent employees, if it does not offer them coverage, and if any of those employees receive premium tax credits. The coverage offered by the employer must have an actuarial value of at least 60 percent, and it must be offered to at least 95 percent of the firm's full-time workers. For 2016, the penalty is $2,160 per full-time employee (after the first 30). Furthermore, larger employers that offer coverage may nevertheless be liable for a penalty if any of their full-time employees receive premium tax credits; for 2016, that penalty is $3,240 for each of those employees.[40] In subsequent years, the amounts of both penalties are indexed to average growth in premiums.[41]

By itself, the employer mandate is not projected to have a noticeable impact on average insurance premiums, because it has only limited effects on the overall size and composition of the insured population. Although the mandate affects the allocation of coverage among markets—making the share of the privately insured population that has employment-based coverage larger than it would be otherwise, and the share that has nongroup coverage smaller—that shift also will not have a noticeable effect on average premiums.

Regulations Governing Insurance Benefits

States have traditionally been the primary regulators of insurance benefits. In 2014, however, many federal regulations established by the ACA went into effect that governed the benefits that new policies sold in small-group and nongroup markets must provide. Those that have the largest effects on premiums govern coverage of specified health benefits, coverage of preexisting conditions, and minimum actuarial value.

Requirement to Cover "Essential Health Benefits." New plans sold in the small-group and nongroup markets must cover 10 categories of health benefits that the ACA defines as essential.[42] Within federal guidelines, states specify which particular services and treatments are included in each category. Those specifications generally reflect earlier coverage patterns in each state's small-group market. The specifications probably vary more for some categories—such as rehabilitative and habilitative services and devices—both because they are difficult to define and because coverage of benefits in those categories varied widely under prior law. Other categories, such as hospitalization, are more clear-cut.

Prohibition on Excluding Preexisting Conditions. Another federal regulation requires small-group and nongroup insurers to cover essential health benefits for the treatment of enrollees' preexisting health conditions. Insurers in the nongroup market commonly declined to cover services to treat preexisting conditions before 2014 even when a state generally required coverage of those services. Such exclusions were more limited in employment-based plans, partly because of prior federal regulations.

Minimum Actuarial Value. A third set of regulations specifies the share of costs for covered services that new plans must cover. Starting in 2014, the ACA requires the actuarial value of most newly sold plans in the nongroup and small-group markets to be at least 60 percent.[43]

39. The implementation of that mandate and of the associated penalties was originally scheduled for 2014 but was delayed until 2015. For discussion of that delay, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), p.17, www.cbo.gov/publication/45231.

40. An employee of a firm that offers coverage may qualify for premium tax credits or cost-sharing subsidies if the law does not deem that coverage affordable by that employee, if the coverage is not offered to that employee, or if it does not meet federal requirements. For more information, see Internal Revenue Service, "Types of Employer Payments and How They Are Calculated" (accessed November 24, 2015), http://go.usa.gov/c2MWj.

41. For more information, see Minimum Value of Eligible Employer-Sponsored Health Plans, 80 Fed. Reg. 52678 (proposed September 1, 2015), http://go.usa.gov/c2M94.

42. The categories are ambulatory patient services (such as visits to a doctor); emergency services; hospitalization; laboratory services; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; pediatric services, including oral and vision care; prescription drugs; preventive and wellness services and chronic disease management; and rehabilitative and habilitative services and devices. (Habilitative services are health care services that help a person keep, learn, or improve skills and functioning for daily living.)

43. Some people, such as those younger than 30, may purchase catastrophic-coverage plans in the nongroup market; those plans have relatively high deductibles and limits on out-of-pocket costs. Several analysts have estimated that the actuarial value of those plans is about 57 percent, on average. See Gary Claxton and others, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Kaiser Family Foundation, February 2013), http://tinyurl.com/nc3rrvj; and Catherine Murphy-Barron and others, *Ten Critical Considerations for Health Insurance Plans Evaluating Participation in Public Exchange Markets* (Milliman, December 2012), http://tinyurl.com/q3268tf (PDF, 216 KB).

Actuarial value is the percentage of total costs for covered benefits that a plan pays when covering a standard population, which means that the plan will pay more for some enrollees and less for others—depending on the services that they use and the requirements for out-of-pocket spending that apply to those services.

Effects on Premiums. In 2009, CBO and JCT analyzed the effects on premiums of a proposal akin to the ACA; among other things, the proposal included regulations similar to the three sets of regulations just discussed.[44] In 2010, the agencies concluded that those estimated effects on premiums would probably be quite similar to the effects of the three corresponding sets of regulations in the ACA.[45] Although CBO and JCT have not formally updated the 2009 estimates, they would probably still be broadly similar to the effects of the ACA regulations if they were updated today. However, average premiums for exchange plans have proved lower than CBO and JCT originally anticipated, and one possible reason for that difference is that the regulations may have had smaller effects, on net, than the agencies expected.[46]

The regulations in the proposal governing insurance benefits would have made nongroup premiums 27 percent to 30 percent higher in 2016 than they would have been otherwise, the 2009 analysis found (although other provisions in the proposal would have reduced premiums). Most of that increase would have resulted from the regulation of actuarial values, which had averaged about 60 percent; the other two sets of regulations, which required insurers to cover more services than was typical in the nongroup market and to cover preexisting conditions, would also have raised premiums, but less. An offsetting consideration was that standardizing insurance offerings would have fostered more vigorous competition by making it easier for consumers to compare nongroup plans—which would have reduced premiums to a small degree, the two agencies estimated.

The estimated effects of the proposal on the other markets for health insurance were much smaller. CBO and JCT concluded that those regulations in the proposal would affect only a small share of policies sold in the small-group market and virtually no policies sold in the large-group market. Nearly all small-group plans were already covering most of the proposed benefits and already had actuarial values of at least 60 percent. Large-group plans were required by prior law to cover preexisting conditions in most cases; furthermore, they were exempted from most of the proposal's new regulations. As a result, the agencies estimated that the proposal would increase small-group premiums only slightly and would have negligible effects on large-group premiums.[47]

Regulations Governing Insurance Offers and Pricing

The ACA also established regulations governing the terms under which insurance policies could be offered and priced. Some of those regulations raise average premiums by making it easier or less expensive for people with higher expected health care costs to obtain coverage. Others, which govern the review of insurers' proposals for premium increases, have effects on premiums that are probably small but are harder to estimate.

Guaranteed Issue and Guaranteed Renewability. Starting in 2014, the ACA required health plans to accept all applicants during specified open-enrollment periods and to renew that coverage at the employer's or enrollee's request. Those regulations tend to raise average premiums by increasing the likelihood that people with higher health care costs will enroll.

The effects on premiums are strongest in the nongroup market, because only a few states had previously imposed similar regulations on that market. The small-group market, by contrast, was already governed by guaranteed-issue and guaranteed-renewability requirements under

44. Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

45. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (Final Health Care Legislation) (March 20, 2010), p. 15, www.cbo.gov/publication/21351.

46. For more discussion about changes in projected premiums, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), www.cbo.gov/publication/45231, and *Updated Budget Projections: 2015 to 2025* (March 2015), www.cbo.gov/publication/49973.

47. The ACA, like the earlier proposal, includes provisions that apply in all markets, such as a prohibition on annual or lifetime limits on certain insurance benefits and a requirement to cover certain preventive services without cost sharing. CBO expects those provisions to have minimal effects on average premiums, in part because plans may alter cost-sharing requirements for other benefits to limit the overall effects on premiums.

prior law.[48] The large-group market was also subject to guaranteed-renewability requirements, and it is not subject to guaranteed-issue requirements.

Modified Community Rating. In addition, the ACA has instituted modified community rating of premiums; that is, it limits the degree to which premiums may vary and the factors that insurers may use to set them. Premiums for a given plan sold in a given area may vary only on the basis of the age of the enrollee, whether the enrollee uses tobacco, and the number of people covered by a particular policy. Even though premiums may vary on the basis of the enrollee's age, they may not vary for that reason by a ratio of more than 3 to 1 among adults, and variation because of tobacco use is also limited. Insurers are newly barred from varying a plan's premium on the basis of an enrollee's health status or sex. Previously, most states allowed insurers to charge higher premiums to enrollees who had more health problems and thus higher expected costs.

Modified community rating tends to raise average premiums for two reasons. First, prohibiting insurers from varying premiums on the basis of health lowers premiums for people with higher expected costs and raises them for people with lower expected costs; that encourages the former to enroll and discourages the latter, which results in a less healthy pool of enrollees. Second, the 3-to-1 limit on varying premiums by age increases premiums for younger enrollees and decreases them for older ones—because older people's health care costs exceed younger people's by a larger degree than that, on average. According to one recent study, for example, average spending among people who are 64 years old is about 4.8 times as high as average spending among people who are 21 years old.[49] The 3-to-1 limit thus encourages older people to enroll and discourages younger people, and because the costs of the former are greater, average premiums rise.

Requirements for Review of Proposed Premium Increases. States have historically been responsible for reviewing and approving insurers' proposed premiums in the nongroup and small-group markets. The states' procedures vary widely, however: Some require insurers only to file their premium rates, whereas others apply strict scrutiny. As of 2010, according to several studies, insurers in about half of the states had to obtain approval for their premiums or premium increases.[50] In many of those states, oversight requirements applied differently to the nongroup and small-group markets, and in some cases, they applied only to particular insurers or types of plan. The specific rules governing the review and approval process also varied widely. To take just one example: Wisconsin's health insurance commission had the authority to reject premium increases that it considered excessive—but only in markets that, in the commission's judgment, lacked reasonable levels of competition among insurers.

Since its enactment in 2010, the ACA has provided federal funding to expand such state-level reviews. Also, insurers that increase premiums by more than a specified percentage (currently 10 percent) must submit a justification to HHS and the state. HHS does not have the authority to reject proposed increases, but if it or the state deems an increase unreasonable, the insurer must post an explanation of the increase on its website, and the state may choose to exclude the insurer from the state's health insurance exchange.

Reviews appear to yield premiums that are lower than those initially proposed by insurers. One study found that insurers' proposed premium increases in 2011 would have resulted in an average increase of 6.8 percent—but that in the end, premiums rose by just 5.4 percent.[51] More recently, an HHS report found that average premium

48. The Health Insurance Portability and Accountability Act of 1996 included guaranteed-issue and guaranteed-renewability requirements for the small-group market. See Hinda R. Chaikind and others, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, Report for Congress RL31634 (Congressional Research Service, January 2005).

49. See Dale H. Yamamoto, *Health Care Costs—From Birth to Death* (Society of Actuaries, June 2013), p. 44, http://tinyurl.com/q5z2zb9.

50. See Kathryn Linehan, *Individual and Small-Group Market Health Insurance Rate Review and Disclosure: State and Federal Roles After PPACA*, Issue Brief 844 (National Health Policy Forum, September 2011), http://tinyurl.com/7h36w32 (PDF, 430 KB); Sabrina Corlette and Janet Lundy, *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable* (Kaiser Family Foundation, December 2010), http://tinyurl.com/ougbqt6; and National Conference of State Legislatures, *States Implement Health Reform: Premium Rate Reviews* (December 2010), www.ncsl.org/documents/health/HRPremium.pdf (577 KB).

51. Cynthia Cox and others, *Quantifying the Effects of Health Insurance Rate Review* (Kaiser Family Foundation, October 2012), http://tinyurl.com/pwqyp5s.

increases in the nongroup and small-group markets fell by about 1 percentage point after going through review procedures in 2013.[52] The final rates may have been lower than the proposed rates because they were modified by a state or an insurer, because a state denied an insurer's proposal, or because an insurer withdrew its proposal.

Whether reviews reduce premiums on net is not clear, however. For one thing, insurers might propose higher premiums initially than they would have otherwise, expecting them to be reduced during the review process. Also, over a longer period than the ones examined by those two studies, insurers might limit premium increases during years of high cost growth, when regulatory scrutiny is probably heavier, but make up for it with larger increases during years of low cost growth. Insurers probably have more latitude to take such steps in areas where the insurance market is less competitive.

Risk Adjustment

The ACA established several programs to redistribute risk among insurers. One of them is the reinsurance program discussed above, which takes funds from some insurance plans and distributes them to others to cover some of the costs of nongroup enrollees with very high levels of medical spending. Another is the risk-adjustment program, in which payments are based not on insurers' actual costs but on their predicted costs.[53] Specifically, certain insurers receive payments from the federal government if their enrollees have more health problems and thus are expected to have higher-than-average costs for health care. Conversely, plans with enrollees who are healthier have to make payments to the federal government.[54]

The risk-adjustment program applies to all fully insured plans that are newly sold in the nongroup or small-group markets. CMS estimates that transfers among plans for 2014 amounted to 10 percent of premiums in the nongroup market and 6 percent of premiums in the small-group market.[55] Overall, the program is budget neutral, and CBO currently projects that payments to and from the government will each total nearly $150 billion over the next decade.

Because risk adjustment redistributes revenues among insurers, it is not expected to have significant effects on average premiums—but it does dampen variation in premiums. Insurers with sicker enrollees can charge lower premiums than they would have otherwise, because some of their costs will be covered by risk-adjustment payments that they receive, whereas insurers with healthier enrollees will not be able to charge correspondingly low premiums, because they will need to use some of their revenues to make risk-adjustment payments to the federal government.

Minimum Medical Loss Ratios

The ACA requires fully insured plans to maintain a minimum medical loss ratio. The MLR is generally defined as the percentage of premium revenues that insurers spend on medical claims. Requiring a minimum MLR is thus equivalent to capping the share of premiums that may go to insurers' administrative costs and profits, which are the other uses of premium revenues. However, in the calculation of MLRs, federal and state taxes and fees are deducted from premium revenues, so they do not count as administrative costs. Furthermore, administrative expenditures on certain activities designed to improve the quality of health care are treated as medical claims—so they too do not count as administrative costs. (For a more extensive analysis of insurers' administrative costs and profits, see the appendix.)

Since 2011, large-group plans have been required to maintain an MLR of at least 85 percent, and small-group

52. Department of Health and Human Services, *Rate Review Annual Report for Calendar Year 2013* (September 2014), http://go.usa.gov/3WGAe.

53. The third is a temporary system of risk corridors, which will affect certain plans sold in the nongroup and small-group markets from 2014 through 2016. Under that program, insurers whose actual costs substantially exceed the costs that they had anticipated when they set their premiums receive a payment that covers part of the additional costs, and insurers whose costs turn out to be much lower than they had expected have to pay the government some of the difference. Because that program is temporary and because its operations have not had a significant effect on CBO's projections of premiums, it is not discussed more extensively in this report. For additional discussion, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), www.cbo.gov/publication/45231.

54. For more information, see Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (January 2014), http://tinyurl.com/kajtag4.

55. Those figures exclude payments to and from catastrophic coverage plans in the nongroup market. See Centers for Medicare & Medicaid Services, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (September 2015), p. 6, http://go.usa.gov/cYnKj (PDF, 1 MB).

and nongroup plans have been required to maintain an MLR of at least 80 percent. In general, plans not meeting those standards have been required to issue rebates to enrollees to make up the difference. According to one analysis, more than three-quarters of insurers met or exceeded the standards in 2011 and 2012.[56] Insurers not meeting the standards paid about $1.1 billion in rebates in 2011, $504 million in 2012, $332 million in 2013, and $469 million in 2014.[57]

In those four years, the rebates effectively reduced the premiums that enrollees paid. Determining the program's net effect on premiums over the longer term is difficult, however, because insurers could respond either by limiting their administrative costs and profits (which would lower premiums) or by allowing costs for medical claims to increase (which would increase premiums). Before the ACA was enacted, CBO estimated that the MLR requirement would reduce premiums slightly.[58] More recently, the agency reaffirmed that judgment—but projected that by 2022, the requirement would make premiums only 0.1 percent lower than they would have been otherwise.[59]

Exemptions

Because some plans are exempt from them, many federal regulations have limited effects on premiums. Self-insured plans, for example, are exempt from many regulations. Also, if plans in the nongroup and small-group markets were in effect before 2014, they may qualify for exemptions from most regulations.

Self-Insured Health Plans. When a health plan is self-insured, the enrollees' employer generally pays for their claims. The employer therefore bears most or all of the risk that those claims will be higher than expected. Most self-insured plans are administered by an intermediary, often an insurance company, which provides various services (such as enrollment and claims processing) and arranges contracts with health care providers. About 60 percent of the workers who have employment-based coverage are in a self-insured plan.[60]

However, that share is much smaller among workers for small employers, partly because becoming self-insured tends to be more advantageous for large ones. For many years, federal law has effectively exempted self-insured plans from all state laws governing health insurance—an exemption that is particularly attractive to large employers, which are likelier to have workers in many states with different regulations. Also, the risk of self-insuring is greater for small employers, because they have fewer workers, and higher-than-expected costs for just a few could therefore result in a substantial percentage increase in the employer's costs. Employers can mitigate that risk by buying stop-loss insurance, which provides protection against catastrophic or unexpected expenses. Self-insured employers of all sizes may buy stop-loss insurance, but it is more common for smaller employers to do so.

The share of people with employment-based insurance who are enrolled in self-insured plans has increased over time—driven by increases among larger firms—but whether that trend will continue is unclear (see Figure 4). Some studies suggest that more small employers may choose to self-insure to avoid new fees and regulations that apply to fully insured plans.[61] No such trend is

56. Government Accountability Office, *Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees*, GAO-14-580 (July 2014), http://www.gao.gov/products/GAO-14-580.

57. The 2011 data come from Government Accountability Office, *Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees*, GAO-14-580 (July 2014), www.gao.gov/products/GAO-14-580. The remaining data come from Centers for Medicare & Medicaid Services, "Medical Loss Ratio Data and System Resources" (accessed November 24, 2015), http://go.usa.gov/cYnM9.

58. Congressional Budget Office, cost estimate for the Patient Protection and Affordable Care Act, incorporating the manager's amendment (December 19, 2009), p. 19, www.cbo.gov/publication/41877.

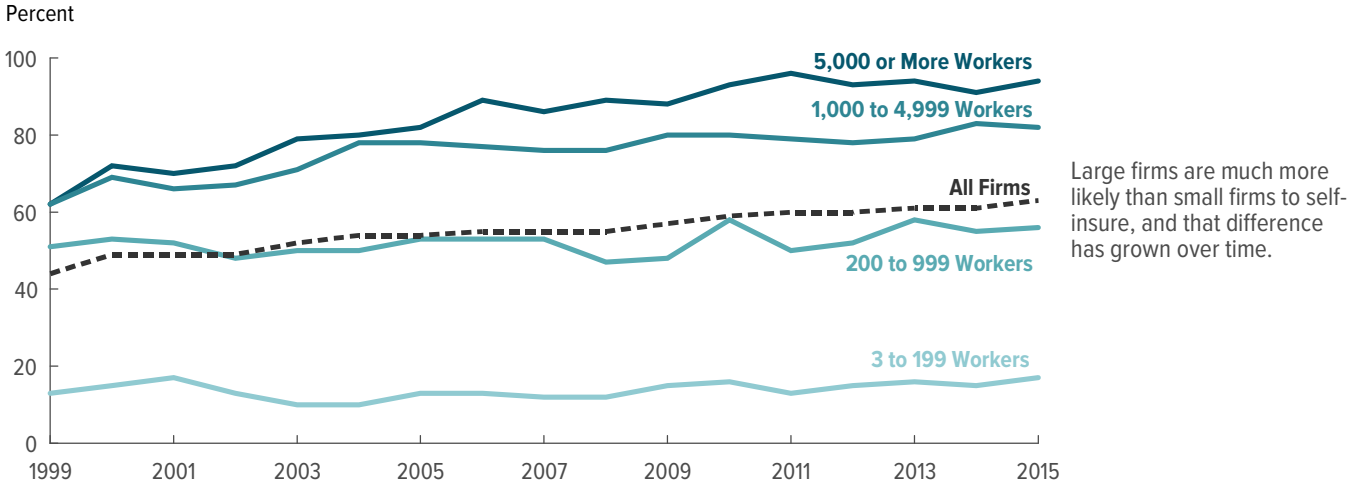
59. Congressional Budget Office, cost estimate for H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011 (November 7, 2012), p. 3, www.cbo.gov/publication/43702.

60. See Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), Section 10, http://tinyurl.com/oj7dhwp.

61. Kevin Lucia, Christine Monahan, and Sabrina Corlette, *Factors Affecting Self-Funding by Small Employers: Views from the Market* (Urban Institute, April 2013), http://tinyurl.com/pv732g5; and Christine Eibner and others, *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)* (RAND Corporation, March 2011), www.rand.org/pubs/technical_reports/TR971.html.

Figure 4.

Share of Workers With Employment-Based Coverage Who Are in Self-Insured Plans, by Firm Size



Source: Congressional Budget Office, using data from the *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust).

In this figure, employment-based coverage is defined as health insurance obtained through a worker's employment or a retiree's former employment, including coverage provided by private firms and state and local governments but excluding coverage provided by federal employers.

A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

evident yet, and whether it materializes will depend partly on whether state regulations allow small employers to buy more stop-loss coverage.[62]

At the same time, other studies suggest that employers are becoming increasingly interested in offering their workers coverage through privately established insurance exchanges, in which employers make a defined contribution toward the premium and workers may choose coverage from a menu of insurance plans.[63] Many private insurance exchanges appear to offer only fully insured products, so increased use of those exchanges could reduce the extent of self-insuring.

Certain Noncompliant Health Plans. Nongroup and small-group insurance plans in two additional categories are exempt from many of the regulations described above. First, plans that were in effect when the ACA was enacted in March 2010 and that have been maintained continuously without substantial changes are "grandfathered" and thus exempt from many of the regulations. However, the share of people enrolled in plans with that exemption is declining, partly because nongroup plans that are grandfathered may not have new enrollees. Employment-based plans do not face such a restriction; nevertheless, the share of workers at small firms who were enrolled in a grandfathered plan has also declined since 2011.[64]

Second, certain plans that existed in the nongroup or small-group markets before January 2014, when many of the new regulations took effect, could also obtain an

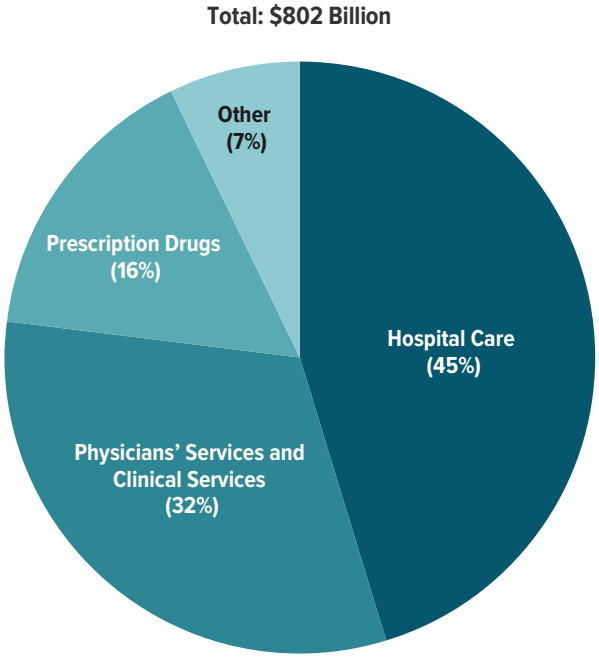
62. See Mark A. Hall, "Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers From Undermining Market Reforms," *Health Affairs*, vol. 31, no. 2 (February 2012), pp. 316–323, http://dx.doi.org/10.1377/hlthaff.2011.1017. For more information, see Department of Labor, *Guidance on State Regulation of Stop-Loss Insurance*, Technical Release 2014-01 (November 2014), www.dol.gov/ebsa/newsroom/tr14-01.html.

63. Alex Alvarado and others, *Examining Private Exchanges in the Employer-Sponsored Insurance Market* (Kaiser Family Foundation, September 2014), http://tinyurl.com/qy8yrxr; and HR Policy Association, *Private Health Insurance Exchanges: A Potentially Viable Alternative for Employer-Provided Health Care in Uncharted Waters* (September 2013), http://tinyurl.com/qgwdzhv (PDF, 168 KB).

64. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), Section 13, http://tinyurl.com/oj7dhwp.

Figure 5.

Spending on Health Care Claims by Private Insurers in 2014



Source: Congressional Budget Office, using data on national health expenditures from the Centers for Medicare & Medicaid Services.

This figure excludes payments for dental services and nursing home care.

exemption for a few years. That exemption depended, though, on whether the state in which the plan was offered took advantage of regulatory flexibility that HHS granted in late 2013 and early 2014. CBO and JCT expect that the percentage of people enrolled in such noncompliant plans will continue to decline over time, and the exemption will end in 2017.[65]

Actions by Insurers That Affect Premiums

Premiums represent insurers' operating revenues; like other businesses, insurers aim to set prices low enough to attract customers but high enough to cover their costs and generate some profits. Those costs consist of payments for enrollees' health care claims and administrative costs. Any remaining premium revenues become profits.

Health care claims constitute the largest share of insurers' costs and thus are the most important consideration for insurers as they set premiums. To keep premiums down and stay competitive, insurers employ various strategies to control health care costs. Some strategies, such as increasing enrollees' cost-sharing requirements, reduce premiums primarily by shifting health care costs to people who use more health care, which also increases the variability of enrollees' costs. Other strategies, such as limiting enrollees to health care providers in a plan's network, may reduce total health care costs as well as premiums, but they may also raise concerns about the accessibility or quality of care. Or insurers may try to attract lower-cost enrollees, which can allow them to offer lower premiums, but that strategy may simply increase premiums for other plans correspondingly and thus have no effect on average premiums. Furthermore, some of the regulations discussed above prohibit such practices or limit insurers' incentives to engage in them.

Competition among insurers affects premiums as well. Operating in a more competitive market gives insurers a stronger incentive to limit the premiums that they charge and to constrain their administrative costs and profits—but in many parts of the United States, insurance markets are not very competitive.

Insurers' Costs

Insurers spend the great majority of premium revenues on enrollees' health care. According to CMS, private insurance plans paid $802 billion in health care claims in 2014, excluding payments for dental services and nursing home care.[66] Of that money, 45 percent paid for inpatient and outpatient care provided by hospitals, 32 percent paid for physicians' services and clinical services, and 16 percent paid for outpatient prescription drugs (see Figure 5).[67] The remaining 7 percent paid for home health care, durable medical equipment (such as wheelchairs), and other health care.

In 2012, according to CMS, such spending on health care accounted for 88 percent of private insurance costs, and insurers' administrative costs and profits accounted

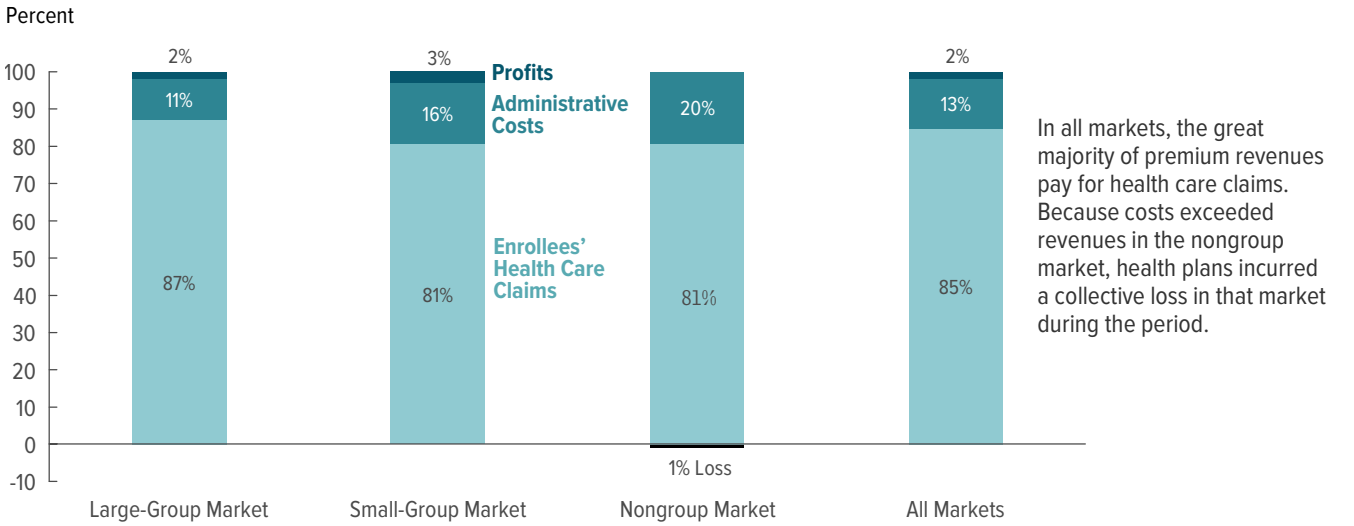
65. For more discussion, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), pp. 9 and 17, www.cbo.gov/publication/45231.

66. That figure represents the payments made by insurers; it does not include enrollees' out-of-pocket payments. CBO excluded insurers' payments for dental services and nursing home care because those services are often covered by separate insurance policies that are outside the scope of this report.

67. Payments for physicians' services and clinical services commonly include fees for surgeons and anesthesiologists who deliver their services in hospitals, as well as payments for outpatient lab tests and imaging services, such as X-rays.

Figure 6.

Uses of Premium Revenues in Fully Insured Markets, 2010 to 2012



Source: Congressional Budget Office, using 2010 filings of the Supplemental Health Care Exhibit (National Association of Insurance Commissioners) and 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form (Centers for Medicare & Medicaid Services).

The small-group market generally serves employers with up to 50 employees.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

for the remaining 12 percent.[68] That estimate applies to the entire private insurance market; that is, it covers the nongroup, small-group, and large-group markets, and it includes both self-insured and fully insured plans.

Insurers' costs often differ by market, however, both in absolute terms and as a percentage of premium revenues. To examine such differences, CBO analyzed data on all fully insured plans sold from 2010 to 2012. All told, about 85 percent of premium revenues were used to pay health care claims, 13 percent went to insurers' administrative costs, and the remaining 2 percent constituted insurers' profits (see Figure 6).[69] In the large-group market, 87 percent of revenues went to health care claims, 11 percent went to administrative costs, and 2 percent became profits. Insurers in the small-group market spent a smaller share on health care and a larger share on administration—81 percent and 16 percent of revenues, respectively; the remaining 3 percent constituted their profits. Insurers in the nongroup market also spent 81 percent of revenues on health care claims, but their administrative costs averaged 20 percent; as a result, they incurred losses equal to about 1 percent of premiums, on average. Those losses, which would not be sustainable over the long term, may have resulted from the recession and slow recovery—for example, if relatively healthy people decided to go without coverage when their income dropped—or from other temporary factors.

The differences among markets reflect a variety of factors. For example, certain administrative costs are fixed; in the large-group market, those costs can be spread over more enrollees and thus are generally lower per enrollee. Another example: Administrative costs per enrollee were *lower* for nongroup plans than for small-group plans when expressed in dollars—but because nongroup plans

68. Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts—Historical" (December 3, 2015), Table 4, http://go.usa.gov/3WGtP. Those figures include spending by some forms of private insurance that are outside the scope of this report, such as dental insurance and Medigap plans.

69. CBO's definition of profits included only gains or losses resulting from the provision of insurance, which are sometimes called underwriting profits; it did not include gains or losses that insurers realized by investing assets. CBO treated taxes on profits as administrative costs, so its profit estimates are of net profits rather than gross profits. Also, as this report explains above, federal requirements specify the minimum medical loss ratio, or percentage of premium revenues spent on medical costs, that insurers must achieve. The MLR calculation, however, excludes taxes and fees and counts certain administrative expenses as medical costs. As a result, the calculated MLRs are higher, on average, than CBO's estimates of the percentage of premium revenues that go to health care claims.

tend to provide less extensive coverage and thus spend less on health care claims, the share of premiums going to administrative costs was noticeably higher in the nongroup market. (For more analysis of administrative costs and profits for fully insured plans, see the appendix.)

Estimating how self-insured employers allocate premium revenues is more difficult. For one thing, detailed data about those plans' expenses are hard to obtain. Also, measuring total premiums for self-insured plans is complicated; instead, surveys of self-insured employers generally measure their premium equivalent—the costs incurred for health care claims and administration per enrolled employee—because those costs roughly match the costs financed by premiums for a fully insured plan. Furthermore, because employers generally offer health benefits as part of a larger compensation package, identifying the share of administrative costs attributable to the health benefits alone can be difficult. The way self-insured plans account for profits is also unclear.

On balance, however, self-insured plans appear to devote a larger share of premiums to health care claims, and a lower share to administrative costs and profits, than fully insured plans do. That difference can be seen by comparing CMS's estimate of the share of *all* private insurance revenues that were spent on health care claims in 2012 (88 percent) with the share that CBO observed for fully insured plans in that year (85 percent). To pull the overall average up to 88 percent, the share for self-insured plans must have been higher than 88 percent.

Insurers' Strategies to Control Their Spending on Health Care

Because spending on health care claims accounts for the majority of premium revenues, that spending is the largest factor that insurers consider when determining premium levels. Limiting it helps the insurers keep costs down—which they generally want to do, both to maximize their profits and to stay competitive. Insurers use a number of strategies to limit their spending on health care; in recent years, they have particularly emphasized increasing cost-sharing requirements. Such requirements are a prominent feature of high-deductible health plans, which have been growing more common, but they have also increased in health care plans generally.

Limiting Provider Networks. One way that insurers control their health care spending is limiting their provider networks—the doctors, hospitals, and other providers that enrollees are required or encouraged to use. Insurers may include only providers that charge lower prices or that tend to provide fewer or less expensive services and treatments. Or insurers may negotiate lower payment rates with the network's providers, which may be willing to accept those rates in return for more patients. Many of the plans first offered in the health insurance exchanges used this strategy extensively, holding down their premiums by adopting very limited networks of providers that accepted relatively low payment rates.[70]

Insurers may face several constraints in using the strategy, however. In areas where there are few doctors and hospitals competing against each other, it may be difficult for an insurer to develop a network that includes only some of the available providers. Even in areas with many doctors and hospitals, some high-cost providers may deliver such good care or have such good reputations that enrollees would be reluctant to join a plan that did not include them. More generally, enrollees may feel that the choices offered by an insurer's network are too limited. And certain regulations, such as those that require plans to include in their network any provider that accepts their payment terms, can make it difficult to craft a limited-network plan. Historically, states have enacted most of those regulations. The federal government does, however, require health plans participating in the federal health insurance exchanges to include providers of certain types (such as those considered "essential community providers").[71] Moreover, CMS recently proposed regulations that would increase federal requirements governing those plans' networks, starting in 2017.

Managing Enrollees' Use of Services. Another strategy to control health care costs involves managing enrollees' use of services more directly. For example, insurers may cover certain expensive services only if they have authorized them in advance; require enrollees to get a referral from their primary care physician before seeing a specialist; decline to cover a more expensive treatment before enrollees try a less expensive one; or exclude certain

70. See Sabrina Corlette and others, *Narrow Provider Networks in New Health Plans: Balancing Affordability With Access to Quality Care* (Center on Health Insurance Reforms and Urban Institute, May 2014), http://tinyurl.com/qhmrb8v (PDF, 310 KB).

71. See Centers for Medicare & Medicaid Services, *Final 2016 Letter to Issuers in the Federally-Facilitated Marketplaces* (February 20, 2015), pp. 22–31, http://go.usa.gov/cYezh (PDF, 472 KB).

expensive services or medications from coverage altogether. Such steps grew more common during the 1990s.

However, some enrollees may find this strategy cumbersome and intrusive, and some doctors may feel that their medical judgment is being questioned or that the treatments that insurers will readily approve are not the best options for their patients. Patients and doctors are generally allowed to appeal insurers' decisions about coverage, but pursuing appeals may delay treatment and be burdensome. Objections to this strategy and also to limited provider networks led to a shift away from both strategies after the 1990s, though their use has begun rising again in recent years.

Increasing Cost-Sharing Requirements. Over the past 15 years or so, insurers have made more use of a third strategy: increasing cost-sharing requirements and thereby increasing enrollees' out-of-pocket spending. Out-of-pocket spending consists of health care expenses for which insurance does not pay, such as deductibles, coinsurance (the share of costs that the enrollee must pay for each service), and copayments (fixed amounts that the enrollee must pay for certain services). Plans generally include an annual out-of-pocket limit—a maximum yearly amount that an enrollee can be required to pay for covered services received within the plan's network.

In addition to raising deductibles, coinsurance, and copayments, insurers often tailor cost-sharing requirements to encourage enrollees to use less expensive services or providers. For example, insurers usually charge lower copayments for generic drugs than for brand-name drugs, which tend to be more expensive. And insurers often design cost-sharing requirements to dovetail with their provider networks—say, by having two different coinsurance rates, one for the providers in a network and a higher one for other providers. In a related practice, balance billing, the insurer pays the same amount for a visit to any provider but requires the enrollee to pay the difference between that amount and the provider's fee.

Increasing cost-sharing requirements reduces insurers' spending on health care both directly and indirectly. The direct reductions occur simply because some spending shifts from the insurers to the enrollees. The indirect reductions occur because shifting costs to enrollees encourages them to use fewer services—which reduces total spending on health care and thus insurers' spending as well. Because demand for health care does not fall very sharply when the amount that enrollees pay rises, the direct reductions tend to be larger than the indirect ones.[72]

The strategy, however, increases enrollees' financial risk. That is, people who have more health problems will tend to pay more overall for their health care, and people who have fewer health problems will tend to pay less; the larger the cost-sharing requirements, the greater that difference will be. As a result, enrollees in plans with higher cost-sharing requirements face more variability in their health care costs.

Insurers' use of cost-sharing requirements has grown over time in the market for employment-based coverage. One survey found that of all enrollees in employment-based plans, the share who were enrolled in a plan with an annual deductible for single coverage increased from 55 percent in 2006 to 81 percent in 2015; moreover, the average deductible for single coverage rose from $303 to $1,077 over that period.[73] Less is known about trends in the cost-sharing requirements of nongroup plans, though they have historically been higher, on average, than the cost-sharing requirements of employment-based plans.

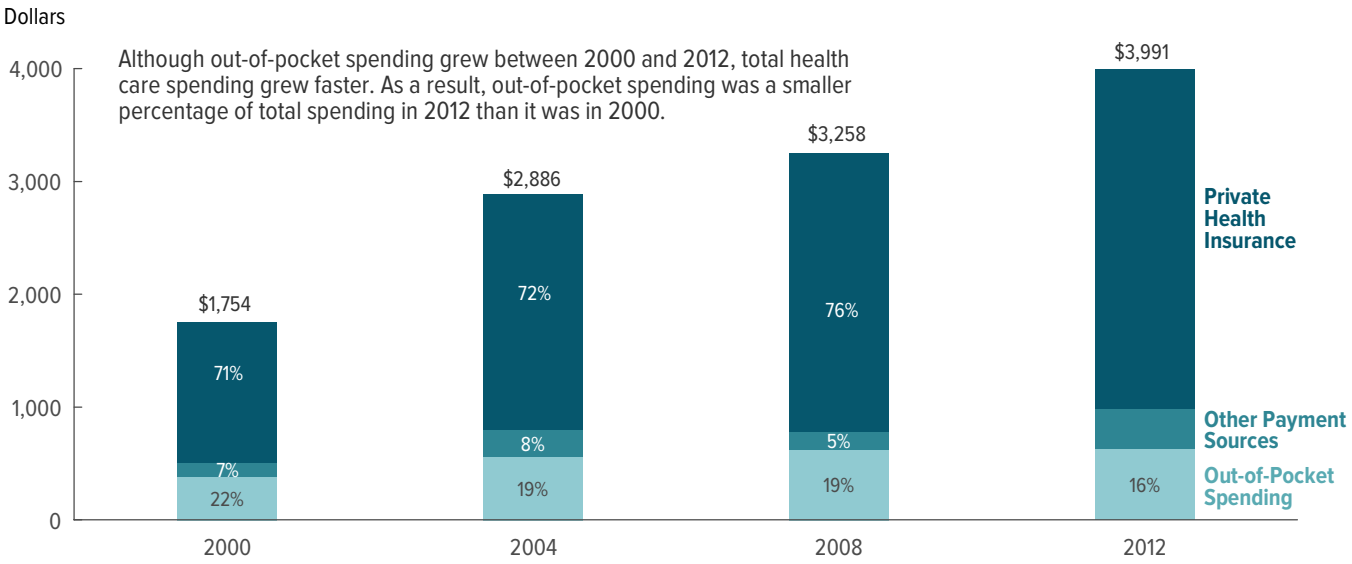
Although the use of cost-sharing requirements has been increasing, CBO has found that the share of total health care costs for privately insured people that was paid out of

72. Studies have found that a 10 percent increase in the amount that people pay for health care indirectly reduces total spending on their care by about 1 percent or 2 percent, on average. Thus, a reduction in a health plan's actuarial value from 80 percent to 78 percent, which would increase the average share of costs that enrollees pay by 10 percent (that is, from 20 percent to 22 percent), would indirectly reduce total spending on their care by about 1 percent or 2 percent. By comparison, the direct reduction in insurers' spending in that case would be 2.5 percent—that is, the 2 percentage-point reduction in actuarial value divided by the initial actuarial value of 80 percent. (The direct and indirect effects on *premiums* would be slightly smaller, because those calculations include effects on administrative costs.) For more discussion about the effects of cost sharing on the use of services, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 61–62, www.cbo.gov/publication/41746.

73. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), Exhibits 7.2 and 7.32, http://tinyurl.com/oj7dhwp. The calculation of average deductibles included plans with no deductible. Average deductibles for family plans are more difficult to summarize because plans may have an aggregate deductible for all family members, separate deductibles for each member, or a combination of the two.

Figure 7.

Health Care Spending per Privately Insured Nonelderly Person



Source: Congressional Budget Office, using data from the household component of the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality).

"Other Payment Sources" refers primarily to public programs (such as Medicare, Medicaid, and health care for veterans) that provide supplemental or partial coverage to some privately insured people.

pocket fell from 22 percent in 2000 to 16 percent in 2012 (see Figure 7). CMS estimates of national health expenditures also show that the share of *all* spending on personal health care that was paid out of pocket has declined over time, from 17 percent in 2000 to 14 percent in 2012.[74] Although that calculation includes health care spending for people enrolled in Medicare, Medicaid, and other sources of insurance, as well as for people who are uninsured, it is strongly influenced by the large share of people who are privately insured.[75]

If cost-sharing requirements have been rising, why has the share of health care spending paid out of pocket been falling? Three factors may be at work:

- Costs that *are* covered by insurance have also been rising fairly rapidly—by about 7.5 percent per year between 2000 and 2012, according to the data on spending per privately insured person that CBO analyzed. Over the same period, according to those data, total health care spending per privately insured person grew slightly more slowly (by about 7 percent per year). The faster growth of spending covered by insurance thus reduced the *share* of total spending that was paid out of pocket.

- Increases in cost-sharing requirements may not translate into equal increases in total out-of-pocket payments. For example, when an enrollee's deductible is raised, the enrollee does not owe as much in coinsurance as he or she would previously have paid; the deductible will replace some of the coinsurance.

- If increases in cost-sharing requirements prompt enrollees to reduce their use of services, their out-of-pocket spending may fall.

Nevertheless, the recent increases in cost-sharing requirements may explain why the decline in the share of spending paid out of pocket has been slower since 2000 than it was before 1995. According to the CMS estimates, the share of spending on personal health care that was paid out of pocket declined from 33 percent in 1975 to

74. Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts—Historical" (December 3, 2015), Table 3, http://go.usa.gov/3WGtP.

75. The decline in the share of health costs paid out of pocket explains why, even as growth in overall health care spending has exceeded growth in GDP, out-of-pocket payments as a share of GDP have held steady. From 2000 to 2012, according to CMS, national health expenditures grew from 13.4 percent of GDP to 17.4 percent—but as a share of GDP, out-of-pocket payments barely changed, rising from 1.96 percent of GDP to 2.03 percent.

Table 4.

Key Characteristics of Employment-Based Health Plans in 2015

	HMOs	PPOs	POS Plans	HDHPs[a]	All Plans
Share of Employment-Based Enrollment (Percent)[b]	14	52	10	24	100
Average Yearly Premium for Single Coverage (Dollars)	6,212	6,575	6,259	5,567	6,251
Average Yearly Premium for Family Coverage (Dollars)	17,248	18,469	16,913	15,970	17,545
Share of Enrollees With an Annual Deductible (Percent)	42	85	72	100	81
Average Deductible for Single Coverage (Dollars)[c]	431	814	886	2,099	1,077

Source: Congressional Budget Office, using data from the *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust).

In this table, employment-based coverage is defined as health insurance obtained through a worker's employment or a retiree's former employment, including coverage provided by private firms and state and local governments but excluding coverage provided by federal employers.

HDHP = high-deductible health plan; HMO = health maintenance organization; POS = point-of-service; PPO = preferred provider organization.

a. The Kaiser survey counts plans as HDHPs if their deductibles are at least $1,000 for single coverage or $2,000 for family coverage. Federal regulations use higher minimums: $1,300 and $2,600 in 2015.

b. Less than 1 percent of workers are enrolled in indemnity plans (sometimes called fee-for-service plans). Those plans allow enrollees to see any provider without a referral and generally do not distinguish between in-network and out-of-network providers.

c. The calculation of average deductibles includes plans with no deductible. Average deductibles for family plans are more difficult to summarize because plans may have an aggregate deductible for all family members, separate deductibles for each member, or a combination of the two.

17 percent in 1995—a much steeper decline than the drop of 3 percentage points over the 2000–2012 period.

Cost-Control Strategies in Health Plans of Various Types. Health insurers offer plans of many different types, and those types are largely defined by their varying uses of the strategies outlined above. The result is that premiums differ among those types (see Table 4).

A defining characteristic of health maintenance organizations (HMOs) is that they do not cover services obtained outside their provider network, except in emergencies. Moreover, HMO plans usually require enrollees to select a primary care physician and to get a referral from that physician before seeing a specialist. But cost-sharing requirements in HMO plans tend to be relatively low; most do not charge a deductible, for example.

By contrast, preferred provider organizations (PPOs) tend to limit spending by using cost-sharing requirements; a large majority of them charge a deductible. But PPOs are less active than HMOs in managing enrollees' use of services directly. For example, they generally do not require enrollees to designate a primary care provider or to obtain a referral before seeing a specialist, and they generally cover services received outside a provider network—though they encourage enrollees to receive in-network care by requiring lower out-of-pocket payments for it.

Point-of-service (POS) plans may be regarded as a middle ground between HMOs and PPOs. Like HMOs, POS plans generally require enrollees to get a referral from their designated primary care physician before seeing a specialist. Like PPOs, POS plans cover services provided both inside and outside a provider network but increase enrollees' out-of-pocket payments for the latter. As HMOs have broadened their provider networks, the distinctions among these three types of health plan have blurred somewhat.

High-deductible health plans rely heavily on deductibles and other out-of-pocket payments to limit insurers' spending on health care; they typically expect enrollees to manage their own care and may provide tools to help them do so, such as information about providers' costs or quality. HDHPs often combine a high-deductible insurance policy with a tax-exempt account that enrollees may use to cover their deductible and other out-of-pocket costs.[76] Like PPOs, HDHPs usually cover services that enrollees receive from a wide range of providers and do not require enrollees to get referrals for specialty care.

76. The most common kinds of account are health savings accounts (which were described earlier in this report) and health reimbursement arrangements. See Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006), www.cbo.gov/publication/18261.

HDHPs have become much more prevalent in recent years; enrollment in employment-based HDHPs grew from 8 percent of workers in 2009 to 24 percent in 2015.[77] Two recent studies cite growth in HDHP enrollment as one reason for the recent slowdown in the growth of health care costs.[78]

On average, premiums for single coverage obtained through employers are similar among HMOs, PPOs, and POS plans; premiums for family coverage vary more widely. HDHPs tend to have lower premiums but higher out-of-pocket costs than plans of other types do; for example, among employment-based HDHPs, the average deductible for single coverage was about $2,100, more than double the average among the other types of plan.

Competing for Enrollees. Because prospective enrollees may differ significantly in their use of health care, insurers' costs depend strongly on the makeup of their enrollee pool. Insurers therefore have an incentive to seek enrollees with lower expected costs for health care and to avoid enrollees with higher expected costs—for example, by limiting coverage of certain procedures or treatments, requiring higher cost sharing for them, or limiting provider networks in ways that would make them less attractive to people with more health problems. An insurer that succeeds in doing so can charge lower premiums than its competitors can.

Insurers' incentives to seek low-cost and avoid high-cost enrollees have probably changed more in the nongroup market than in the other markets. Before 2014, nongroup insurers in most states could deny coverage to applicants or charge them higher premiums on the basis of their health, practices that could limit enrollment by people with higher expected costs. Both practices are now prohibited. So is engaging in favorable selection through the design of a health plan—but enforcing that prohibition can be difficult, partly because it can be hard to distinguish such efforts from other steps to control a plan's costs.

The ACA's risk-adjustment program for the nongroup and small-group markets limits insurers' incentive to engage in favorable selection, but it is unclear how much. According to one recent study, "even with the best risk-adjustment formulas, insurers have substantial incentives to engage in risk selection."[79] But other researchers have a different view. Two recent studies have found that Medicare's current risk-adjustment procedures are effective at reducing favorable selection—and the ACA's risk-adjustment program is modeled on those procedures.[80]

Competition Among Insurers

Competition among insurers also affects health insurance premiums. Insurers operating in competitive markets have a strong incentive to keep their costs and premiums down: If they do not, they may lose business to competitors. But if the market is concentrated—that is, if only a few insurers cover most of the enrollees in the market—that incentive is weaker. At the same time, insurers operating in competitive markets may have a more difficult time bargaining with doctors and hospitals if the markets for those providers' services are concentrated.

Extent of Competition. Several studies have found that most health insurance markets in the United States are not very competitive. For example, the American Medical Association reported that in 2012, there were 45 states in which the two largest health insurers together accounted for at least half of the private insurance market; in 17 of those states, a single insurer held at least half of the market.[81] Furthermore, the study found, the insurance markets in 72 percent of the country's 388 metropolitan

77. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), http://tinyurl.com/oj7dhwp.

78. Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, *Is This Time Different? The Slowdown in Healthcare Spending*, Working Paper 19700 (National Bureau of Economic Research, December 2013), www.nber.org/papers/w19700; and Anne B. Martin and others, "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year," *Health Affairs*, vol. 33, no. 1 (January 2014), pp. 67–77, http://tinyurl.com/lps9o3x.

79. Wynand P. M. M. van de Ven, Richard C. van Kleef, and Rene C. J. A. van Vliet, "Risk Selection Threatens Quality of Care for Certain Patients: Lessons From Europe's Health Insurance Exchanges," *Health Affairs*, vol. 34, no. 10 (October 2015), p. 1713, http://dx.doi.org/10.1377/hlthaff.2014.1456.

80. Joseph P. Newhouse and others, "Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges," *Health Affairs*, vol. 31, no. 12 (December 2012), pp. 2618–2628, http://dx.doi.org/10.1377/hlthaff.2012.0345; and Joseph P. Newhouse and others, *How Much Favorable Selection Is Left in Medicare Advantage?* Working Paper 20021 (National Bureau of Economic Research, March 2014), www.nber.org/papers/w20021.

statistical areas would be considered "highly concentrated" under federal guidelines.[82]

Other studies have reported similar results. An analysis by the Government Accountability Office found that in the average state, the largest insurer accounted for about half of the nongroup and small-group markets for fully insured coverage, and the four largest insurers together accounted for nearly 90 percent of those markets.[83] In 2010, according to another study, there were 30 states in which a single insurer accounted for over half of all nongroup enrollees and 26 states in which the same was true for small-group enrollees.[84] Other evidence suggests that large-group markets are also highly concentrated, and recent literature reviews find that health insurance markets in the United States have become more concentrated over time.[85] Recently proposed mergers between major insurers could increase concentration further, depending partly on whether (and with what restrictions) those mergers are approved by federal regulatory agencies.

The Relationship Between Competition and Premiums. Data limitations have long made it difficult to study the relationship between the degree of competition among insurers and the level of premiums. However, several recent studies of the new health insurance exchanges have found that premiums fall as the number of competitors in a market rises. According to a recent study that examined exchange plans in 2014, "premiums in less competitive markets [were] higher than in more competitive insurer markets."[86] Another study estimated that premiums for exchange plans would have been about 11 percent lower if all insurers that had previously been active in each state's nongroup insurance market had participated in the exchanges.[87]

An important and related consideration is that many markets for hospital care and some markets for physicians' services are also highly concentrated—and some evidence suggests that when that is the case, more concentrated insurance markets may actually *reduce* premiums.[88] That is because reduced competition among insurers would mean more bargaining power for them when negotiating with providers over payment rates—and lower payment rates tend to translate into lower premiums. Illustrating that point, one recent study found that when hospital markets were highly concentrated, premiums were slightly lower when the insurance market was also highly concentrated than they were when the insurance market was more competitive.[89]

81. David W. Emmons and Jose R. Guardado, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (American Medical Association, October 2014), http://tinyurl.com/pocd2gz. The markets examined in that study consisted of fully insured and self-insured plans.
82. Market concentrations are often defined by means of the Herfindahl-Hirschman Index, or HHI, which is calculated as the sum of every firm's squared market share and ranges from zero to 10,000. For instance, if one firm had 100 percent of the market, the market's HHI would be 100 squared, or 10,000; a market consisting of four firms with a 25 percent market share apiece would have an HHI of 2,500 (or 25 squared times four). Under current federal guidelines, a market with an HHI greater than 2,500 is considered highly concentrated, and one with an HHI lower than 1,500 is considered competitive or not concentrated.
83. Government Accountability Office, *Patient Protection and Affordable Care Act: Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657 (August 2014), pp. 9–10, www.gao.gov/products/GAO-14-657.
84. Cynthia Cox and Larry Levitt, *How Competitive Are State Insurance Markets?* (Kaiser Family Foundation, October 2011), http://tinyurl.com/oaoc9yu.
85. See Martin Gaynor and Robert J. Town, "Competition in Health Care Markets," in Mark V. Pauly, Thomas G. McGuire, and Pedro P. Barros, eds., *Handbook of Health Economics*, vol. 2 (Elsevier, 2011), pp. 499–637, http://tinyurl.com/ptu3fzm; and Martin Gaynor, Kate Ho, and Robert Town, *The Industrial Organization of Health Care Markets*, Working Paper 19800 (National Bureau of Economic Research, January 2014), www.nber.org/papers/w19800.
86. John Holahan and Linda Blumberg, *Marketplace Competition & Insurance Premiums in the First Year of the Affordable Care Act* (Robert Wood Johnson Foundation and Urban Institute, August 2014), p. 3, http://tinyurl.com/kn4md2q.
87. Leemore Dafny, Jonathan Gruber, and Christopher Ody, *More Insurers Lower Premiums: Evidence From Initial Pricing in the Health Insurance Marketplaces*, Working Paper 20140 (National Bureau of Economic Research, May 2014), www.nber.org/papers/w20140.
88. For a summary of the extensive body of research indicating the concentration of markets for hospital care and physicians' services, see Martin Gaynor and Robert J. Town, "Competition in Health Care Markets," in Mark V. Pauly, Thomas G. McGuire, and Pedro P. Barros, eds., *Handbook of Health Economics*, vol. 2 (Elsevier, 2011), pp. 597–598, http://tinyurl.com/ptu3fzm.
89. See Erin E. Trish and Bradley J. Herring, "How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics*, vol. 42 (July 2015), pp. 104–114, http://dx.doi.org/10.1016/j.jhealeco.2015.03.009.

Appendix: Insurers' Administrative Costs and Profits

Insurers use their premium revenues to pay health care claims and administrative costs, and any remaining revenues become profits. The main body of this report examines insurers' strategies to control costs for health care claims, which account for the majority of premium revenues; it focuses less on the administrative costs and profits. This appendix therefore offers a more detailed analysis of how administrative costs and profits vary among the fully insured health care markets, using administrative data covering all policies that were sold in those markets between 2010 and 2012.[1]

Insurers' Administrative Costs

The Congressional Budget Office's analysis found that in dollar terms, administrative costs per enrollee were highest in the small-group market, at $687; they were $548 in the nongroup market and $472 in the large-group market (see Table A-1). As a share of premiums per enrollee, however, administrative costs in the nongroup market were noticeably higher, at 20 percent, than in the small-group market (16 percent) or the large-group market (11 percent). The main reason for the discrepancy is that nongroup plans provided less extensive coverage of enrollees' health care costs and therefore had lower premiums, on average; as a result, they had a smaller base of total costs over which to spread their administrative costs. By contrast, the administrative costs of large-group plans were lower—per enrollee and also as a share of premiums per enrollee—than those of other plans. That was partly because large-group plans had more enrollees over whom to spread fixed administrative costs and partly because large-group plans had higher medical claims per enrollee.

Insurers' administrative costs can be divided into four categories:

- **Costs for claims processing and adjustment,** which include a wide range of activities, such as managing enrollees' use of care, managing a plan's network of providers, ensuring that those providers have appropriate credentials, and processing appeals of a plan's coverage and payment decisions. Spending in that category was similar in the three fully insured markets: about $100 per enrollee, or 2 percent to 4 percent of premium revenues.

- **Taxes and fees,** which may be levied at the federal or state level. They were highest in the small-group market, at $159 per enrollee, and lower in the large-group market ($112) and the nongroup market ($74). Those differences were partly the result of differences in gross profits among the markets, which translated into different payments of corporate income taxes; for example, because profits per enrollee were highest in the small-group market, corporate taxes per enrollee were also highest in that market.

- **Costs for sales, marketing, and brokers' fees,** which were also highest in the small-group market—$226 per enrollee—and lower in the nongroup market ($157) and the large-group market ($97). One reason may be that small employers are more likely to use brokers to buy insurance policies for their employees.

- **Other administrative costs,** including such items as corporate salaries, legal fees, costs for actuarial services, spending on information technology, and other overhead costs (which may be difficult to assign to particular activities). Those costs were highest in the nongroup market—$221 per enrollee—and lower in the small-group market ($200) and the large-group market ($170).

1. CBO analyzed administrative data derived from two sources: insurers' 2010 filings of the Supplemental Health Care Exhibit with the National Association of Insurance Commissioners, and insurers' 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form with CMS. The data were compiled for CBO by Milliman, Inc., an actuarial firm. The two sources include enrollment and premium data for all fully insured plans in the United States and report those data in the same way.

Table A-1.

Insurers' Average Health Care Claims Costs, Administrative Costs, and Profits per Enrollee in Fully Insured Markets, 2010 to 2012

Dollars

	Large-Group Market	Small-Group Market	Nongroup Market	Overall
Health Care Claims Costs	3,693	3,421	2,164	3,387
Administrative Costs				
Claims processing and adjustment	94	103	96	96
Taxes and fees	112	159	74	118
Sales, marketing, and brokers' fees	97	226	157	139
Other administrative costs	170	200	221	185
Subtotal	472	687	548	539
Net Profits	78	129	-30	74
Total Premium	**4,243**	**4,237**	**2,682**	**4,000**

Source: Congressional Budget Office, using 2010 filings of the Supplemental Health Care Exhibit (National Association of Insurance Commissioners) and 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form (Centers for Medicare & Medicaid Services).

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

The small-group market generally serves employers with up to 50 employees.

Many recent changes in federal law may ultimately help constrain administrative costs, particularly in the nongroup and small-group markets. For example, the advent of health insurance exchanges, coupled with increased enrollment in nongroup plans, may help insurers achieve greater economies of scale for some fixed expenses in that market. Requirements to standardize the benefits and actuarial values of new plans may reduce the cost of designing and marketing such plans. Two prohibitions—on using a person's health status as a basis for offering or pricing a policy, and on declining to cover services for preexisting conditions—are likely to reduce costs associated with reviewing applications, varying the prices of policies, and determining which services treated an enrollee's preexisting conditions. Requirements to provide more extensive coverage and to maintain a minimum medical loss ratio also seem likely to increase the share of premiums going to medical claims and decrease the share going to administration.[2]

In the short term, however, some of the changes made by the Affordable Care Act are likely to generate additional administrative costs, such as the costs of adapting to the administrative requirements of the insurance exchanges and of determining how to price policies under the new rules.

Insurers' Profits

Profits are simply the difference between insurers' premium revenues and their costs for health care claims and administration. For-profit insurers have a clear incentive to maximize their profits: Shareholders or owners may demand those profits as compensation for the financial risks and costs that they have incurred. According to one recent analysis, however, roughly half of all people covered by private health insurance are enrolled in plans administered by nonprofit insurers.[3] Nonprofit insurers are allowed to generate profits and to use them to pay rebates to enrollees—but not to distribute them to investors. As a result, they may have less of an incentive to generate profits.

2. For more discussion, see Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

3. Alliance for Advancing Nonprofit Health Care, "Basic Facts & Figures: Nonprofit Health Plans" (accessed November 24, 2015), http://tinyurl.com/lojxcx2 (PDF, 171 KB). The calculation includes fully insured and self-insured plans and is based on a survey conducted in 2012.

Profits varied by market, according to CBO's analysis.[4] They amounted to about 3 percent of premium revenues in the small-group market and 2 percent in the large-group market. Insurers in the nongroup market, by contrast, sustained a collective loss.

It is difficult to determine whether those profits and losses are typical. Year-to-year variations in profits and losses would not be surprising, particularly in the smaller nongroup market. And the results observed from 2010 to 2012 were probably affected by the economic recession and slow recovery, which may have increased the likelihood of losses. Although most of the Affordable Care Act's major provisions did not go into effect until 2014, some of its other provisions may have affected profits in earlier years. In particular, the law's requirements to maintain a minimum medical loss ratio—the percentage of premium revenues that insurers spend on medical claims and certain related activities—may have affected insurers' costs and profits in 2011 and 2012.

Another possible reason for the nongroup market's losses is that during the period in question, some states required nonprofit insurers operating in that market to provide subsidized coverage to some unhealthy people who would otherwise have had difficulty obtaining insurance. (Most states require nonprofit insurers to provide some form of community benefit in return for their tax-exempt status.) The requirement tends to reduce those insurers' profits. And according to CBO's analysis, most of the losses in the nongroup market were borne by nonprofit insurers: Collectively, for-profit insurers in that market earned profits of about 0.4 percent of premium revenues, whereas nonprofit insurers incurred losses of about 3.2 percent of premium revenues.

Another explanation for the losses observed in the nongroup market is that the calculation may not be accurate; many insurers offer both nongroup and employment-based coverage, and determining how they should divide administrative costs among the markets is difficult. Alternatively, insurers operating in multiple markets may be willing to accept short-term losses in the nongroup market, as long as their profits in the employment-based markets are large enough that they remain profitable as a whole.

Finally, insurers sometimes try to attract more enrollees by charging premiums that do not fully cover their expected costs; to cover those temporary losses, they draw down excess reserves that they have already built up. Continued losses in the nongroup market would ultimately be unsustainable, however.

4. CBO's definition of profits included only gains or losses resulting from the provision of insurance, which are sometimes called underwriting profits; it did not include gains or losses that insurers realized by investing assets. CBO treated taxes on profits as administrative costs, so its profit estimates are of net profits rather than gross profits.

Glossary

actuarial value: The percentage of costs for covered health care services that a health care plan pays, on average, for a representative group of enrollees.

cost-sharing requirements: Rules regarding the costs (such as deductibles) that enrollees in an insurance plan are required to pay for covered health care services.

cost-sharing subsidy: A payment from the government to an insurer to reduce the cost-sharing requirements of some enrollees in coverage purchased through a health insurance exchange.

deductible: The amount that an enrollee must pay out of pocket each year for covered health care services before the insurer begins to pay.

employment-based coverage: Health insurance obtained through a worker's employment or a retiree's former employment. Includes coverage provided through labor unions and public employers.

flexible spending account (FSA): An account into which employees may direct a predetermined portion of their paycheck; that money is exempt from income and payroll taxes and may be used only to pay qualifying costs for health care.

fully insured plan: A health insurance plan in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

health insurance exchange: An entity through which individuals and small employers may shop for and purchase coverage and determine their eligibility for premium tax credits and cost-sharing subsidies. Exchanges are also known as marketplaces.

health savings account (HSA): An account into which a person with a qualifying high-deductible health plan (and that person's employer) may contribute funds that are exempt from income and payroll taxes. The funds remain tax-exempt indefinitely if they are used to pay for qualifying medical spending.

large-group market: The market for health insurance generally purchased by or through employers with more than 50 employees; states may limit the definition to employers with more than 100 employees, starting in 2016.

medical loss ratio (MLR): The percentage of premium revenues that insurers spend on medical claims and certain related activities.

nongroup coverage: Coverage that a person purchases directly from an insurer or through a health insurance exchange, rather than through an employer.

out-of-pocket costs: The costs for health care services that an enrollee pays, including deductibles, other cost-sharing requirements, and payments for services not covered by the health plan, but excluding premium payments.

premium: The payment made to an insurer in exchange for enrollment in a health plan; it may be paid entirely by the enrollee or through a combination of payments from the enrollee, an employer, and the federal government.

premium tax credit: A payment from the federal government to an insurer to cover a portion of an enrollee's premium for qualifying coverage purchased through a health insurance exchange.

reference plan: The second-lowest-cost silver plan available to a person through a health insurance exchange.

risk-adjustment system: A system that transfers funds from health care plans with healthier-than-average enrollees to plans with sicker-than-average enrollees; in the Affordable Care Act's risk-adjustment system, those payment adjustments occur retroactively.

self-insured plan: A health insurance plan in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

silver plan: A plan that pays about 70 percent of the costs of covered health care services for a broadly representative group of enrollees; other levels of coverage, such as bronze and gold, pay different percentages.

small-group market: The market for health insurance generally purchased by or through employers with up to 50 employees; states may expand the definition to include employers with up to 100 employees, starting in 2016.

List of Tables and Figures

Tables

Figures

About This Document

This Congressional Budget Office report was prepared at the request of the Chairman of the Senate Committee on Health, Education, Labor, and Pensions. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Alice Burns and Philip Ellis wrote the report with important contributions from Allison Percy and assistance from Justin Lee and Kyle Redfield. Several former CBO employees contributed significantly to earlier drafts, including James Baumgardner, Alexia Diorio, Stuart Hagen, Paul Jacobs, and Julia Mitchell. Elizabeth Bass, Justin Falk, Kate Fritzsche, Ed Harris, Sarah Masi, Eamon Molloy, Lyle Nelson, and the staff of the Joint Committee on Taxation contributed to the analysis or provided helpful comments. Jessica Banthin, Linda Bilheimer, and Holly Harvey provided guidance and helpful comments.

Gary Claxton of the Henry J. Kaiser Family Foundation, Leemore Dafny of Northwestern University, and Mark Hall of Wake Forest University reviewed a draft of the report and provided helpful comments. The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.

Jeffrey Kling and Robert Sunshine reviewed the report, Benjamin Plotinsky edited it, and Jeanine Rees prepared it for publication. An electronic version is available on CBO's website (www.cbo.gov/publication/51130).

Keith Hall
Director

February 2016

California State Auditor

February 2016

High Risk—Covered California

It Must Ensure Its Financial Sustainability Moving Forward, and Its Use of Sole-Source Contracts Needs Improvement

Report 2015-605

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

February 16, 2016 2015-605

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

This report presents the results of our high risk audit concerning Covered California's administration of California's Health Benefit Exchange (exchange). State law required Covered California to create and operate the exchange to implement provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act).

This report concludes that Covered California has made progress in implementing key federal and state requirements pertaining to the establishment of an exchange, but certain concerns remain. Covered California is required to be self-supporting and, although it has developed a plan to help ensure its future financial viability, it needs to continue to monitor its plan and conduct a formal analysis of its reserve level. Covered California projects that in fiscal year 2017–18 it will have enough consumers enrolled in qualified health plans that its revenues will cover its operating expenditures. Covered California annually updates its enrollment projections and used six key assumptions to determine its multiyear enrollment projections. Using these assumptions, Covered California has developed a range of enrollment estimates, from low to high, all of which show continued enrollment growth through fiscal year 2018–19. However, as with all forecasts, some degree of uncertainty about future enrollment should be anticipated, and Covered California's short operational history suggests that its enrollment projections are an area of risk that it will need to carefully monitor in order to ensure its financial sustainability.

Covered California's contracting practices must be improved to ensure the integrity of the process it uses to award sole-source contracts. We reviewed the justifications for 20 of Covered California's sole-source contracts and another 20 applicable amendments to those contracts, for a total of 40 justifications. The policy adopted by Covered California's board of directors (board) and in place during our review stated that sole-source contracts should be justified in writing. In our review, we found that nine of the 40 justifications were insufficient according to Covered California's board-adopted policy. For example, Covered California did not sufficiently justify the use of a noncompetitive procurement method to award a contract for marketing and outreach services totaling nearly $134 million. In addition, we question the validity of an additional three justifications because, even though Covered California asserts either *timeliness* or *unique expertise* as a basis for using the noncompetitive procurement process, available documentation indicates that either Covered California had sufficient time to use a competitive procurement process or the vendor was not unique. Finally, although the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is functional, its rapid design, development, and implementation have resulted in some risks to system maintainability. Without continued oversight, specifically from independent verification and validation, these system issues may go unidentified or unresolved, resulting in long-term cost and schedule implications for the ongoing maintenance of CalHEERS.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Contents

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Summary

Results in Brief

Covered California has made progress in implementing key federal and state requirements that pertain to establishing a health insurance exchange (exchange), but certain concerns remain. In our July 2013 report *New High-Risk Entity: Covered California Appears Ready to Operate California's First Statewide Health Insurance Exchange, but Critical Work and Some Concerns Remain,* Report 2013-602, we noted that Covered California's financial sustainability depends wholly on enrollment in qualified health plans (QHPs) offered through the exchange. We also pointed out that future enrollment is both unpredictable and based on market factors outside of Covered California's control. Thus, we concluded that enrollment in the exchange and the financial sustainability of Covered California will need to be monitored. In this current audit we found that Covered California will exhaust available federal funds by September 2016 and, without any federal funds or the State's General Fund to assist it in its operations, Covered California is required to be self-supporting. As a result, it must continue to monitor its revenues from enrollment and its expenditures to ensure its future financial sustainability. For this reason, we believe Covered California should continue to be designated as a high-risk state agency under the California State Auditor's high risk program. In addition, we identified some issues regarding its sole-source contracting practices.

Although Covered California has developed a plan to help ensure its future financial viability, it needs to continue to monitor that plan and conduct a formal analysis of its reserve level. Covered California projects that in fiscal year 2017–18, it will have enough consumers enrolled in QHPs that its revenues will cover its operating expenditures. Until then, if Covered California does not meet its revenue goals, it can increase its plan assessments (the charge it assesses on QHPs), use its reserves, or cut expenditures as necessary to maintain its solvency. However, Covered California has yet to formally analyze whether its goal of maintaining a reserve of three to six months is sufficient. Although Covered California has done some work in this area, we believe that it could benefit from a formal analysis of its reserve level to ensure it maintains financial solvency if enrollment significantly decreases.

Covered California annually updates its enrollment projections. For its *Fiscal Year 2015–2016 Budget* (2015–16 budget), Covered California based enrollment projections primarily on prior year or other recent data as well as the California Simulation of

Audit Highlights . . .

Our review of Covered California highlighted the following:

- *Although it has developed a plan to help ensure its future financial viability, Covered California needs to:*
  - *Continue to monitor its revenues from enrollment and its expenditures.*
  - *Conduct a formal analysis of its reserve level to ensure it maintains financial solvency if enrollment significantly decreases.*
- *Its contracting practices must be improved.*
  - *It did not sufficiently justify nine of the 40 sole-source contracts and applicable amendments we reviewed.*
  - *Its board-adopted policy in place during our review used generic terms such as timeliness and unique expertise as justification for using a noncompetitive process.*
- *Along with the California Department of Health Care Services and the Centers for Medicare and Medicaid Services, Covered California spent $493 million to rapidly build a system that interfaces with certain state, federal, and private entities—CalHEERS—and which has resulted in some risks to system maintainability.*

Insurance Markets.[1] However, as with all forecasts, some degree of uncertainty about future enrollment should be anticipated, and Covered California's short operational history and its uncertainty about the adequacy of its reserves suggest that its financial sustainability remains an area of risk that needs to be closely monitored.

To help meet its enrollment goals, Covered California's marketing division and its outreach and sales division use strategies that target the populations they need to reach. Under state law, Covered California is required to market and publicize the availability of health care coverage and federal subsidies through the exchange. To satisfy this requirement and to target key populations, the marketing division has adjusted its marketing strategy for each open enrollment period to reach consumers eligible for health insurance. The outreach and sales division generates reports from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), the computerized system that enables consumers to enroll in Covered California's QHPs, among other functions. The outreach and sales division uses these reports to review the performance of certified enrollment representatives who inform consumers about and help them enroll in QHPs, and to identify new outreach opportunities to increase enrollment during future enrollment periods.

We also found that Covered California's contracting practices must be improved. State law requires Covered California to establish and use a competitive process to award contracts, and the law also gives it broad statutory authority to establish its own procurement and contracting policy. Covered California's board of directors (board) adopted a procurement policy in 2011 that provided Covered California the flexibility to use sole-source contracts when *timeliness* or *unique expertise* are required. However, we found that Covered California did not sufficiently justify nine of the 40 sole-source contracts and applicable amendments we reviewed from fiscal years 2012–13 through 2014–15, thereby not consistently following its board-adopted policy to do so. Further, we question the validity of an additional three justifications because, even though Covered California asserted either *timeliness* or *unique expertise* as the basis for using the noncompetitive procurement process in these cases, available documentation indicates that Covered California had sufficient time to use a competitive procurement process or that the vendor was not unique.

[1] The California Simulation of Insurance Markets model, a joint project of the University of California, Los Angeles Center for Health Policy Research and the University of California, Berkeley Center for Labor Research and Education, is designed to estimate the impacts of elements of the federal Patient Protection and Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California.

Without competitively bidding such contracts, Covered California cannot be assured that the contractor it chooses is the most qualified or cost-effective.

Further, on June 24, 2015, state law was revised to implement a new requirement that Covered California adopt a contract manual that is substantially similar to the provisions in the *State Contracting Manual.* The *State Contracting Manual* permits the use of a noncompetitive process when there is an emergency requiring immediate acquisition for the protection of the public health, welfare, or safety, or when no known competition exists. Our review identified concerns with Covered California's board-adopted policy that was in place during our review which used generic terms such as *timeliness* and *unique expertise* as justification for using a noncompetitive process. These terms are overly broad and do not limit the use of sole-source contracts to the conditions under which such contracts are allowed by the *State Contracting Manual*. In our review of the November 2015 draft procurement manual, we determined that it included criteria allowing for sole-source contracts in circumstances that the *State Contracting Manual* does not authorize. After bringing this to the attention of Covered California, they made changes to the draft procurement manual to address our concerns, which the board formally adopted in January 2016.

Finally, over the first three full fiscal years of the project, fiscal years 2012–13 through 2014–15, Covered California, the California Department of Health Care Services, and the Centers for Medicare and Medicaid Services together spent about $493 million on CalHEERS, which interfaces, or communicates, with certain state, federal, and private entities. Although CalHEERS is functional, its rapid design, development, and implementation have resulted in some risks to system maintainability, and several changes to systems interfacing with CalHEERS will necessitate continual releases to update the system for several years. Covered California has contracted with consultants for independent oversight of the system, and they have identified various risks, such as risks to the system's maintainability—its ability to isolate and easily correct system issues to maximize the cost-effective productive life of the system—or delays to or partial release of change requests, which could increase project costs. However, the contract with one of these key oversight consultants recently expired and according to the chief of the project management office at CalHEERS, as of January 2016, independent project oversight services have ended. Given the size and technical complexity of the project, as well as the significant number of maintenance items and change orders that remain outstanding, our information technology (IT) expert believes the project should reinstitute the independent verification and validation (IV&V) services. Without this oversight, our

IT expert believes certain system issues may go unidentified or unresolved, resulting in long-term cost and schedule implications for the ongoing maintenance of CalHEERS.

Recommendations

Covered California should continue to monitor its plan for financial sustainability and revise the plan accordingly as factors change. Further, it should complete a formal analysis of the adequacy of its reserve level by December 31, 2016, and update this analysis as needed so that it is prepared if it does not meet its revenue projections and needs to increase its funding or decrease its expenditures to maintain solvency. This formal analysis should identify those contracts it could quickly eliminate, among other actions it would take, in the event of a shortfall in revenues.

Covered California should continue to regularly review its enrollment projections and update the projections as needed to help ensure its financial sustainability.

To comply with state law, Covered California should ensure that its staff comply with the changes to its recently-adopted procurement manual that incorporate contracting policies and procedures that are substantially similar to the provisions in the *State Contracting Manual*.

Before executing any sole-source contracts, Covered California should adequately document the necessity for using a noncompetitive process in its written justifications and, in doing so, demonstrate valid reasons for not competitively bidding the services.

To ensure that CalHEERS does not face delays and cost overruns in the implementation of planned releases, Covered California should immediately contract with an independent party for IV&V services to highlight and address potential risks going forward.

Agency Comments

Covered California agreed with our recommendations and indicated that it has already taken steps to address them, although it recognizes that its work is not complete.

Introduction

Background

State law authorizes the California State Auditor to establish a state high risk audit program and to issue reports with recommendations for improving state agencies or statewide issues that it identifies as high risk. Programs and issues that are high risk include not only those that are particularly vulnerable to fraud, waste, abuse, and mismanagement but also those that have major challenges associated with their economy, efficiency, or effectiveness.

To expand health insurance coverage and make health care more accessible and affordable, in March 2010 the U.S. Congress enacted the Patient Protection and Affordable Care Act (Affordable Care Act). California was the first state to enact legislation creating a state-operated health insurance exchange (exchange), one of the provisions of the Affordable Care Act. This exchange is a competitive insurance marketplace in which eligible individuals and small businesses have been able to purchase qualified health plans (QHPs) since October 1, 2013.

In our July 2013 report titled *New High-Risk Entity: Covered California Appears Ready to Operate California's First Statewide Health Insurance Exchange, but Critical Work and Some Concerns Remain,* Report 2013-602, we reviewed Covered California's establishment of this exchange. In that report we concluded that although Covered California had made great strides in implementing key federal and state requirements pertaining to the exchange and its operations, critical work and some concerns remained. Specifically, we made four initial recommendations to Covered California, including that it conduct regular reviews of enrollment, costs, and revenue; that it make prompt adjustments to its financial sustainability plan based on those reviews; and that it develop monitoring, recertification, and decertification procedures for QHPs offered through the exchange. In this report we update our analysis of Covered California's implementation of those recommendations and reassess its status as a high-risk state agency.

Because of our continuing concern regarding financial sustainability, Covered California remains on our high risk list. We will continue to monitor the risk we have identified and the actions Covered California takes to address this risk. When, in our professional judgment, Covered California's actions result in sufficient progress toward resolving or mitigating the risk, we will remove the high risk designation.

Governance and Funding of Covered California

Covered California is an independent public entity governed by a five-member board of directors (board). The board's membership consists of the secretary of the California Health and Human Services Agency, or the secretary's designee, and four other California residents—two appointed by the governor, one by the speaker of the Assembly, and one by the Senate Committee on Rules. State law requires the board to meet the minimum requirements of the Affordable Care Act, as well as other specified criteria, and prohibits it from using California's General Fund to establish or operate Covered California. To provide initial funding, the federal government has awarded Covered California more than $1 billion in State Planning and Establishment Grants for the Affordable Care Act's Exchanges (establishment grants) since September 2010. Covered California may spend these establishment grants on a wide range of activities, including marketing, service centers, finance and accounting, and information technology (IT) development.[2] Beginning with fiscal year 2012–13 an independent auditing firm annually reviews Covered California's compliance with the requirements of the establishment grants. As of December 2015, the most recent available audit report concluded that Covered California complied for the fiscal year ending June 30, 2014, in all material respects, with the establishment grants' requirements, including that it spend these funds only on allowable activities.

Although the Affordable Care Act requires Covered California to be self-sustaining beginning in January 2015, Covered California requested—and was granted—two extensions to continue spending a federal establishment grant it began receiving in January 2013. As of November 2015, documentation from Covered California indicated that it had roughly $107 million in federal funds remaining and it intends to expend these funds by the new deadline of September 2016.

To generate revenue to support its development, operations, and cash management, Covered California assesses a charge on the QHPs—referred to as *plan assessments*—offered by insurance issuers (issuers). These plan assessments are paid by the issuers who sell insurance to consumers from within the exchange. Since the pooling of risk is fundamental to health insurance, federal regulations require each QHP issuer to spread the cost of plan assessments across all of its insured consumers, both those whom the issuer serves through Covered California and those whom it

[2] Covered California's service centers are staffed by representatives who assist consumers with understanding health plan options, determining eligibility for subsidies and tax credits, and enrolling consumers in health plans.

insures through its other insurance plans. Specifically, issuers are to include plan assessments in their determination of all consumers' health plan premiums. In fiscal year 2014–15, according to its financial records, Covered California charged QHP issuers more than $210 million in plan assessments.

In addition, Covered California for Small Business (CCSB), California's small business health options exchange, is available to small businesses with one to 50 employees, as described in Covered California's *Fiscal Year 2015-2016 Budget*. The program makes it possible for small businesses to offer their employees a wide choice of health insurance plans. Although Covered California's financial records indicate that CCSB generated a very small amount of its $210 million in revenue, beginning January 1, 2016, the program is scheduled to expand to businesses with up to 100 employees, and that larger market should increase the revenue this program generates.

CalHEERS

The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is an online system that consumers can use to request evaluation for enrollment in QHPs offered through Covered California and other affordability assistance programs, including the California Medical Assistance Program (Medi-Cal). According to the chief of the CalHEERS project management office, consumers can either complete the application process themselves or seek assistance from certified enrollment representatives, such as insurance agents; Covered California's service center representatives; or county eligibility workers. Once eligibility has been determined, consumers can either continue to shop and enroll in QHPs offered through Covered California or be electronically transferred for assistance to their local county office for confirmation of eligibility and enrollment in California's affordability assistance programs, such as Medi-Cal. CalHEERS consists of three major system components that provide eligibility determination, enrollment functionality, and financial accounting in conjunction with other entities that interface, or communicate, with the system. According to the CalHEERS project management office, these entities include the Centers for Medicare and Medicaid Services, the Internal Revenue Service, and the California Employment Development Department.

Covered California and the California Department of Health Care Services (Health Care Services) jointly sponsored CalHEERS and, according to documentation from the CalHEERS project management office, the cost for the IT project totaled approximately $493 million over its first three full fiscal years, 2012–13 through 2014–15. This documentation further

indicates that the total costs of the project are estimated to reach more than $700 million by the end of fiscal year 2015–16. During the first two fiscal years of the project, Covered California paid for 80 percent of the system's development and implementation costs. However, beginning in fiscal year 2014–15, it has paid for less than 20 percent of the system's operations and maintenance costs, as Health Care Services and the Centers for Medicare and Medicaid Services have since become the project's primary funders.

Scope and Methodology

Table 1 presents the status of the four recommendations we made in our 2013 report that we followed up on during this audit. For the first of these recommendations, we found that as of October 2015, Covered California had not updated its administrative manual to agree with the current version of state law pertaining to Covered California's contract transparency, which became effective October 2013. After our inquiry regarding its outdated administrative manual, Covered California updated its policy in November 2015 to not only remove its reference to obsolete state law but also to further limit its use of its statutory authority to those deliberative processes, discussions, and communications relating to its contract negotiations. As a result of this action, it has fully addressed this recommendation.

In addition, we reviewed Covered California's contracting processes and practices for its use of sole-source contracts. To review the contracting practices, we accessed Covered California's contracts database and identified the number of sole-source contracts that Covered California awarded during fiscal years 2012–13 through 2014–15. We judgmentally selected 20 of the 64 sole-source contracts awarded during this period to determine whether Covered California appropriately justified the need to bypass the competitive bidding process. In addition, we judgmentally selected five contracts exempt from competitive bidding, which include interagency agreements and legal services, and we determined that Covered California appropriately classified these contracts as exempt from competitive bidding.

Further, with the assistance of our IT expert, we obtained an understanding of the status of CalHEERS by interviewing key staff from the CalHEERS project management office. In addition, we reviewed the six most current oversight reports as of July 2015 from the independent verification and validation (IV&V) consultant and the independent project oversight (IPO) consultant to identify any significant concerns or risks regarding the project. IV&V is used to ensure that a system satisfies its intended use and user needs, whereas IPO is used to ensure that effective project management practices are in place and in use.

Table 1
Status of Actions Taken in Response to Recommendations in the California State Auditor's Report 2013-602 and the Methods Used to Assess Their Status

RECOMMENDATION	METHOD	STATUS OF RECOMMENDATION
1. To provide as much public transparency as possible, Covered California's board should formally adopt a policy to retain confidentiality only for contracts, contract amendments, and payment rates that are necessary to protect Covered California's interests in future contract negotiations.	• Identified and documented the relevant state law pertaining to contract transparency and confidentiality. • Determined whether Covered California's policy and procedures regarding release of contracts are consistent with state laws. • Selected five contracts that had been requested through the California Public Records Act to determine whether Covered California acted in accordance with federal and state laws and regulations and with its own policies regarding the release of information in these contracts. • Tested these five contracts and found minor inconsistencies with state law that had no material effect on the information sought by requesters.	Fully implemented
2. To comply with federal requirements, Covered California should develop a plan and procedures for monitoring, recertification, and decertification of qualified health plans.	• Identified and documented the relevant federal and state laws and regulations pertaining to qualified health plans (QHPs). • Determined whether Covered California's plan and procedures regarding monitoring, recertification, and decertification of QHPs are consistent with federal and state laws and regulations. • For each of the three largest QHP issuers by enrollment and one small QHP issuer, determined whether Covered California performed monitoring and recertification procedures for contracts ending December 31, 2015. Reviewed the data collected using these procedures and determined whether the QHP issuers were compliant with key federal and state regulations. • For any QHPs that Covered California decertified, determined whether Covered California acted in accordance with key federal and state regulations.	Fully implemented
3. To ensure the success of its outreach effort, Covered California should track the effect on enrollment figures of its planned outreach and marketing activities and of its assister program.	• Identified and documented the relevant federal and state laws and regulations pertaining to marketing and outreach requirements under the Patient Protection and Affordable Care Act, and determined whether Covered California complied with these requirements. • Determined whether Covered California documented its marketing campaign. Identified its goals and actions for accomplishing those goals. Determined whether Covered California had met its marketing goals during the two open enrollment cycles since its inception, and whether any changes were necessary for the third open enrollment cycle. • Obtained evidence that Covered California tracks the effectiveness of its marketing approach. Interviewed relevant staff and determined whether Covered California used these data in its strategic planning efforts to inform future marketing endeavors. • Interviewed relevant staff to determine how the outreach and sales division managed its certified enrollment representatives. Identified and documented navigator grants from fiscal years 2014–15 and 2015–16 to identify the goals outlined in the agreements and, for fiscal year 2014–15, determined whether the grant recipients achieved those goals. Interviewed staff to determine how the performance of the navigator program during fiscal year 2014–15 affected its strategic planning approach for fiscal year 2015–16. • Obtained and reviewed reports generated by the outreach and sales division to determine the type of information it tracks regarding the effectiveness of its outreach campaign. Interviewed relevant staff and determined whether Covered California used these data to inform its strategic planning efforts for future outreach.	Fully implemented
4. To ensure financial sustainability, Covered California should conduct regular reviews of enrollment, costs, and revenue and make prompt adjustments to its financial sustainability plan as necessary.	• Identified and documented the relevant federal and state laws and regulations pertaining to financial sustainability and determined whether Covered California complied with these requirements. • Using Covered California's *Fiscal Year 2015–2016 Budget,* documented the enrollment forecasting methodology and identified the factors, or assumptions, used in this methodology. • Documented how annual budget forecasts have changed since the program began. • Identified which expenditures are fixed and which are projected to decrease to lower total expenditures. • Reviewed its reserve level and determined whether it has conducted a formal analysis of the adequacy of the reserve level.	Partially implemented

Sources: Recommendations made in the report by the California State Auditor titled *New High-Risk Entity: Covered California Appears Ready to Operate California's First Statewide Health Insurance Exchange, but Critical Work and Some Concerns Remain,* Report 2013-602, July 2013, and analysis of information and documentation identified in the table column titled *Method.*

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on Covered California's data maintained in the California Department of Finance's (Finance) California State Accounting and Reporting System (CALSTARS). We used data from CALSTARS for the period from July 1, 2013, through June 30, 2015, for the purpose of identifying Covered California's expenditures by fiscal year. To evaluate these data, we performed data-set verification procedures and electronic testing of key data elements and did not identify any significant issues. Further, we tested the completeness of the CALSTARS data by comparing Covered California's expenditures to the California State Controller's Office's appropriation control ledger. We found the data to be materially complete. Finally, we tested the accuracy of the CALSTARS data by tracking key data elements for a selection of 31 transactions to supporting documentation and found no errors. Therefore, we found that Covered California's CALSTARS data that are maintained by Finance are sufficiently reliable for the period from July 1, 2013, through June 30, 2015, for the purpose of identifying its expenditures by fiscal year.

Chapter 1

COVERED CALIFORNIA MUST CONTINUE TO MONITOR ITS FINANCIAL SUSTAINABILITY AND ENROLLMENT PROJECTIONS TO ENSURE ITS SOLVENCY

Chapter Summary

Covered California has demonstrated progress in implementing key federal and state requirements that pertain to establishing a health insurance exchange (exchange), but some concerns remain. In our July 2013 report we recommended that Covered California conduct regular reviews of enrollment, costs, and revenue and make prompt adjustments to its financial sustainability plan as necessary. During this current audit we found that Covered California has conducted these reviews and made necessary adjustments as part of its annual budget process. Nevertheless, to better ensure its financial sustainability, Covered California should formally analyze whether its proposed reserve is adequate and determine the steps it would take to reduce its operating expenditures in the event that enrollment significantly decreases. For instance, it could identify the contracts it would eliminate to reduce its expenditures.

This audit found that Covered California has annually updated its enrollment projections. Using six key assumptions to determine its multiyear enrollment projections, Covered California has developed a range of enrollment estimates, from low to high, which show continued enrollment growth through fiscal year 2018–19.

To help ensure that Covered California meets its enrollment projections, the marketing division develops and executes marketing campaigns promoting the products and services offered through the State's exchange. In addition, Covered California has established a network of certified enrollment representatives consisting of entities and individuals that educate consumers on, and enroll them in, qualified health plans (QHPs) and the California Medical Assistance Program (Medi-Cal).

Although Covered California Has a Plan to Help Ensure Its Financial Sustainability, It Must Complete a Formal Analysis of Whether Its Reserve Is Adequate

State law requires Covered California's board of directors (board) to ensure that the costs of establishing, operating, and administering the exchange do not exceed the combination of federal funds, private donations, and other available money. Covered California may not use money from the State's General Fund to help support

If Covered California falls short of achieving its enrollment goals, its financial condition will suffer.

its operations. Its revenue is generated from plan assessments—charges on the QHPs that insurance issuers offer, as state law requires and as discussed in the Introduction. As a result, if Covered California falls short of achieving its enrollment goals, its financial condition will suffer.

In our July 2013 report we found that, given the limits of its information at the time, Covered California appeared to have engaged in a thoughtful planning process to ensure that it would remain solvent in the future. We also noted that Covered California's financial plans greatly depend on patterns of enrollment in its QHPs by individuals and small business employers, which could only be projected at that time. Consequently, we concluded that financial sustainability would continue to be an area of risk that would need to be closely monitored, and we recommended that Covered California conduct regular reviews of enrollment, costs, and revenue and make prompt adjustments to its financial sustainability plan as necessary.

During our current audit we found that Covered California has conducted these reviews and made necessary adjustments as part of its annual budget process. According to Covered California's *Fiscal Year 2015–2016 Budget* (2015–16 budget), this process was conducted over six to seven months, with particular attention paid to updating its enrollment forecast, which relies to a great extent on its actual enrollment experience in 2014 through the end of the second open enrollment period in February 2015. The goal of this process is for Covered California to ensure that its revenues will cover its expenditures for each fiscal year as state law requires. For fiscal year 2015–16 Covered California created a robust budget document that outlines the steps it needs to be financially sustainable. In that document Covered California explains that its fiscal year 2015–16 budget reflects a multiyear financial strategy of providing continuous fiscal integrity, transparency, and accountability. The budget includes low, medium, and high enrollment forecasts and corresponding revenue projections. In its budget Covered California states that, to the extent that enrollment varies from the medium forecasted amounts, it will be able to adjust its revenue by increasing or decreasing its plan assessments or by adjusting its budgeted expenditures.

Table 2 shows Covered California's multiyear budget forecast through fiscal year 2018–19. As the table indicates, Covered California projects that expenditures will decrease while revenues increase so that both are balanced at approximately $300 million in fiscal year 2017–18—the first year in which Covered California estimates that its operations will break even. Covered California plans to begin fiscal year 2016–17 with approximately $197 million in reserve funding to address any

unforeseen economic uncertainties and to facilitate the transition to supporting its operations solely on plan assessments. The table also shows that in the beginning of fiscal year 2015–16, Covered California estimated that $100 million in federal establishment funds were remaining. As of November 2015, documentation provided by Covered California indicated that it had roughly $107 million in federal funds remaining, which it can spend on a variety of purposes, including consulting with stakeholders and developing information technology (IT). As described in the Introduction, the federal government has extended the deadline by which Covered California must spend these funds to September 30, 2016, and Covered California intends to ensure that it will exhaust these funds by that deadline. Table 3 on the following page summarizes Covered California's progress in complying with certain federal and state requirements for funding its operations.

Table 2
Covered California's Multiyear Budget Forecast
(Dollars in Millions)

	FISCAL YEAR			
	2015–16	2016–17	2017–18	2018–19
Effectuated enrollment*	1,476,342	1,666,617	1,809,095	1,977,792
Beginning balance of unrestricted funds	$197.9	$197.2	$156.4	$160.0
Balance of federal establishment funds	100.0†	-	-	-
Opening balance	**$297.9**	**$197.2**	**$156.4**	**$160.0**
Plan assessments—cash basis	$234.4	$269.2	$303.6	$329.2
Total funds	**$532.3**	**$466.4**	**$460.0**	**$489.2**
Expenditures	($335.0)	($310.0)	($300.0)	($300.0)
Year-end operating reserve	**$197.2**	**$156.4**	**$160.0**	**$189.2**
Estimated number of months the operating reserve will cover expenditures	7.1	5.6	5.4	6.1

Sources: Adapted from Covered California's *Fiscal Year 2015-2016 Budget* (2015–16 budget), dated June 30, 2015, and documentation provided by Covered California's financial management division.

* *Effectuated enrollment* is the number of enrollees who complete an application, select a qualified health plan, and pay at least their first month's premium.

† Although Covered California estimated in its 2015–16 budget that it would have $100 million in federal funds for this fiscal year, as of November 25, 2015, Covered California reported that it had roughly $107 million of these funds remaining that it plans to spend by September 30, 2016.

Covered California's 2015-16 budget indicates that if it falls short of meeting its enrollment goals, it will consider increasing plan assessments, reducing costs, or using its reserves to maintain its solvency. Covered California's interim chief actuary stated that a large body of work from different health economists shows that if health insurance premiums were to increase by 1 percent, with all other factors held constant, the resulting reduction in enrollment

would not be significant—between 0.2 and 0.6 percent. Therefore, Covered California believes that if it needs to moderately increase its plan assessments, the small increases that insurance issuers would distribute across all of their California members would have little effect in causing current enrollees in the exchange to cancel their coverage or in deterring individuals from enrolling in the future.

Table 3
Covered California's Compliance With Key Federal and State Requirements for Funding Its Operations

REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION	STEPS THAT COVERED CALIFORNIA HAS TAKEN
Federal		
Have sufficient funding to support its ongoing operations beginning January 1, 2015.*	↑	Created a financial sustainability plan (financial plan), which it submitted to the federal government in November 2012 as a part of its grant application. Through its annual budget process, Covered California conducts reviews of enrollment, costs, and revenues; develops multiyear budget forecasts to help ensure its financial sustainability going forward; and makes necessary adjustments.
State		
Assess a fee on the qualified health plans (QHPs) offered by health insurance issuers through the health insurance exchange (exchange) that is reasonable and necessary to support the operations of the exchange.	↑	Established an initial fee of $13.95 assessed on a per-member, per-month basis for individual QHPs sold through the exchange and created a similar fee structure for QHPs offered to small businesses. In its *Fiscal Year 2015–2016 Budget*, Covered California indicated that it will consider adjusting the fees, or plan assessments, based on enrollment.
Maintain enrollment and expenditures to ensure that expenditures do not exceed revenue, and institute appropriate measures to ensure fiscal solvency.	↑	Through its annual budget process, Covered California develops a budget to help ensure that it covers operating costs under a range of enrollment scenarios. Beginning in fiscal year 2013–14, its goal has been to maintain a three- to six-month reserve.

Sources: 42 United States Code, section 18031; 45 Code of Federal Regulations, part 155.160; California Government Code, section 100503; Covered California's 2012 Financial Sustainability Plan; and Covered California's *Fiscal Year 2015–2016 Budget*.

* Covered California must spend its remaining federal establishment grant funds by September 30, 2016. These funds can be used for establishment costs but cannot be used to support ongoing operations.

↑ = Progressing as expected.

According to Covered California's 2015-16 budget, an increase in its plan assessments would require between nine and 18 months to have an impact on revenue. As explained by its chief financial officer, this delay would be necessary because an increase in the plan assessments must be approved by Covered California's board and then presented during Covered California's next round of negotiations with insurance issuers for the following plan year. Consequently, a plan assessment increase can take effect only on January 1 of the year following the next contract negotiation. According to Covered California's *Health Insurance Companies and Plan Rates for 2016*, QHP premiums increased by an average of approximately 4 percent in 2015 and 2016; however, Covered California has not increased its plan assessments. For the

projections it includes in its 2015-16 budget, Covered California used its monthly plan assessments for the individual and small business markets of $13.95 and $18.60, respectively, as the basis for its projections through fiscal year 2018–19.

Covered California projects that its expenditures will decrease and level out over the next several years and that it will achieve a balance between its revenues and expenditures in fiscal year 2017–18. Specifically, its costs for the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and for outreach, sales, and marketing represented 70 percent of Covered California's expenditures in its fiscal year 2013–14 budget. In subsequent fiscal years expenditures for CalHEERS have decreased, and Covered California projects that expenditures for outreach, sales, and marketing will decrease for the current fiscal year. In its 2015–16 budget Covered California projects that these expenditures will continue to decrease through at least fiscal year 2016–17 as it becomes more established. Table 4 presents a breakdown of Covered California's budgeted and actual expenditures for the last two fiscal years and its budgeted expenditures for fiscal year 2015–16.

Table 4
Covered California's Budgeted and Actual Expenditures for Fiscal Years 2013–14 and 2014–15 and Budgeted Expenditures for Fiscal Year 2015–16

	FISCAL YEAR 2013–14		FISCAL YEAR 2014–15		FISCAL YEAR 2015–16
	BUDGET	ACTUAL*	BUDGET	ACTUAL*	BUDGET
Service centers†	$64,732,239	$79,031,302	$97,022,224	$96,836,382	$100,103,078
California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)	181,042,718	114,714,737	88,177,616	93,607,718	42,410,485
Outreach & sales, marketing‡	134,218,916	131,718,285	189,831,459	153,558,948	121,512,473
Plan management and evaluation	22,788,018	4,939,390	17,334,578	11,286,694	17,300,582
Administration	36,556,839	32,571,736	37,796,386	36,460,965	46,159,372
Other expenditures#	9,504,885	151,547	12,589,363	1,543,057	13,493,138
Total expenditures‖	**$448,843,615**	**$363,126,997**	**$442,751,626**	**$393,293,764**	**$340,979,127**

Sources: California State Auditor's analysis of data obtained from Covered California's data as maintained in the California Department of Finance's California State Accounting and Reporting System; *Covered California Policy and Action Items*, dated June 19, 2014; Covered California's *Fiscal Year 2015–2016 Budget*, dated June 30, 2015; and budget reconciliation documents provided by Covered California.

* These amounts exclude prior year expenditures for each fiscal year and any pass-through payments to issuers of qualified health plans (QHPs) and insurance agents.

† Covered California's service centers are staffed by representatives who assist both consumers and certified enrollment representatives with understanding health plan options, determining eligibility for subsidies and tax credits, and enrolling consumers in QHPs.

‡ For fiscal year 2013–14 this expenditure was listed as "Enrollment Activities," whereas for fiscal years 2014–15 and 2015–16, it was listed as "Outreach & sales, marketing."

\# For fiscal year 2013–14 these budgeted amounts are for Covered California for Small Business (CCSB). For fiscal years 2014–15 and 2015–16 these budgeted amounts are for statewide general administrative costs and strategic initiatives. However, according to Covered California the actual expenditures for these categories are reported in different categories. Specifically, the actual expenditures for CCSB are included in the "Outreach & sales, marketing" actual column. In addition, Covered California stated while the actual expenditures for statewide general administrative costs remain in this category, the actual expenditures for the strategic initiatives are reported within the appropriate organizational category.

‖ These totals do not include reimbursements or CalHEERS cost-sharing.

State law requires Covered California to establish and maintain a prudent reserve and as of January 1, 2016, it requires Covered California to reduce plan assessments during a subsequent fiscal year if, at the end of any fiscal year, the reserve is equal to or more than Covered California's operating budget for the subsequent fiscal year. As shown earlier in Table 2 on page 13, Covered California projects that it will end fiscal year 2015–16 with approximately seven months of operating funds in its reserve, and it will have nearly six months in its reserve as of the end of fiscal year 2016–17. As expressed in its 2015–16 budget, one of Covered California's guiding financial principles is to maintain a reserve that is sufficient to cover its financial obligations and allow for time to adjust revenue and expenditures in the event of an unanticipated event. The chief financial officer stated that Covered California's board has established a target reserve of three to six months of operating expenditures rather than a one-year reserve—the maximum state law allows. He explained that building a larger reserve would be possible but at the expense of increasing the plan assessments, which would increase the premiums paid by enrollees in QHPs.

The chief financial officer also stated that the targeted reserve of three to six months would allow Covered California sufficient time to make adjustments to revenue or expenditures in order to maintain solvency. For example, most, if not all, of Covered California's contracts allow it the flexibility to cancel them with 30 days' notice and according to its 2015–16 budget, over $200 million of its expenditures are for contracts. However, he acknowledged that a thorough review of the contracts would be necessary to determine which ones could be canceled. In addition, he stated that if a significant revenue change were to surface, Covered California would evaluate the magnitude of that change and develop plans to resolve the resulting issues. These plans might include initiating adjustments to the plan assessments charged to QHP issuers, reducing discretionary expenditures, and reducing contract expenditures. Further, he said that Covered California would consider a hiring freeze, terminating temporary employees, or reducing vacant positions.

Were Covered California to undertake such a large reduction in expenditures in such a brief period of time, it might not be adequately prepared to respond effectively to the market conditions that necessitated those expenditure reductions.

Were Covered California to undertake such a large reduction in expenditures in such a brief period of time, it might not be adequately prepared to respond effectively to the market conditions that necessitated those expenditure reductions. For example, Covered California could find that it is without the funds necessary to undertake additional marketing efforts that might be necessary to increase enrollment and, in turn, to increase revenues. Despite these risks and the fact that it is now nearing completion of its third open enrollment period, Covered California has not completed a formal analysis of the adequacy of its reserve level. Nonetheless, Covered California has conducted some work in this area, such as a review

of a reduction in enrollment countered with adjustments to plan assessments and expenditures. When we inquired about this, the chief financial officer stated that as Covered California gathers more data over time on expenditure trends and revenues, it will continue to fine-tune its reserve requirement estimates. Specifically, he explained that the data from 2014 and 2015 would not be indicative of typical business cycles and reserve requirements; thus, using these data would likely lead to overestimating the reserve. He stated that although 2016 data should be more reflective of future years' business cycles, it would be premature to establish the reserve using only one year of data. Covered California would like to use data for 2016 and 2017 to prepare a formal reserve analysis soon after December 2017.

However, we believe that Covered California can conduct a meaningful, formal analysis to determine an adequate reserve level with the data available following this third open enrollment period, which was scheduled to end on January 31, 2016. In addition, to ensure that the most recent data are incorporated into its analysis, Covered California should update the analysis periodically. Covered California's financial plans are highly dependent upon its enrollment projections, which in turn largely rely on its limited experience from its first two open enrollment periods. If Covered California does not enroll as many consumers as its fiscal year 2015–16 budget projects, its revenues will suffer. Further, increasing its revenues by adjusting its plan assessments could take nine to 18 months, as described earlier. To better position itself to ensure its financial sustainability in this scenario, Covered California could formally analyze the steps it would take to ensure that its reserve is adequate to cover its operating expenditures. For instance, as part of this analysis, it could identify the contracts it would eliminate to reduce its expenditures. Although Covered California has done some work in this area, we believe it could benefit from a formal analysis related to its reserve level to ensure it maintains its financial solvency if enrollment significantly decreases. Consequently, financial sustainability continues to be an area of risk that will need to be closely monitored.

Financial sustainability continues to be an area of risk that will need to be closely monitored.

It Is Too Early To Tell Whether Enrollment Projections Accurately Reflect the Market

To ensure Covered California's financial sustainability, our July 2013 report recommended that it conduct regular reviews of enrollment, as well as other factors, and make prompt adjustments to its financial sustainability plan as necessary. During our current audit, we found that Covered California has annually updated its enrollment projections. For its fiscal year 2015–16 budget, Covered California primarily based these enrollment projections on prior

Summary of Covered California's Six Key Assumptions Used to Forecast Enrollment

Enrollment of the subsidy-eligible population: Proportion of the population eligible for federal subsidies that has enrolled in the exchange.

Effectuation rate: Proportion of enrollees who completed an application, selected a qualified health plan, and paid at least their first month's premium.

Monthly enrollment rate during special enrollment: Average number of new monthly enrollments in Covered California for qualifying events, such as loss of coverage from loss of employer-provided insurance or loss of coverage under the California Medical Assistance Program.

Monthly disenrollment rate: Proportion of current effectuated enrollees terminated each month.

Nonrenewal rate: Proportion of enrollees who did not renew or were found ineligible for renewal.

Subsidized and unsubsidized enrollments: Ratio of subsidy-eligible enrollees to enrollees not eligible for subsidies.

Source: Covered California's *Fiscal Year 2015-2016 Budget*, as of June 30, 2015.

year or other recent data, as well as the California Simulation of Insurance Markets.[3] However, as Covered California has acknowledged, a number of potential developments could lead to more or less enrollment and revenue than anticipated. In fact, Covered California stated that the biggest uncertainty in its forecasts is the pace at which the population eligible for federal subsidies on health insurance (subsidy-eligible population) enrolls in QHPs through Covered California. Thus, future enrollment is uncertain, and Covered California's limited operational history suggests that its enrollment projections are an area of risk that it will need to carefully monitor in order to ensure its financial sustainability.

Covered California used six key assumptions to determine its multiyear enrollment projections. Using these assumptions, Covered California developed a range of enrollment estimates—from low to high, which show continued enrollment growth through fiscal year 2018–19. The text box describes Covered California's six key forecasting assumptions.

One of Covered California's key assumptions is the proportion of the subsidy-eligible population that has enrolled in health insurance through the exchange. Covered California used external estimates and participation in similar programs, such as the Healthy Families program, to arrive at low, medium, and high alternatives for this assumption in its forecast. Covered California forecasts that by 2018 it will enroll 75 percent—the medium alternative—of those who are eligible for subsidies and do not already have coverage. According to Covered California's 2015–16 budget, the California Simulation of Insurance Markets model estimates the subsidy-eligible population in California to be approximately 2.5 million, increasing to 2.7 million by 2017.

Another of Covered California's key assumptions is the monthly enrollment rate during special enrollment, which consists of individuals who enroll outside of the open enrollment period because of qualifying events, such as the loss of employer-provided

[3] The California Simulation of Insurance Markets model, a joint project of the University of California, Los Angeles, Center for Health Policy Research and the University of California, Berkeley, Center for Labor Research and Education, is designed to estimate the impacts of elements of the Patient Protection and Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California.

insurance or the loss of Medi-Cal coverage.[4] Although an average of 31,000 special enrollments occurred each month from June 2014 through November 2014, Covered California used a conservative assumption of 25,000 new monthly special enrollments for its projection, in part because the actual month-to-month pace slowed noticeably after July 2014.

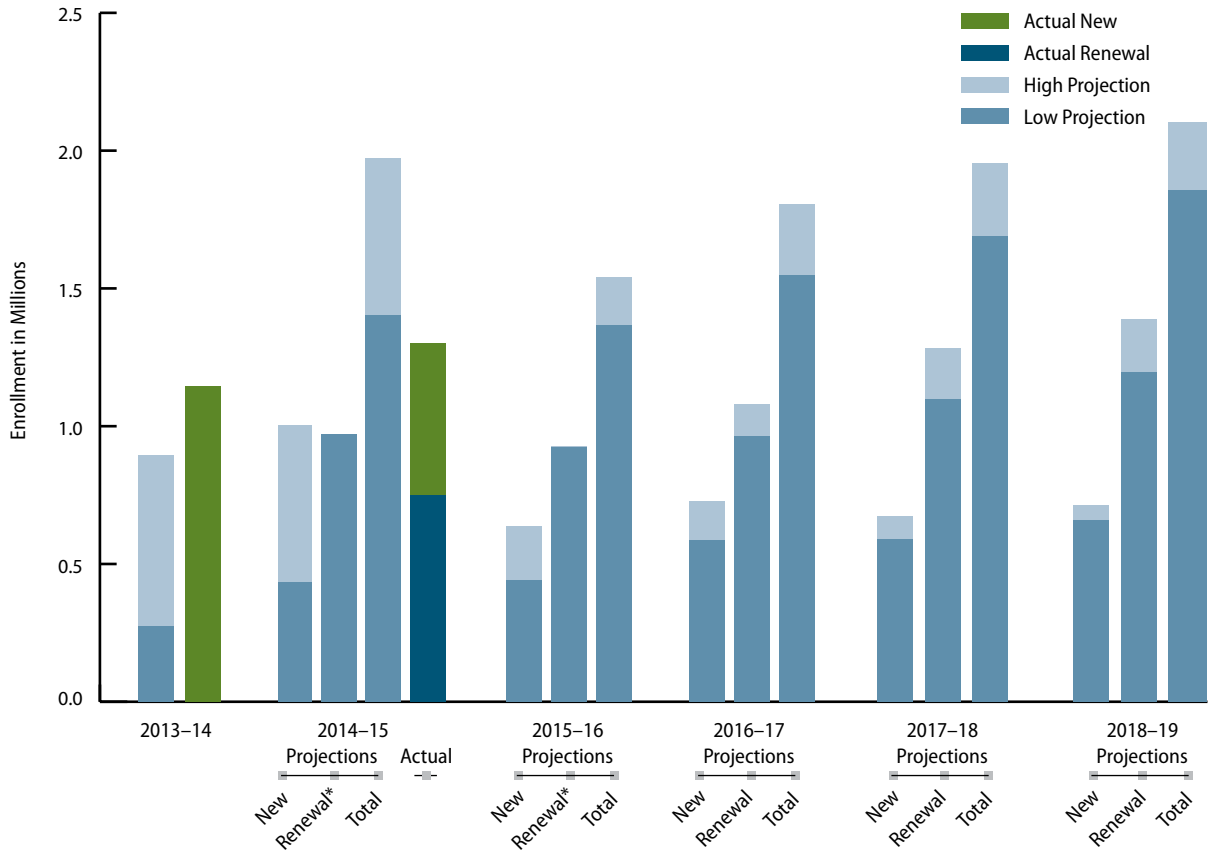
A third assumption that Covered California used is its *effectuation rate*, which is the proportion of enrollees who completed an application, selected a QHP, and paid at least their first month's premium. Covered California based its effectuation rate for subsequent years on the actual effectuation rate of those who enrolled in 2014, which was approximately 80 percent for those enrolled during open enrollment and approximately 75 percent for those enrolled outside of the open enrollment period. Using this data, Covered California projected an 80 percent effectuation rate during open enrollment and a 75 percent effectuation rate during special enrollment.

Covered California bases its budgets on its medium enrollment projections. According to its 2015-16 budget, individuals from the subsidy-eligible population made up 83 percent of its 2014 enrollment; therefore, Covered California's revenues are primarily dependent on the number of individuals it enrolls from this subpopulation of Californians. As shown in Figure 1 on the following page, in fiscal year 2013–14, the year of its first open enrollment period, Covered California exceeded its high projection of roughly 894,000 by enrolling more than 1.1 million consumers. For its second open enrollment period, Covered California's enrollment, including renewals, was nearly 1.3 million, falling slightly short of its low projection of 1.4 million and well below its high projection of nearly 2 million. As of September 30, 2015, Covered California had roughly 1.3 million consumers enrolled in the exchange. Its third open enrollment period began on November 1, 2015, and continued through January 31, 2016.

Covered California's revenues are primarily dependent on the number of individuals it enrolls from the subsidy-eligible population of Californians.

[4] Open enrollment is a designated period during which all eligible consumers may apply for health coverage.

Figure 1
Covered California's Projected and Actual Enrollment
Fiscal Years 2013–14 to 2018–19



Sources: Covered California's *Request for Approval of Proposed FY 2013–14 Budget*; *Covered California Policy and Action Items*, June 19, 2014; *Fiscal Year 2015–2016 Budget*; and data provided by Covered California.

Note: Data for actual enrollment consist of consumers who effectuated, which means they completed an application, selected a qualified health plan, and paid at least their first month's premium.

* Covered California did not include distinct renewal data in its projections. Therefore, we arrived at its renewal data by subtracting nonrenewals and disenrollments from its beginning effectuated enrollment. The fact that its high projections for these fiscal years contained much larger numbers of disenrollments than its low projections was primarily responsible for reducing the high renewal projections that we calculated for these fiscal years to below the level of its low renewal projections.

Covered California Evaluates and Modifies Its Marketing Approach to More Effectively Reach Eligible Program Participants

Covered California's marketing division develops and executes marketing campaigns promoting the products and services offered through the State's exchange. Under state law Covered California is required to market and publicize the availability of health care coverage and federal subsidies through the exchange. To satisfy this requirement and to target key populations and ensure a positive effect on enrollment, the marketing division has adjusted its marketing strategy for each open enrollment period to reach consumers eligible for health insurance. Table 5 summarizes how Covered California's key marketing strategies have evolved for each of the three enrollment periods based on its evaluations of enrollment and survey data.

For the first open enrollment period, the marketing division focused on educating consumers throughout the State about the exchange. According to documentation regarding its marketing campaign, Covered California's objective was to establish a media presence to generate awareness about the exchange and reach the subsidy-eligible population. To accomplish this objective, its marketing campaign included television advertisements that promoted the benefits of enrolling in a health plan through Covered California and newspaper advertisements regarding sources of more information about available plans and services such as a toll-free phone number and website. The advertisements emphasized that Covered California provides financial assistance for those who need help with their monthly insurance bills and that nobody can be denied coverage because of a preexisting condition.

Table 5
Summary of Selected Key Marketing Strategies by Enrollment Period

	ENROLLMENT PERIOD ONE	ENROLLMENT PERIOD TWO	ENROLLMENT PERIOD THREE
Marketing expenditures (Dollars in millions)	$74	$67.5	$60.8*
Selected marketing strategies	• Allocate the media plan budget based on the percentage of the uninsured population in different areas of the State, with adjustments made to account for media costs. • Advertise in as many as eight different languages depending on the area, using different forms of media channels, such as television, radio, print, and digital. • Raise awareness of Covered California and how to access information regarding affordable health coverage.	• Increase awareness and enhance the image of Covered California, with particular focus on Hispanic and African American segments, while building loyalty among current enrollees. • Promote messages through media channels frequently accessed by members of the non native English-speaking communities, including Hispanic and Asian population segments, as well as the African American and lesbian, gay, bisexual, and transgender communities. • Use social media to remind consumers of open enrollment dates, and direct mail to describe the benefits of membership to current enrollees.	• Market to a population that more closely aligns with the core target age of 25 through 54, and reallocate the media budget to increase digital advertising and revise its radio advertising strategy. • Outreach to the Hispanic market statewide with enhanced direct mail in areas with a high concentration of Hispanics. • Planned use of innovative technology to advertise to specific market groups instantly.
Total enrollment by period†	**1,395,929**	**1,408,362**	**Not available as of December 2015**

Sources: Various documents, including those related to its marketing campaigns and expenditures, provided by Covered California and selected executive director reports to Covered California's board of directors.

Note: The enrollment periods include designated open enrollment periods, during which all eligible consumers may apply for health coverage, and special enrollment periods, during which consumers with certain qualifying life events, such as loss of health insurance or marriage, may apply.

* Enrollment periods one and two include actual marketing expenditures according to Covered California's financial documents. For enrollment period three we present its marketing budget because, as of December 2015, all expenditures had not yet occurred.

† Enrollment figures include those consumers who selected a plan and enrolled during open enrollment periods, but who may or may not have made a payment to maintain insurance. These amounts do not include enrollees who signed up during special enrollment periods. These amounts are distinguishable from those in Figure 1, which include only those consumers who enrolled during open and special enrollment periods and paid their first month's premium.

According to documents related to its marketing campaign for the first open enrollment period, Covered California designated roughly half of its marketing budget to the Los Angeles market, which includes San Bernardino and Orange counties.

According to documents related to its marketing campaign for the first open enrollment period, Covered California designated roughly half of its marketing budget to the Los Angeles market, which includes San Bernardino and Orange counties. Covered California designated the remainder of the marketing budget across the additional 11 marketing areas in the State, including San Francisco–Oakland–San Jose, Sacramento–Stockton–Modesto, San Diego, and Fresno–Visalia, with an emphasis on the type of media it determined to be most effective to reach the target populations it identified.

To determine the effectiveness of the strategies it used to inform consumers about its products and services, and to increase enrollment following the first open enrollment period, Covered California evaluated data, such as demographic data, regarding the consumers enrolled in QHPs. Further, it analyzed survey data regarding public awareness of Covered California and consumers' overall experience with the exchange. According to the director of marketing, Covered California relied on these data to determine whether its marketing efforts were effective in enrolling consumers in QHPs.

Covered California used consumer enrollment data during and after the first open enrollment period to develop future targeted marketing campaigns. It determined that enrollment among Hispanic and African American consumers during the first three months of the first open enrollment period was significantly lower than its projections for that period. Although enrollment figures for these consumers eventually increased by the end of the first open enrollment period, Covered California focused its efforts for the second open enrollment period in part, toward underrepresented segments of the population, including the Hispanic and African American populations, to better ensure that they were aware of the opportunities to acquire health insurance. For example, Covered California used local platforms such as community newspapers and television advertisements specific to those communities to reach the underinsured in these target populations. According to Covered California's available enrollment data, the percentage of new Hispanic and African American enrollees increased in 2015 from the previous year.

In addition, during and following the first open enrollment period, Covered California surveyed or interviewed enrolled consumers; members of its outreach community, such as its service center representatives and enrollment counselors; and uninsured consumers to identify barriers to enrollment and to adjust its marketing strategy. For example, it conducted interviews to gauge consumer attitudes toward health insurance, awareness of Covered California, and barriers to obtaining health insurance through

Covered California. The results indicated that, although consumers were generally aware of Covered California, many indicated that they would not enroll because they were confused about how Covered California works and were concerned about not being able to afford insurance. Further, based on interviews with enrollment counselors, Covered California learned that the biggest barriers to enrollment of Hispanic consumers were confusion surrounding the program, technological barriers, and cost.

Covered California's second open enrollment marketing campaign included an advertising approach aimed at addressing the results of these surveys and interviews. Specifically, this campaign included advertisements containing testimonials from actual enrollees discussing positive experiences, such as cost savings and peace of mind, from enrolling in QHPs. In addition, Covered California encouraged consumers to seek free, in-person enrollment assistance or to visit its multilanguage website to obtain additional information. In March 2015, after the close of the second open enrollment period, one of Covered California's consultants conducted focus groups of uninsured consumers in select areas to understand key barriers and motivators for enrolling in a health insurance plan, among other factors. The results the consultant reported indicated that, although nearly all participants had heard of Covered California, those who had looked into it had not found what they considered an affordable plan. In addition, some had negative experiences with the website and, as a result, had not returned. The consultant also reported that almost all focus group participants wanted health insurance but were resigned to the idea that they could not currently afford to enroll in a plan.

After the close of the second open enrollment period, a consultant reported that although nearly all participants had heard of Covered California, those who had looked into it had not found what they considered an affordable plan.

Following the second open enrollment period, Covered California used survey data to inform its marketing strategies moving forward. In particular, it contracted with the National Opinion Research Center (NORC) at the University of Chicago to conduct market research and evaluation. NORC surveyed approximately 2,200 California residents during March through May of 2015. The purpose of the survey was to assess recent changes in public knowledge, attitudes, and behaviors related to purchasing health insurance and the effectiveness of Covered California's marketing and outreach campaigns. The resulting report, released in October 2015, reached two important conclusions that affected Covered California's marketing strategy. It indicated that overall consumer awareness of Covered California rose from 12 percent in 2013 to 85 percent in 2015. The report also stated that 72 percent of respondents who purchased a health plan through Covered California indicated that financial assistance was an extremely important motivator in obtaining insurance. Further, the survey closely examined respondents' knowledge of the availability of financial assistance for lower income groups and the tax penalty for not having minimum essential coverage. According to the report

Because of a moderate level of awareness of the subsidy, Covered California runs the risk that some uninsured individuals may decline health care coverage because of the cost, even though they may qualify for financial assistance.

the results showed that 64 percent of the uninsured population were aware of the subsidy in 2015. As a result of this moderate level of awareness of the subsidy, Covered California runs the risk that some uninsured individuals may decline health care coverage because of the cost, even though they may qualify for financial assistance.

Covered California has taken steps to address the report's findings in its marketing campaign for the third open enrollment period. According to its director of marketing, in addition to facilitating retention and renewal of existing members, Covered California's goals include attracting new enrollees who are unsure about how to enroll or are unaware of the available federal subsidies. To accomplish these goals Covered California is promoting radio and television advertisements to inform general and Hispanic audiences that most uninsured Californians can receive financial assistance to pay for insurance, and that four out of five consumers who receive their insurance through Covered California have received financial assistance. In addition, Covered California's English and non-English language advertisements include notice of a deadline to enroll to avoid a tax penalty. Although it anticipates that this effort will increase awareness of the subsidy and tax penalties, according to the director of marketing, Covered California plans to reevaluate both enrollment and awareness data following the third open enrollment period to determine whether its efforts were effective.

Covered California Has Established a Network of Entities to Help Strengthen Its Outreach Efforts

Covered California's outreach and sales division reviews the performance of certified enrollment representatives (enrollment representatives) and provides numerous resources and service center support to the entities that educate and enroll program participants. Under federal requirements the exchange must conduct outreach and education activities that meet specified standards to inform consumers about the exchange and insurance affordability programs to encourage participation. Similarly, state law requires Covered California to conduct public education actions to raise awareness of the availability of QHPs and to conduct outreach activities to assist enrollees. In our July 2013 report we concluded that Covered California's planned outreach efforts were extensive and appeared to satisfy federal and state requirements. Covered California has established a network of enrollment representatives, consisting of entities and individuals that educate consumers on, and enroll them in, QHPs and Medi-Cal. As shown in Table 6 enrollment representatives include certified application entities and counselors as well as certified insurance agents.

Table 6
Summary of the Types and Responsibilities of Covered California's Certified Enrollment Representatives

TYPE OF CERTIFIED ENROLLMENT REPRESENTATIVE (ENROLLMENT REPRESENTATIVE)	NUMBER OF ENROLLMENT REPRESENTATIVES AS OF NOVEMBER 2015	RESPONSIBILITY	FISCAL YEAR ENROLLMENT REPRESENTATIVES BEGAN WORK
Certified application entity or certified application counselor	340 certified application entities, 1,797 certified application counselors	A public or private entity designated by Covered California to certify its staff members or volunteers as certified application counselors that provide information to consumers about the full range of qualified health plans (QHP) options and insurance affordability programs for which they are eligible, assist them in applying for coverage, and facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.	2015–16
Certified insurance agent	14,037	Agents, certified by Covered California to transact in the individual and Small Business Health Options Program exchanges, now called Covered California for Small Business.	2013–14
In-person assister (certified enrollment entity and certified enrollment counselors)	Program discontinued	Staff at entities, such as nonprofit community organizations, faith-based organizations, or local government agencies, whose responsibilities include maintaining expertise in eligibility, enrollment, and program specifications; providing information and services in a fair, accurate, and impartial manner; and facilitating consumers' selection of a QHP.	2013–14*
Navigator	68 contractors and an additional 64 subcontractors	Entities, receiving grant funding to perform services for consumers, that demonstrate an existing relationship or could readily establish relationships with employers and employees, consumers, or self-employed individuals likely to be eligible for enrollment. These groups include community and consumer-focused nonprofit groups, trade and professional associations, and state or local human services agencies. The navigator's responsibilities include maintaining expertise in eligibility, enrollment, and program specifications and facilitating consumers' selection of a QHP.	2014–15
Plan-based enroller	11 QHP issuers, and 1,602 plan-based enrollers	Staff employed or contracted by a QHP issuer to provide enrollment assistance to consumers. The enrollers' responsibilities include maintaining an expertise in eligibility enrollment and program specifications, providing information and services to consumers, informing consumers of the availability of other QHP products offered through the exchange, and facilitating enrollment in QHPs.	2013–14

Sources: Documentation and information provided by Covered California; 45 Code of Federal Regulations, parts 155.205(d), 155.210, 155.215, 155.220, and 155.225; 10 California Code of Regulations, sections 6652, 6654, 6664, 6702, 6710, 6800, and 6802.

* Covered California used the in-person assister program, which compensated enrollment representatives for each person enrolled in the program, to help enroll as many consumers as possible during the first two enrollment periods. The certified application entity and certified application counselor program took over the role of the in-person assister program beginning in fiscal year 2015–16. This role is administered by local entities whose mission it is to provide services to people without being paid an incentive for their efforts.

The outreach and sales division generates reports from CalHEERS to review the performance of enrollment representatives. It uses this information to determine gaps in services and to identify new outreach opportunities to increase enrollment during future enrollment periods. For example, the outreach and sales division generates certain detailed reports to better inform local enrollment representatives during their planning processes. Using these reports, enrollment representatives can quickly identify consumers

who began working with a team member but who never enrolled. The enrollment representatives can use this information to contact those consumers and continue to discuss enrollment options.

The outreach and sales division uses other reports to better assess overall program performance and make necessary changes that can help enrollment representatives in better serving consumers. For example, Covered California modified the structure of its navigator program, described in Table 6 on the previous page, from an incentive-based grant program during fiscal year 2014–15 to a block grant program for fiscal year 2015–16, after evaluating the program's milestones and enrollment data. Covered California began the navigator grant program shortly before the beginning of the second open enrollment period, using its operational funds and not federal establishment funds, in accordance with the Patient Protection and Affordable Care Act. We reviewed data Covered California collected that specifies each grant recipient's target goals for new effectuated enrollments (enrollment goals) and whether those goals were reached during the grant award period, which included the second open enrollment period. According to these data, many navigators fell short of reaching the enrollment goals outlined in their grant agreements.

Many navigators fell short of reaching the enrollment goals outlined in their grant agreements.

Specifically, according to the grant agreements for the first award period of October 1, 2014, through June 30, 2015, each navigator received an initial payment, or 25 percent of its total grant award, for achieving the milestone of submitting a strategic work plan and campaign strategy to Covered California. The grant agreements further specify that the navigators would receive subsequent payments whenever they achieved 25, 75, or 100 percent of their enrollment goals and satisfied certain reporting requirements. However, many navigators failed to reach their enrollment goals. Of the 65 entities awarded navigator grants, only 10 met or exceeded 100 percent of their enrollment goals, and seven achieved only 75 percent of their goals. Of the remaining 48 navigators that fell short of achieving 75 percent of their enrollment goals, 20 did not even attain 25 percent of the goals. As a result, many navigators were in jeopardy of not receiving additional grant payments since they were not achieving the enrollment goals specified in their grant agreements.

In January 2015 Covered California's executive director indicated during a presentation to the board that navigators were spending much of their time helping consumers renew and enroll in health plans. The former acting deputy director of Covered California's outreach and sales division told us that the support many navigators were providing to consumers was more extensive than anticipated, particularly for non-native English speakers. As a result, in January 2015 Covered California's board approved a one-time

payment modification of the grant agreements to base payments on the number of consumers who enroll in a plan while assisted by a navigator rather than on effectuated enrollment, the number of consumers who enroll in a plan and make their first monthly payment. The former acting deputy director of the outreach and sales division stated that this change alone would allow navigators to attain the next payment. She also explained that those who still fell short of the revised enrollment goals could demonstrate progress and achievement of goals through a narrative report to receive grant funding.

After the second open enrollment period, Covered California evaluated the results of the navigator program and modified its approach to funding navigators.

After the second open enrollment period, Covered California evaluated the results of the navigator program and modified its approach to funding navigators. Specifically, at an April 2015 board meeting, the former acting deputy director of the outreach and sales division asserted that these entities are key contributors to the effort to provide outreach, education, enrollment and renewal assistance, and post-enrollment support, implying that the navigators' compensation should reflect this effort. Subsequently, the board approved changes to the navigator grant program for the third open enrollment period so that it operates in a manner similar to a traditional block grant program by paying navigators in equal installments on an established schedule. Navigator grantee payments are now not based solely on achieving actual enrollment and renewal goals but are also based on the work they perform related to consumer outreach, education, enrollment, renewal assistance, and post-enrollment support on behalf of Covered California. As a result, navigators can earn the full installment amount without reaching their enrollment goals, provided their work in these other areas has been satisfactorily documented in their progress reports and approved by Covered California.

As a result of these changes, Covered California's new navigator agreements, which have a duration that includes the third open enrollment period, require additional accountability measures. In addition to the monthly performance reporting previously required, the new grant agreements require information pertaining to performance and quality assurance. This added information includes the number of consumers assisted or enrolled by demographic category, successful educational and enrollment strategies, and any barriers or technical difficulties preventing navigators from meeting their enrollment or renewal goals. According to a manager in the navigator grant program, Covered California will finalize its evaluation of the success of the navigator program under the new funding format at the conclusion of the third open enrollment period, and it will make necessary modifications to help grant recipients better deliver services to consumers. This evaluation should help inform any necessary changes to the navigator program.

The outreach and sales division also routinely informs the enrollment representatives of new developments and strategies to help generate additional enrollments or renewals. To assist in this effort, the outreach and sales division provides numerous webinars to keep enrollment representatives informed of ways to promote their business and provide effective service to consumers. Covered California also provides its enrollment representatives, which include certified insurance agents, with online access to webinars and information about the open enrollment and renewal process as well as electronic agent briefings that describe pertinent information, such as reminders, and available resources. Moreover, Covered California established service centers to help ensure that all enrollment representatives have their enrollment questions answered.

Finally, the outreach and sales division is using geographic information software (GIS) to further inform Covered California's outreach efforts. As of November 2015 using GIS technology, the outreach and sales division had created and allowed regional sales staff and community partners to access a map book displaying the estimated remaining subsidy-eligible population. The map book hones in on certain regions within the State's eight sales areas and provides overlaid, color-coded information about estimated subsidy-eligible populations and the location of enrollment representatives in the region. The map book enables regional sales staff and local enrollment representatives to identify underserved areas with high levels of uninsured consumers who qualify for the federal subsidy. A manager within the outreach and sales division stated that, by tracking the enrollments made by enrollment representatives before and after they began using this tool, Covered California intends to evaluate the effectiveness of the map book and establish best practices for enrollment representatives.

Recommendations

Covered California should continue to monitor its plan for financial sustainability and revise the plan accordingly as factors change. Further, it should complete a formal analysis of the adequacy of its reserve level by December 31, 2016, and update this analysis as needed, so that it is prepared if it does not meet its revenue projections and needs to increase its funding or decrease its expenditures to maintain financial solvency. This formal analysis should identify those contracts it could quickly eliminate, among other actions it would take, in the event of a shortfall in revenues.

Covered California should continue to regularly review its enrollment projections and update the projections as needed to help ensure its financial sustainability.

Chapter 2

COVERED CALIFORNIA'S SOLE-SOURCE CONTRACTING PRACTICES NEED TO BE IMPROVED, AND CALHEERS NEEDS CONTINUED OVERSIGHT

Chapter Summary

Covered California needs to improve its contracting practices to ensure the integrity of the process it uses in awarding sole-source contracts. In reviewing sole-source contracts, we found that nine out of 40 justifications were insufficient. Specifically, we found that two of its contracts were missing justifications, and the remaining seven failed to assert either *timeliness* or *unique expertise* as the basis for sole-sourcing the contracts. Covered California's policy, which was approved by its board of directors (board) and in place during our review, permitted the use of sole-source contracts when timeliness or unique expertise may be required. In some instances the justifications asserted reasons that the board had not approved for using a noncompetitive procurement process. In other instances the justifications failed to explain why Covered California was using a sole-source contract at all. Rather, the justifications explained the reasons for the respective services and why the selected vendor was qualified to provide them.

Our review also identified concerns with Covered California's board-adopted policy itself, particularly in light of the new requirement that Covered California's contract manual be substantially similar to the *State Contracting Manual*. Specifically, Covered California's policy referenced generic terms such as *timeliness* and *unique expertise* as justification for using a sole-source contract. We believe that these terms are overly broad and are not substantially similar to the *State Contracting Manual*. Without competitively bidding such contracts, Covered California cannot be assured that the contractor it hires is the most qualified or cost-effective vendor.

Further, the aggressive schedule and rapid design, development, and implementation of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), although resulting in a functional system, has required trade-offs that in some cases present longer-term risks to system maintainability. Without independent verification and validation (IV&V) oversight, our information technology (IT) expert believes certain system issues may go unidentified or unresolved, resulting in long-term cost and schedule implications.

Covered California Often Did Not Adequately Justify Its Use of Sole-Source Contracts

State law requires Covered California to establish and use a competitive process to award contracts, and it also provides Covered California with broad statutory authority to establish its own procurement and contracting policy. In December 2011 the board adopted a procurement policy, updated in February 2013 and in place during our review, that provided Covered California the flexibility to use standard state procurement methods such as leveraged procurement agreements, (which allow departments to buy directly from suppliers through existing competitively bid contracts and agreements) or to use its own competitive contracting methods. However, Covered California's board-adopted policy also included a noncompetitive process that allows Covered California to use sole-source contracts when *timeliness* or *unique expertise* may be required. In addition, the board-adopted policy stated that the use of sole-source contracts should be justified in writing.

During fiscal years 2012–13 through 2014–15 Covered California did not consistently follow the part of its board-adopted policy that addresses noncompetitive procurements.

During fiscal years 2012–13 through 2014–15 Covered California did not consistently follow the part of its board-adopted policy that addressed noncompetitive procurements. We reviewed the justifications for 20 of Covered California's sole-source contracts and another 20 applicable amendments to those contracts, for a total of 40 justifications. Our review found that nine of the 40 justifications were insufficient according to the board-adopted policy. Specifically, Covered California was missing two justifications altogether—one for an original contract and another for an amendment; the remaining seven justifications—five for original contracts and two for amendments—failed to assert either timeliness or unique expertise as the basis for sole-sourcing these contracts. In two instances the justifications asserted other nonboard approved reasons for using a noncompetitive procurement process. In other instances the justifications failed to explain why a sole-source contract was being used at all. Rather, the justifications explained only the reasons Covered California needed the respective contract or amendment and why the selected contractor was qualified to provide the services, none of which were reasons covered in the board-adopted policy for justifying a noncompetitive process.

For example, Covered California did not sufficiently justify the use of a noncompetitive procurement method with respect to Covered California's largest sole-source contract (and the third largest contract overall): a contract for marketing and outreach services with Weber Shandwick for nearly $134 million, as shown in Table 7. In December 2011 Covered California released a solicitation for a variety of marketing and outreach services, to which it received 13 proposals. Covered California executed the contract, ultimately worth over

$28 million, with Ogilvy Public Relations Worldwide (Ogilvy) in April 2012. Covered California's director of marketing reported that Ogilvy executed the first two phases of the marketing plan, which laid the foundation for Covered California's advertising campaign. She explained that at that time, Covered California decided another vendor would be better suited to carry out the advertising campaign. As a result, Covered California executed a sole-source contract with Weber Shandwick in May 2013. Covered California initially awarded the contract on the basis that (1) Weber Shandwick had submitted the second best proposal for the solicitation that led to awarding the contract to Ogilvy, (2) the services were needed, and (3) the vendor was qualified. However, none of these reasons were appropriate justifications for using a sole-source procurement method under the board-adopted policy. Instead, Covered California determined that, having excluded Ogilvy, Weber Shandwick remained the best value. However, the scope of the Weber Shandwick contract was more focused on the implementation of the advertising campaign, whereas the scope of the Ogilvy contract was initially centered on creating a marketing plan, and it later developed and implemented a public relations plan.

Table 7
Covered California's 10 Largest Contracts by Final Dollar Amount From July 1, 2012, Through June 30, 2015

	ORIGINAL CONTRACT AMOUNT	FINAL CONTRACT AMOUNT, INCLUDING AMENDMENTS	FISCAL YEAR ORIGINALLY AWARDED	VENDOR	PROCUREMENT TYPE	SCOPE OF WORK (TOTAL CONTRACT TERM IN YEARS*)
1	$294,038,767	$423,711,058	2012–13	California Health and Human Services Agency	Interagency agreement	California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) project management (2.75)
2	157,000,000	157,000,000	2014–15	Campbell Ewald Company	Competitive	Advertising and marketing campaign (3)
3	98,694,500	133,915,722	2012–13	Weber Shandwick	Sole-source	Marketing and publicity (2.25)
4	50,037,142	61,098,334	2012–13	Pinnacle Claims Management, Inc.	Competitive	Small Business Health Options Program administration (3.5)
5	36,613,862	52,499,973	2012–13	California Department of Social Services	Interagency agreement	CalHEERS reimbursement (3.25)
6	25,398,647	33,754,425	2012–13	Contra Costa County	Competitive	Provide additional service center (4.5)
7	813,600	33,594,509	2013–14	Richard Heath and Associates, Inc.	Sole-source	Outreach and education grant (4)
8	9,800,000	23,700,000	2014–15	Faneuil, Inc.	Competitive	Call center support and data entry (0.75)
9	6,716,000	16,784,000	2013–14	California Department of Social Services	Interagency agreement	Review appeals of applicant eligibility (2.75)
10	9,145,400	16,369,720	2013–14	K/P Corporation	Competitive	Develop and disseminate print materials (3)

Source: California State Auditor's review and analysis of all contracts awarded during fiscal years 2012–13 through 2014–15.

Note: Includes amendments awarded before August 2015.

* Contract term rounded to nearest quarter of a year.

Covered California amended the Weber Shandwick contract twice using the noncompetitive procurement method in both instances. Neither of the justifications for the amendments cited the reasons that were included in the board's adopted policy as a basis for avoiding a competitive process. Rather, the amendment justifications only indicated that the services were needed and that Weber Shandwick was qualified to provide the needed services. Finally, in March 2015 when Weber Shandwick's $134 million contract neared expiration, Covered California sought competitive bids for a vendor to undertake a new advertising and marketing campaign. Although Weber Shandwick submitted a proposal for the new advertising and marketing campaign, Covered California determined that another contractor, Campbell Ewald Company, was the best value for that bid. When we brought this to the attention of Covered California, the marketing director stated that it takes anywhere from six months to one year to competitively bid a marketing contract and there was not enough time to competitively bid for a marketing contract after Ogilvy. In addition, she stated that Weber Shandwick did an outstanding job on Covered California's behalf in terms of quick turnaround, quality of work, and cost-efficiencies. The term of the contract began in May 2013 and by September 2013, she stated, Weber Shandwick had a comprehensive campaign on air to launch the first open enrollment of Covered California. Nevertheless, as we stated earlier, we believe Covered California did not sufficiently justify using a noncompetitive procurement process as its board-adopted policy outlined.

We believe Covered California did not sufficiently justify using a noncompetitive procurement process as its board-adopted policy outlined.

We also question the validity of three additional justifications. Specifically, although Covered California asserted either timeliness or unique expertise as the basis for using the noncompetitive procurement process, in these three instances available documentation suggests that either the vendor was not unique or that Covered California had sufficient time to use a competitive procurement method. As noted previously, in April 2012 Covered California executed a contract with Ogilvy to provide marketing and outreach services. Richard Heath and Associates, Inc. (Richard Heath) became a subcontractor to Ogilvy for this contract. The original Ogilvy contract was set to expire in October 2013. In late September 2013 Covered California executed a sole-source contract with Richard Heath for more than $813,000 for the purpose of supporting, training, and managing the Outreach and Education Grant, In-Person Assister, and Navigator Grant Programs. Covered California then amended the Ogilvy contract by removing, among other things, the corresponding portions related to these grant programs. Three days after it removed these items from the Ogilvy contract, which was 18 days after awarding Richard Heath's original contract, Covered California amended the contract with Richard Heath to increase the contract total to

just over $44 million—again without using a competitive process. As of January 2016 the contract totaled nearly $37 million after a subsequent amendment lowered the total contract amount.[5]

Covered California justified the original Richard Heath contract and the subsequent first amendment on the basis that the sole-source contract was necessary because of the severe time constraints it was facing. However, we question this justification in light of the fact that Covered California had the time and capacity to seek competitive bids for these services. As previously indicated, when Covered California executed the contract with Ogilvy, it was aware that the contract would expire in October 2013. Further, in its justification to use a sole-source contract with Richard Heath, it stated that during the first year of the contract with Ogilvy, which began in March 2012, Covered California determined that it needed a different vendor to provide services related to Ogilvy's marketing plan. This acknowledgement indicates that Covered California was aware that it needed another contract by or before March 2013; thus, it could have begun a competitive procurement process and successfully awarded a contract by October, when the Ogilvy contract was set to expire. Considering the size of the contract award and that Covered California had time to competitively bid the contract, we believe it was paramount for Covered California to ensure that it awarded this contract using a method that offered the best opportunity for selecting the most qualified vendor at the most competitive cost.

Considering the size of the contract award and that Covered California had time to competitively bid the contract, we believe it was paramount for Covered California to ensure that it awarded this contract using a method that offered the best opportunity for selecting the most qualified vendor at the most competitive cost.

In response to our review, the assistant general counsel noted that the federal requirements for the outreach program and all its components were new and complex. He also stated that conducting a competitive procurement process for the outreach services that Richard Heath had already performed for over a year under the Ogilvy contract would have been more costly than awarding the contract to Richard Heath, as a new contractor would have had to expend additional time and resources to get up to speed on the program. Covered California believes awarding a sole-source contract to Richard Heath for these services was the best value. He further noted that by the time Covered California realized it needed a direct contract with Richard Heath, there was not enough time to competitively bid the contract and have the contractor certify and support the enrollment personnel in advance of open enrollment. Even with using a noncompetitively bid contract, the Richard Heath contract was only executed one week before the start of the first open enrollment period. He stated that for these reasons Covered California followed its board-adopted policy, which allowed the use of noncompetitively bid contracts under these conditions. Regardless of the assistant general counsel's rationale, we still question the justification used in this instance. Covered California was aware as early as April 2012 that

[5] The contract total here differs from the total in Table 7 because the table information is as of August 2015.

outreach services were needed and it knew the federal requirements for the outreach program were new and complex; we therefore believe it could have competitively bid for these services earlier.

In addition, we found that in April 2014 the board granted Covered California staff the authority to enter into a competitive procurement process for a vendor to develop and implement a data analytics program. About five months later, Covered California awarded a $540,000 sole-source contract to Equanim Technologies, Inc. (Equanim) to perform lead responsibility over the request for proposal process, oversee the competitive process to be used in selecting the vendor to develop and implement the data analytics program, and to manage the project. In its justification Covered California indicated, in part, that the competitive procurement process was unnecessary because the selected project management vendor was uniquely qualified and had to begin work immediately. However, we question whether the project management vendor was unique, that is, that it was the only vendor that could provide the type of project management services Covered California wanted to procure. In fact, many vendors provide project management services. Further, in Covered California's justification for a noncompetitive procurement process, it also claimed that time was of the essence. However, we believe that Covered California should have been aware of the complexity of the data analytics program when it requested approval to competitively bid for that program and, therefore, had the time to also competitively bid for the project management services. Covered California's delay is not an acceptable reason to use a sole-source contract. Using such justifications as the basis for entering into sole-source contracts undermines the integrity of the competitive procurement process.

The assistant general counsel stated that Covered California needed specific expertise in creating and implementing the data analytics program in order to support its statutory charge to be a driver of the health care quality improvement goals laid out in the Patient Protection and Affordable Care Act. He explained that it needed a project management vendor that had unique experience in this area. Specifically, he stated that because Equanim had successfully assisted other state agencies in getting similar programs up and running, Covered California believed Equanim had the unique expertise that justified the sole-source contract. Additionally, he noted that if Covered California had competitively bid these services, its ability to operationalize the data analytics program and deliver critical data to inform policy decisions would have been jeopardized. However, we believe Covered California could have identified the need for a project management vendor earlier in the process. Further, although Equanim had assisted other state agencies by providing project management services for data analytics programs, this experience does not make it the only vendor available to provide such services.

Although Equanim had assisted other state agencies by providing project management services for data analytics programs, this experience does not make it the only vendor available to provide such services.

As shown in Table 8, over the last three fiscal years, the total number of sole-source contracts Covered California has used has decreased each year. The assistant general counsel stated that Covered California faced many challenges at the inception of the exchange because it was a newly created public entity. He stated that it had no office, no employees, no technology platform, and only about two years to implement the largest health care reform legislation since the creation of Medicare. He explained that the exchange could not have been successfully implemented without using sole-source contacts. However, as we pointed out previously, we identified certain instances where Covered California had time to competitively bid certain services and because it did not, it lacks assurance that the contractor was the most qualified or cost-effective vendor. In April 2015 Covered California implemented a *noncompetitive bid justification form* to provide more specific guidance on the information that staff requesting a sole-source contract need to include in their justifications. Our review of the form found that using it could contribute to adequately justifying the need for sole-source contracts.

Table 8
Covered California Contracts Awarded July 1, 2012, Through June 30, 2015
(Dollars in Thousands)

	FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15		TOTAL	
PROCUREMENT TYPE	NUMBER OF CONTRACTS	TOTAL DOLLAR AMOUNT	NUMBER OF CONTRACTS	TOTAL DOLLAR AMOUNT	NUMBER OF CONTRACTS	TOTAL DOLLAR AMOUNT	NUMBER OF CONTRACTS	TOTAL DOLLAR AMOUNT
Competitive								
Competitive	76	$149,080	52	$28.195	105	$226,991	233	$404,266
Leveraged procurement agreement*	15	3,329	17	1,688	12	2,938	44	7,960
Noncompetitive								
Interagency agreement	14	377,583	28	(2,540)	8	1,172	50	376,215
Nonmonetary contracts†	2	-	7	-	10	-	19	-
Sole-source	27	147,958	24	40,825	13	10,053	64	198,836
Exempt‡	8	68	14	1,133	17	1,321	39	2,522
Grand Total	**142**	**$678,018**	**142**	**$69,306**	**166**	**$242,501**	**450**	**$989,799**

Sources: *State Contracting Manual*, Covered California's draft procurement manual, California State Auditor's review and analysis of all contracts awarded in fiscal years 2012–13 through 2014–15.

Note: Includes amendments awarded before August 2015.

* Leveraged procurement agreements allow departments to buy directly from suppliers through existing competitively bid contracts and agreements; under certain circumstances these contracts may be exempt from bidding.

† As defined by Covered California, these types of agreements are created to protect the State's interests to complete a project or comply with regulations but do not require the exchange of funds. These agreements, such as memorandums of understanding, are not subject to normal procurement processes.

‡ As defined by the California Department of General Services, contracts exempt from bidding include those for legal services and contracts with other public entities or with a certified small business.

Covered California Needs to Improve Its Noncompetitive Procurement Policy

As of June 24, 2015, state law requires Covered California to adopt a contract manual that is substantially similar to the State Contracting Manual.

As previously noted, while state law requires Covered California to establish and use a competitive process to award contracts, it also provides Covered California with broad statutory authority to establish its own procurement and contracting policy. For example, state law exempts Covered California from certain contracting requirements, such as obtaining approval from the California Department of General Services (General Services) before entering into a contract. However, as of June 24, 2015, state law requires Covered California to adopt a contract manual that is substantially similar to the *State Contracting Manual.*

Contrary to the board-adopted policy in place during our review, which permitted Covered California to use the noncompetitive procurement process when timeliness or unique expertise may be required, the *State Contracting Manual* allows for the use of a noncompetitive process in two types of situations: when there is an emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety; or when the acquisition of goods and services are the only goods and services that meet the State's need and no known competition exists. Our review identified concerns with the board-adopted policy in light of the new requirement that Covered California's contract manual be substantially similar to the *State Contracting Manual*. The board-adopted policy used generic terms such as *timeliness* and *unique expertise* as justification for using a sole-source contract. We believe that these terms are overly broad and are not substantially similar to the *State Contracting Manual.* The term *timeliness* does not restrict the use of a sole-source contract to those instances where there is an emergency. Further, the term *unique expertise* does not restrict the use of a sole-source contract to those instances when only one vendor with the requisite qualifications is available to complete the needed work.

Covered California's procurement manual has been revised in its draft form numerous times and the manager within its business services branch and contracts section indicated that Covered California's staff has been using it since the inception of the exchange. In our review of the November 2015 draft manual, we found that it includes criteria that allow for a sole-source contact in circumstances other than those that the *State Contracting Manual* permits. Specifically, in addition to allowing for the use of a sole-source contract when there is an emergency or when only one vendor with the requisite qualifications is available, the draft procurement manual allowed the use of a noncompetitive process when "the services are urgently needed to fulfill Covered California's obligations or mission." After bringing this to the attention of Covered California,

staff made subsequent changes to the draft procurement manual to address our concerns. Covered California's draft procurement manual was adopted by the board in January 2016 and takes the place of the 2011 board-adopted policy. Our review of the January 2016 board-adopted procurement manual found that it is substantially similar to the *State Contracting Manual* as state law requires.

We found an instance in which Covered California's staff followed the draft procurement manual instead of the board-adopted policy.

Although Covered California was required to comply with the board-adopted policy in place during our review, we found an instance in which its staff followed the draft procurement manual instead of the board-adopted policy. Specifically, the board-adopted policy suggests a written justification is necessary for all sole-source contracts regardless of the amount. However, the October 2013 draft procurement manual and all subsequent draft versions allow staff to award sole-source contracts for less than $25,000 without a written justification. Our review included one sole-source contract that was less than $25,000 and, contrary to the board-adopted policy, no written justification was provided. Covered California staff explained that they were following the draft procurement manual, not the board-adopted policy. Similarly, the assistant general counsel stated that the draft procurement manual served as Covered California's formal contract amendment policy. Inconsistent policies and procedures regarding its procurement processes further affect Covered California's ability to comply with state laws.

Covered California's Contracts Database Is Inaccurate, Hindering Its Ability to Keep Adequate Records of Its Contracts

Covered California's database of the contracts that it has awarded suffers from inconsistent and inaccurate information. According to the chief of business services, Covered California uses this database as its internal tracking tool and to provide quarterly reports to the board. However, although Covered California has written desk procedures for entering information into its database, we found errors in the data provided. These problems occur, in part, because staff enter contract information inconsistently and adequate review does not occur to ensure accurate entry as called for by Covered California's desk procedures. For instance, we found that some contracts were categorized under an incorrect procurement type, such as contracts labeled as exempt from bidding when they were competitively bid. In addition, we noted a contract in the database for $130,000 that, according to the contracts manager, was never executed.

Because of our concerns regarding the accuracy of the information in this database, we recreated three years of data using Covered California's hard-copy contract files and discovered a significant

We determined that the award values of 75 individual contracts had been incorrectly recorded in the database. The value of 44 contracts was understated by about $11.7 million, and the value of 31 contracts was overstated by roughly $32.2 million.

number of errors. Our results indicated that Covered California had entered into 449 contracts valued at just less than $990 million during fiscal years 2012–13 through 2014–15. However, we determined that the award values of 75 individual contracts had been incorrectly recorded in the database. Specifically, the value of 44 contracts was understated by about $11.7 million, and the value of 31 contracts was overstated by roughly $32.2 million with a net discrepancy of about $20.5 million. In one instance, Covered California's database shows a contract with Pinnacle Claims Management, Inc., for almost $65 million, but we determined that this contract was actually worth $61 million. Because state and federal law require Covered California to keep an accurate accounting of all activities, receipts, and expenditures, and because the contracts database is used as the central information system for its contract management activities, it is essential that Covered California follow its procedures to ensure the database's accuracy.

CalHEERS Needs Continued Oversight

The aggressive schedule and rapid design, development, and implementation of CalHEERS, although resulting in a functional system, has required trade-offs that present longer-term risks to system maintainability in some cases. According to federal regulations, each state is to develop, for all applicable state health subsidy programs, a secure electronic interface for the exchange of data that allows a consumer's eligibility to be determined for all health care programs based on a single application. Covered California entered into a contract with a systems developer in 2012 to provide design, development, implementation, and maintenance services for CalHEERS, which supports the maintenance, operations, and on-going business of Covered California. CalHEERS is also one of the systems that supports the same functions for the California Department of Health Care Services. The system also interfaces, or communicates electronically, with an array of federal, state, and private entities. This communication involves sharing sensitive data that are used for potential eligibility for other programs, such as CalFresh and California Work Opportunities and Responsibility to Kids. Given that the continuing development and maintenance activities for the system are anticipated to occur until 2017, CalHEERS must receive adequate technical oversight in order to identify risks and issues that threaten system viability and to ensure such risks and issues are adequately resolved.

To assist the CalHEERS project by ensuring that deficiencies are detected and corrected as early as possible, Covered California contracted with a system expert to evaluate every aspect of the design, development, and implementation phase and to provide

monthly IV&V reports. These reports assess the strengths and weaknesses of the project and include recommendations for correcting the findings and risks identified. We had our IT expert review the six most recent IV&V reports for the periods covering August 2014 through January 2015, the month the final report was issued (the IV&V contract with Covered California expired in February 2015). According to our IT expert, although the IV&V reports do not suggest that the CalHEERS project is deficient, the risks identified in the reports are significant and may pose threats to system maintainability moving forward. For example, the IV&V consultant identified concerns over the ability to isolate and easily correct defects in order to cost-effectively maximize the productive life of the system. This type of risk represents a challenge to the future ability of the system to readily expand its capacity in users served or increased transaction volumes.

According to the project director of CalHEERS, decisions were made to prioritize certain system fixes, based on the risk they presented, at specific times in an effort to meet project release deadlines. According to the chief of the CalHEERS project management office, the management team established a quality assurance team in July 2014 to undertake activities focusing on continual improvement of processes and products, among other issues. However, as of November 2015, this team was still working through a list of issues that may affect system functionality that, according to its documentation, CalHEERS plans to address through future releases. As a result, the risks related to the underlying system issues have not been fully mitigated.

According to the project director, the project management team is actively considering whether an IV&V skill set is needed going forward. Our IT expert believes that given the size and technical complexity of the project, as well as the significant number of maintenance items and change orders that remain outstanding, the project should reinstitute IV&V services as soon as practical. In fact, he explained that the CalHEERS project should maintain IV&V services until the size and frequency of significant modifications greatly diminish. The IV&V processes determine whether the development products of a given system activity conform to the requirements of that activity and whether the product satisfies its intended use and user needs. Tasks involved in making this determination may include the analysis, evaluation, review, inspection, assessment, and testing of products. Our IT expert believes that effectively implemented IV&V services will assist the CalHEERS project with technical oversight, inform decisions about system development processes, and identify the implications of any technical trade-offs that the system builder might make or propose.

Our IT expert believes that effectively implemented IV&V services will assist the CalHEERS project with technical oversight, inform decisions about system development processes, and identify the implications of any technical trade-offs that the system builder might make or propose.

Selected Significant Risks to the CalHEERS System as of a July 2015 Independent Project Oversight Consultant Report

- Continued loss of skilled contractor staff in key positions, which has affected the release schedule and quality of deliverables.
- A delay in or partial implementation of change requests, which could increase project costs.
- A struggle to enforce the change management process to ensure that the new functionality added to a release has the appropriate design document approval and provides an assessment of when it is best to add a change without affecting other changes.

Source: July 2015 independent project oversight consultant report.

Covered California also entered into a contract with the Office of Systems Integration—an office within the California Health and Human Services Agency (Health and Human Services)—for project management and quality assurance services. Health and Human Services entered into a memorandum of understanding with the California Department of Technology for independent project oversight (IPO) to provide additional advice and consulting on the management of the project during the design, development, and implementation phase. Our IT expert reviewed six of the IPO reports for February through July 2015. The reports include updates on project releases of a list of overdue action items, a summary of the status of recent project deliverables, and a description of pending and resolved risks. The text box gives examples of the unresolved risks that are most significant to completing the system within the approved schedule. The IPO consultant's reports indicate whether the CalHEERS project team has taken steps to address them. The July 2015 report, the last issued by the IPO consultant, identified outstanding risks that still need to be addressed. However, according to the chief of the CalHEERS project management office, as of January 2016 IPO services have ended because the project met its milestones and moved into the operations and maintenance phase.

Our IT expert indicated that the necessity of IPO diminishes as a project evolves from development to ongoing operations. As a consequence, he suggested there is a reduced need for IPO and he said that it might be reasonably terminated. He indicated that the size and complexity of the system and the ongoing effort to enhance it, however, suggest that quality assurance processes remain key to the efforts to maintain the project. Although CalHEERS has moved into operations and maintenance mode, the level of development activity remains high; thus, our IT expert suggests IV&V be continued. According to the project director, the CalHEERS project management office has instituted a number of processes in recent months to address issues in the IPO reports and it continues to prioritize improvements to the system based upon severity and risk to the project. Nevertheless, our IT expert indicated that the most critical risks regarding the system architecture and management, if not mitigated, could compromise system functionality. Without adequate oversight at this point in the project, specifically from an IV&V standpoint, these system issues may go unidentified or unresolved, resulting in long-term cost and schedule implications for the ongoing maintenance of CalHEERS.

Covered California Has Created a Process to Monitor, Recertify, and Decertify Qualified Health Plans As Federal Law Requires

Federal regulations require state health insurance exchanges to monitor QHP issuers for their demonstration of ongoing compliance with certification requirements. In addition, the exchanges must establish a process for recertifying QHPs that includes a review of general certification criteria, and they must create a process for decertifying QHPs that meets federal requirements. Similarly, state law requires the board to implement procedures for recertifying and decertifying QHPs that are consistent with guidelines from the U.S. Secretary of Health and Human Services. Our July 2013 report noted that Covered California correctly prioritized the QHP certification process over other considerations and that this process ensured that the QHPs selected for sale through the exchange would, among other requirements, provide essential health benefits and be available for Covered California's first open enrollment in October 2013.

Moving forward, however, we recommended in that 2013 report that Covered California develop a plan and procedures for monitoring, recertifying, and decertifying QHPs, or it would risk not complying with federal requirements. Our current review found that Covered California has developed these procedures in addition to its comprehensive, multistep certification process for QHPs that are sold through the exchange. Specifically, we reviewed QHPs for three of the largest insurance issuers and for one small issuer and found that Covered California appropriately monitored these QHPs using data the issuers provided. These data include numerous measures of quality and network management. Covered California uses the data to develop performance scores and customer service metrics, and to determine the extent to which issuers are paying health care providers based on the quality and outcomes of their services. Table 9 on the following page shows the federal requirements for QHPs that we determined Covered California has satisfied.

Our current review found that Covered California has developed procedures for monitoring, recertifying, and decertifying QHPs.

Further, Covered California's annual recertification process results in an extensive review of QHPs' compliance with state and federal requirements. Covered California annually recertifies QHPs, even though federal regulations do not specify how often they must be recertified. Covered California's contracts with QHP issuers are detailed, lengthy documents that result in an extensive recertification process. According to Covered California's general counsel, its recertification process requires the issuer to demonstrate why its QHPs should be recertified and may take the issuer months to perform. Based on our review of selected contracts between Covered California and QHP issuers, we determined that these contracts incorporate applicable

federal regulations. The general counsel also noted that Covered California's annual recertification process is, in effect, another mechanism for monitoring QHPs for compliance with federal and state requirements. Therefore, we believe the annual frequency and extensive nature of this recertification process is reasonable, considering that Covered California is using the process as a component of its monitoring activities.

Table 9
Covered California's Compliance With Key Federal and State Requirements for Qualified Health Plans

REQUIREMENTS FOR COVERED CALIFORNIA	PROGRESS TOWARD COMPLETION, JULY 2013*	PROGRESS TOWARD COMPLETION, FEBRUARY 2016	STEPS COVERED CALIFORNIA HAS TAKEN
Federal			
Establish and complete a process for certifying qualified health plans (QHPs).	✓	Previously completed	Established a QHP certification process and, for each plan year, has selected issuers to offer QHPs through the health insurance exchange.
Monitor QHP issuers for ongoing compliance with certification requirements.	↑	✓	Monitors QHP issuers monthly using issuer metrics and annually via the recertification process.
Establish a process for recertifying and decertifying QHPs.	X	✓	Established a process and an application for recertification and a process template for decertification of QHPs.
State			
In each region of the State, provide a choice of QHPs at each of the five federally specified coverage levels.	✓	Previously completed	Each region of the State has a choice of QHPs at each of the five federally specified coverage levels.

Sources: 45 Code of Federal Regulations, part 155; California Government Code, section 100503; and California State Auditor's analysis of documents obtained from Covered California.

✓ = Completed.

↑ = Progressing as expected.

X = Yet to begin.

* We most recently reported on the progress of Covered California in our July 2013 report—*New High-Risk Entity: Covered California Appears Ready to Operate California's First Statewide Health Insurance Exchange, but Critical Work and Some Concerns Remain,* Report 2013-602.

Covered California has also developed a decertification procedure, which consists of a series of action steps across its program areas, and it followed this decertification procedure for one QHP issuer in July 2014. Specifically, the issuer of the QHP withdrew from the exchange because it chose to no longer offer the same plans both through and outside of Covered California. We reviewed Covered California's application of its decertification procedure for this issuer's QHPs and found that it was consistent with federal regulations.

Recommendations

To comply with state law, Covered California should ensure that its staff comply with the changes to its recently-adopted procurement manual that incorporate contracting policies and procedures that are substantially similar to the provisions contained in the *State Contracting Manual*.

Before executing any sole-source contracts, Covered California should adequately document the necessity for using a noncompetitive process in its written justifications and, in doing so, demonstrate valid reasons for not competitively bidding the services.

Covered California should improve its project management of contracts to ensure that it allows adequate time so it can use the competitive bidding process as appropriate.

Covered California needs to develop a process by June 2016 to ensure that it accurately enters information regarding its contracts into its contract database.

To ensure that CalHEERS does not face delays and cost overruns in the implementation of planned releases, Covered California should immediately contract with an independent party for IV&V services to highlight and address potential risks going forward.

We conducted this audit under the authority vested in the California State Auditor by section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

Date:	February 16, 2016
Staff:	Laura G. Kearney, Audit Principal Rosa I. Reyes Ryan Grossi, JD Michaela Kretzner, MPP Derek J. Sinutko, PhD
Legal Counsel:	Heather Kendrick, Sr. Staff Counsel
IT Audits:	Michelle J. Baur, CISA, Audit Principal Richard W. Fry, MPA, ACIOA Lindsay H. Harris, MPA, CISA

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

COVERED CALIFORNIA

January 27, 2016

Elaine M. Howle*
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Subject: Covered California Response to State Draft Audit Report 2015-605

Dear Ms. Howle:

As Covered California nears the end of its third open enrollment period, it continues to expand on its efforts to improve the health of all Californians by ensuring their access to affordable, high quality care. While we have made great strides in our efforts to implement the Affordable Care Act, we also recognize that work remains to be done. The California State Auditor's (CSA) report entitled *High Risk – Covered California It Must Ensure Its Financial Sustainability Moving Forward, and Its Use of Sole-Source Contracts Needs Improvement* offers Covered California recommendations on areas for improvement. We agree that these areas are important and have taken them seriously since the establishment of Covered California. With regard to the specific recommendations, we have already undertaken efforts to address. For example, in the area of financial management, Covered California has conducted informal analyses and stress-testing of expenditures, revenue and reserve requirements. With respect to CalHEERS, in addition to utilizing an Independent Verification and Validation vendor during our critical, formative years, we have established a quality assurance team, a user acceptance testing program and engaged an independent expert in cost analysis. We recognize that our work in these areas is not complete and we appreciate CSA's suggested recommendation for further refinement.

Covered California would like to thank the CSA staff for their hard work and for their assistance during this audit. Similar to the oversight of Covered California by its contracted, independent auditors and by federal agencies such as the Office of Inspector General and the Centers for Medicare and Medicaid Services, we find the

* California State Auditor's comments begin on page 51.

additional input from our State Auditor to be critical to the future success of California's Health Benefit Exchange. If you have any questions, please contact Jennifer Lum, Audit Coordinator at (916) 228-8276.

Sincerely,

Peter V. Lee
Executive Director

cc: Board of Directors, Covered California

Enclosure

Covered California Response to State Auditor Report 2015-605

Chapter 1

Recommendation No. 1

Covered California should continue to monitor its plan for financial sustainability and revise it accordingly as factors change. Further, it should complete a formal analysis of the adequacy of its reserve level by December 31, 2016, and update this analysis as needed, so that it is prepared in the event that it does not meet its revenue projections and needs to increase its funding or decrease its expenditures to maintain its financial solvency. This formal analysis should include an identification of those contracts it could quickly eliminate, among other actions it would take, in the event of a shortfall in revenues.

Response

Covered California agrees with this recommendation. It has built budget planning, expenditure and revenue monitoring into its day-to-day activities and will continue to perform these functions. We will conduct a formal analysis of the reserve and will incorporate the results into our existing forecasting and stress testing.

Recommendation No. 2

Covered California should continue to conduct regular reviews of its enrollment projections and update the projections as needed to help ensure its financial sustainability.

Response

Covered California agrees with this recommendation. Covered California currently reviews enrollment projections on a monthly basis and revisits the forecast on a quarterly basis and will continue to do so.

Chapter 2

Recommendation No. 3

To comply with state law, by April 2016, Covered California's board should adopt a procurement manual incorporating contracting policies and procedures that are substantially similar to the provisions contained in the *State Contracting Manual*. Specifically, it should expressly limit its use of sole-source contracts to only those situations authorized by the *State Contracting Manual*.

Response

The California Health Benefit Exchange Board adopted the Covered California *Procurement and Contract Manual* during the Board meeting on January 21, 2016. The contracting policies and procedures contained in the Covered California *Procurement and Contract Manual*, including those pertaining to non-competitive bidding, are substantially similar to those contained in the *State Contracting Manual*. ①

Covered California Response to State Auditor Report 2015-605

Recommendation No. 4

Before executing any sole-source contracts, Covered California should adequately document the necessity for using a noncompetitive process in its written justifications and, in doing so, demonstrate valid reasons for not competitively bidding the services.

Response

② The Covered California *Procurement and Contract Manual* adopted by the California Health Benefit Exchange Board on January 21, 2016 requires a written justification for all non-competitively bid contracts of $25,000 and above. Covered California has developed a noncompetitive bid justification form which was further refined in April 2015 to provide more specific guidance for staff to use when preparing a justification supporting a sole-source contract.

Recommendation No. 5

Covered California should improve its project management of contracts to ensure it allows adequate time to use the competitive bidding process as appropriate.

Response

③ Covered California implemented a process in 2015 where program staff receive advance notice of contracts which are set to expire within the next six months. This notice affords staff sufficient time to consult with contract management staff on the appropriate contracting method necessary to continue or procure the services needed. Covered California will continue to improve on this process.

Recommendation No. 6

Covered California needs to develop a process by June 2016 to ensure it accurately enters information regarding its contracts into its database.

Response

Covered California agrees that it should implement a quality assurance process to ensure the database is accurate. Although the contract database is primarily an internal tool for the contracts unit, because it is used for other purposes, Covered California, as a result of this audit, has developed a process to ensure inaccurate information is corrected and accurate information is entered into the database moving forward.

Recommendation No. 7

To ensure that CalHEERS does not face delays and cost overruns in the implementation of the planned releases, Covered California should immediately contract with an independent party for IV&V services to highlight and address potential risks going forward.

Covered California Response to State Auditor Report 2015-605

Response

We concur with the recommendation that Covered California perform IV&V services. However, we believe that such services can adequately and competently be performed by a mix of both civil service staff and independent contractors. In 2012, Covered California issued a competitive solicitation and awarded a contract to an independent vendor to perform IV&V services. This independent contractor performed the IV&V services from 2012 until 2015. Effective 2015, Covered California began transitioning the performance of IV&V services to a combination of internal staff and external entities. For example, Covered California established a quality assurance team that includes both external quality assurance consultants and state staff. In 2015/2016, Covered California also entered into a contract with an expert in cost estimation to perform independent verification of costs for change requests. Further, the CalHEERS project will formally transition to the Office of Systems Integration on July 1, 2016, pending approval of the Governor's Budget, which will allow independent oversight by a separate state agency. ④

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM COVERED CALIFORNIA

To provide clarity and perspective, we are commenting on Covered California's response to our audit. The numbers below corresponds to the numbers we have placed in the margin of Covered California's response.

During the course of our audit work, Covered California informed us that it anticipated that its draft procurement manual would be presented to its board of directors (board) for approval in February 2016. However, as indicated in Covered California's response, the board adopted the draft procurement manual at its meeting on January 21, 2016, which was the first day of Covered California's official review of our draft report. As a result, we modified the text in our report on pages 3, 36, and 37 to reflect the board's action. Additionally, we revised our recommendation on pages 4 and 43 to clarify that Covered California should ensure that its staff comply with the changes to its board's recently-adopted procurement manual. (1)

Although Covered California's recent board-adopted procurement manual requires a written justification for all noncompetitively bid contracts of $25,000 and above, it will be important for Covered California to ensure that its staff adequately document the necessity for using a noncompetitive process in its written justification. Further, on page 35 we acknowledge that Covered California implemented a *noncompetitive bid justification form*, as it indicates in its response, to provide more specific guidance on the information that staff requesting a sole-source contract need to include in their justifications. Also, on page 35 we conclude that our review of the form found that using it could contribute to adequately justifying the need for sole-source contracts. (2)

Despite our numerous discussions with Covered California, it never informed us of the process described in its response that it asserts was implemented in 2015 by which staff receive advance notice of contracts which are set to expire within the next six months. We look forward to Covered California's 60-day response to further explain and provide evidence of this process. (3)

We are concerned about Covered California's belief that it can adequately and competently perform independent verification & validation (IV&V) services by using a mix of both its civil service staff and independent contractors. Specifically, industry standards require the responsibility for the IV&V effort to be vested in an organization that is separate from the development (4)

and program management organizations. However, as stated on page 40, Covered California contracted with the Office of Systems Integration (OSI) for project management and quality assurance services. Further, this is the first time Covered California has mentioned the potential transition of the California Healthcare Eligibility, Enrollment, and Retention System project to the OSI, and it is unclear to us how this transition will address our recommendation. Nevertheless, we stand by our recommendation that IV&V services are still needed and should be contracted for immediately.

California Health Care Foundation

Room for Improvement:
Consumers' Experience Enrolling Online with Covered California

FEBRUARY 2016

Contents

Acknowledgments

The research for this report was conducted by gotoresearch. Gotoresearch is a division of gotomedia, a strategic consultancy specializing in research, user experience, and mobile design.

Learn more at www.gotoresearch.com.

Claudia Page, a consultant working on enrollment in health coverage and health information technology, served as project manager.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Covered California is the state's health insurance marketplace created under the Affordable Care Act. Widely acknowledged as one of the most successful state-based health insurance exchanges in the country, Covered California had facilitated over 1.3 million Californians in obtaining health insurance as of June 2015.

During each of the three Covered California open enrollment periods (OEPs), gotoresearch conducted real-time consumer user testing with individuals seeking to enroll or renew their health insurance online with Covered California. This research sought to better understand the online consumer experience and to provide detailed, actionable findings to help Covered California, and other insurance marketplaces, provide a first-class consumer experience online.

Research findings from OEP 1 (2013-14) were published by the California Health Care Foundation ("Assessing the Covered California Online User Experience," May 2014, www.chcf.org). Findings from OEP 2 (2014-15) were presented to Covered California and the California Department of Health Care Services (DHCS) in the spring of 2015. The OEP 3 (2015-16) research, conducted in November and December 2015, assessed how the user experience compared to the previous OEP. This report synthesizes key research findings from OEP 2 and 3, and presents conclusions and recommendations.

User experience research is detailed and time-intensive. It does not involve a large number of subjects, but offers meaningful insights into the consumer experience and problems that need to be addressed. Direct observation of consumers as they attempt online enrollment uncovers usability challenges that cannot be learned from other assessment methods such as website analytics, customer surveys, or call center data.

Applying for insurance is complex. Many consumers find comparing plans and understanding insurance terminology to be difficult. All online health insurance marketplaces are grappling with how to address these challenges. This report focuses on the application, website design, and navigation challenges faced by Covered California consumers — areas that can and should be improved.

Methods

User experience research is a method of studying people while they use a product, such as a website, an app, or a physical device, to uncover ways in which the product can be improved. It involves direct, unscripted, real-time observation of consumers — in this case, people applying for or renewing coverage through Covered California online — and captures sources of consumer satisfaction, knowledge, confusion, and frustration.

To conduct this study, gotoresearch:

- Recruited 30 participants for OEP 2 in November and December 2014.
  - Twelve were renewals interested in exploring new plan options for 2015.
  - Eighteen were enrolling in health insurance via Covered California for the first time.
- Recruited 12 participants for OEP 3 in October and December 2015.
  - Six were renewals interested in exploring new plan options for 2016.
  - Six were enrolling in health insurance for the first time.
- Watched and recorded live sessions via webcam with all participants. Participants were given 45 to 90 minutes if they were renewing coverage, and they were given 90 to 120 minutes if they were first-time enrollees.

The participant pool was diverse in ethnicity, gender, family structure, and income. Participants were also from different geographic regions across the state. Most participants were under age 35 (two-thirds in OEP 2 and all in OEP 3). All were English speakers and had high-speed Internet access.

In OEP 2, researchers recruited people eligible for Medi-Cal to observe the hand-off to the county to complete Medi-Cal enrollment. In OEP 3, people eligible for Medi-Cal were excluded from the recruitment pool. Researchers wanted to observe changes to the online renewal and enrollment process between OEP 2 and OEP 3, including plan choice, and those eligible for Medi-Cal are not able to choose plans online via Covered California.

Most consumers start their online Covered California experience through CoveredCA.com. On that site, they can "Explore" educational content and use a "Shop and Compare" tool to do anonymous window shopping for the health plans available through Covered California. Through CoveredCA.com, consumers can also access the state's eligibility and enrollment engine, California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), which is jointly managed by Covered California and DHCS. CalHEERS includes a different anonymous shopping feature called "Preview Health Plans" and allows consumers to create and sign into a personal account that they can use to apply for, enroll in, and renew coverage. Researchers observed participants engaging with both CoveredCA.com and CalHEERS.

Key Research Findings

Across both OEP 2 and OEP 3, only one of 31 people eligible to enroll in or renew a Covered California health plan did so during the observed research session. (A total of 42 individuals participated in user testing. Eleven were estimated to be eligible for Medi-Cal while applying online; these applications are handed off to county systems for final eligibility determination.)

Participants consistently experienced significant difficulty with the Covered California website and online application. While there were some improvements between the two enrollment periods, many problems experienced in OEP 2 persisted into OEP 3.

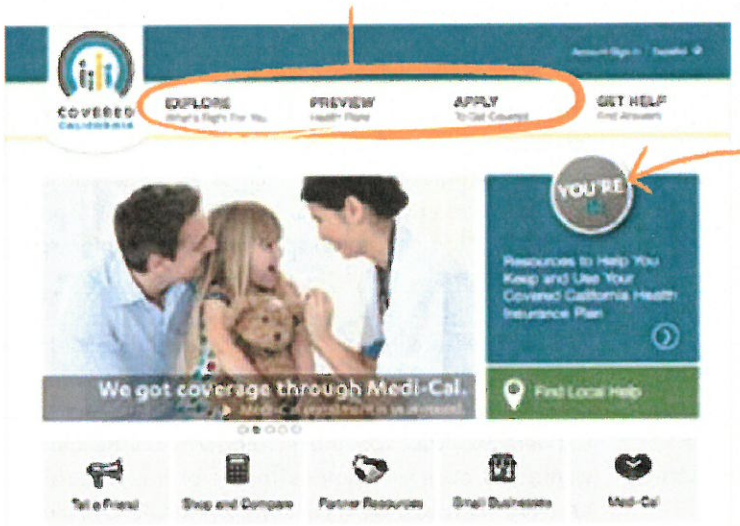
Key research findings include:

1. **Improvements to the CoveredCA.com home page between OEP 2 and OEP 3 resulted in less confusion for participants starting the application or renewal process.**

   During OEP 2, while many users commented favorably on the look of the CoveredCA.com home page, participants were frequently confused about how to begin the enrollment and renewal processes from this page (see Figure 1).

   Refinements to the CoveredCA.com home page for OEP 3 provided clearer options — particularly in the top navigation bar (see Figure 2, page 5). Most participants felt the website looked straightforward, clean, and official. While the home page still did not provide a "renew" button, renewal participants navigated to the "Account Sign In" link. Most new users

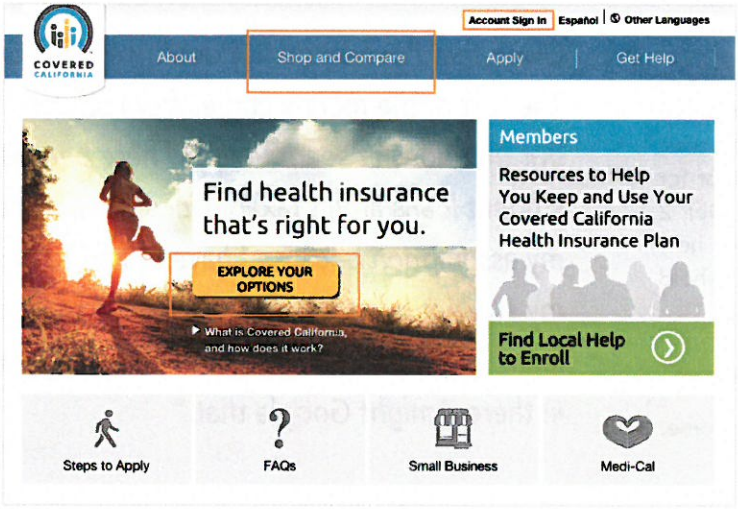
Figure 1. CoveredCA.com Home Page During OEP 2



"It's a little confusing because I want to look at new plans, and 'Explore,' 'Preview,' 'Apply' — these ones at the top, these all look the exact same . . . so I don't really know where to click first."

— Alonso, OEP 2

Figure 2. CoveredCA.com Home Page During OEP 3



RENEWALS: All participants used "Account Sign In" as their point of entry.

NEW ENROLLEES: "Explore Your Options" was the favored starting point, with four selecting this and two selecting "Shop and Compare."

"Wished it would have made me create an account at the beginning. It seems like I'm doing the application process again, and I'd rather do it in one step."

— Jacob, OEP 3

chose "Explore Your Options," which took them to the "Shop and Compare" tool.

2. **In both OEP 2 and OEP 3, many participants spent a significant amount of time reviewing plan options in the "window shopping" parts of the website, not realizing that actual plan choice occurs only in the application itself. This confused participants and delayed progress in completing their application.**

"I see different plans than what I was looking at before, so I am confused as to why I was looking at those [other] plans at first. This is more like what I was expecting in the beginning."

— Dan, OEP 3

Two tools — "Shop and Compare" on CoveredCA.com and "Preview Health Plans" within CalHEERS — are designed to provide consumers with a quick estimate of their eligibility and a view of the health plan options available to them. These are commonly known as "window shopping" tools. Consumers can access either of these tools before inputting all their application data. The final plan choices presented to consumers after completing their full application may be different from those shown in "Shop and Compare" or "Preview Health Plans" because the application draws upon more detailed data.

Most participants didn't understand this distinction. In both years, participants spent a lot of time, sometimes their entire session, in "Shop and Compare" and "Preview Health Plans" thinking this was the pathway to choosing a final plan and enrolling. This was observed even though language on the "Shop and Compare" page notes that the results are "an estimate only" and that consumers will "need to re-enter . . . information during the enrollment process." Some participants abandoned the enrollment process or had already reached the end of the testing session by the time they arrived at a second (or even third) set of plan choices in their application and realized that they were not the same choices they had been evaluating in "Shop and Compare" or "Preview Health Plans."

In OEP 2, the "Preview Health Plans" link was featured prominently on the top navigation bar of the CoveredCA.com home page, drawing the attention of users. (See Figure 1, page 4.) In OEP 3, the "Preview Health Plans" link was removed from the top navigation bar, so research participants did not access that tool at the outset of their session. However, some still accessed "Preview Health Plans" later in the process, while filling out the application or renewal, not understanding that it did not present final plan choices.

3. Unclear guidance and questions related to income and size of household resulted in errors in critical sections of the application.

Household income and the number of members in the household are two critical pieces of information in the insurance application and renewal process. These data determine eligibility for Medi-Cal or for the level of subsidy consumers can access. In OEP 2 and 3, many participants were confused about how to answer questions related to income and household size, and the website was often of little help.

For income, common sources of confusion included:

- Whether to include an unmarried partner's income.
- How or if to enter student loans.
- What to enter if they were currently unemployed but expected to start working in the coming year.
- How to complete the "Last Date Paid" field in the "Income" section of the application for current jobs. (Some participants missed the instructions to leave the field blank for current employment because of the placement of these instructions.)

Household income. In particular, the instructions in "Shop and Compare" for household income were unclear to users and seemed inconsistent. The instructions read: "Enter your projected income for the year in which this health plan will be effective. Self-employed individuals should include all taxable income and subtract any allowable self-employed expenses that they plan to deduct from their taxes."

One participant explained his confusion:

"Household income — so that means everyone in my family, everyone I live with, I assume. I'm not sure if it means just me or everyone. It says enter your predicted income. To me that's a little confusing because it says 'household income,' but then it says 'your projected income.'"

— Jacob, OEP 3

Another participant had questions about student loans:

"Given that I'm a student, I don't work full-time. The rest of the money comes from student loans, but that doesn't seem to apply here because student loans aren't taxable income. But that's just my assumption because I haven't had to declare my student loans . . . if I included my student loans . . . so perhaps I do need to include my loans in there. I might Google that."

— Dan, OEP 3

Household size. Participants were also confused about how to represent the size of their households. To properly fill out the application, users must include anyone in their "tax household," which means all those included on their tax return. However, unclear questions and help text left some wondering whether to include roommates, significant others, or parents.

In "Shop and Compare," the form instructions for entering household members do not mention tax household. The instructions read: "Enter the AGE of each person, whether they are enrolling or not. Uncheck the ENROLLING box next to the age for those household members not enrolling. Note: Premium estimates assume same age for each member as of coverage effective date."

"If I live with roommates . . . does this think that these are my family members? The head of the household . . . I guess I'm the oldest, but it's tricky because we're not really a family."

— Susan, OEP 2

The "Shop and Compare" help text for the question "number of people in the household" is more accurate and specific. This text read: "Include anyone you include on your tax return, including yourself, children who live with you, and any other tax dependents. Include household members here even if they do not need health coverage." However, not all participants

clicked on the help text, and some counted people they live with but who are not on their tax return.

This confusion about how to answer income and household questions not only took up time but sometimes may have led to errors in eligibility determination.

4. **Poorly designed online forms and processes frustrated participants and diminished their confidence in the site.**

Signature for renewal page. In OEP 3, consumers renewing health coverage were required to complete a "Signature for Renewal" form, which asked them to confirm changes they had made to their application information and provide an electronic signature. All participants who encountered this form were confused by several elements:

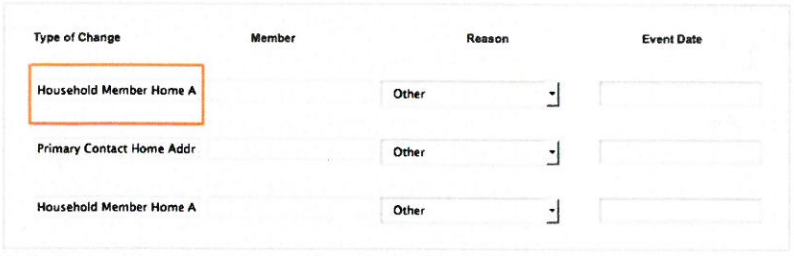
- Instructions on the page did not provide adequate information for participants to understand what was being asked of them.
- Participants could not read the "types of change" they were being asked to confirm because the field box did not extend the full length of the text. Participants had to use a scroll bar to read the full text in the small text box, but some did not know to do this. (See Figure 3.)
- The page listed fields that participants said they had not made changes to.
- The page requested dates and information for a specific change multiple times.

Renewal participants were required to specify dates (selecting from a calendar popup) and "reason for change" (selecting from a dropdown menu) for every change made to the application, and in some cases changes that were not made, making the process even more confusing. Choosing a date and reason could not be skipped, yet frequently, the choices provided did not apply to the consumer's specific circumstances. Some participants made up answers or chose an irrelevant option to satisfy these requirements. For example, one participant, who had no change in health status, was required to select a "reason for change" from options including "became pregnant," and "became disabled." In the end, she chose "became abled," which was not relevant to her situation, but she felt it was better than any of her other choices.

"None of these apply to me, but I have to put in something, or it won't let me go on. I'm not really giving correct information because they aren't allowing me to move to the next step without doing this."

— Anthony, OEP 3

Figure 3. "Types of Change" Text Box



"I can't really see what I'm supposed to have changed. I don't really know what I'm signing right now because I can't read it. I wish they would have what the application question was so I would know what the point of reference was for this change."

— Liz, OEP 3

Creating passwords. Password creation was onerous and confusing. New enrollees received multiple error messages because they had not followed the eight requirements for creating a valid password — even though the rules are not provided at the outset of the process. All five participants who created accounts during the OEP 3 research became frustrated by the effort needed to create such a complex password. For one participant, it took ten minutes and seven attempts to create an acceptable password.

"This one is pretty annoying. They are making it difficult. It keeps saying it must not be a dictionary word. I'm not too sure what they mean by that. I honestly don't give websites that much time; I would almost be willing to give up and call it [quits] at this point."

— Ethan, OEP 3

Recommendations

Over the last three years, the gotoresearch user experience findings have provided insight into the practical, cognitive, and emotional challenges that consumers face in applying for or renewing their health insurance online with Covered California. The following overarching recommendations are based on these research findings:

- Covered California should conduct consumer usability testing regularly for continuous quality improvement.
- Covered California should monitor and report on website analytics that, in conjunction with consumer testing and other sources of data, can identify where in the online enrollment process applicants experience delays and errors.

The following changes are recommended to address this report's specific findings:

- Further emphasize to consumers that the "Shop and Compare" and "Preview Health Plans" tools are not final plan selection.
- Consider adding a feature that allows users to save favorite plans identified in "Shop and Compare" to easily review them at the point of actual plan selection.
- Define terms such as "household member" explicitly and consistently in the text of questions and in all help text. Eliminate confusing terminology to the extent possible. Where required questions still might not be easily understood, such as the "Last Date Paid" field for employment, make explanations prominent and easy to find.
- Correct the design of the "Signature for Renewal" page so that users can read all text and duplicate confirmations are not required.
- Clearly list all password creation requirements in advance.

Conclusion

User experience research findings suggest that many consumers seeking to enroll or renew their coverage online with Covered California may have experienced similar problems. In general, study participants were experienced website users and did not have complex enrollment or renewal circumstances. The study outcomes were, in large part, the result of problems with the website and online application. Many of the difficulties that participants experienced have fairly straightforward and simple solutions.

While consumers can enroll in Covered California offline, in person, by phone, or by mail, providing consumers with a user-friendly and efficient online experience should be a top priority. In fact, for millenials, one of Covered California's key target populations, it is crucial.

However, after three years, consumer user testing continues to show that consumers are experiencing significant difficulty enrolling or renewing Covered California health insurance online. This report points to improvements Covered California should make so that consumers can have the first-rate online experience they expect and deserve when purchasing health insurance.

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

State Innovation Waiver Update

AUDREY MORSE GASTEIER
Director of Policy and Outreach

EMILY BRICE
Senior Policy Advisor on State Innovation Waivers

Board of Directors Meeting, January 14, 2016

Overview of ACA Section 1332

- Today we will update the Board on progress exploring an "innovation waiver" under Section 1332 of the Affordable Care Act (ACA), including a proposed initial waiver to stabilize small group plans by maintaining status quo timing of rating and enrollment
- 1332 waivers offer states flexibility to develop alternatives to specific provisions of the ACA, including:
  - Exchange marketplace structure, offerings and subsidies
  - Merged market plan design and benefits
  - Individual and employer mandates
- States must demonstrate that a proposed waiver meets equivalency safeguards:

Scope of Coverage	Comprehensiveness	Affordability	Federal Deficit
Must provide coverage to as many people as the ACA	Must provide coverage as comprehensive as the ACA	Must provide coverage as affordable as the ACA	Must not increase the federal deficit

Update on Federal Guidance

- Previous federal guidance in 2012 was largely procedural
- Guidance issued in December 2015 offered new detail about federal standards for waiver applications, indicating high expectations of states seeking a waiver:
  - States must consider potential impact of waiver on vulnerable populations, not just population as a whole
  - States must consider deficit neutrality broadly, including changes in revenue and indirect spending as well as direct spending
  - States may not consider "cross-waiver" savings in demonstrating deficit neutrality
  - States seeking "pass-through" funds may not "claim" federal administrative savings
  - The Internal Revenue Service (IRS) is unable to administer different rules for different states – state may propose to waive tax provisions entirely if state assumes administration, but IRS cannot administer an alteration to the provision
- Recent guidance is subregulatory and may evolve over time (*e.g.*, as federal agencies gain capacity to accommodate state differences)

Update on Stakeholder Process

- Extensive stakeholder engagement throughout fall 2015:
  - Website and distribution list
  - Seven public stakeholder meetings
  - Open call for comment (Comments to date: Massachusetts Association of Health Plans, Blue Cross Blue Shield, ACT!!, Health Care for All, Massachusetts Hospital Association, Boston Medical Center Health Plan)
  - Open door for one-on-one meetings, with request that feedback is also raised publicly
  - Additional outreach to key stakeholders (*e.g.*, tribes, General Court, Congressional staff)
  - Transparent policy evaluation framework and process
- Stakeholder themes to date:
  - Desire for greater simplification for individuals and employers
  - Remaining concerns about affordability for individuals and employers
  - Interest in a period of stability before undertaking additional systemic reforms

Phased Waiver Strategy

- Given recent federal guidance and stakeholder feedback, we recommend considering a phased waiver strategy:

Issues for Phase 1 Application

- Enjoy broad consensus;
- Could be analyzed fully within a relatively brief timeframe; and
- Does not require extensive implementation planning prior to application

Issues for Phase 2 Application

- Require lengthier and more detailed stakeholder feedback;
- Require extensive analysis; or
- Require complex implementation planning prior to application

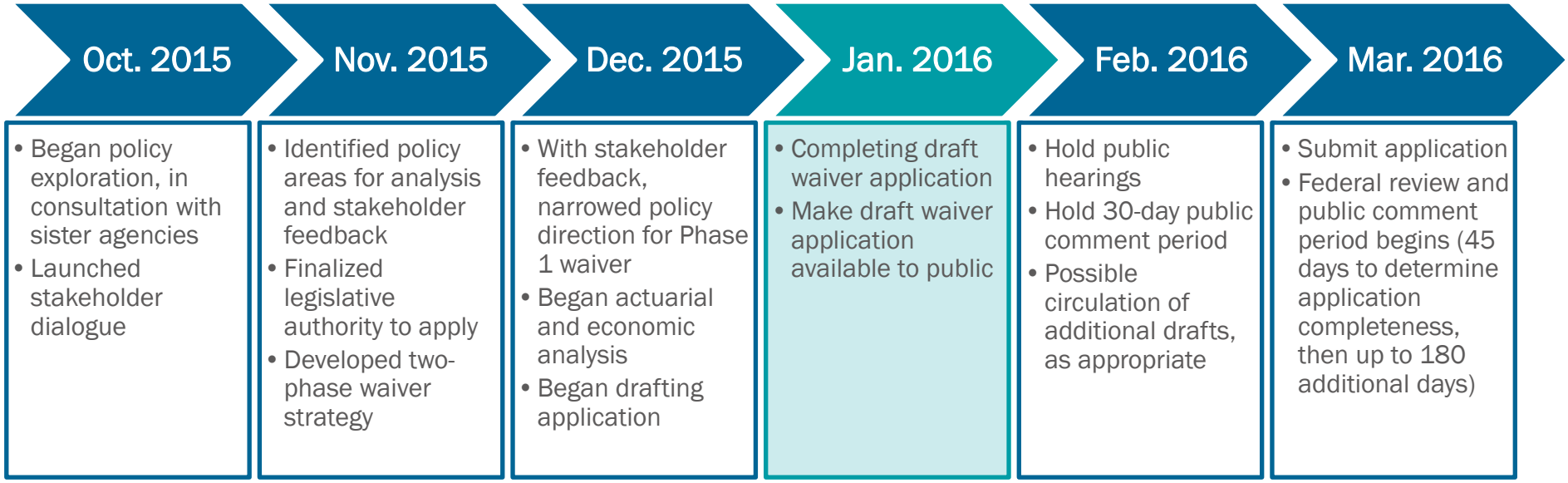
- Factors supporting a phased strategy:
  - Stakeholder desire to approach complex changes with careful and thoughtful planning
  - Recent federal guidance indicates high bar for federal review
  - Mindful of continuity and capacity issues with upcoming federal administrative change
  - Not aware of any federal limit on multiple waiver applications

Phase 1 Topic: Small Group Timing

	Description
Context	• In states with a single risk pool for the small group market, issuers may file index rates: (1) annually, (2) annually with quarterly trend updates or (3) annually and quarterly. Issuers may enroll groups on a rolling basis throughout the year • Per ACA, in states with a merged market, issuers may only file index rates: (1) annually or (2) annually with quarterly trend updates. Issuers may only enroll groups on a calendar year basis
Issue	• Starting in 2018, issuers of small group plans can no longer file quarterly rates and sell small group plans on a rolling basis. This issue is unique to MA and other merged market states (VT, DC) • The change could disrupt the small group market, including: (1) higher premiums as issuers rate more cautiously, (2) fewer choices for employers during the year and (3) member disruption due to shortened plan years in initial "change-over"
Approach	• Seek a waiver to make a limited modification to the definition of the merged market, such that MA could maintain a single risk pool for the merged market while maintaining select features unique to the small group market: rolling enrollment and quarterly rating. This would preserve the status quo in MA's market
Rationale	• Could contribute to rate stability at a time when other items are in flux – *e.g.*, transition to ACA-compliant rating factors, end of risk corridors and reinsurance • Could minimize coverage disruptions, *e.g.*, shortened plan years for groups with mid-year anniversary dates • Could be implemented with virtually no administrative burden or cost to state, issuers or employers • Would maintain shared calendar-year rating for broader merged market
Areas for continuing analysis	• With support from Division of Insurance and actuarial vendor, modeling likelihood of volatility in small group costs, with and without waiver

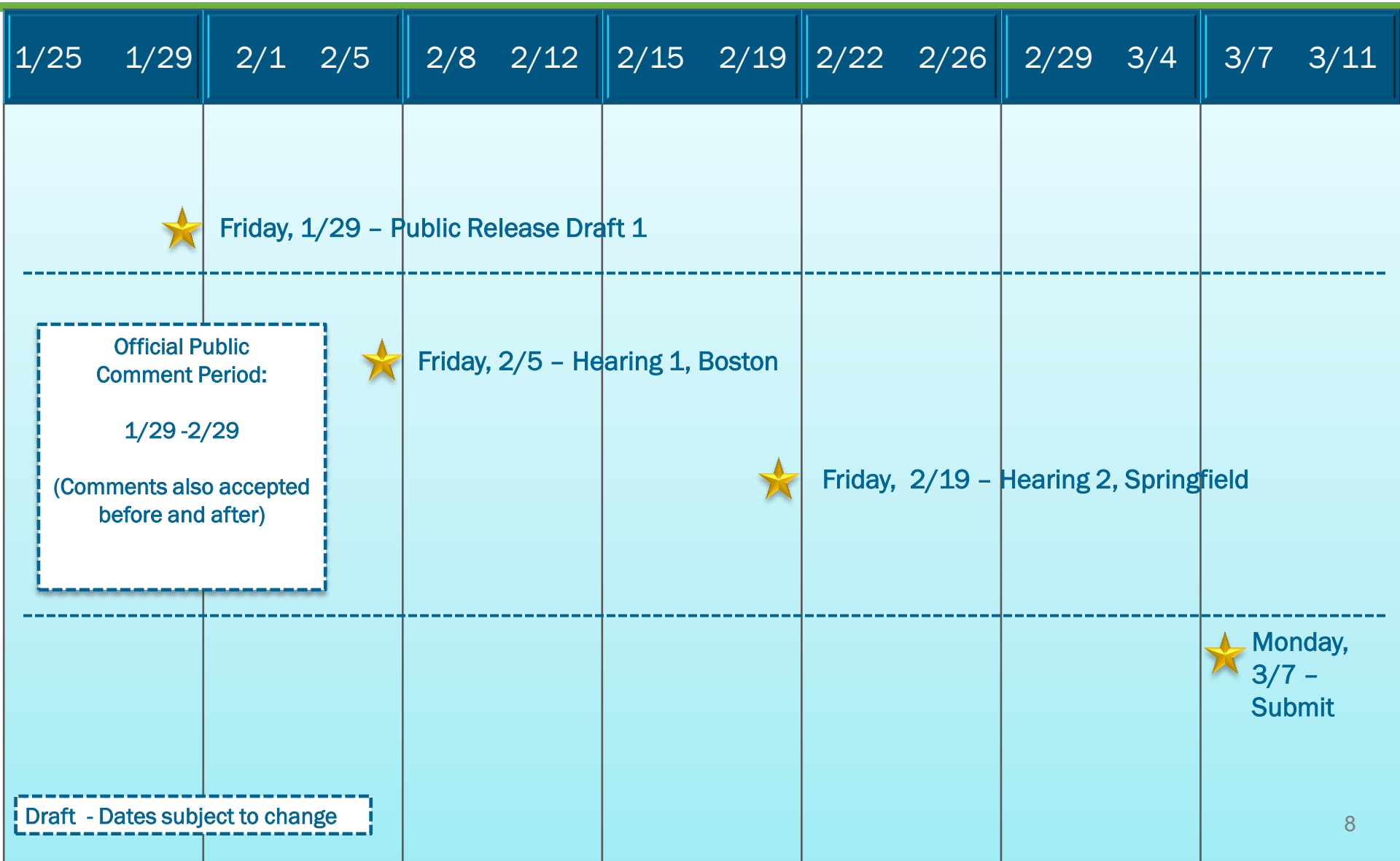
Phase 1 Application Timeline

- Massachusetts is preparing to submit a limited-scope waiver in Spring 2016



- Phase 1 waiver limited to timing of rating and enrollment for small group plans
- If approved, this waiver could begin as soon as January 1, 2017

Phase 1 Upcoming Key Dates



Continued Section 1332 Exploration

- Concurrent with Phase 1 application preparations, the Health Connector continues active exploration of additional policy issues raised by stakeholders, such as:
  - Impact of federal actuarial value calculator on plan design in merged market
  - Scope of eligibility gaps that prevent some lower-income residents from accessing subsidies
- As Phase 1 application process winds down, the Health Connector will ramp up exploration of a possible Phase 2 waiver application:
  - Dialogue with state and federal partners about timing
  - Ongoing policy analysis and stakeholder conversations
- Expect to return to the Board in spring with an update:
  - Update on progress of Phase 1 application following public comment period
  - Update on Phase 2 exploration and analysis

Commonwealth of Massachusetts

Request for a State Innovation Waiver

Under Section 1332 of the Affordable Care Act

February 2, 2016

Table of Contents

1.0 Executive Summary

The Commonwealth of Massachusetts has long embraced innovation and reform in its health insurance market. In 2006, Massachusetts enacted landmark health reform legislation that yielded the highest rate of insurance in the nation, protected insurance consumers, and paved the way for national health reform. Starting in 2010, Massachusetts implemented the additional reforms of the Patient Protection and Affordable Care Act (Affordable Care Act). In 2010 and 2012, Massachusetts enacted legislation to promote health care quality and cost-containment.

Today, the Massachusetts health insurance market is thriving. Over 96 percent of Massachusetts residents are insured, 89 percent of residents report regular access to health care, and the Commonwealth is beginning to make strides toward better value in health care purchasing.[1] The employer-based insurance market is robust—76 percent of Massachusetts employers offer insurance to their workers, compared to 55 percent nationally,[2] and a unique "merged market" structure supports affordability and continuity by requiring issuers to offer the same health insurance products to individuals and small employers, with rates based on their pooled experience.

Massachusetts now seeks to enhance these gains with a State Innovation Waiver under Section 1332 of the Affordable Care Act. Massachusetts appreciates the Affordable Care Act's recognition that local circumstances may merit a state-specific approach to supporting the overall goals of the law. Massachusetts seeks this flexibility to preserve the Commonwealth's long-standing version of a merged market, which blends the shared risk pool and common products of a federally-defined merged market with two features of a typical small group market: currently, (1) small groups can enroll and renewal on a rolling basis throughout the year, and (2) issuers can offer new products and refresh their rates for small group plans on a quarterly basis, in addition to submitting filings for the broader merged market annually.

While this hybrid merged market structure has functioned effectively for nearly a decade in Massachusetts, it does not fully align with the federal definition of a merged market, which requires not only a shared risk pool but also calendar-year enrollment and rating. Without a waiver, the Commonwealth will need to ensure that all aspects of its merged market meet federal requirements by 2018. The Commonwealth expects that meeting these requirements by transitioning small groups to a calendar-year cycle will cause significant disruption and costs for small employers and their employees, which could destabilize the merged market as a whole.

To avoid this disruption, the Commonwealth seeks a modest accommodation to preserve its innovative hybrid version of a merged market. The Commonwealth requests latitude to continue its merged single risk pool to promote affordability and continuity for individuals, while maintaining the rolling enrollment and quarterly rating that ensures stability and flexibility for small employers. The Affordable Care Act contemplates state flexibility under Section 1332 for precisely this reason—to permit local variations in implementation, so long as the state's proposal is equivalent to the federal law. The Commonwealth's proposal is consistent with the purposes of the Affordable Care Act, as it mirrors the federal policies permitted for other, non-merged states.

Massachusetts appreciates federal consideration of this initial proposal, and looks forward to future collaboration through the Affordable Care Act's many opportunities for state flexibility and innovation.

2.0 Assurances

Massachusetts anticipates that its proposal will meet the safeguards set forth in Section 1332 of the Affordable Care Act because the proposal will maintain equivalent coverage at no greater cost to its residents, employers, insurance issuers, the Commonwealth, or the federal government. Indeed, the Commonwealth seeks a waiver because it expects federal waiver flexibility will promote *greater* stability of coverage and affordability in its merged market, over the baseline under the Affordable Care Act that would otherwise apply.

The Commonwealth of Massachusetts provides the following assurances:

- Equivalent or greater scope of coverage. The Commonwealth's proposal will not decrease the number of Massachusetts residents covered or the number of Massachusetts' employers offering coverage. The Commonwealth does not anticipate any negative coverage impacts on vulnerable populations due to the proposed waiver.

- Equivalent or greater affordability of coverage. The Commonwealth's proposal will not increase the costs of health coverage for its residents or employers. Rather, the proposal will promote affordability by allowing issuers to continue pricing their small group plans accurately and without disruption. The Commonwealth does not anticipate negative cost impacts on vulnerable populations due to the proposed waiver.

- Equivalent comprehensiveness of coverage. The Commonwealth's proposal will not decrease the comprehensiveness of benefits for Massachusetts' residents or employers. Individuals and employers accessing insurance through the merged market will continue to receive the Commonwealth's Essential Health Benefits and additional benefits required by state law. The Commonwealth does not anticipate negative benefit impacts on vulnerable populations due to the proposed waiver.

- Deficit neutral. The Commonwealth's proposal will not increase federal spending, net of federal revenues, in any one year or in total over the ten-year budget period. The proposal will not require any additional direct spending or administrative costs, and the Commonwealth anticipates that any indirect economic impacts would be minimal and deficit neutral. The proposal does not request pass-through funding.

- No impact on federally-facilitated marketplace. The Commonwealth's proposal will not impact the federally-facilitated marketplace since the Commonwealth maintains a state-based marketplace for individuals and small groups and expects to continue to do so.

- No impact on other public programs. The proposal will not impact public coverage programs, such as Medicaid and the Children's Health Insurance Program.

- Meaningful public input. The Commonwealth has engaged in an extensive public stakeholder process to develop and refine the proposed waiver. The application and related materials have been publicly posted for notice and the public has had an opportunity to be heard at hearings and through written comments. The Commonwealth provided equal access for individuals with limited English proficiency or disabilities to participate in its public notice-and-comment process on the proposed waiver. In addition, the Commonwealth has engaged in a separate consultation process with the federally-recognized tribes residing within its borders.

3.0 Characteristics of Massachusetts

3.1 Health Insurance Market Overview

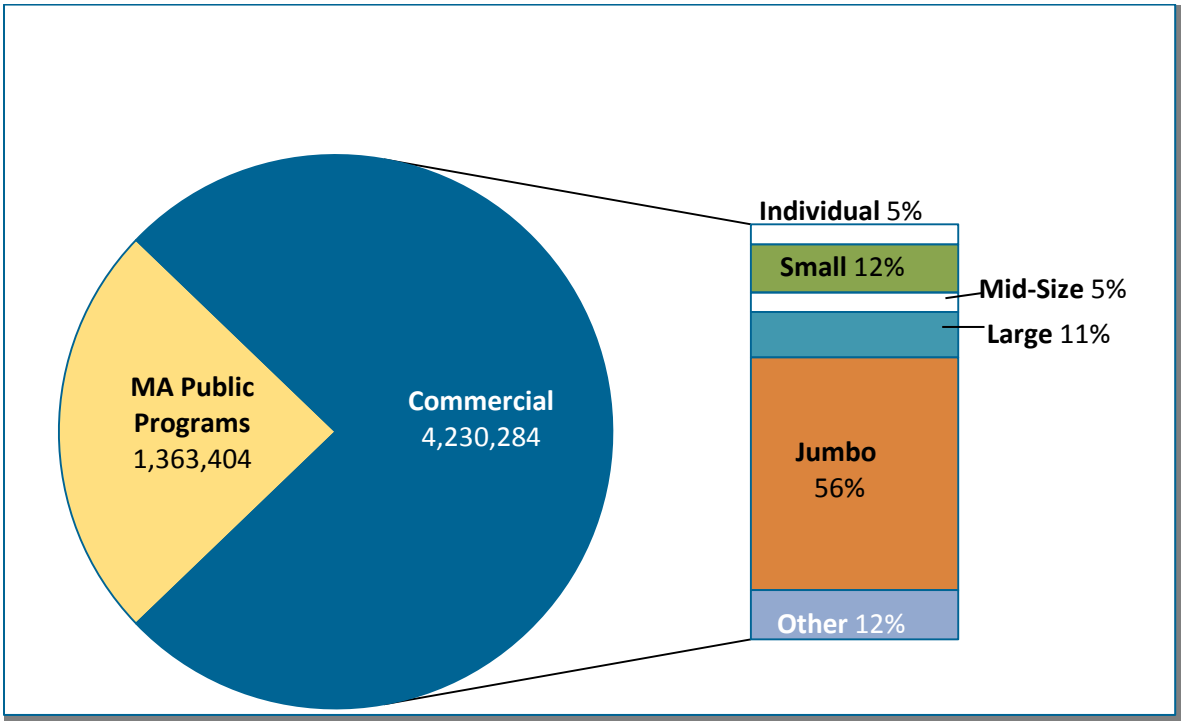
Over the course of the last three decades, the Commonwealth of Massachusetts has engaged deeply in comprehensive reform of its health insurance market and health care system.

Starting in the late 1980s, Massachusetts embarked on a series of ambitious reforms that generated the highest rate of insurance coverage in the nation, introduced critical protections for health insurance consumers, and launched initial steps toward cost containment and quality improvement. These reforms accelerated in 2006 with the introduction of Massachusetts' landmark comprehensive health reform law, which served as a foundation for the Affordable Care Act. In the commercial market, key reform milestones have included:[3]

1989
• Massachusetts enacted one of the first insurance mandates in the nation, a mandate for students enrolled in higher education to maintain health insurance.
1998
• Massachusetts enacted a first effort at broad reform, introducing a preliminary version of an employer mandate and investments in the health care safety net for vulnerable populations.
1992 1996
• Massachusetts introduced consumer protections to the non-group and small group market, including guaranteed issue and adjusted community rating.
2006 2008
• Massachusetts enacted Chapter 58 of the Laws of 2006 (Chapter 58), comprehensive reforms that aimed to achieve near-universal health coverage. • Key components of Chapter 58 and subsequent amendments included: o The creation of the Health Connector Authority (Health Connector), an independent agency that serves as an "exchange" marketplace to assist individuals and small employers in accessing health insurance, as well as subsidies to promote affordable coverage for residents with incomes up to 300% of the Federal Poverty Level (FPL), through the Commonwealth Care program. o Individual mandate for adults to have minimum creditable coverage, if it is considered affordable based on a state schedule. o Employer mandate to contribute to employee coverage or pay a penalty. o The merger of the non-group and small group markets into a single risk pool to stabilize premiums for individuals purchasing their own insurance in the Commonwealth.
2010 2014
• Massachusetts embarked on robust implementation of the Affordable Care Act, including adopting the Medicaid expansion and opting to retain its state-based marketplace. With federal support, Massachusetts maintained its subsidies for individuals in the Health Connector. • Massachusetts enacted comprehensive cost-containment legislation, including Chapter 288 of the Acts of 2010 (Chapter 288) and Chapter 224 of the Acts of 2012 (Chapter 224), to limit the growth of health care costs, improve health care access and quality, and promote public health.
2014 2016
• Massachusetts retained its state-based marketplace, the Health Connector, ensuring smooth enrollment and renewal for more than 190,000 enrollees by January 2016. • Successful transition of Commonwealth Care enrollees to ConnectorCare, using new federal premium tax credits and cost-sharing reductions to support affordable coverage for residents.

Today, Massachusetts has one of the most robust health insurance markets in the nation. Roughly two-thirds of non-elderly Massachusetts' residents have commercial health insurance.[4] The commercial market is competitive, with over a dozen companies actively marketing coverage throughout the Commonwealth.[5] The vast majority of premium dollars (89 percent) goes toward member health care, rather than administration, profits, or other overhead—exceeding the national medical loss ratio standards set in the Affordable Care Act.[6]

Figure 1. Massachusetts Non-elderly Enrollment by Commercial Market Sector (Snapshot as of March 2015)



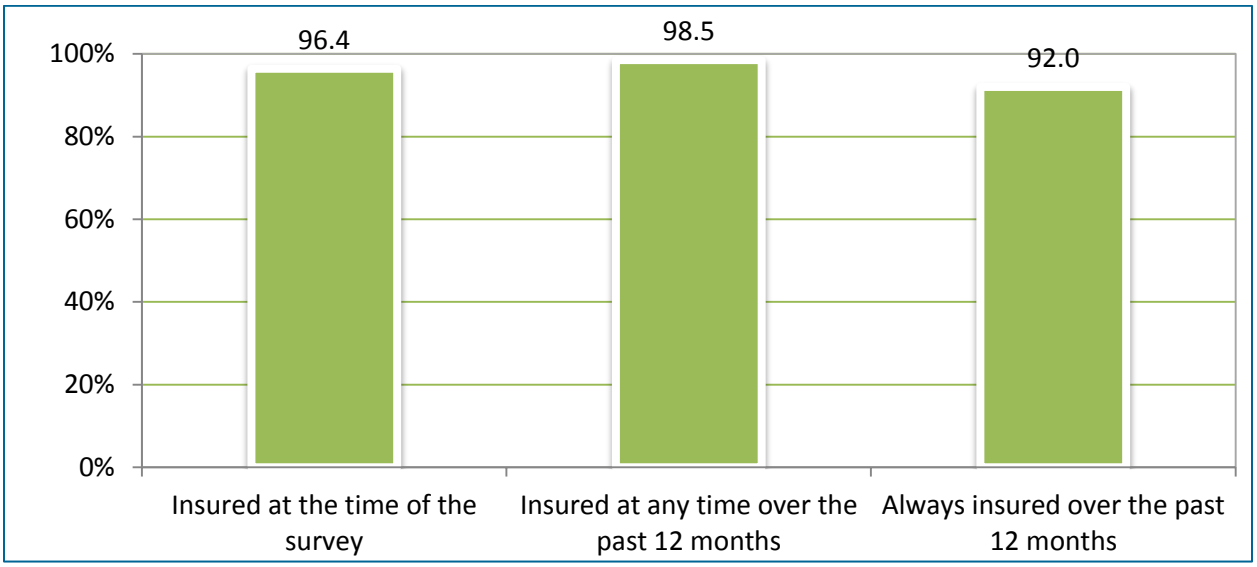
Source: CHIA, March 2015 Massachusetts Health Insurance Enrollment Trends

As of 2015, 96.4 percent of Massachusetts' residents are estimated to have health coverage, compared to 90.8 percent for the rest of the nation.[7] Of the state's nearly 6.8 million residents, only roughly 200,000 residents are estimated to remain without coverage at any given point—the majority of whom are working age adults, disproportionately male, single, Hispanic, and with family income below 400% of the Federal Poverty Level (FPL).[8] More than half of the remaining uninsured report cost of coverage as a key factor in their uninsurance (54.8 percent); other key factors include loss of employer-based coverage (31.5 percent) and lack of availability of employer-based coverage (20 percent).[9] The Commonwealth continues to work to reach and enroll the remaining uninsured using tailored outreach strategies.

The Commonwealth's coverage gains are reflected in greater access to care as well. Continuity of coverage has become the norm in Massachusetts, with fewer than one in ten residents reporting a period of uninsurance over the past twelve months.[10] Residents are usually able to access care, with 89 percent reporting a usual source of care and 88.6 percent reporting a visit to a general doctor or non-physician practitioner in the past twelve months.[11] Four out of five residents report that the quality of care they receive is very good or excellent.[12]

Despite these improvements and Massachusetts' investments in subsidized coverage, health care costs remain a concern. Among residents surveyed in 2015, roughly one in six reported difficulty paying medical bills or deferring health care due to costs.[13]

Figure 2. Health Insurance Coverage in Massachusetts (2015)

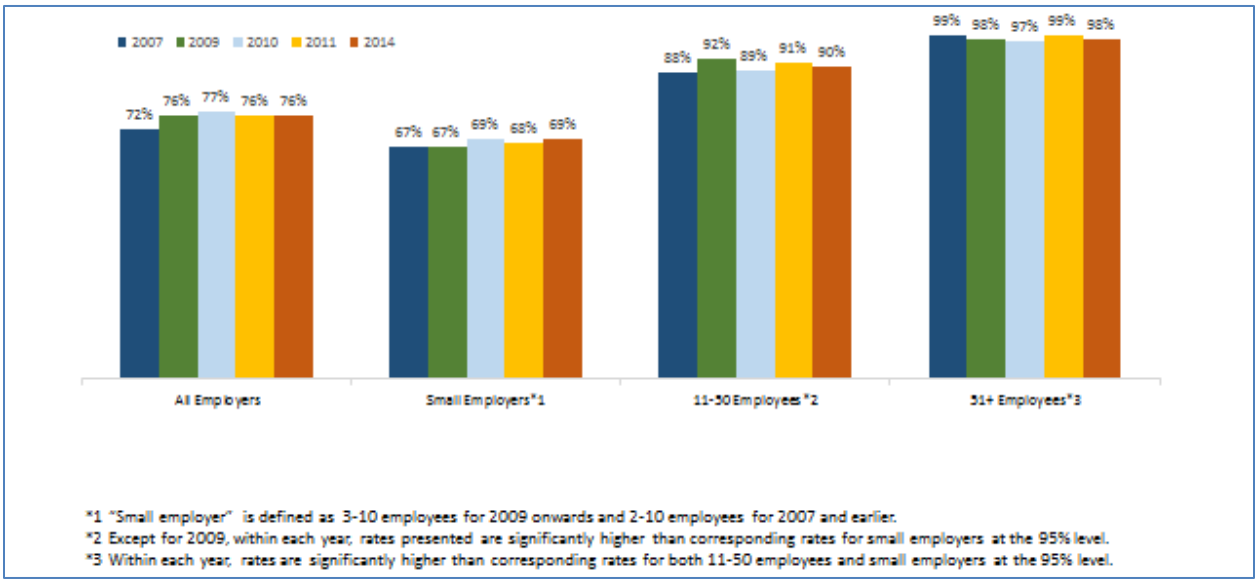


Source: CHIA, 2015 Massachusetts Health Insurance Survey

3.2 Employer-Based Coverage in Massachusetts

Employer-based coverage is the dominant source of coverage in Massachusetts, accounting for about 60 percent of all covered lives.[14] For years, Massachusetts employers have offered insurance to their workers at rates much higher than the national average: in 2014, for instance, 76 percent of Massachusetts employers offered insurance, compared to 55 percent nationally.[15] Smaller employers offer at a decreasingly lower rate corresponding to the size of the firm—while 98 percent of those with over 50 workers offer insurance, only 90 percent of those with between 11 to 50 workers offer, and this declines further to 69% percent of those with under 10 workers.[16] Across all employer sizes, roughly three out of four eligible employees choose to enroll.[17]

Figure 3. Massachusetts Employers Offering Health Insurance, By Employer Size (2007-2014)



Source: CHIA, 2014 Massachusetts Employer Survey

Though Massachusetts employers offer health coverage at a high rate overall, this type of coverage is not evenly distributed among different populations of Massachusetts' residents. Those with employer-based coverage are most likely to be non-elderly, male, white and non-Hispanic, in good health, and with higher household incomes.[18] These employees are also more likely to live in certain geographic regions, such as the Metro West area (65.7 percent) versus the South Coast area (40.8 percent).[19]

Table 1. Characteristics of Massachusetts Residents with Employer-Based Coverage (2015)

	Children (0 to 18)	Non elderly Adults (19 to 64)	Elderly Adults (65 and older)	Total Population
Number with ESI	920,146	2,419,164	398,759	3,738,069
Percent with ESI	63.4%	59.6%	40.2%	57.5%

	Male	Female	Total Population
Number with ESI	1,801,282	1,936,787	3,738,069
Percent with ESI	58.4%	56.7%	57.5%

	White, non Hispanic	Black, non Hispanic	Other/Multiple Race, non Hispanic	Hispanic	Total Population
Number with ESI	3,105,334	216,676	196,049	220,010	3,738,069
Percent with ESI	62.2%	48.7%	57.7%	30.5%	57.5%

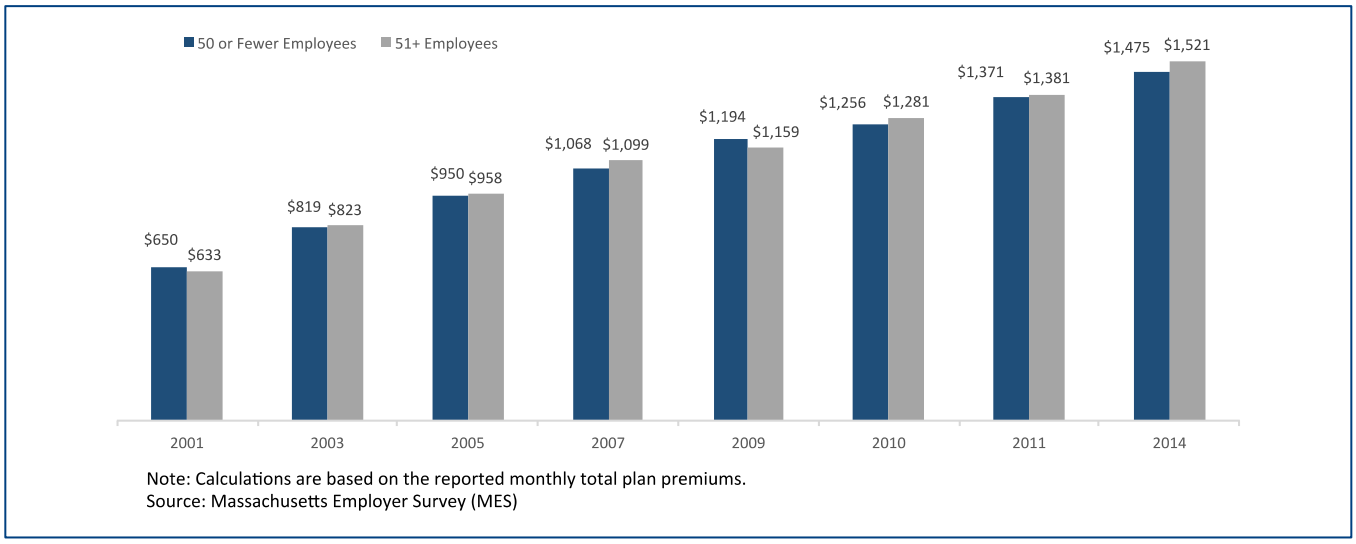
	Good, Very Good, or Excellent Health and No Activity Limitation	Fair or Poor Health or an Activity Limitation	Fair or Poor Health and an Activity Limitation	Total Population
Number with ESI	2,943,478	586,430	208,161	3,738,069
Percent with ESI	65.8%	44.6%	29.2%	57.5%

	Family Income At or Below 138% FPL	Family Income Between 138 and 299% FPL	Family Income Between 300 and 399% FPL	Family Income At or Above 400% FPL	Total Population
Number with ESI	264,849	736,944	524,513	2,211,763	3,738,069
Percent with ESI	16.2%	46.1%	75.7%	85.8%	57.5%

Source: CHIA, 2015 Massachusetts Health Insurance Survey

Despite Massachusetts' high rate of employer-based coverage, Massachusetts' employers report significant concerns with the cost of coverage. Massachusetts' employers pay approximately 70 percent of premiums for their workers.[20] Over the past decade, the total median monthly premium for family health insurance plans has grown from $650 in 2001 to $1,479 in 2014.[21] Nearly 90 percent of those employers that do not offer coverage cite high costs as a top reason for not offering coverage.[22] Employers that provide coverage cite cost and flexible plan design as their most important criteria when selecting a plan, with cost cited as particularly important to smaller employers.[23]

Figure 4. Massachusetts Median Monthly Total Premium for Family Health Insurance Plans by Firm Size (2014)



Source: CHIA, 2014 Massachusetts Employer Survey

Increasingly, employees are shouldering a greater share of the costs of their employer-based coverage. Over the past decade, Massachusetts' median monthly employee contribution to family plan premiums has grown from $172 in 2001 to $456 in 2014.[24] While the percentage of premium contribution between employer and employees has remained relatively stable in recent years, high-deductible health plans and other cost-sharing arrangements are becoming more common. Nearly half of Massachusetts' employers offered high-deductible health plans in 2014, more than double the national average.[25]

Facing rising costs, some employers have also opted not to participate in the fully-insured market. In 2011, roughly 11 percent of employers with fewer than 10 employees and 10 percent of employers with fewer than 50 employees offered self-funded plans. By 2014, these rates had risen to 19 percent of employers with fewer than 10 employees and 15 percent of employers with fewer than 50 employees.[26]

3.3 Massachusetts' Merged Market

One of the most exceptional aspects of Massachusetts' insurance market is its merged market for individuals and small employers with up to 50 employees.[27] Only Vermont, Washington D.C., and Massachusetts feature a merged market.[28] In 2015, Massachusetts' merged market included nearly 80,000 employers[29] and 473,811 enrollees in small group plans and 257,175 enrollees in non-group plans.[30] The merged market accounts for 17 percent of the commercial market as a whole, with 5 percent of the commercial market enrolled in non-group plans and 12 percent enrolled in small group plans.[31]

Massachusetts merged its non-group and small group markets in 2007, as part of the implementation of state health reform under Chapter 58. The Commonwealth did so for a number of reasons, including ensuring consistent consumer protections across the market, improving continuity of coverage for residents transitioning between group and non-group insurance due to changes in employment, and broadening the risk pool to improve overall affordability in the market. Studies performed prior to the merger of the markets estimated that non-group rates would decrease by 15 percent and small group rates would increase by only 1 to 1.5 percent as a result of the merger.[32] While small group rates actually increased by 2.6 percent following the merger,[33] the merger has still yielded significant increases in overall affordability for Massachusetts' residents.

Over time, the merged market has evolved in Massachusetts to feature a blend of typical merged market characteristics and some remaining characteristics of a typical small group market. This hybrid structure allows Massachusetts residents the benefits of a shared market while maintaining features attractive to small employers, such as enrollment cycles that can respond to industry-specific business characteristics (*e.g.*, different fiscal years or seasonal business). Today, Massachusetts' merged market includes:

- A common risk pool that combines the experience of non-group and small group enrollees for the purpose of setting rates;
- Common insurance products for individuals and small employers, with identical benefits, cost-sharing, and provider network designs (although subsidies are available for some enrolled through the Health Connector, and catastrophic plans are only available to eligible individuals);
- A calendar-year enrollment and renewal cycle for non-group enrollees, but a rolling enrollment and renewal cycle for small groups;
- Establishment of index rates each calendar year, but also quarterly updates to the index rate for small groups enrolling or renewing at other points in the year; and
- Certain small group rating factors which differ from the rating factors specified in the Affordable Care Act, but which Massachusetts has been permitted to use during a transition period.

In recognition of Massachusetts' well-functioning market under state health reform, Massachusetts received federal approval in 2013 for a transition period for certain elements of its merged market to come into full alignment with the Affordable Care Act, such as the small group rating factors not specified under federal law. During this transition period, the federal Department of Health and Human Services (HHS) has not required Massachusetts' version of a merged market to fully meet the federal definition of a merged market. The Commonwealth has appreciated this federal flexibility to date, authorized under Section 1321(e) of the Affordable Care Act.[34] Unless additional flexibility becomes available, Massachusetts is preparing to sunset its state-specific rating factors for all plans sold on or after January 1, 2018.[35] At that point, Massachusetts' merged market would need to align with all aspects of the federal definition of a merged market, including calendar-year enrollment and renewal.

The Commonwealth anticipates that fully transitioning the current merged market to the federal definition of a merged market will cause significant market disruption and instability in pricing. An analysis in 2013 indicated that 181,000 small employer enrollees could see premiums increase by more than 10 percent under the rating factors transition.[36] Of these enrollees, 6,000 could face premium increases of more than 30 percent. Given the potential impact of these pending changes, the Commonwealth seeks to maximize stability for its merged market. This is particularly important in light of other market trends impacting the small group portion of the merged market, such as declining enrollment and recent premium increases, as illustrated in **Table 2** and **Table 3** below.

Table 2. Enrollment Trends for Small Group Plans Within the Merged Market (2014 to 2015)[37]

Small Group Enrollment							Sept. 2014 Sept. 2015 Change	
3/31/14	6/30/14	9/30/14	12/31/14	3/31/15	6/30/15	9/30/15	Absolute	Percentage
523,271	509,422	502,656	494,279	484,512	478,862	473,811	-28,845	-5.7%

Source: CHIA, Sept. 2015 Enrollment Data

Table 3. Weighted Rate Changes for Small Groups Within the Merged Market, Annually in the 2nd Quarter[38]

	2012 2013 (Second Quarter)	2013 2014 (Second Quarter)	2014 2015 (Second Quarter)
Weighted Rate Change	2.7%	2.8%	6.1%

Source: DOI rate filings

4.0 Proposed Waiver

Massachusetts seeks federal approval for Section 1332 waiver flexibility to preserve key features of the Commonwealth's local variation on a merged market. Flexibility under Section 1332 will allow the Commonwealth to preserve structural elements of the current merged market that promote continuity and stability. This will be particularly important for small employers and their employees as their issuers prepare to phase down state-specific rating factors in 2018, buffering 12 percent of the Commonwealth's insurance market from these changes by preventing additional disruption.[39]

4.1 Provisions State Seeks to Waive

Massachusetts seeks to modify one section of the Affordable Care Act: 42 U.S.C. § 18032(c)(3), the provision of the Affordable Care Act that allows states the option of a merged risk pool for the non-group and small group market. Massachusetts does not anticipate any impact of this limited proposal on other sections of the Affordable Care Act.

Section 1312(c) of the Affordable Care Act, codified at 42 U.S.C. 18032(c), generally requires a single risk pool for all enrollees in a non-group market and a single risk pool for all enrollees in a state's small group market, unless a state chooses to merge the two markets into a single risk pool.[40] This provision may be waived or modified under Section 1332 because it corresponds to ACA Section 1312, which falls under Subtitle D, Part 2 of the Affordable Care Act, a section that is listed as waivable in Section 1332(a)(2).

Massachusetts does not seek to waive the federal merged market provision entirely – indeed, Massachusetts wishes to preserve its merged market under a single risk pool. Massachusetts simply requests flexibility to implement its merged market in a manner consistent with single risk pool principles, but modified to permit the traditional rate filing, enrollment, and renewal timing that would otherwise be permitted in a small group risk pool. If its waiver is granted, Massachusetts will continue to align its small group rate filing, enrollment, and renewal timing practices to the federal regulatory approach permitted for small group plans in other states.

In **Figure 5**, the Commonwealth provides language that illustrates the nature of the modifications it seeks, side-by-side with the current language of the federal statute. This illustrative language is modeled after amendments to 45 C.F.R. § 156.80 that have been proposed in the federal Notice of Benefit and Payment Parameters for 2017.[41] The Commonwealth provides this illustration to demonstrate that its proposed waiver is consistent with the federal law that applies in states with a small group single risk pool. With its waiver, Massachusetts only seeks parity with these other states.

Figure 5. Illustrative Modification to Section 1312(c)(3) of the Affordable Care Act

42 U.S.C. § 18032. Consumer choice

"(c) Single risk pool

(1) Individual market—A health insurance issuer shall consider all enrollees in all health plans (other than

grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) Small group market—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) Merger of markets—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate. A State that merges its individual and small group insurance markets into a single risk pool may nonetheless elect to permit issuers of small group plans to modify the index rate and permitted plan-level adjustments, no more frequently than quarterly and only for small group plans. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan...

4.2 Rationale for Waiver

The Affordable Care Act includes strict risk pooling requirements to prevent the kind of risk segmentation that could lead to discrimination for populations with higher health care needs. Massachusetts recognizes and supports the overarching purpose of the single risk pool requirement, and approving the Commonwealth's request will not diminish this requirement.

The Commonwealth maintains that under Massachusetts' specific circumstances, strict application of the current federal regulatory scheme for merged markets may have deleterious unintended consequences. Under current federal law, Massachusetts' small employers are disadvantaged, compared to small employers in other markets. Specifically:

- In states with a single risk pool for the small group market, issuers are permitted to enroll small groups on a rolling monthly basis throughout the year.[42] In states with a federally-defined merged risk pool, however, issuers may only enroll small group plans on a calendar year basis.[43]

- In states with a single risk pool for the small group market, issuers are permitted to file index rates: (1) annually, (2) annually with quarterly trend updates, or (3) annually and quarterly.[44] In states with a federally-defined merged single risk pool, however, issuers are only permitted to file index rates annually. By federal regulation, issuers in merged market states may not file a change to index rates quarterly.[45]

Without a waiver, the Commonwealth would need to ensure that its merged market meets federal requirements by January 1, 2018 when its current federal flexibility expires, including transitioning to a calendar year enrollment and rating cycle.[46, 47] After this date, issuers may only sell to small employers annually for a January effective date, and may only file index rates on an annual basis. The impact of these federal requirements are unique to Massachusetts because of its merged market—other states have flexibility to permit quarterly rating and rolling enrollment for their small groups.[48]

The Commonwealth is concerned that this transition to the federal definition of a merged market will cause undue disruption and risk for employers and employees participating in small group plans. For nearly a decade, Massachusetts has operated a merged market under a hybrid structure that offers the best of both worlds: the stability and continuity of a single risk pool, with the ability to customize business practices for the different needs of individuals and employers.

Without federal flexibility, Massachusetts' small employers and their employees could experience disruptions in coverage, additional cost-sharing, and additional premiums. These changes could weaken the delicately-balanced merged market structure that Massachusetts' issuers, employers, and residents have come to support over the years, threatening to destabilize the broader merged market. Without a waiver, Massachusetts could experience:

- Disruptions to coverage and care for nearly one-half million residents

Today, small employers in Massachusetts can enroll and renew their small group plans at any month of the year, so long as they comply with requirements meant to minimize adverse selection, such as minimum participation and contribution. Many small employers currently participating in the merged market renew their coverage during a month other than January. For example, of groups sold through the Health Connector in 2014, 234 groups had renewal anniversaries in April 2015, versus 107 groups with renewal anniversaries in January 2015.[49] Group coverage sold outside the Health Connector is similarly spread across the calendar year, as indicated in **Table 4** below.[50] This differs from other merged markets – for example, when Vermont transitioned its small group plans to the calendar year in 2014, the majority of its groups already renewed in January.[51]

Table 4. Distribution of Small Group Members Enrolling By Calendar Month and Metal Level

Metal Level	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Total
Bronze	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Silver	2%	1%	2%	5%	2%	2%	2%	1%	2%	1%	1%	3%	24%
Gold	6%	3%	5%	11%	4%	4%	3%	2%	3%	3%	3%	7%	53%
Platinum	2%	1%	2%	7%	1%	1%	1%	1%	1%	1%	1%	2%	22%
Total	**10%**	**5%**	**9%**	**23%**	**7%**	**7%**	**6%**	**5%**	**6%**	**5%**	**5%**	**12%**	**100%**

Source: Oliver Wyman analysis of DOI 2015 rate filings

If Massachusetts were to switch to calendar-year enrollment in 2018 to align with current law for federal merged markets, 90 percent of small employers and employees participating in the Massachusetts' merged market would experience a mid-year disruption to their coverage because they currently renew during another month. For example, an employer whose plan is due for renewal in July 2017 would face a difficult choice – to forgo coverage for a gap period until calendar-year enrollment begins in January 2018, or to purchase a plan for the remainder of 2017 and then again in January 2018, recognizing that the covered employees could lose accruals to their deductibles and maximum out-of-pocket limits with the start of the 2018 plan year.

These additional cost-sharing losses could be significant, as detailed in Section 5.3 below, particularly because 43 percent of those receiving coverage through small employers were enrolled in a high-deductible health plan at last count (defined as a deductible exceeding $1,250). Each transition to a new plan also presents risks to continuity of care, if employees need to select from new participating provider networks or face short gaps in coverage due to administrative processes.

- Risk of rate increases or other cost volatility

As detailed below in Section 5.3, the Commonwealth is concerned that transitioning to annual rating could contribute to higher premiums for small group plans in the merged market. By extension, any increases in

premiums for small group plans would also impact non-group plans, including plans offered through the Health Connector that are subject to federal premium tax credits.

Diverse stakeholders have expressed concerns that transitioning to annual rating could lead to overly-conservative pricing as issuers prepare for the uncertainty of a new and unfamiliar rating cycle.[52] Health insurance issuers, brokers, and business representatives attest that small group rates are likely to rise in response to a calendar-year rating cycle, as issuers will be less able to respond to market dynamics throughout the year. Because Massachusetts has a merged market structure with a shared index rate for all non-group and small group plans effective in January, any increases in premiums for small group plans under a calendar-year cycle would also negatively impact non-group plans.

These concerns are exacerbated by other factors in the market, including: (1) the alignment of state small group rating factors with federal rating factors; (2) the end of the federal reinsurance and risk corridors program, and (3) other market changes, such as the introduction of high-cost prescription medication.[53] Each of these factors is likely to contribute to rate instability and conservative pricing. Recent rate filings for 2016 reflect significant rate increases for the merged market, and Massachusetts would like to take all available steps to mitigate additional premium increases.[54]

- Risk of employer flight from the merged market

While Massachusetts has traditionally enjoyed relatively strong participation from small employers in the merged market, there are some indications that the disruption discussed above could amplify the risk of employers exiting the merged market altogether.

Facing changes to the market that would occur without a waiver and in the absence of a mandate for small employers with 50 or fewer employees to offer coverage, some employers may decide to stop offering coverage altogether. If this were to occur, Massachusetts could incur significant additional liability from lower-income employees who would qualify for subsidized coverage. At last estimate, Massachusetts has approximately 1,526,306 residents whose incomes are below 400 percent FPL and have employer-based coverage.[55] If even a small portion of these residents were to lose their current employer-based coverage and seek public coverage, this would represent a major cost to the Commonwealth and could also increase costs for the federal share of subsidy programs.

4.2 Statutory Authority for Waiver

With the support of the Massachusetts General Court (legislature), Massachusetts has explicit statutory authority to apply for and implement the proposed waiver application. Ch. 119, Sec. 20 of the Acts of 2015 authorizes the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.[56]

Specifically, the Health Connector has authority "to make applications to the United States Secretary of Health and Human Services to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time, as provided for by 42 U.S.C. § 18052, and to implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the United States Secretary of Health and Human Services pursuant to said 42 U.S.C. § 18052."

4.3 Waiver Implementation Plan

Because Massachusetts seeks to preserve current market conditions through its proposed waiver, the Commonwealth's proposed implementation plan is modest. The proposed waiver would not require additional resources or extensive planning, beyond current insurance market and regulatory activities.

The responsibility to implement the proposed waiver would reside primarily with the Commonwealth's Division of Insurance (DOI), with support from the Commonwealth Health Insurance Connector Authority (Health Connector) and the Baker-Polito Administration more broadly. DOI and the Health Connector have worked collaboratively for a decade to ensure that quality, affordable health plans are available to small employers and their employees, and the two agencies are well equipped to implement the proposed waiver together. The Commonwealth also expects substantial waiver implementation support from sister agencies within the Baker-Polito administration, as well as merged market stakeholders that have indicated their support for the proposal, including small group plan issuers, brokers, and representatives of the business community.

- Implementation Oversight from the Division of Insurance

The DOI administers the laws of the Commonwealth as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. The DOI monitors financial solvency, licenses insurance companies and producers, reviews and approves rates and forms, and coordinates the takeover and liquidation of insolvent insurance companies and the rehabilitation of financially-troubled insurance issuers. The DOI also investigates and enforces state insurance laws and regulations, responds to consumer inquiries and complaints, and provides small employers and other members of the public with information regarding various types of insurance.

Under the proposed waiver, DOI would continue its current role as the primary regulatory entity for the merged market, including supervision of issuers' rating and enrollment practices. By state law, DOI has authority to review and approve rates for health insurance products offered in the merged market by insurance issuers, health maintenance organizations, non-profit hospital service corporations, and medical service corporations.[57]

DOI's current regulatory guidance supports the policies in this waiver request. DOI Bulletin 2014-11 indicates that "eligible small businesses or groups continue to have the right to apply for coverage anytime during the year…"[58] 211 CMR 66.09 supports a quarterly cycle for the timing of rate filings, requiring issuers to file small group base premium rates and rating factors 90 days before their proposed effective dates.[59] These policies could serve as a regulatory foundation for the proposed waiver, with DOI supplying additional guidance to issuers as needed.

- Implementation Support and Outreach from the Health Connector

The Health Connector is an independent quasi-governmental authority that has helped residents and small employers compare and enroll in high-quality, affordable health plans since its inception in 2006.[60] In addition to serving as a source of coverage, the Health Connector also serves as a policymaker and regulator regarding elements of state health reform, including the state's individual mandate. In 2014, the Health Connector began serving as a designated state-based marketplace under the Affordable Care Act, refining its offerings to meet new federal requirements.

As part of this marketplace role, the Health Connector operates the Commonwealth's Small Business Health Options Program (SHOP), facilitating health insurance enrollment for over 5,544 small group enrollees and 1,223

employer groups.[61] The Health Connector also offers educational resources and incentives to small employers offering coverage, including access to the federal small business tax credit and Wellness Track, a state rebate program that supports workplace wellness with financial assistance for participating employers. Further, Health Connector staff have established relationships with the employer and broker community over the years through its licensed on-staff brokers, advisory councils and other outreach mechanisms. This has allowed effective education and collaboration with members of those communities on key policy changes in the past.

Given its historical role in administering the Commonwealth's version of an employer mandate and its current role as an enrollment facilitator for small employers, the Health Connector is well-equipped to serve as an ongoing educational resource for small employers and employees with questions about the proposed waiver.

- Implementation Timeline

Implementation Activity	Timing	Entity	Specific Activity
(Assumes waiver approval by early fall 2016)			
Notify public of waiver approval	Fall 2016	DOI	Release information sheet via DOI regulatory webpage
			Encourage outreach about waiver in continuing education seminars for licensed agents and brokers
		Health Connector	Release waiver approval document and other information describing the waiver via Section 1332 webpage and stakeholder distribution list
			Provide update at Broker Advisory Council, Employer Advisory Council, and other educational fora with small employer stakeholders
		Issuers	Release advisory to agents and brokers
Review regulatory guidance to ensure clarity in expectations	Fall 2016	DOI	If needed for clarity, release bulletin to health insurance issuers regarding implementation roll-out and timeline
(Waiver period begins January 1, 2017)			
Rate filing instructions	Spring 2017	DOI	Remind health insurance issuers of waiver terms and implementation in filing instructions, all-filer seminar, or other appropriate industry fora
Post-award public forum	Summer 2017	DOI and Health Connector	Hold public forum to solicit comments on the progress of the waiver (publishing the date, time, and location on the DOI and/or Health Connector websites, 30 days in advance)
Monitor market trends and seek ongoing public feedback	Annually	DOI and Health Connector	Following public release of merged market rates effective January of each year, hold public forum to solicit comments on the progress of the waiver (publishing the date, time, and location on the DOI and/or Health Connector websites, 30 days in advance)
		DOI and Health Connector	
Determine whether to seek waiver renewal	Fall 2020	DOI and Health Connector	Hold public forum to solicit comments
Prepare for waiver wind-	Winter	DOI and	Seek extension of waiver authority or prepare for

down or renewal	2021	Health Connector	transition from waiver, in partnership with HHS
(Waiver period ends January 1, 2022)			

Though Massachusetts is seeking Section 1332 flexibility to accommodate its current merged market conditions, the Commonwealth recognizes that market conditions could change over the course of the waiver period. If the proposed waiver is granted, Massachusetts requests the ability to revert to the federal merged market approach, if: (1) market conditions require a calendar-year approach to rating and enrollment, and (2) the Commonwealth engages in an appropriate process with HHS to withdraw from the waiver and prepare the insurance market for transition.

4.4 Public Waiver Development Process

The Commonwealth began exploration of a possible Section 1332 waiver in fall 2015 at the direction of Governor Charlie Baker and the Massachusetts General Court.[62] The Health Connector was asked to lead a collaborative interagency effort to engage the public about potential opportunities available under Section 1332.

In October 2015, the Health Connector launched a series of public meetings to discuss possibilities under Section 1332. The Health Connector included partners in the executive and legislative branches of the Commonwealth in the public meetings, including representatives from:

- The Office of the Governor;
- The Office of the Attorney General;
- General Court committees, including the Joint Committee on Health Care Financing and other committees related to health insurance;
- The Health Connector's governing Board of Directors;
- The Executive Office of Housing and Economic Development and its Division of Insurance (DOI);
- The Executive Office for Administration and Finance;
- The Executive Office of Health and Human Services and its MassHealth Division;
- The Center for Health Information and Analysis;
- The Group Insurance Commission; and
- The Health Policy Commission.

The Health Connector convened seven public meetings in the initial stakeholder series, as detailed below. These meetings were announced publicly, via a dedicated e-mail distribution list and a dedicated webpage on the Health Connector's website: https://betterhealthconnector.com/about/policy-center/state-innovation-waiver. The public was notified of the opportunity for language or disability accommodations for each meeting, and the dedicated webpage offers language and disability assistance options and meets applicable "Section 508" standards. Meeting materials were distributed via the distribution list and posted after each meeting on the dedicated webpage. The Health Connector encouraged public comment at each meeting, and kept a record of comments.

Topic(s)	Meeting Details
Introductory Launch • Overview of Section 1332 waivers and federal guidance to date	**Wednesday, October 7, 2016** Boston location

Open Policy Forum # 1 • Individual mandate • Employer mandate	**Friday, October 16, 2015** Boston location and phone
Open Policy Forum # 2 • Exchange and qualified health plan structure • Individual and group market structure • Essential health benefits	**Friday, October 23, 2015** Boston location and phone
Open Policy Forum # 3 • Exchange subsidies • Exchange eligibility	**Friday, October 30, 2015** Boston location and phone
Roll-up of Discussion To Date • Roll-up of discussion to date • Timeline of possible next steps in Commonwealth's consideration of a waiver	**Friday, November 6, 2015** Boston location and phone
Targeted Policy Forum # 1 • Draft policy options for consideration	**Wednesday, November 25, 2015** Boston location and phone
Targeted Policy Forum # 2 • Draft policy options for consideration	**Wednesday, December 9, 2015** Phone

Massachusetts is fortunate to have a deeply engaged health care stakeholder community. Because of its historical experience implementing multiple waves of health reform, the Commonwealth has developed strong working relationships across a diverse array of stakeholders, including consumer representatives, health plan issuers, provider entities, agents and brokers, business representatives, labor representatives, and others. The Health Connector drew upon this list of known interested stakeholders to develop its initial distribution list of stakeholder participants in its public meetings, and updated this dedicated list over time as new stakeholders expressed interest. Stakeholders attending the meetings most frequently included representatives from:

Consumer representatives	• Community Catalyst • Health Care For All • Health Law Advocates • Massachusetts Law Reform Institute
Health plan issuers	• Blue Cross and Blue Shield of Massachusetts, Inc. • Boston Medical Center Health Plan, Inc. • CeltiCare Health Plan of Massachusetts, Inc. • Dental Service of Massachusetts, Inc. (Delta Dental of Massachusetts) • Fallon Community Health Plan, Inc. • Harvard Pilgrim Health Care, Inc. • The Guardian Life Insurance Company of America • Health New England, Inc. • Massachusetts Association of Health Plans • Metropolitan Life Insurance Company • Minuteman Health Plan of Massachusetts, Inc. • Neighborhood Health Plan, Inc. • Tufts Associated Health Plan • United Health Care Insurance Company
Provider	• Massachusetts Hospital Association

entities	• Massachusetts Council of Community Hospitals • Massachusetts League of Community Health Centers • Partners Health Care • Steward Health Care
Business entities	• Associated Industries of Massachusetts • Boston Chamber of Commerce • Massachusetts Business Roundtable • Massachusetts Food Association • Massachusetts Municipal Association • Massachusetts Retailers Association
Agents & Brokers	• Borislow Insurance
Labor representatives	• Massachusetts Coalition of Taft-Hartley Trust Funds • SEIU 1199 United Health Care Workers East
Other	• Blue Cross Blue Shield Foundation of Massachusetts • Massachusetts Budget and Policy Center

Throughout the course of its initial public meetings, the Health Connector accepted written public comment regarding possible Section 1332 waiver content. The Health Connector received seven public comments during this pre-proposal phase, all of which were made publicly available on the Health Connector's dedicated Section 1332 webpage. Two of the comments were from health plan issuers, specifically supporting the Commonwealth's proposed waiver to retain the current timing of enrollment, renewal, and rating for small group plans. The remaining comments did not address the proposed waiver content, but instead suggested other possible waiver topics for the Commonwealth's future consideration. The Commonwealth continues to explore these remaining policy topics.

In addition to the aforementioned public meetings, the Health Connector engaged in a separate consultation with the sovereign federally-recognized tribes within Massachusetts borders. Together with MassHealth, the Health Connector engaged members of the agencies' joint Tribal Workgroup through a separate outreach effort, including a tribal consultation meeting on January 14, 2015. Tribal members did not express any comments or concerns regarding the proposed waiver.

The Health Connector also conducted specific outreach to other key stakeholders during this pre-proposal phase, including members of the Health Connector's Broker Advisory Committee and representatives from the General Court (legislature).

At the conclusion of this initial policy exploration, on February 2, 2016, the Health Connector announced its specific intention to apply for a Section 1332 waiver, and made the draft application available for public comment. The notice provided a description of the proposed waiver, a web link to access the draft application and instructions to obtain paper copies, information about the public comment period and process, information about public hearings, and information about how to request language or disability accommodations. The notice was disseminated through the Health Connector's dedicated distribution list and publicly available website, as well as through the State Register and a specific outreach message to tribal representatives. The draft application was made available through the Health Connector's distribution list and publicly available website for a public comment period of at least 30 days, from February 2, 2016 through March 4, 2016.

During the public comment period, the Health Connector accepted written public comments on a rolling basis and held two open public hearings in locations that ensured accessibility for members of the public from different regions of the state. The first was held February 5, 2016 in Boston, Massachusetts, and the second was held February 19, 2016 in Springfield, Massachusetts. These public meetings were held in locations accessible to residents with disabilities.

The Health Connector received the following public comments during the course of the formal comment period: *[This section will be added following the public comment period].*

5.0 Estimated Waiver Impact

5.1 Affected Population

The Commonwealth anticipates that the proposed waiver will directly impact only the small group portion of its merged market. This includes nearly 80,000 employers[63] and 473,811 enrollees in small group plans.[64]Based on available data, the Commonwealth expects that the small group portion of the merged market likely reflects similar demographics as the broader commercial market in Massachusetts as a whole (as detailed in **Table 1**). While race, income, and health status information are not available with granularity at this time, the age and gender of small group enrollees closely mirrors the broader commercial market population (**Table 5**).

Table 5. Age and Gender of Massachusetts Residents with Small Group Insurance (Snapshot as of Sept. 2015)[65]

	Gender		
	Female	Male	Total
Small Group	49%	51%	473,811
Total Commercial Insurance	51%	49%	4,162,231

	Age (In Years)						
	0 9	10 19	20 26	27 44	45 64	65+	Full Population
Small Group	10%	14%	11%	26%	37%	2%	473,811
Total Commercial Insurance	10%	13%	11%	26%	34%	5%	4,162,231

Source: CHIA, Enrollment Trends Jan. 2016

The Commonwealth does not expect the proposed waiver to impact large group (employers with over 50 employees) coverage. Since Massachusetts regulates the merged market and other insurance plans under a different set of laws and procedures, the Commonwealth would not expect any aspect of the proposed waiver to impact the large group market. Per the federal PACE Act of 2015, Massachusetts has elected not to expand its small group plans to include groups with up to 100 employees at this time, so there is no risk of larger employers being subject to small group rules.[66]

Similarly, the Commonwealth does not expect the proposed waiver to appreciably impact public coverage, such as Medicaid and the Children's Health Insurance Program. To the extent that the proposed waiver promotes the affordability and stability of small group coverage, as described in Section 5.3 below, the Commonwealth anticipates that the proposed waiver could potentially prevent small employers from shedding insurance for

their workers. While this could prevent these employees from seeking public coverage, it would not negatively impact the employees themselves, who would be expected to remain in the same employer-based insurance they have today. The Commonwealth does not anticipate any specific impact to coverage as a result of the proposed waiver for those already enrolled in public coverage programs.

Lastly, while non-group and small group plans are linked through the merged market structure, the Commonwealth does not anticipate any negative impact to the non-group market under the proposed waiver. Under the proposed waiver approach, the Commonwealth would continue to pool the insurance risk of non-group and small group members together on an annual basis. Non-group enrollees would continue to benefit from the broader risk pool of the merged market during calendar year rating, which improves affordability overall, and would continue to enroll and renew on a calendar year cycle without any disruption. Moreover, to the extent that the waiver keeps rates steady, as described in Section 5.3 below, the waiver could potentially maintain or improve affordability for individuals in the non-group market.

5.2 Comprehensiveness of Coverage

The Commonwealth expects that the proposed waiver would have no impact on the comprehensiveness of coverage otherwise available to its residents under the Affordable Care Act. Under the proposed waiver, small group enrollees and other enrollees in the merged market would continue to be guaranteed the Essential Health Benefits and applicable state-required benefits.

Under the Affordable Care Act, enrollees of non-grandfathered small group plans are assured benefits that meet both applicable state requirements and the federal Essential Health Benefits, as defined in Section 1302(b) of the Affordable Care Act and further specified in 45 C.F.R. § 156.100. This benchmark package includes items and services in ten categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

For plan year 2017, Massachusetts has selected the following base benchmark plan and supplemented the plan to meet the Essential Health Benefits requirements:

Plan Type	Small Group Market
Issuer Name	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Product Name	HMO Blue With Deductible
Plan Name	HMO Blue New England $2,000 Deductible
Supplemented Categories	Pediatric dental (CHIP); Pediatric vision (FEDVIP)

This plan also meets Massachusetts's own "Minimum Creditable Coverage" standards, the level of coverage adult residents must carry in Massachusetts to meet the state-specific individual mandate. Further details about Massachusetts' Essential Health Benefits benchmark and applicable state-required benefits are available at: www.cms.gov/cciio/resources/data-resources/ehb.html#Massachusetts.

Under the proposed waiver, enrollees of non-grandfathered small group plans would continue to be assured the same state-required benefits and Essential Health Benefits that would otherwise be required under the Affordable Care Act, including all ten categories of benefits. While the timing of a small group's plan year could impact the specific benchmark plan applicable to enrollees—for example, the specific month in 2018 during

which the 2017 Essential Health Benefits benchmark transitions to the 2018 Essential Health Benefits benchmark for a given group—this timing will not impact the ability of small group enrollees to access the same Essential Health Benefits to which they would otherwise be entitled within their plan year.

Regardless of the timing of the applicable plan year, all residents currently receiving the Essential Health Benefits would continue to do so for each year of the proposed waiver. As such, there would not be any impact on particularly vulnerable residents, such as low-income individuals, elderly individuals, or those with serious health issues or who have a greater risk of developing serious health issues.

5.3 Affordability of Coverage

The Commonwealth expects that the proposed waiver would have a positive impact on the affordability of coverage otherwise available to its residents under the Affordable Care Act. Independent actuarial analysis performed by Oliver Wyman indicates that the proposed waiver is likely to *decrease* out-of-pocket spending for health coverage and services by small group enrollees compared to the Affordable Care Act baseline, particularly for vulnerable enrollees with high health needs who are likely to incur more out-of-pocket spending overall. This analysis also found that there would be no measurable impact on affordability for other portions of the market.

Oliver Wyman performed two analyses to determine the affordability impact of a move to calendar year rating and enrollment for small group plans: (1) an analysis of the impact of applying cost-sharing to groups on a calendar year basis, particularly when this yields a plan year that is shorter than 12 months during the transition to a calendar year cycle; and (2) an analysis of the impact on premiums of setting rates once per year, rather than setting rates quarterly for groups that enroll throughout the year. (See **Appendix D** for details of both analyses, including methodology and assumptions). Both analyses demonstrated that the proposed waiver is likely to yield more favorable premiums and cost-sharing for small group enrollees than these enrollees would otherwise experience without a waiver.

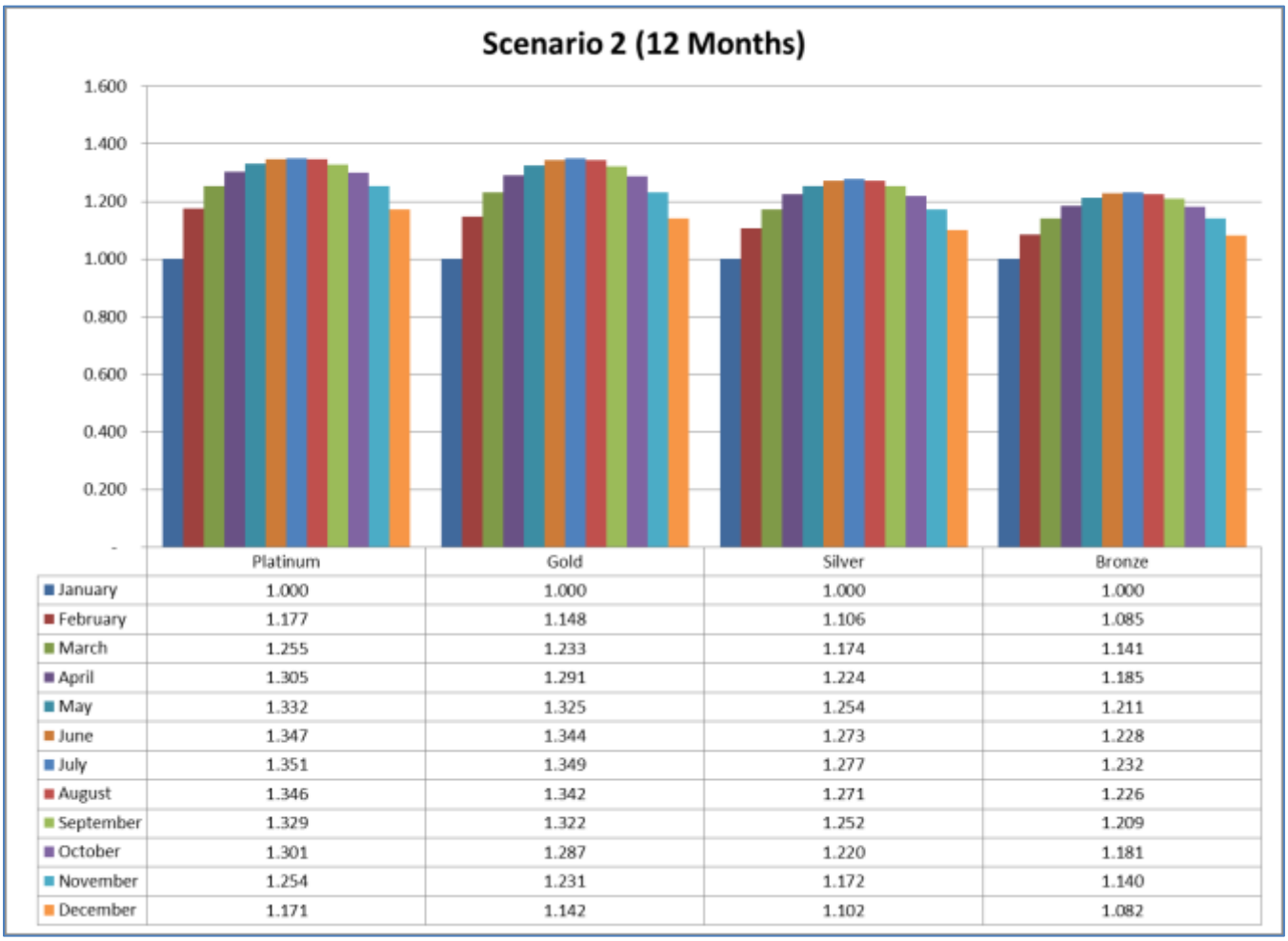
- Summary of Cost-sharing Analysis and Results

Oliver Wyman used Massachusetts claims and enrollment data from a proprietary database to model cost-sharing (including deductibles and out-of-pocket maximums) for four plan designs: bronze, silver, gold, and platinum. Member cost-sharing was then calculated under four scenarios, by effective month and metal level

- *Scenario 1*. Continuation of rolling enrollment; calculating cost-sharing for the 12 months following the 2017 enrollment date.
- *Scenario 2*. Rolling enrollment in 2017 with policy periods lasting only until December 31, 2017; calculating cost-sharing for the 12 months following the 2017 enrollment date.
- *Scenario 3*. Continuation of rolling enrollment; calculating member cost-sharing for the period from the 2017 enrollment date through December 31, 2108.
- *Scenario 4*. Rolling enrollment in 2017 with policy periods lasting only until December 31, 2017; calculating cost-sharing for the period from the 2017 enrollment date through December 31, 2018.

This analysis shows that over the 12 months following the enrollment date, enrollee cost-sharing under a shortened plan year scenario would exceed that of rolling enrollment on average by about 23 percent. Enrollees would experience this significant initial spike in cost-sharing because issuers would need to reset cost-sharing to the calendar year, rather than allowing cost-sharing features such as deductibles to accrue over a full year. This would result in much higher overall maximum out-of-pocket costs for consumers in late 2017 and early 2018.

Figure 6. Ratio of Average PMPM Cost-sharing In 12 Months Following 2017 Renewal – Transition to Calendar Year (Scenario 2) Over Continuing of Rolling Enrollment (Scenario 1)



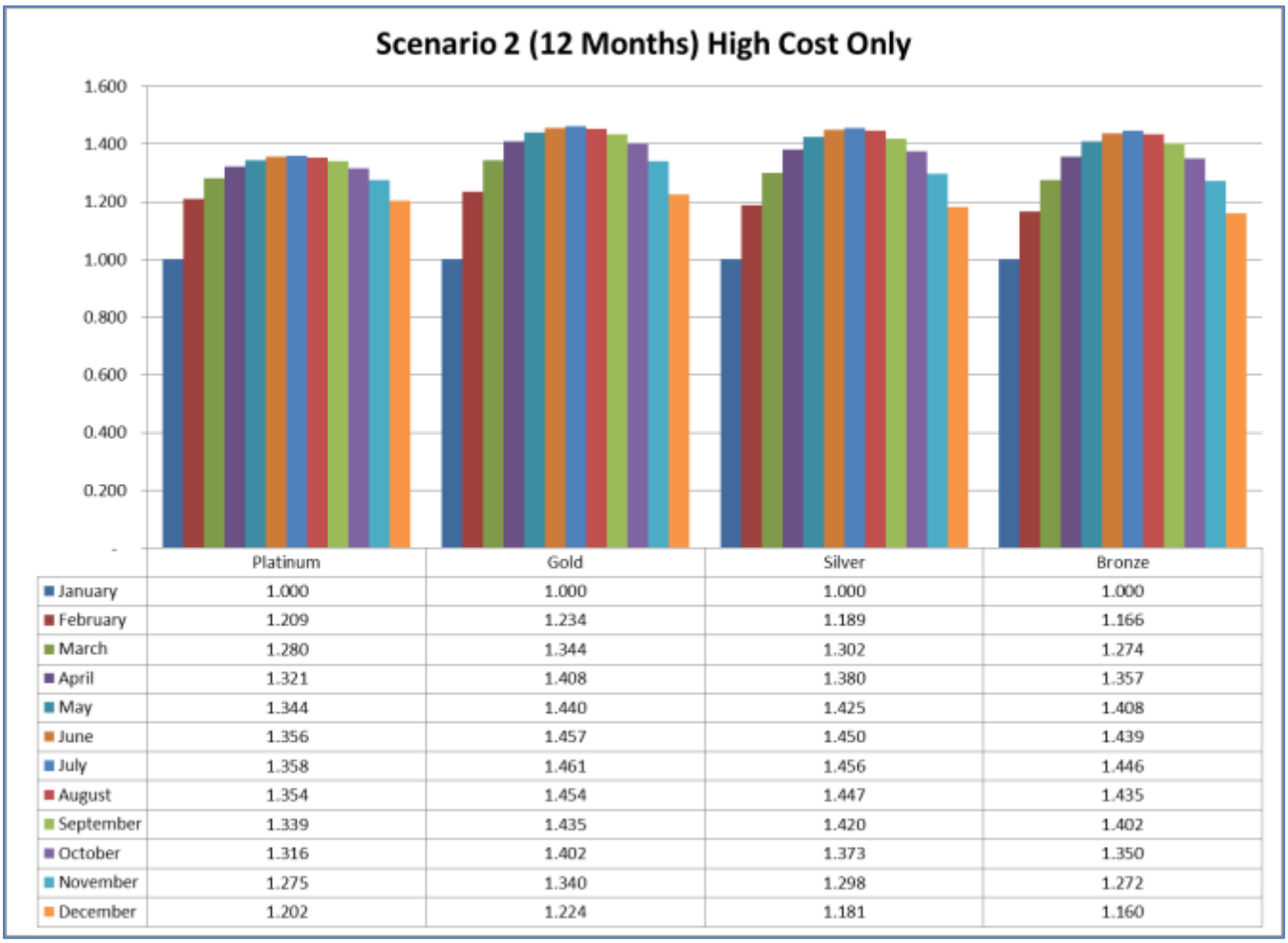
	Platinum	Gold	Silver	Bronze
January	1.000	1.000	1.000	1.000
February	1.177	1.148	1.106	1.085
March	1.255	1.233	1.174	1.141
April	1.305	1.291	1.224	1.185
May	1.332	1.325	1.254	1.211
June	1.347	1.344	1.273	1.228
July	1.351	1.349	1.277	1.232
August	1.346	1.342	1.271	1.226
September	1.329	1.322	1.252	1.209
October	1.301	1.287	1.220	1.181
November	1.254	1.231	1.172	1.140
December	1.171	1.142	1.102	1.082

Source: Oliver Wyman, 2016

Over time, cost-sharing would begin to stabilize; returning to just over baseline by the end of 2018—but the one-time spike could still cause significant shock to the small group market.

This impact would be particularly marked for enrollees with high health care needs who are likely to meet their deductibles or out-of-pocket maximums, such as older individuals or individuals with serious health conditions. Oliver Wyman analysis found that for small group enrollees with the highest claim costs (top 20 percent), the transition to a calendar-year plan could cause a one-time increase of up to 32% increase in cost-sharing in the twelve-month period following the 2017 renewal, versus continuing rolling enrollment.

Figure 7. Ratio of PMPM Cost-sharing for High-Cost Claimants In 12 Months Following 2017 Renewal - Transition to Calendar Year (Scenario 2) Over Continuing of Rolling Enrollment (Scenario 1)



	Platinum	Gold	Silver	Bronze
January	1.000	1.000	1.000	1.000
February	1.209	1.234	1.189	1.166
March	1.280	1.344	1.302	1.274
April	1.321	1.408	1.380	1.357
May	1.344	1.440	1.425	1.408
June	1.356	1.457	1.450	1.439
July	1.358	1.461	1.456	1.446
August	1.354	1.454	1.447	1.435
September	1.339	1.435	1.420	1.402
October	1.316	1.402	1.373	1.350
November	1.275	1.340	1.298	1.272
December	1.202	1.224	1.181	1.160

Source: Oliver Wyman, 2016

- Summary of Premium Analysis and Results

Oliver Wyman used rate filings submitted to the Massachusetts Division of Insurance to determine the experience periods used by issuers in rate development, and the resulting number of months of trend used by the issuers in setting rates for a given combination of filing date and effective date. Oliver Wyman then used distribution of enrollment by month (from rate filings) to determine the average number of months of trend assumed across all small groups using the current practice of quarterly rating with rolling enrollment, compared to the number of months of trend for calendar-year rating and enrollment. The trends from the rate filings were used to observe the variations in trends assumed by different issuers over the four quarterly filings in a given year, to estimate the impact of uncertainty related to additional months of trending in setting rates.

This analysis demonstrates that issuers use varying amounts of trend to fill in gaps in their experience when setting rates at different times of the year. Filings effective for January have the greatest number of months of trend, due to the earlier filing due date needed to finalize rates prior to the open enrollment period for individuals and other marketplace implementation needs. When issuers are permitted to refresh rates on a quarterly basis, however, they have the benefit of two more months of experience from which to draw, rather than relying on trend projections for those two months.

Table 6. Claim Trend by Issuer, 2015 Filings with the Division of Insurance

	Q1	Q2	Q3	Q4
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc	8.12%	8.28%	8.42%	8.18%
Blue Cross and Blue Shield of Massachusetts, Inc	8.12%	8.28%	8.42%	8.18%
BMCHP	8.33%	8.27%	8.22%	12.45%
CeltiCare Health Plan	n/a	n/a	n/a	n/a
Connecticare of Massachusetts, Inc.	10.42%	10.20%	10.21%	10.08%
Fallon Community Health Plan (FCHP)	6.90%	4.70%	7.60%	8.28%
Fallon Community Health Plan (FHLAC)	6.90%	4.70%	7.60%	8.28%
Harvard Pilgrim Health Care, Inc.	7.09%	7.18%	7.11%	7.67%
HPHC Insurance Company, Inc.	7.09%	7.18%	7.11%	7.67%
HNE	6.26%	6.26%	6.26%	6.26%
Minuteman Health, Inc.	0.00%	0.00%	0.00%	0.00%
Neighborhood Health Plan	-1.46%	-0.92%	-0.06%	0.42%
Tufts Associated Health Maintenance Organization	7.34%	7.44%	6.87%	6.81%
Tufts Insurance Company	9.52%	9.72%	7.76%	8.75%
Tufts Public Health Plans	9.86%	10.55%	11.51%	9.39%
United Healthcare	5.20%	6.19%	6.51%	6.51%

Source: Oliver Wyman, 2016

Issuers include a risk charge or contribution to surplus in rates for uncertainty in trending. Because of the substitution of additional risk charge for two months of experience data that would be associated with rate filings without the proposed waiver, issuers' average risk charge would likely be higher if all groups were to renew in January rather than throughout the year on a quarterly basis. A rough estimate of this risk charge indicates that issuers may add up to 1 percent to their rates if all groups renew in January.

This impact would be most apparent to small groups with employees who are older or have high health needs. Since older individuals are charged higher premiums than non-elderly, the dollar impact of increased premiums under calendar year rating would be greater for older individuals. To the extent those with serious health issues select richer benefit plans, they too would see greater dollar premium increase due to the higher premium of richer benefit plans. Such selection might occur if the employer is aware of health issues within the group or if more than one plan is offered to employees.

5.4 Scope of Coverage

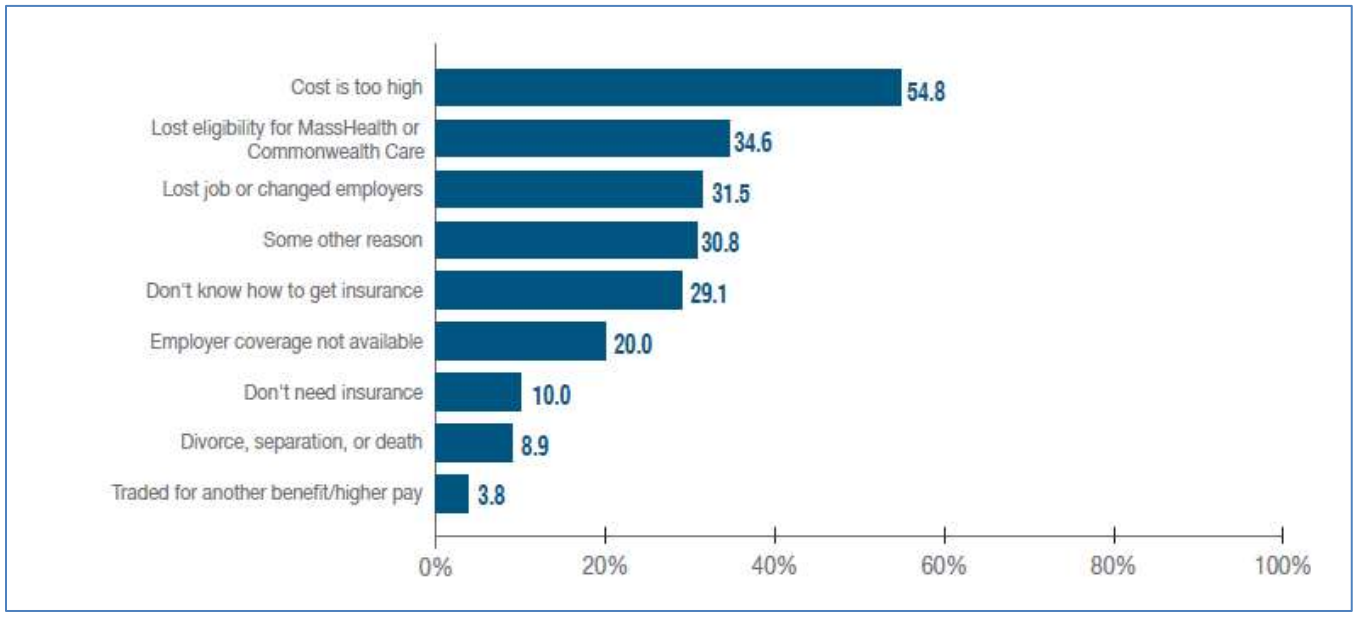
The Commonwealth expects that the proposed waiver would have a positive impact on the number of covered residents, compared to the scope of those covered under the Affordable Care Act without a waiver. Because benefits would remain constant and affordability is likely to improve under the proposed waiver, the Commonwealth anticipates that the number of employers offering coverage and the number of employees choosing to take up coverage would remain at least equivalent under the waiver (after adjusting for other variables, such as rising health care costs overall).

According to a 2014 survey of employers in Massachusetts, cost is a key factor in employer decisions about whether to offer insurance and what level of coverage to offer. When small employers that offer insurance were

surveyed about their decision-making, 33.6 percent of employers with under 10 employees cited cost as a key decision factor, and 39.4 percent of employers with between 11 and 50 employees cited cost as a key decision factor.[67] Among employers of all sizes that choose not to offer insurance to their workers, 89% cited high premiums as a critical factor for this decision.[68] Given this price-sensitivity among employers, the Commonwealth expects that any ability to maintain stability of premium rates under the proposed waiver, even if only to prevent additional increases, would promote stability in the number of small employers offering insurance.

Survey data indicates that Massachusetts' residents are equally sensitive to price in their decisions to take up insurance. Among residents without insurance in 2015, 54.8 percent of those surveyed indicated that the cost of insurance was too high.[69] Given this data, the Commonwealth expects that more stable cost-sharing under the proposed waiver will also enable more employees to take up or remain in their employer-based plans, rather than face a gap in coverage during the transition to calendar-year plans. Again, the Commonwealth expects that the stabilizing effect of the proposed waiver would be particularly important to lower-income individuals and other vulnerable populations, who are most likely to be sensitive to changes in health care costs.

Figure 8. Reported Reasons for Being Uninsured in Massachusetts in 2015



Source: CHIA, 2015 Massachusetts Health Insurance Survey

5.5 Access to Care Out-of-State

The Commonwealth does not expect any impact from the proposed waiver on Massachusetts' residents' ability to access coverage or care out of state. Nothing in the proposed waiver will impact provider networks or other aspects of out-of-state care.

5.6 Administrative Burden

Massachusetts does not anticipate any increase in administrative burden as a result of the proposed waiver. Rather, the proposed waiver is likely to decrease administrative burden because it will spare the Commonwealth, health plan issuers, agents and brokers, small employers, and small employees from

transitioning to a calendar-year business cycle for small groups. Aside from the evaluation and reporting requirements associated with the waiver itself, there will be no new reporting, record-keeping, or other administrative requirements associated with the waiver proposal.

- Health plan issuers and producers

The proposed waiver will save health plan issuers and related insurance professionals, such as agents and brokers, the significant burden of transitioning their enrollees or clients to a calendar year cycle. Under the proposed waiver, there will be no need for issuers or brokers to educate their small groups about the impact of a short plan year on accrued benefits, update and re-issue member material during the middle of a plan year, or conduct special outreach to groups that fail to renew timely due to confusion.

The proposed waiver will also help issuers and brokers spread resources appropriately throughout the year, rather than condensing all activity related to the merged market into one brief timeframe associated with open enrollment. As a result, issuers and brokers will be less likely to need to hire temporary workers, pay over-time, or take other costly measures to keep up the demands of re-rating, renewing, and enrolling the entire merged market during a single time period.

- Small employers and their employees

The proposed waiver will also decrease administrative burdens on small employers and their employees. Under the proposed waiver, small employers can continue to renew their plans at the time of the year that corresponds to their industry-specific business needs, such as a given fiscal year calendar. Small employers will not need to renew, shop or engage in other plan sponsor duties during the middle of their previous plan year, and will not need to educate their workers about calendar-year changes. Small employers who need one-on-one assistance will not need to "compete" for attention from issuers or brokers with the non-group portion of the market during open enrollment, a time when issuers and brokers are likely to have less customer service bandwidth.

Similarly, the proposed waiver will spare employees the hassle of making insurance decisions, such as choosing a new plan, more than once in a given year. The proposed waiver will also ensure that employees do not need to learn about new rules related to their cost-sharing as a result of a shortened plan year.

- Other consumers

While other Massachusetts residents would not be directly impacted, the waiver proposal could potentially avert market confusion and congestion that could indirectly cause administrative burden for consumers. Without a waiver, consumers could be confused by educational materials related to the small group transition, and believe that their insurance is changing.

- Commonwealth of Massachusetts

The proposed waiver would not add new administrative burdens or workload to Commonwealth agencies involved in regulating and administering health insurance, such as the Health Connector and the DOI. Because the proposed waiver seeks to retain the status quo, agencies would not need to make any changes to implement the waiver. Further, agencies would not need to issue regulatory guidance to assist in transitioning to market, as it would without a waiver.

- Federal agencies

The proposed waiver would not create any new administrative burdens or costs to the federal government. Federal agencies would not need to make any new changes to Uniform Rate Review or federal processes or submissions to accommodate the proposed waiver.

5.7 Waste, Fraud, and Abuse

Massachusetts does not expect any impact on waste, fraud, and abuse as a result of the proposed waiver. Because the waiver proposes to preserve current market conditions, currently operating programs will continue to detect and prevent waste, fraud, and abuse in the merged market. For example:

- Health Connector

The Health Connector engages in a robust and continuous program integrity and oversight process that extends to all its business areas, including its interactions with small group issuers through the SHOP. Per 45 C.F.R. §155.1200, the Health Connector engages an independent auditing entity which follows generally-accepted governmental auditing standards to perform an annual independent external programmatic audit. The Health Connector provides the results of this audit to HHS and publishes a public summary of the results. Similarly, the Health Connector engages an independent entity to provide a standard and "A-133" financial audit.

- Division of Insurance

DOI's Financial Surveillance department plays a vital role in monitoring the solvency of health plan issuers chartered in Massachusetts. DOI's staff financial examiners and external consultants conduct statutorily required on-site audits of issuers with domestic licenses, ensuring their financial solvency and ability to continue to meet reserve requirements and pay claims.

DOI's Consumer Service department responds to inquiries and intervenes on behalf of consumers to resolve complaints against health plan issuers and other licensees. Consumer Service provides consumers with general insurance information and intervenes on behalf of consumers to resolve complaints, including consumer complaints involving fraud and abuse.

- Office of the Attorney General

The Attorney General's Consumer Protection Division uses investigation and enforcement actions to protect consumers from fraud, deception, and other unfair business practices. The Attorney General's Health Care Division enforces health care laws to protect the rights of Massachusetts' consumers and to halt unfair or deceptive practices that may harm consumers. The Health Care Division also operates a health care hotline to help consumers understand their health care rights and to mediate consumer disputes with health care payers and providers.

In addition to these government resources, the Commonwealth expects to continue to rely on issuers and their internal systems to monitor and curb waste, fraud, and abuse under the proposed waiver.

6.0 Waiver Deficit Impact

6.1 Assurance of Deficit Neutrality

The Commonwealth does not anticipate any increase in the federal deficit as a result of the proposed waiver. Massachusetts' proposal will not require additional spending from the federal government because it preserves status quo conditions in Massachusetts' health insurance market, using a policy approach that is permitted without federal approval or appropriations for other states. The waiver proposal:

- Will not require any new investments, infrastructure, or administrative processes

The proposal will not require new resources from the federal government. If approved, Massachusetts regulatory entities, insurers, and small group administrators and members are ready to implement the waiver immediately, without additional support.

- Will not appreciably impact other deficit variables, such as changes in revenue

Any possible indirect impacts would be negligible and well within the federal government's existing estimates, since the waiver proposal is aligned with a policy option permitted for other states and its economic impacts will balance to neutrality.

6.2 Discussion of Deficit Neutrality Assessment

The Commonwealth reached the conclusion that the proposed waiver would be deficit neutral after analyzing possible direct and indirect impacts to the federal budget and deficit. The Commonwealth's deficit analysis included the following steps:

- A Landscape Scan Revealed Few Budget Items for Further Analysis

The Commonwealth reviewed available descriptions of the federal budget and deficit to catalogue any possible line items that could be impacted by its waiver proposal, including outlays and revenue estimates from: (1) the President's Fiscal Year 2016 Budget, as originally proposed and later amended in the Mid-Session Review by the Office of Management and Budget (OMB); and (2) Congressional Budget Office (CBO) publications related to the budget and deficit impact of the Affordable Care Act.[70] In the course of this landscape analysis, the Commonwealth first identified the budget items most likely to be impacted by the terms of any Section 1332 waiver – as detailed in **Appendix E** – and then systemically reviewed each item for any interaction with the specific waiver proposal under consideration.

Most of the direct outlays and revenue sources identified in the landscape analysis were irrelevant to the topic of the Commonwealth's waiver. Massachusetts seeks only to impact rating and enrollment practices for the small group portion of the broader merged market. This limited proposal does not directly impact federal outlays, such as financial subsidies through the state-based marketplace or Medicaid/CHIP expenditures (except to the extent that it may keep premiums and subsidies in the merged market lower than they otherwise would be), and it does not directly impact federal revenue sources, such as the shared responsibility penalties applicable to individuals and employers. Further, the proposed waiver would not increase federal administrative expenses because federal agencies are already well-equipped to handle quarterly rating and enrollment for other states— for example, the Uniform Rate Review process already accommodates quarterly rating for states with a single risk pool for the small group market.

In an abundance of caution, the Commonwealth engaged in deeper analysis of two items: direct federal outlays related to the small business tax credit, and indirect revenue impact due to economic decision-making.

- Analysis of Specific Budget Items Did Not Indicate Deficit Impacts

Because Massachusetts' proposed waiver impacts the small group portion of its merged market, the Commonwealth carefully considered whether the waiver could impact federal outlays through changes in take-up of the small business health care tax credit.

At the outset, it is unlikely that Massachusetts' employers would respond to the proposed waiver through increased utilization of the small business health care tax credit. A report by the Government Accountability Office (GAO) found two key factors in small employers' decision-making around the health care tax credit: the amount of the credit, and the perceived complexity of the tax credit process.[71] Neither factor would be impacted by the terms of the proposed waiver.

In the unlikely event that Massachusetts' proposal to maintain the timing of rating and enrollment yielded changes in employer take-up of the small business health care tax credit, any changes would be negligible for three reasons:

First, CBO forecasts static utilization of the small business health care tax credit for the next decade nationwide—estimating that the program will require one billion dollars for each of the next ten years, regardless of other significant shifts in the domain of employer-based coverage.[72] This indicates that the program is not expected to be sensitive to changes in premium or other known variables, such as the decisions of states with single small group risk pools to permit quarterly rating updates.

Second, the small business health care tax credit has a cushion to account for minor changes in take-up. In 2014, the Internal Revenue Service reported 171,000 tax returns claiming the tax credit, in the amount of $502,900,000.[73] This amount is well within the billion-dollar amount estimated for the program by the CBO in 2016 and beyond, allowing room within the current parameters of the program for expansion. Moreover, the President's Fiscal Year 2016 and Mid-Session Review for Fiscal Year 2016 provide for a significant expansion of the program from 2016 through 2025. If these additional investments are appropriated, the cushion for additional take-up within the small business health care tax program would grow still larger.

Third, because Massachusetts administers its own state-based SHOP and has a history of innovation in the small group market, the Commonwealth can nimbly respond to any unexpected changes in take-up through state-specific policy levers. Massachusetts has a demonstrated commitment to flexible policies that respond to emerging needs for small group plans and their sponsors. For example, in 2011, the Commonwealth responded to affordability concerns among small employers by introducing a state-funded rebate for small group wellness programs, the Wellness Track.[74] Given this history of innovation, Massachusetts could be prepared to respond to any emerging market trends.

- Analysis of Broader Economic Behavior Did Not Indicate Deficit Impacts

In addition to assessing any possible impact on specific budget items, the Commonwealth considered any broader shifts in employer or employee behavior that could occur as a result of the proposed waiver, and any subsequent impacts on federal spending or revenue.

This analysis focused on potential changes to premiums for small employers under the proposed waiver, the likely impact of these rate changes on employers' decisions to offer coverage to their employees, and the possible impact of employers' decision-making on the federal deficit.

Small employers can react to changes in their health insurance premiums in a number of ways. Because there is no legal mandate to offer insurance to their employees, small employers can decide to limit or withdraw their offer of insurance or limit their share of contributions toward insurance. However, studies suggest that employers are more likely to respond by lowering wages, rather than limiting their offers of health coverage.[75] This economic principle is supported by Massachusetts' experience – despite increases in premiums in recent years, Massachusetts' small employers have maintained relatively constant rates of insurance offers for their employees.[76]

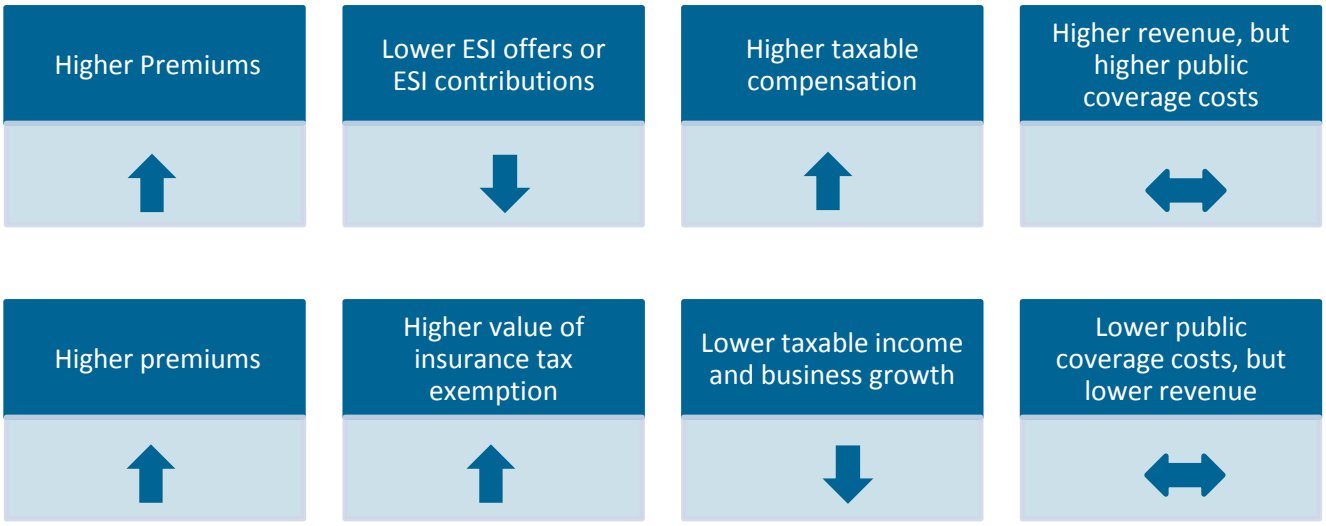
In 2012, Massachusetts-based economists studied the relationship between health insurance premiums and employer compensation behavior in Massachusetts' labor market. Using the Gruber Microsimulation Model (GMSIM), the study estimated the effects of possible increases in health insurance premiums on Massachusetts' employers and employees. The study estimated that a decrease in health insurance premiums by even a single percentage point could result in significant savings to employers that could be reinvested in compensation and other economic benefits: over a period of 2011-2019, employers would save $10 billion on their health spending, preserve $7.8 billion in employee take-home pay, and preserve $1 billion for workforce investments and business profit.[77] This study demonstrates the significant economic importance of the waiver proposal to Massachusetts' economy – the ability to maintain stable rates for small insurers could yield billions in savings for Massachusetts over the course of the waiver period.

While the waiver proposal could yield significant benefits for the local Massachusetts economy, the Commonwealth does not expect the waiver to impact the federal deficit because of the balancing interplay of different budgetary factors.

Changes in the extent of employer-based coverage can potentially affect federal revenue because most payments toward that coverage are exempt from income and payroll tax. If employers increase or decrease the amount of nontaxable compensation they provide in the form of health insurance, they are likely to hold total compensation steady by offsetting these changes in wages or other forms of taxable compensation, which can increase or decrease federal revenue.[78] However, the Congressional Budget Office (CBO) has also recognized that decisions about employer-based coverage have multi-faceted effects on the deficit that tend to converge at neutrality.[79] In addition to revenue from taxable compensation, decisions about employer-based coverage also impact the value of the tax exclusion for employees and employers, take-up of public coverage such as Medicaid and subsidies available through the exchange marketplaces, and economic growth overall.

Given these balancing factors, CBO has concluded that even substantial changes to employer-based coverage have "limited effects on the budgetary impact" because changes in the availability and take-up of such insurance affect the federal budget in several ways that are offsetting.[80] **Figure 9** includes two possible employer responses to changes in premiums, and illustrates the balancing factors that tend toward deficit neutrality.

Figure 9. Possible Employer Responses to Higher Premiums Balance to Neutrality



7.0 Expected Evaluation and Reporting

If the proposed waiver is approved, Massachusetts will hold public fora six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the Commonwealth Health Connector Authority and Division of Insurance websites and also be shared with known interested stakeholders, such as tribal representatives, health insurance issuers participating in the merged market, business associations, and consumer representatives. As with previous public meetings in the waiver process, these meetings will afford equal access to those with limited English proficiency or disabilities.

While the Commonwealth is open to providing quarterly reports to the Secretary, the proposed limited waiver does not seem to warrant such scrutiny. In the interest of administrative simplification, Massachusetts respectfully proposes to report upon the completion of the first six months of the waiver and annually thereafter, following the public forum. The Commonwealth will, of course, cooperate fully with any independent evaluation conducted by the Secretary or the Secretary of the Treasury.

In its reports, which will be made publicly available, Massachusetts proposes to include:

- Evidence of compliance with public forum requirements, including date, time, place, description of attendees, the substance of public comment, and the Commonwealth's response, if any;
- Information about any challenges the Commonwealth may face in implementing and sustaining the waiver program and its plan to address the challenges;
- A description of any substantive changes in Massachusetts' insurance landscape applicable to the terms of the waiver, such as trends in the costs of small group insurance and enrollment trends in the merged market; and
- Any other information applicable to the terms and conditions in the State's approved waiver.

8.0 State Contact Information

The Commonwealth wishes to acknowledge the array of partner agencies contributing to this application. Special thanks are due to partners at the Division of Insurance, Executive Office for Administration and Finance, and Executive Office of Health and Human Services, and the Center for Health Information and Analysis. Inquiries regarding Section 1332 or this application can be directed to the Health Connector, with support from its partner DOI, as follows.

Waiver Application	Audrey Morse Gasteier (lead contact) Director of Policy & Outreach Commonwealth Health Insurance Connector Authority 617-388-5832 audrey.gasteier@state.ma.us Emily Brice (lead contact) Senior Advisor on State Innovation Waivers Commonwealth Health Insurance Connector Authority 617-933-3156 emily.brice@state.ma.us Kevin Beagan Deputy Commissioner, Health Care Access Bureau Massachusetts Division of Insurance 617-521-7323 kevin.beagan@MassMail.State.MA.US Niels Puetthoff Senior Health Research Analyst Massachusetts Division of Insurance 617-521-7326 Niels.puetthoff@state.ma.us
Permanent Contact	Commonwealth Health Insurance Connector Authority 100 City Hall Plaza Boston, MA 02108 617-933-3030 StateInnovations@state.ma.us

9.0 Appendixes

Appendix A: Frequently Used Abbreviations

ACA	Patient Protection and Affordable Care Act of 2010
CBO	Congressional Budget Office
CCA or the Connector	Commonwealth Health Insurance Connector Authority
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DOI	Massachusetts Office of Consumer Affairs and Business Regulation, Division of Insurance
FPL	Federal Poverty Level
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
JCT	Joint Committee on Taxation
OMB	Office of Management and Budget
Secretary	Secretary of the Department of Health and Human Services

Appendix B: Text of State Enabling Legislation

Ch. 119, Sec. 20 of the Acts of 2015 (HB 3829) authorizes the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.

Under the language therein, the Connector has authority "to make applications to the United States Secretary of Health and Human Services to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time, as provided for by 42 U.S.C. § 18052, and to implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the United States Secretary of Health and Human Services pursuant to said 42 U.S.C. § 18052."

Appendix C: Public Notice and Comment Materials

[This section will be added following the public comment period].

Appendix D: Actuarial Analysis and Certification

[Attached].

Appendix E: Deficit Neutrality Worksheet

[Attached].

[1] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

[2] Center for Health Information and Analysis. (2014, Oct.) *2014 Massachusetts Employer Health Insurance Survey (chartbook).* Retrieved from www.chiamass.gov/massachusetts-employer-health-insurance-survey. *Citing* Kaiser Family Foundation and Health Research and Educational Trust. (2014). *Survey of Employer Sponsored Benefits*. Retrieved from: http://kff.org/health-costs/report/2014-employer-health-benefits-survey/.

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[12] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

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[14] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

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January 14, 2016

Proposed Exchange Standardized Benefit Designs Expand First-Dollar Coverage for Services and Drugs

As the government considers rules for 2017 insurance plans offered through exchanges, a new analysis by Avalere finds that proposed 2017 benefit designs could increase coverage of certain services and drugs, while lowering out-of-pocket costs for many consumers. Specifically, in recently issued regulations, the federal government proposes establishing "standardized" benefit designs wherein all cost-sharing features (i.e. deductibles, out-of-pocket limits, etc.) are the same for plans within a metal level. While these benefit designs would be optional for plans, the government is strongly encouraging plans to sell at least one standard silver plan.

Importantly, unlike how most plans on HealthCare.gov currently elect to structure their benefits, these new, optional plan designs would provide first-dollar coverage for physician visits, and all tiers of prescription drugs in silver and gold plans. First-dollar coverage means that consumers pay cost sharing for services (i.e. copayment, coinsurance) immediately, rather than having to pay the full cost of care until meeting their deductible. While first-dollar coverage reduces overall consumer cost sharing, it may also result in higher utilization and thereby increase premiums. Health plans have largely opposed standardized benefits, which can limit consumer choice, reduce geographic variation, and constrain plans' ability to evolve benefit designs over time in response to consumer preferences.

"Standardized benefit designs might increase access to care for certain services and drugs by providing first-dollar coverage," said Caroline Pearson, senior vice president at Avalere. "In particular, first-dollar coverage may be appealing to some healthier consumers who are paying a monthly premium but never meet their deductible and therefore are not seeing the value of their insurance."

For plans sold on HealthCare.gov, silver-level exchange plans, which are the highest-enrollment plans, have routinely featured high deductibles, averaging $2,889 in 2016 (Figure 1). This means many consumers must first spend close to $3,000, in addition to their premiums, before their plan starts to share in the cost of their care. While most plans (34 percent) in 2016 cover primary care visits without requiring consumers to fulfill their deductible, specialist visits and prescription drugs typically do apply to the deductible (Figure 2). As shown below, 64 percent of silver plans cover specialist visits only after the deductible is met, and 74 percent of plans similarly subject specialty drugs to the deductible.

Notably, many state-based exchanges (CA, CT, DC, DE, MA, NY, OR, and VT) already use standardized plan designs for some or all products sold in 2016. For instance, California's plans exempt physician visits from the deductible and apply non-generic drugs to a separate, low drug deductible.

"Introducing standardized benefit designs into the federal exchange builds on the existing approach of many states," said Elizabeth Carpenter, vice president at Avalere. "While standard benefits limit flexibility for plans and could increase costs, the structure may appeal to some consumers by making it easier to compare plans and choose insurance."

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January 14, 2016

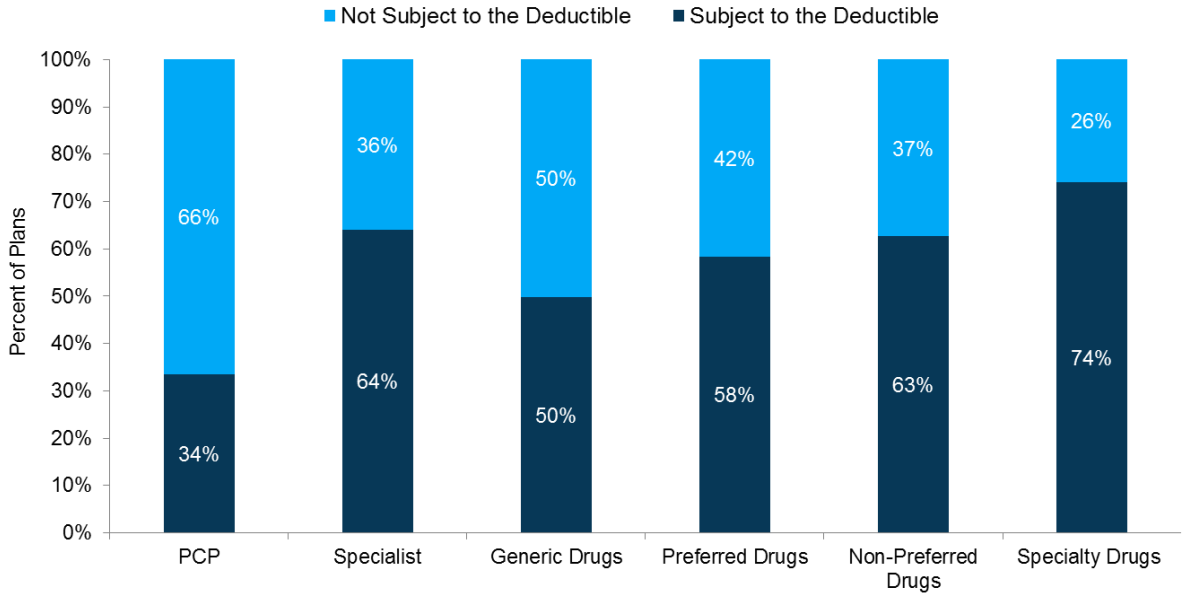
The federal government is currently working to finalize rules for the 2017 plan year, with comments on the annual Letter to Issuers due on Sunday, January 17.

Figure 1. Comparison of Average HealthCare.gov Cost-Sharing Levels (2016) to Proposed Standardized Silver Cost-Sharing (2017)[1]

	Deductible	MOOP	Primary Care Visit	Specialist Visit	Prescription Drugs			
					Generic Drugs	Preferred Drugs	Non-Preferred Drugs	Specialty Drugs
HC.gov Average (2016)	$2,889	$6,172	$27	$59	$10.60	$43.58	$73.62	31%
Proposed Silver Standard Design (2017)	$3,500	$7,150	$30 (*)	$65 (*)	$10 (*)	$50 (*)	$100 (*)	40% (*)

(*) indicates exemption from deductible
HC.gov: HealthCare.gov; MOOP: Maximum Out-of-Pocket Limit; ER: Emergency Room

Figure 2. Applicability of Benefit Categories to the Deductible in Silver Plans, 2016[2]



1 HealthCare.gov averages based on unique benefit designs included in the Individual Landscape file released October 2015.
2 HealthCare.gov plans only. Centers for Medicare & Medicaid Services. Health Insurance Marketplace Public Use Files (Marketplace PUF). November 2015. https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html.

January 14, 2016

Methodology

Data in this analysis is based on the benefit designs for 2016 exchange plans sold on HealthCare.gov, the Individual Landscape file released October 2015, and the Public Use Files released November 2015. To compare the "HC.gov Average" to the standardized benefit designs, Avalere took the average of the cost sharing for unique benefit designs by state. Cost sharing may be copayments in some plans and coinsurance in other plans. Data displayed in this release reflects the cost-sharing method (copay or coinsurance) proposed for the 2017 standard plan. For example, if the 2017 FFM standard silver benefit design includes copayments for preferred brand drugs, Avalere calculated the average of those silver plans that implemented copayments for their preferred band drugs. In all cases, the implementation of coinsurance or copays by the proposed 2017 standardized silver benefit design was the same as the majority of plans in the FFM.

The proposed 2017 standardized silver benefit design was proposed in the HHS Notice of Benefit and Payment Parameters for 2017 proposed rule. This rule has yet to be finalized and HHS has accepted comments on the proposals.

An important caveat to the analysis is that it ignores the cost of the premiums. As this proposal has not been finalized and no plans have submitted rates for these benefits designs, it is impossible to know whether the premiums for a standardized silver plan will be higher or lower than the market average, which would factor into the estimates of savings for the consumer.

###

Avalere Health is a strategic advisory company whose core purpose is to create innovative solutions to complex healthcare problems. Based in Washington, D.C., the firm delivers actionable insights, business intelligence tools and custom analytics for leaders in healthcare business and policy. Avalere's experts span 230 staff drawn from Fortune 500 healthcare companies, the federal government (e.g., CMS, OMB, CBO and the Congress), top consultancies and nonprofits. The firm offers deep substance on the full range of healthcare business issues affecting the Fortune 500 healthcare companies. Avalere's focus on strategy is supported by a rigorous, in-house analytic research group that uses public and private data to generate quantitative insight. Through events, publications and interactive programs, Avalere insights are accessible to a broad range of customers. For more information, visit avalere.com, or follow us on Twitter @avalerehealth.

CIN Partners Share:

Marketing Makeover: Patient and Member Engagement Post-ACA

Main Takeaway:
For success, there has to be good patient experience and quality to support any marketing. You can't promote what you don't have.

The Affordable Care Act (ACA) has changed the landscape of health care marketing in California. This is true for providers and health plans on both the commercial and the safety-net sides of the delivery system. Safety-net providers are focused on patient retention, as most patients now have more choice about where to go for care than before the ACA. For commercial groups and health plans, the large numbers of new Medi-Cal beneficiaries is changing the messages and the goals of their marketing efforts.

In the November 2015 meeting of the California Improvement Network, partner organizations discussed the science of marketing in this business environment. Presentations were provided by OLE Health, Monarch HealthCare, and Kaiser Permanente.

OLE Health www.olehealth.org

OLE Health is the only Federally Qualified Health Center in Napa County. OLE serves 25,000–35,000 patients a year with its 220 employees at seven sites. OLE's patients are approximately 60% Latino and 40% white.

Rebranding the Health Center

When Tanir Ami started as CEO of what was then Clinic Ole in 2010, she launched immediately into brand and marketing work. Based on research conducted by the California Primary Care Association (CPCA) that found that patients react negatively to the term "clinic," Ami set out to remove the word from her organization's name. Her board and staff, however, disagreed; they were wedded to the organization's name and logo and the history they represented.

With implementation of the Affordable Care Act, OLE Health, like so many other health care organizations, saw the growth in the number of insured patients and a new ability for Medi-Cal recipients to choose providers. OLE Health took this opportunity to renew its image. During this process, OLE Health's leaders and staff members came to a shared understanding that "the name is not that important; it's about what you have to offer." Rather than lead with a name change, the organization decided to first define its core values and services.

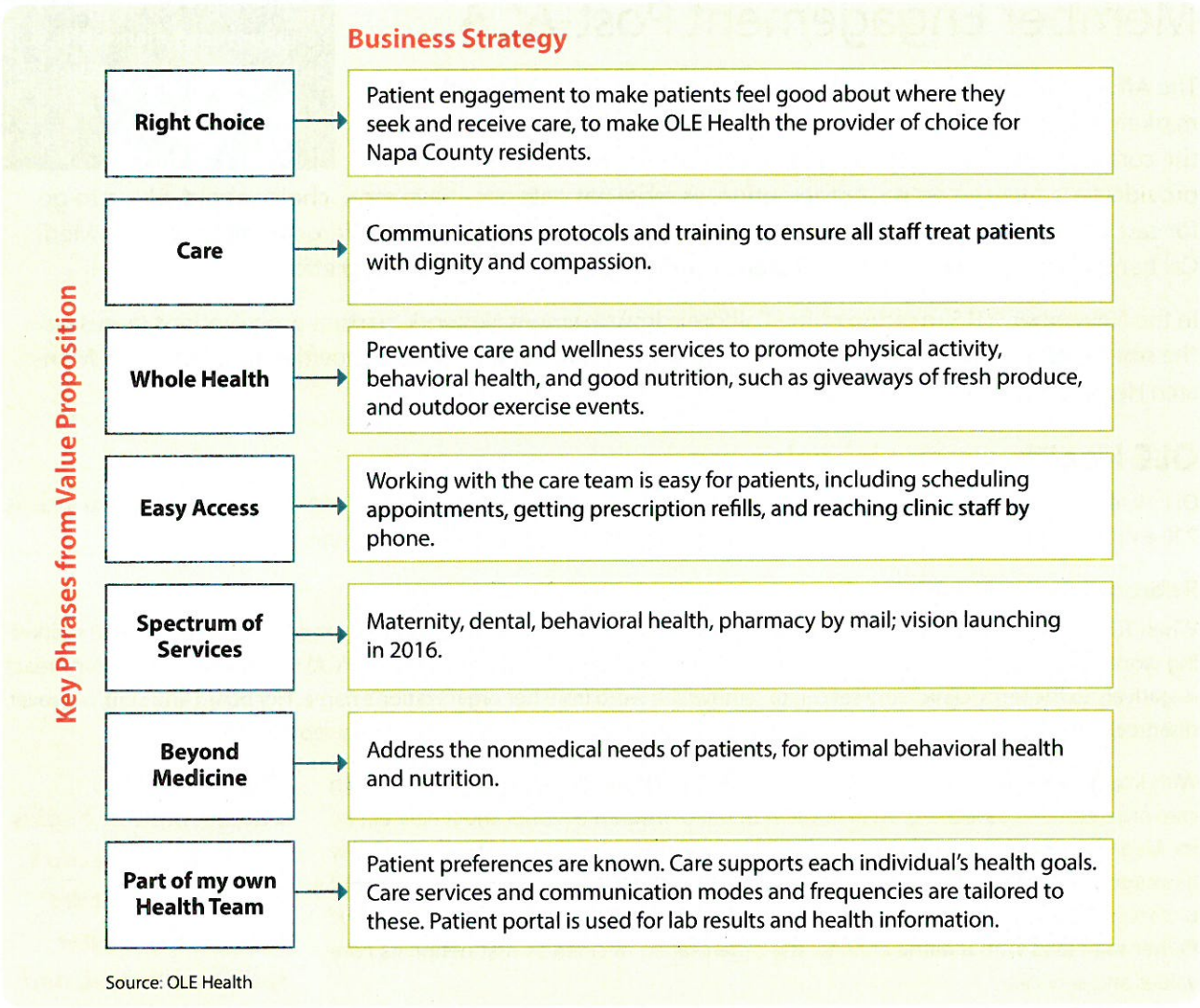
"Organizational transformation begins internally — we can't help our consumers believe that we are special, different, and valuable unless we believe it ourselves."
Tanir Ami, OLE Health

Staff and marketing consultants spent a year and a half conducting focus groups, staff discussions, and an internal communications campaign about the value they provide their patients, such as bilingual care providers, nutrition support, behavioral health services, help with benefits, and social service referrals. The result was the organization's "brand value proposition," which Ami defined simply as "what you want the patients to be thinking when they walk in our door."

The OLE Health Brand Value Proposition

*"As a patient at OLE Health, I feel like I've made the **right choice** because they **care** about my **whole health** and make it **easy to access** an impressive **spectrum of services** that go **beyond medicine**. They make me **part of my own health team**."*

The organization aligned its new value proposition and brand to its business strategy. OLE Health's approach to alignment included its seven major business strategies, which were identified directly from the brand value proposition.



Source: OLE Health

To maintain momentum and focus after the branding exercise, all executive team meetings are now starting with the OLE brand value proposition, no matter the meeting topic, because "all decisions need to flow from the value proposition." OLE leadership also initiated a new communication tool: "Monday Morning Minutes" are 60-second videos emailed from the CEO to all staff. These quick reports promote the organization's quality agenda and report on improvement efforts.

In August, OLE Health held an all-staff celebration to launch the organization's new name, new logo, new website, and even new work attire — scrubs and polo shirts with colors and fabrics chosen by staff.

Next Steps

OLE Health will continue to refine and execute its business strategies to ensure that the organization is delivering on the promise of the brand. This is the most difficult part — to deliver a high-quality experience to patients every time they interact with the system. The organization also wants to increase its direct communication and engagement with patients and elicit more frequent feedback.

There are many ways OLE Health is communicating with patients directly to improve patient engagement:

- Newsletters from each patient's personal clinician
- Appointment reminder texts
- Improved patient portal (increased functionality, more health information available)
- Interactive website
- Active social media outlets
- Communications protocols for staff in their interactions with patients, developed with staff to support brand
- Patient Advisory Committee, currently in action and being developed further, group membership continuing to grow through referrals from primary care teams
- Instant feedback surveys

In forums such as its Patient Advisory Committee, OLE asks patients what they want. The two chief problems identified by patients were prompt access to primary care appointments and continuity with their own primary care provider. In surveys about what services to include at OLE's recently opened seventh clinic site, OLE found something surprising: People wanted to engage with others socially. As a result, the leadership team is working on ways to maximize social connections in group visits and other services.

Monarch HealthCare www.monarchhealthcare.com

Monarch HealthCare is the largest independent practice association (IPA) in Orange County. It has approximately 200,000 members, consisting of 700 primary care providers and 1,500 specialists. Monarch is expanding its provider network into northern Orange County. Monarch is part of Optum, which is owned by UnitedHealth Group.

Learning About a New Patient Population

Medi-Cal beneficiaries are Monarch's largest and fastest-growing patient population, a change from the past, when it was Medicare seniors. Most Medi-Cal patients come to Monarch through auto-assignment, so the work of marketing is focused on retention. Monarch's marketing staff members are asking themselves, "How do we change as the population changes? How often do we reassess our marketing strategy? Can we use the same strategies we use with our Medicare patients to help younger Medi-Cal enrollees?"

Optum provides Monarch with market segmentation data and recommendations. With this deeper understanding of patient groups, the marketing team can partner with other parts of the business to offer tailored services to better meet patient needs. Market segmentation takes three basic approaches:

1. **Behavioral:** segmentation by choice, lifestyle, how people spend their time.
2. **Demographic:** segmentation by variables such as income, geography, language, ethnicity. (Most marketing focuses here.)
3. **Attitudinal:** segmentation by opinion, by what people think and say. (Optum has begun to focus here in past two years.)

Optum's health care consumer research identified several main patient concerns, including cost savings, flexibility, time concerns, information, cynicism based on past experience, reliance, and confusion. With the patient archetypes they developed based on these concerns, Monarch considers what aspects of care and services each archetype would value, such as convenience of services, choice of provider, or customer service by phone. Monarch aims to both influence the services delivered and to emphasize these values in marketing materials. Like OLE Health, Monarch wants to align its business operations with its brand and deliver a care experience that matches what its members want. As Monarch's member population diversifies beyond Medicare, the organizations is considering how often it needs to re-evaluate member segments and business strategy.

"If you can address this concern/need, you win the patient."
Claire Ferrante, Monarch HealthCare

Tailored Communications

Monarch staff members call members to help activate them and to support their next steps in care, such as scheduling a primary care visit or learning more about their health coverage or self-care for chronic conditions. Members are more likely to stay with Monarch after this type of action-focused engagement. Patients are also sent personalized letters promoting preventive care, which are explained in the initial phone outreach. Senior members are assigned to a specific patient care coordinator, who works directly with the patient's primary care providers. Similar to the findings of the OLE Health patient surveys, Monarch has found that some patients need basic social support.

Monarch collaborates and cobrands with health plans and providers as much as possible, to help patients recognize the related roles in their care and its coordination. Commercial patients tend to identify readily with Monarch the medical group, because they chose the medical group but did not choose the health plan (because often only one option was provided by an employer), whereas seniors may identify more with the health plan because they had the option to make this choice.

Kaiser Permanente www.kp.org

Nationally, Kaiser Permanente has over 10 million patients, but loses between 1.2 and 1.3 million every year to attrition, according to Paul Moody, senior director, National Small Business Individual Plans Direct Marketing. Of this number, between 400,000 and 500,000 leave voluntarily. The organization must acquire that many more members to reach growth targets.

Kaiser Permanente uses an evidence-based marketing approach to reach the goals of their overall lifetime member marketing campaign. Lifetime member marketing targets current, past, and potential future members. Kaiser uses many types of data in its evidence-based marketing to understand its impacts and to continuously improve its work.

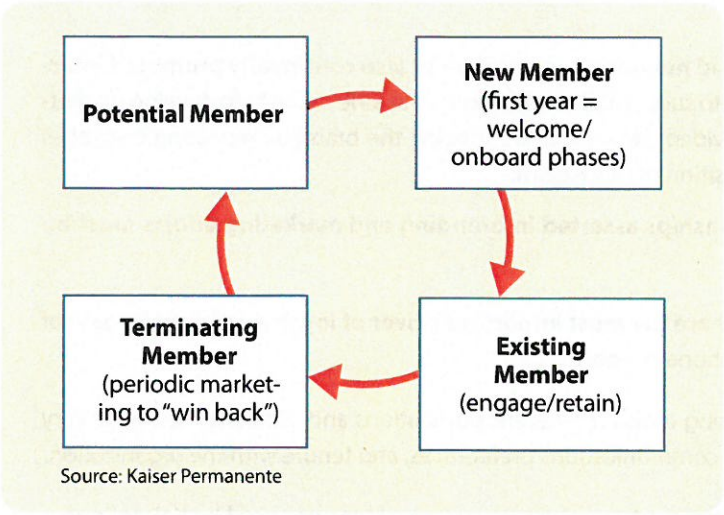
Lifetime Member Marketing

Lifetime member marketing takes the long view of relationships with Kaiser Permanente members, acknowledging that many people change health plans and providers many times over the course of their lives. Lifetime member marketing includes, for example, Kaiser staff support for members moving from commercial insurance to Medicare.

Since implementation of the ACA, Kaiser has seen more churn in membership than ever before. Because new members may have selected Kaiser based on cost and not on brand knowledge, the marketing team reaches out to new patients right away. "In the first year, our goal is to get the member to engage with us: to sign up for our online platform, to use online tools and tips for improving health, to have an appointment with their provider. If there is not engagement, people will shop on price when open enrollment comes around again. The primary driver of retention is relationship with the doctor," said Paul Moody, senior director, Marketing for Small Business and Individual Plans, Kaiser Permanente.

Kaiser's marketing team maps out the first 10 months of a person's enrollment with the actions they want new members to take, as well as the actions Kaiser will take. For example, in month one, members are encouraged to choose a doctor and transfer prescriptions; in month three, Kaiser contacts members to offer help with any health concerns or benefits

Lifetime Member Marketing Cycle



Source: Kaiser Permanente

questions. This staged approach has proven to be more effective than the traditional approach of overwhelming people with a huge amount of information all at once at the time of enrollment.

Kaiser uses multiple communications channels for marketing contact with members, including live calls, interactive voice response (IVR), mail, and email. Kaiser tailors communications to meet the needs of different patient groups. For example, they send more direct mail to seniors than to their younger members. With younger populations who are less concerned about health coverage and preventive care, Kaiser targets messages to their influencers, such as parents.

Evidence-Based Marketing and Retention

Evidence-based marketing involves testing and measuring the impact of marketing interventions and making changes based on the results. A primary driver of the organization's use of evidence-based marketing is the responsibility to use marketing dollars wisely, which in turn helps keep costs low for members. Evidence-based marketing at Kaiser Permanente starts with its robust database on current, past, and potential members. When selecting members for an upcoming marketing campaign, Kaiser looks at who responded to the last campaign and what variables are correlated with those respondents, and then applies that model to the larger population.

"Actionable data is the engine that drives our marketing."
Paul Moody, Kaiser Permanente

Evidence-based marketing does not require the sophisticated data platforms that Kaiser has developed. Testing and continuous learning are practices that any organization can use.

Kaiser uses a structured approach to building marketing campaigns. An example of this approach for member retention:

1. **Messaging**: Use research (online member panels and focus groups, for example), phone surveys, and data analysis to discover why members are terminating. Use this research to develop messages that address these issues. The primary reasons are typically value, quality, and access to care.
2. **Targeting:** Examine data and event-based analysis of terminations to identify common characteristics of members who terminate. Identify current members with those same characteristics to send messages to those who are likely to terminate.
3. **Channel:** Modes for contacting patients are determined based on insights from prior campaigns. Most campaigns use multiple channels (mail, email, IVR, and live calls).
4. **Analysis:** The marketing team tracks the success of each campaign as it happens, as well as after it ends, to continue the cyclical continuous improvement.

Next Steps

Kaiser is working to be less campaign-based and more personalized in its marketing to members. They want to use member behaviors and care activities to trigger specific outreach. For example, if a member creates a login to use the online member platform for the first time, this action triggers a direct communication to that individual.

Quick Takes

- **An organization's brand needs to be promoted not only to members but also continually promoted internally to staff.** Having engaged leaders is crucial to successfully engaging staff at all levels to help develop marketing messages and to improve the services provided. Senior leaders support the brand by repeating messages frequently; for example, the brand value proposition of OLE Health.
- **The quality of the care, services, and relationships asserted in branding and marketing efforts must be real,** particularly to drive long-term loyalty.
- **Patient relationships with primary providers are the most important driver of loyalty,** followed by ease of transactions (including access to services and phone support).
- **One size does not fit all.** Use different marketing tools for different populations and different messages. Vary marketing messages related to patients' needs, communications preferences, and tenure with the organization.
- **Marketing requires its own system of measurement to gauge its success.** Measures used by Kaiser Permanente include member surveys, A/B tests of marketing campaigns with a control group, rates of utilization of preventive services, number of members who engage with their patient portal, percentage of emails opened, and total members retained.

CIN thanks the presenters:

- Tanir Ami, CEO, OLE Health
- Claire Ferrante, marketing manager, and Alison Danielczyk, performance improvement supervisor, Monarch HealthCare
- Paul Moody, senior director, Marketing for Small Business and Individual Plans, Kaiser Permanente

California HealthCare Foundation

California Improvement Network Better Ideas for Care Delivery

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

January 2016

Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey

Prepared by:
Tricia Brooks and Sean Miskell
Georgetown University Center for Children and Families

and

Samantha Artiga, Elizabeth Cornachione, and Alexandra Gates
Kaiser Family Foundation

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Executive Summary

January 2016 marks the end of the second full year of implementation of the Affordable Care Act's (ACA) key coverage provisions. This 14th annual 50-state survey of Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies provides a point-in-time snapshot of policies as of January 2016 and identifies changes in policies that occurred during 2015. Coverage is driven by two key elements—eligibility levels determine who may qualify for coverage, and enrollment and renewal processes influence the extent to which eligible individuals are enrolled and remain enrolled over time. This report provides a detailed overview of current state policies in these areas, which have undergone significant change as a result of the ACA.

Together, the findings show that, during 2015, states continued to implement the major technological upgrades and streamlined enrollment and renewal processes triggered by the ACA. These changes are helping to connect eligible individuals to Medicaid coverage more quickly and easily and to keep eligible people enrolled as well as contributing to increased administrative efficiencies. However, implementation varies across states, and lingering challenges remain. The findings illustrate that the program continues to be a central source of coverage for low-income children and pregnant women nationwide and show the growth in Medicaid's role for low-income adults through the ACA Medicaid expansion.

Eligibility for Children, Pregnant Women, and Non-Disabled Adults

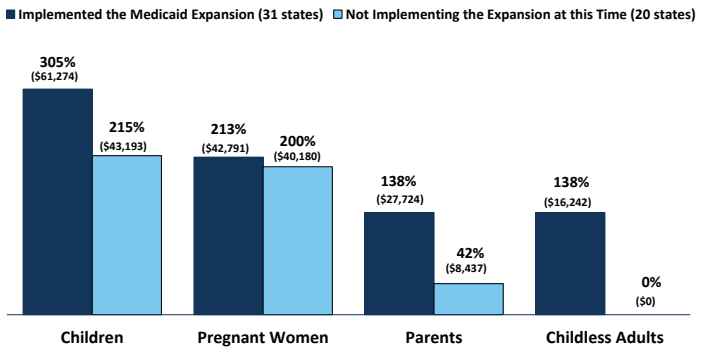
Medicaid and CHIP remained the central sources of coverage for low-income children and pregnant women nationwide during 2015. As of January 2016, 48 states cover children with incomes at or above 200% FPL, with 19 states extending eligibility to at least 300% FPL, while 33 states cover pregnant women with incomes at or above 200% FPL. Eligibility levels for children and pregnant women remained stable during 2015. This stability, in part, reflects the ACA's maintenance of effort provisions, which prevent states from making any reductions in children's eligibility through 2019. Some states made incremental changes that expanded access to coverage for children and pregnant women in 2015, such as eliminating waiting periods that required children to be uninsured for a period of time before enrolling in CHIP (Michigan and Wisconsin), eliminating the five-year waiting period for lawfully residing immigrant children and pregnant women (Colorado), expanding federally-funded CHIP coverage to dependents of state employees (Nevada and Virginia), and offering coverage to former foster youth from other states (New Mexico).

Medicaid's role for low-income adults continued to grow through the ACA Medicaid expansion. As of January 2016, 31 states have expanded Medicaid eligibility to parents and other non-disabled adults with incomes up to at least 138% FPL. This count reflects the adoption of the Medicaid expansion in three states—Alaska, Indiana, and Montana—during 2015. However, in the 20 states that have not expanded, median eligibility levels are 42% FPL for parents and 0% FPL for other adults, leaving many poor adults in a coverage gap since they earn too much to qualify for Medicaid but not enough for tax credit subsidies to purchase Marketplace coverage, which begin at 100% FPL. Aside from adoption of the Medicaid expansion in three states, there were few changes in eligibility for parents and other adults during 2015. Connecticut reduced eligibility for parents, but eligibility remains above the expansion limit and many of those who became ineligible likely qualify for subsidies to purchase Marketplace coverage. In addition, New York implemented a Basic Health Program (BHP) to offer more affordable coverage to adults with incomes up to 200% FPL, joining Minnesota as the second state with a BHP.

Eligibility levels vary across groups and states, and state Medicaid expansion decisions have increased these differences. Median eligibility levels for children and pregnant women remain well above those for parents and other adults in both Medicaid expansion and non-expansion states. Within each eligibility group, median eligibility levels are higher in expansion states than non-expansion states (Figure 1). As expected, these differences between expansion and non-expansion states are largest for parents and other adults. Underlying these medians, there also is significant variation in eligibility levels across states. Eligibility levels range from 152% to 405% FPL for children, from 138% to 380% FPL for pregnant women, from 18% to 221% FPL for parents, and from 0% to 215% for other adults.

Figure 1

Median Medicaid/CHIP Income Eligibility Thresholds, January 2016



NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2015,the FPL was $20,090 for a family of three and $11,770 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

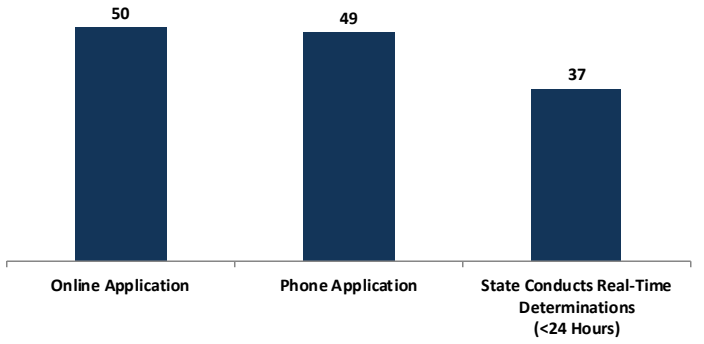
System Enhancements and Streamlined Enrollment and Renewal

Regardless of whether states have implemented the ACA Medicaid expansion to adults, the law ushered in major changes to Medicaid systems and processes in all states. The changes are designed to harness technology to provide a modernized enrollment experience for consumers and may lead to increased administrative efficiencies for states. As documented in last year's survey, many states faced significant challenges implementing new systems and processes when they were launched in 2014. These difficulties resulted in backlogs and delays in enrollments and renewals, which were a major focus during 2014. This year's findings show that, in 2015, states resolved many of these challenges and built on successes to refine and enhance their upgraded systems. However, experiences vary across states and lingering challenges remain.

As of January 2016, individuals can apply for Medicaid online or by phone in nearly all states as envisioned by the ACA (Figure 2). All states, except Tennessee, have an online Medicaid application available either through the state Medicaid agency or an integrated portal that provides access to Medicaid and the State-Based Marketplace (SBM). Two states (Arkansas and Florida) began accepting telephone applications for Medicaid in 2015, bringing the total count of states doing so to 49 as of January 2016.

Figure 2

Number of States with Online and Phone Medicaid Applications and Real-Time Determinations, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

As of January 2016, 37 states report they can make real-time Medicaid eligibility determinations (defined as less than 24 hours) for children, pregnant women, and non-disabled adults. Among the 27 states that were able to report the share of applications for these groups that receive a real-time determination, 11 indicated that more than 50% of applications receive a determination in real time.

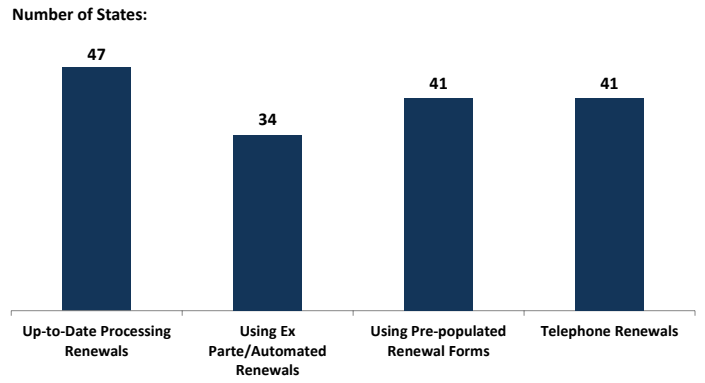
States expanded functionalities of online applications and accounts during 2015. Reflecting this work, all but one of the 50 online Medicaid applications allow applicants to start, stop, and return to the application, and 33 allow applicants to upload documents as of January 2016. In addition, 39 states allow consumers to create an online account to manage their Medicaid coverage. During 2015, a number of states expanded account functionalities, enabling consumers to report changes, view notices, upload documentation, renew coverage, and more.

Coordination between state Medicaid agencies and the Marketplaces improved during 2015, but challenges remain. Among the 17 states operating a SBM, 13 have a single integrated system that makes eligibility determinations for both Medicaid and Marketplace coverage, which eliminates the need for account transfers between programs. However, the 38 states that rely on the Federally Facilitated Marketplace (FFM), Healthcare.gov, for Marketplace eligibility and enrollment must electronically transfer accounts between Medicaid and the FFM to provide access to all insurance affordability programs. As of January 2016, all 38 states that rely on the FFM report they can receive electronic account transfers from the FFM, and 36 states report they can send electronic account transfers to the FFM. Twenty states report they are having problems or delays with transfers, although the scope of these problems varies across states. Although challenges remain, there has been marked improvement in coordination since the Marketplaces were launched in 2014, when states faced major technical difficulties with transfers that contributed to enrollment delays.

As implementation continues, a number of states eliminated delays in processing renewals and put streamlined renewal procedures in place as established by the ACA. When the ACA was first implemented, there was significant focus on implementing streamlined enrollment processes and establishing coordination between Medicaid and the new Marketplaces. As a result, most states delayed implementing new renewal procedures, and 36 states took up a temporary option to postpone renewals for existing Medicaid or CHIP enrollees during 2014. In 2015, most states caught up on renewals and many made gains in implementing streamlined renewal procedures. As of January 2016, 47 states are up to date in processing renewals for Medicaid (Figure 3). A total of 34 states report they can complete automatic or ex parte renewals by using information from electronic data sources, as outlined in the ACA. Among the 26 states that can report the share of renewals completed using automated processes, 10 indicate that over 50% of enrollees are automatically renewed, including 3 that report automatic renewal rates above 75%. In addition, 41 states can send pre-populated renewal forms, which states must use when they are unable to complete an automated renewal under ACA policies; 41 states offer telephone renewals as outlined by the ACA.

Figure 3

Status of Medicaid Renewal Processes, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Premiums and Cost-Sharing

Premiums and cost-sharing in Medicaid and CHIP remain limited, although under waiver authority a few states are charging higher levels than otherwise allowed under federal law. The number of states charging premiums or enrollment fees (30 states) or copayments (26 states) for children

remained the same during 2015. While most states charge nominal copayments for parents (40 states) and expansion adults (23 of 31 expansion states), states generally do not charge these groups premiums given that most of these individuals have incomes below poverty. However, as of January 2016, five states (Arkansas, Indiana, Iowa, Michigan, and Montana) charge adults monthly contributions or premiums under Section 1115 waiver authority. Indiana also received approval to charge parents monthly contributions and, under separate Section 1916 waiver authority, to charge parents and adults higher cost-sharing for non-emergency use of the emergency room than otherwise allowed under federal law.

Looking Ahead

States' Medicaid and CHIP eligibility policies and enrollment and renewal processes will play a key role in reaching the remaining low-income uninsured population and keeping eligible individuals enrolled over time. Together, these survey findings show that:

Medicaid and CHIP continue to be central sources of coverage for the low-income population, but access to coverage varies widely across groups and states. Medicaid and CHIP offer a base of coverage to low-income children and pregnant women nationwide. Eligibility for adults has grown under the Medicaid expansion, but remains low in states that have not expanded. Overall, eligibility continues to vary significantly by group and across states, resulting in substantial differences in individuals' access to coverage based on their eligibility group and where they live.

Upgraded state Medicaid systems help eligible individuals connect to and retain coverage over time, provide gains in administrative efficiencies, and offer new options to support program management. One key outcome of the ACA has been the significant modernization of states' Medicaid eligibility and enrollment systems. These higher-functioning systems help eligible individuals connect to coverage more quickly and easily, keep individuals enrolled over time, reduce paperwork burdens, and lead to increased administrative efficiencies. Moreover, the modernized systems offer new options to support program management. For example, states may have increased data reporting capabilities and expanded options to connect Medicaid with other systems. Further, as systems and processes become more refined over time, states may be able to manage enrollment more efficiently, which may allow them to refocus resources on other activities.

There remain key questions about how recent changes in eligibility and enrollment may be affected by a range of factors moving forward. Funding for CHIP is set to expire in 2017, raising key questions about the future of the program and what might happen in its absence. In addition, the ACA maintenance of effort provisions for children's coverage end in 2019. State Medicaid expansion decisions will likely continue to evolve over time, and it remains to be seen how they might be affected by the gradual reduction in federal funding for newly eligible expansion adults, which begins to phase down in 2017 when it reduces to 95%. Pending proposals in current budget reconciliation legislation would roll back the Medicaid expansion to adults and eliminate the maintenance of effort requirements in 2017. Outside of these potential changes, it also will be important to examine how the Section 1115 waivers that allow states to charge adults premiums and monthly contributions are affecting coverage and program administration, particularly given that waiver authority is provided for research and demonstration purposes.

Introduction

January 2016 marks the second anniversary of the effective date of the Affordable Care Act's (ACA's) key coverage provisions. During 2015, Medicaid and CHIP continued to be central sources of coverage for low-income children and pregnant women nationwide, and Medicaid's role for low-income adults grew as a result of the ACA Medicaid expansion. At the end of the second full year of implementation of the ACA's coverage expansions, states have continued to implement and enhance new and upgraded eligibility and enrollment systems that underpin the ACA's vision for a modernized data-driven enrollment experience. States also worked to implement automated renewal processes and improve coordination between Medicaid and the Marketplaces, resolving many problems and delays faced during the initial year of ACA implementation.

This annual report presents Medicaid and CHIP eligibility, enrollment, renewal and cost-sharing policies based on a survey of state program officials. It provides a point-in-time snapshot of policies in place as of January 2016 and identifies changes in state policies that occurred between January 2015 and 2016. These changes provide insight into how state policies are evolving from the new baseline that was established at the end of 2014, after the first full year of ACA implementation. State-specific information is available in Tables 1 to 21 at the end of the report.

Medicaid and CHIP Eligibility

The ACA established a new minimum Medicaid eligibility level of 138% of the federal poverty level (FPL) for children, pregnant women, parents and non-disabled adults as of January 2014. This new minimum increased eligibility for parents in many states and provided a new eligibility pathway for other non-disabled adults who were largely excluded from Medicaid prior to the ACA. Although the expansion to adults with incomes up to 138% FPL was effectively made a state option by the Supreme Court's 2012 ruling on the constitutionality of the ACA, the Court's decision did not impact other eligibility changes in the law. As a result of the new 138% FPL minimum for children in Medicaid, some states moved certain children from CHIP to Medicaid. Moreover, all states implemented the ACA change to determine financial eligibility for Medicaid for children, pregnant women, parents, and non-disabled adults and CHIP based on Modified Adjusted Gross Income (MAGI). This change created alignment with the method used for determining eligibility for subsidies to purchase Marketplace coverage. States continue to determine eligibility for other groups, such as individuals with disabilities and elderly individuals, based on previous non-MAGI-based rules.

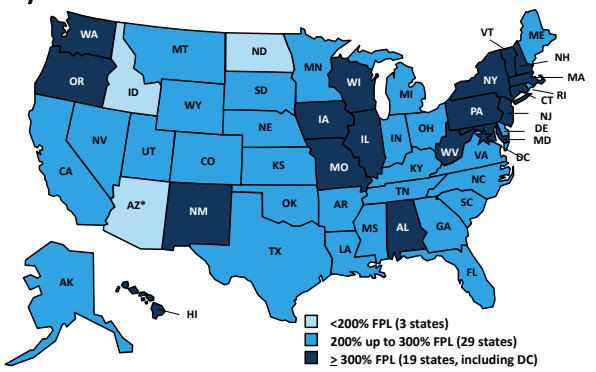
The findings below show Medicaid and CHIP eligibility levels for children, pregnant women, parents, and other non-disabled adults as of January 2016 and identify changes in eligibility that occurred between January 2015 and January 2016. These data show that Medicaid and CHIP continue to be central sources of coverage for the nation's low-income children and pregnant women, with some states adopting optional policies in 2015 that expand access to coverage for certain children and pregnant women. They also highlight the continued growth of Medicaid's role for low-income adults through the ACA Medicaid expansion.

Children and Pregnant Women

Coverage for children in Medicaid and CHIP remains strong and steady with median eligibility at 255% FPL. Under the ACA's maintenance of effort protections, states cannot make reductions in children's eligibility through 2019. Reflecting this protection, there were no policy changes to children's eligibility in 2015. However, in Kansas, the state's CHIP eligibility level is tied to the 2008 FPL; thus, CHIP eligibility declined from 247% to 244% FPL and will continue to erode over time. As of January 2016, 48 states cover children with incomes up to at least 200% FPL through Medicaid and CHIP, including 19 states that cover children at or above 300% FPL (Figure 4). Across states, the upper Medicaid/CHIP eligibility limit for children ranges from 152% FPL in Arizona to 405% FPL in New York.

Figure 4

Income Eligibility Levels for Children in Medicaid/CHIP, January 2016



NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2015 was $20,090. Thresholds include the standard five percentage point of the FPL disregard. * Arizona provides coverage up to 200% FPL through a separate CHIP program but enrollment is closed.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

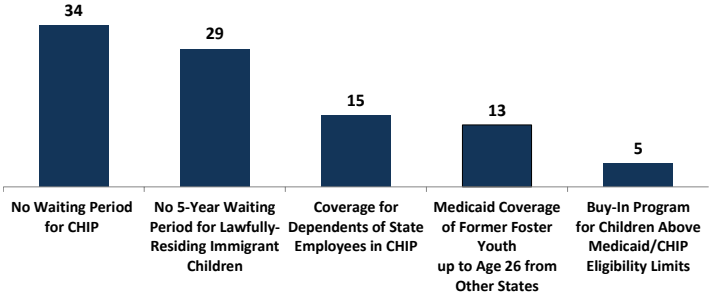
Mirroring previous action taken by California and New Hampshire in 2014, Michigan transitioned all children from its separate CHIP program into Medicaid as of January 2016. In contrast, Arkansas established a new separate CHIP program and moved children with family incomes from 147% to 216% FPL from its CHIP-funded Medicaid expansion to the new separate CHIP program. Enrollment remains open in all states with separate CHIP programs except in Arizona. Arizona froze enrollment in its separate CHIP program at the end of 2009, prior to enactment of the ACA eligibility protections.

States continued to take up options to enhance children's access to coverage during 2015.

- ***Eliminating waiting periods for CHIP coverage.*** During 2015, Wisconsin eliminated its waiting period for its separate CHIP program. In addition, Michigan's CHIP waiting period was eliminated when it transitioned all children from its separate CHIP program to Medicaid. With these changes, 24 states have eliminated waiting periods for CHIP since the ACA was enacted in 2010. As of January 2016, 34 states do not have a waiting period for CHIP coverage (Figure 5). However, 16 of the 36 states with separate CHIP programs have a waiting period that requires a child to be uninsured for a period of time prior to enrolling. These waiting periods may not exceed 90 days.
- ***Expanding coverage to recent lawfully residing immigrant children.*** With the addition of Colorado during 2015, 29 states have taken up the option to eliminate the five-year waiting period for lawfully present immigrant children in Medicaid and/or CHIP as of January 2016. In addition, six states (California, District of Columbia, Illinois, Massachusetts, New York, and Washington) use state-only funds to cover some income-eligible children regardless of immigration status.[1] This count includes California, which has some local programs that

Figure 5

Number of States that have Adopted Selected Options to Expand Children's Access to Medicaid and CHIP, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

cover children regardless of immigration status and recently passed legislation to cover children regardless of immigration status on a statewide basis starting in 2016.

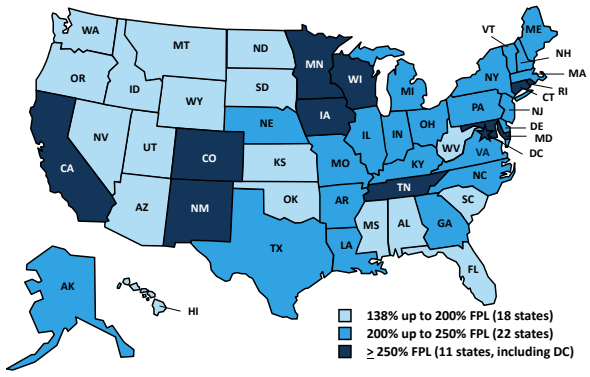
- ***Expanding federally-funded CHIP coverage to dependents of state employees.*** As of January 2016, 2 additional states (Nevada and Virginia) took up the option to cover otherwise eligible children of state employees in a separate CHIP program, bringing the total number of states that have taken up this option to 15.
- ***Expanding coverage for former foster youth.*** Under the ACA, all states must provide Medicaid coverage to youth who were in foster care in the state up to age 26, but it is a state option to extend this coverage to former foster youth from other states. During 2015, New Mexico took up this option, raising the total number of states covering former foster youth from other states to 13 as of January 2016.

Following a trend since enactment of the ACA, the number of states offering buy-in programs for children in families above Medicaid or CHIP income limits continued to decline. States may offer buy-in programs to allow families with incomes above the upper limit for children's coverage to buy-in to Medicaid or CHIP for their children. In 2015, North Carolina lifted the income limit on its buy-in program, while Connecticut eliminated its buy-in program. The number of states offering buy-in programs has declined from a peak of 15 in 2011 to 5 as of January 2016, reflecting that families above Medicaid and CHIP income thresholds may have new coverage options available through the Marketplaces.

Coverage for pregnant women remained stable in 2015. The median eligibility level for pregnant women in Medicaid or CHIP held steady at 205% FPL, with eligibility ranging from 138% FPL in Idaho and South Dakota to 380% FPL in Iowa. Overall, 33 states cover pregnant women with incomes up to at least 200% FPL (Figure 6). The number of states that have eliminated the five-year waiting period for lawfully residing immigrant pregnant women in Medicaid and/or CHIP remained constant at 23. However, Colorado, which had previously covered recent lawfully-residing pregnant women in Medicaid, expanded this option to pregnant women in CHIP during 2015. The number of states covering income-eligible pregnant women regardless of immigration status through the CHIP unborn child option (15 states) or with state-only funds (3 states) remained unchanged.

Figure 6

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2016



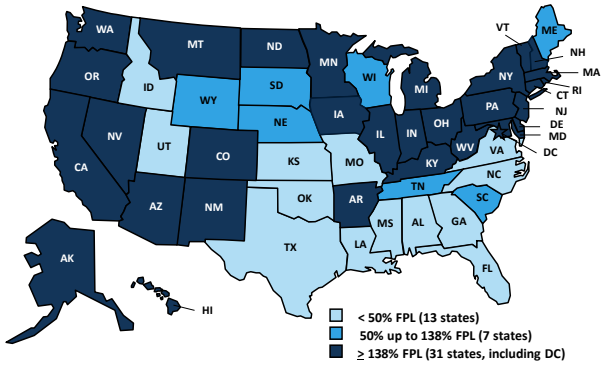
NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2015 was $20,090. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Parents and Adults

As of January 2016, 31 states, including the District of Columbia, have expanded Medicaid eligibility to parents and other non-disabled adults[2] with incomes up to at least 138% FPL. This finding reflects adoption of the ACA Medicaid expansion to low-income adults in three states during 2015–Indiana, Alaska, and, most recently, Montana, where the expansion went into effect on January 1, 2016. Indiana and Montana joined four other states (Arkansas, Iowa, Michigan, and New Hampshire) that expanded Medicaid for adults under Section 1115 waiver authority, allowing them to implement the expansion in ways that extend beyond the flexibility provided by the law.[3] During 2015, Pennsylvania moved from implementing its expansion through a waiver to regular expansion coverage, while New Hampshire moved from a regular expansion to a waiver as of January 2016. There is no deadline for states to adopt the Medicaid expansion, and additional states may expand in the future. Medicaid eligibility extends to parents and other adults with incomes up to at least 138% FPL in all 31 expansion states (Figures 7 and 8). Additionally, the District of Columbia covers parents up to 221% FPL and other adults up to 215% FPL. Connecticut reduced parent eligibility during 2015, lowering eligibility from 201% to 155% FPL. However, parent eligibility remains above the 138% FPL minimum, and many parents who lost Medicaid eligibility are likely eligible for subsidies to purchase Marketplace coverage.

Figure 7

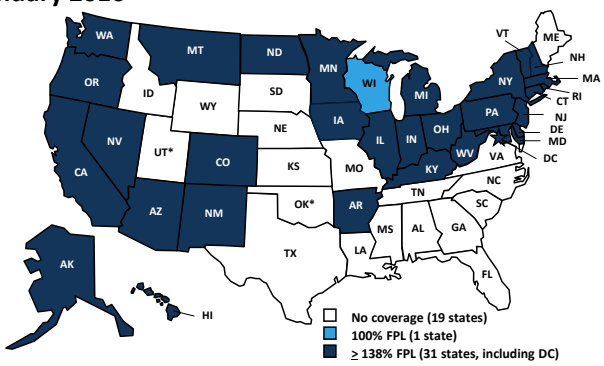
Medicaid Income Eligibility Levels for Parents of Dependent Children, January 2016



NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2015 was $20,090. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Figure 8

Medicaid Income Eligibility Levels for Childless Adults, January 2016



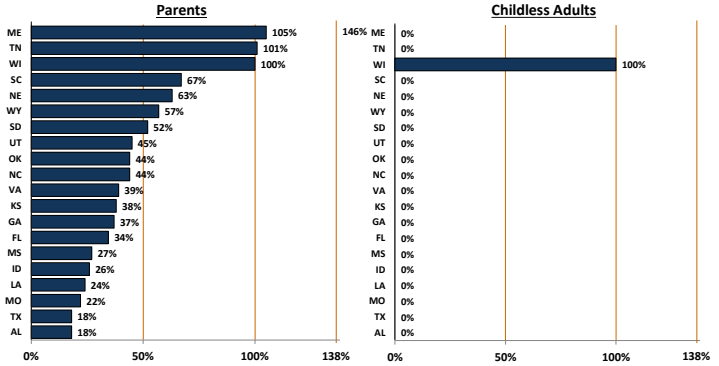
NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for an individual. The FPL for an individual in 2015 was $11,770. Thresholds include the standard five percentage point of the FPL disregard.
*OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

As of January 2016, two states—Minnesota and New York—have implemented Basic Health Programs. The ACA provides an option for states to create a Basic Health Program (BHP) for low-income residents with incomes between 138% and 200% FPL, who would otherwise be eligible to purchase Marketplace coverage. Through this option, states provide alternative coverage that may cover more services or be more affordable than what is offered through the Marketplaces, which may reduce movement between plans and coverage types for people whose incomes fluctuate above and below Medicaid levels.[4] New York's BHP will be fully phased in as of January 2016, joining Minnesota as the second state with a BHP. When New York implemented its BHP, it stopped providing some additional Medicaid-funded subsidies to parents with incomes between 138% and 150% FPL who can now receive coverage through the BHP.

In the 20 states that have not expanded Medicaid, the median eligibility level for parents is 42% FPL; other adults remain ineligible regardless of income in all of these states except Wisconsin. Among the 20 non-expansion states, parent eligibility levels range from 18% FPL in Alabama and Texas to 105% FPL in Maine (Figure 9). Only 3 of these states—Maine, Tennessee, and Wisconsin—cover parents at or above 100% FPL, while 13 states limit parent eligibility to less than half the poverty level ($10,045 for a family of three as of 2015). Wisconsin is the only non-expansion state that provides full Medicaid coverage to other non-disabled adults, although its 100% FPL eligibility limit is lower than the ACA expansion level. While this study reports eligibility based on a percentage of the FPL, it also is important to note that 13 non-expansion states base eligibility for parents on dollar thresholds (which have been converted to an FPL equivalent in this report). Of those states, 12 do not routinely update the standards, resulting in eligibility levels that erode over time relative to the cost of living. Other analysis shows that three million poor adults fall into a coverage gap as a result of these low Medicaid eligibility levels in non-expansion states.[5] These adults earn too much to qualify for Medicaid, but not enough to qualify for subsidies for Marketplace coverage, which are available only to those with incomes at or above 100% of FPL.

Figure 9

Medicaid Income Eligibility Limits for Adults in States that Have Not Implemented the Medicaid Expansion, January 2016

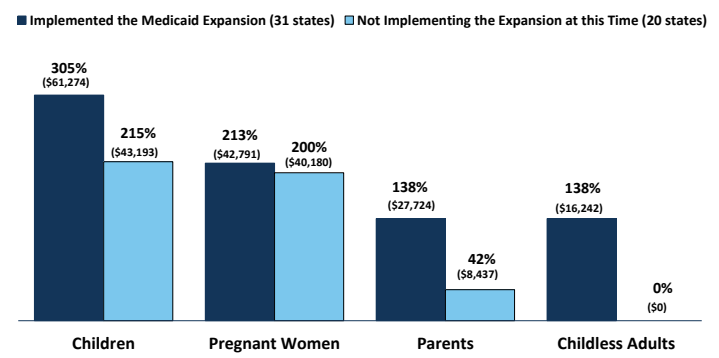


NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2015,the FPL was $20,090 for a family of three and $11,770 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Eligibility levels for parents and other adults remain lower than those for children and pregnant women. Among expansion and non-expansion states, median eligibility levels for parents and other adults remain lower than those for pregnant women and children (Figure 10). In expansion states, median Medicaid and CHIP eligibility levels are 305% FPL for children and 213% FPL for pregnant women compared to 138% FPL for parents and other adults. However, these differences are more pronounced in states that have not implemented the Medicaid expansion. In the non-expansion states, the median Medicaid and CHIP eligibility level is 215% for children and 200% for pregnant women compared to 42% FPL for parents and 0% for other adults.

Figure 10

Median Medicaid/CHIP Income Eligibility Thresholds, January 2016



NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2015,the FPL was $20,090 for a family of three and $11,770 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Medicaid and CHIP Enrollment and Renewal Processes

During 2015, states continued to implement system enhancements and adopt processes to implement the ACA's vision of a modernized data-driven enrollment experience and a largely automated renewal process. Adoption of these procedures represents significant transformation and streamlining in many states that previously relied on paper-based enrollment and renewal processes for Medicaid and CHIP. As states continued work developing the information technology systems that underpin enrollment and renewal, their functionality increased as demonstrated by the growing number of states that are able to make real-time eligibility determinations and automatically renew coverage. Coordination between Medicaid and the Marketplaces also improved considerably in 2015, but there are lingering challenges to ensure smooth transitions between coverage programs for individuals.

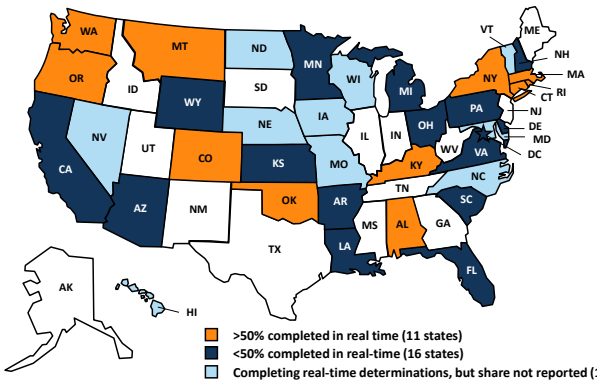
Eligibility and Enrollment Systems

In order to implement the new enrollment and renewal processes outlined in the ACA, most states needed to make major improvements to or build new Medicaid and CHIP eligibility and enrollment systems and coordinate enrollment with the Marketplaces. To support system development, the federal government provided 90% federal funding for system design and development. This increased funding level was initially set to expire at the end of 2015, but CMS finalized a rule in December 2015 to extend the higher federal match permanently.[6] The extension of this funding will support continued work in states that have not implemented enhanced system functionality to fully meet ACA requirements. It also will support continued state work to phase in additional capabilities and consumer features and keep systems current as technology evolves in the future. Higher functioning systems facilitate the ability to enroll and keep eligible individuals in coverage by reducing paperwork burdens and allowing individuals to manage more activities through an online environment. They also may contribute to increased administrative efficiencies. Moreover, as these systems and processes become more refined, they may enable states to manage larger enrollments more efficiently, allowing them to refocus resources on other services such as helping individuals understand how to use their health care services. They may also provide new tools and options to support program management, such as increased data reporting and data connections with other systems or programs.

As of January 2016, 37 states can complete MAGI-based eligibility determinations in real-time (defined as less than 24 hours), and 11 states indicate that at least 50% of MAGI-based applications receive a real-time determination. Among the 27 states that were able to report the percentage of MAGI-based applications that receive a real-time determination, 11 states report a success rate that exceeds 50%, including 9 that report a rate over 75%. In the remaining 16 states, less than half of MAGI-based applications receive a determination in real-time (Figure 11). Looking ahead, many states will continue to work to increase the share of applications that receive a real-time determination.

Figure 11

Real-Time Determinations for MAGI-Based Medicaid, January 2016

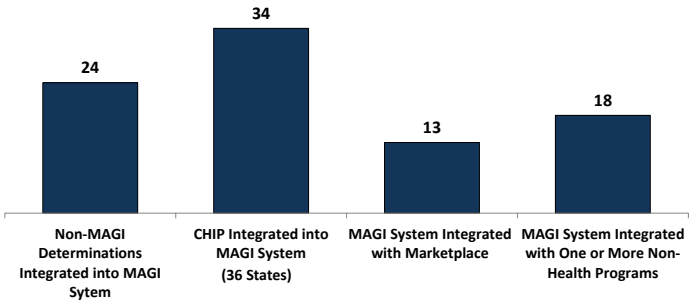


NOTE: Real-time defined as less than 24 hours.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

As of January 2016, states vary in the integration of other health programs in their MAGI-based Medicaid systems (Figure 12). During 2015, three states (Florida, Nebraska, and Virginia) integrated eligibility determinations for non-MAGI groups, which include elderly individuals and individuals with disabilities, into their MAGI-based systems. With these additions, 24 states process MAGI and non-MAGI groups through the same system as of January 2016. Most states with a separate CHIP program (34 of 36 states) have CHIP integrated into the MAGI-based system. Among the 17 states operating a State Based Marketplace (SBM), 13 have a single, integrated system that makes eligibility determinations for both MAGI-based Medicaid and Marketplace coverage. With Hawaii transitioning eligibility determinations from its SBM to the Federally Facilitated Marketplace (FFM) in 2015, 4 SBM states and the 34 FFM and Partnership states are using Healthcare.gov for Marketplace eligibility and enrollment functions as of January 2016. These 38 states all must maintain a separate Medicaid eligibility and enrollment system at the state level.

Figure 12

Integration of MAGI-Based Medicaid Eligibility Systems, January 2016



Note: Real time determinations are completed in less than 24 hours.
SOURCE: Based on results from national surveys conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

In 18 states, the MAGI-based Medicaid system is integrated with at least one non-health program, and a number of states are planning further integration in the future. Prior to the implementation of the ACA, 45 states had integrated systems to determine eligibility for Medicaid and other non-health programs such as the Supplemental Nutrition Assistance Program (SNAP or food stamps), Temporary Assistance for Needy Families (TANF), and childcare assistance. As states upgraded or built new Medicaid eligibility systems, many delinked these programs from the Medicaid system due to the large scale of the changes. However, as of January 2016, 18 states had integrated at least one non-health program into their MAGI-based Medicaid system. Colorado delinked non-health programs from its Medicaid system when it integrated its Medicaid system with its Marketplace system in 2015. However, a number of states plan to phase in additional non-health programs into their Medicaid system in 2016 or beyond. The continuation of enhanced funding for system development, as well as flexibility provided by CMS that requires other programs to pay only the incremental integration costs, support these efforts. Although this flexibility was slated to end at the close of 2015, CMS extended it for three more years.[7]

Coordination between Medicaid and Marketplace systems improved considerably in 2015, but there are lingering challenges. In the 38 states relying on the FFM for Marketplace eligibility and enrollment functions, electronic accounts must be transferred between the federal and state systems to provide a coordinated, seamless enrollment experience for individuals as envisioned by the ACA. Such transfers are not necessary in the 13 SBM states with an integrated Medicaid and Marketplace eligibility system although, in some cases, data transfers must occur after the eligibility determination to complete enrollment. Among the 38 states relying on the FFM for eligibility and enrollment, 8 states have authorized the federal system to make final Medicaid eligibility determinations, which can expedite the enrollment process. However in these states, the FFM still must transfer accounts to the Medicaid agency to complete enrollment. The remaining 30 states allow the FFM to assess rather than determine Medicaid eligibility. These counts reflect three states (Louisiana, North Dakota, and Oregon) choosing to rely on the FFM for assessments rather than final determinations, and

one state (Alaska) adopting the option for the FFM to make final determinations rather than assessments during 2015. States relying on the FFM for assessments must use the information received in the account transfer to determine eligibility based on the same verification requirements in place for individuals who apply directly through the state Medicaid agency. This process may require checking other data sources or requesting documentation for information that cannot be confirmed electronically. During 2014, there were significant difficulties with account transfers that contributed to delays in Medicaid enrollment. However, there have since been improvements in transfer functionality with all 38 states that rely on the FFM for Marketplace eligibility and enrollment functions reporting that they are receiving electronic account transfers from the FFM, and 36 states reporting that they are sending electronic account transfers to the FFM as of January 2016. A little more than half of these states (20 states) report they are still experiencing some delays or difficulties with transfers, although the scope of these challenges varies across these states.

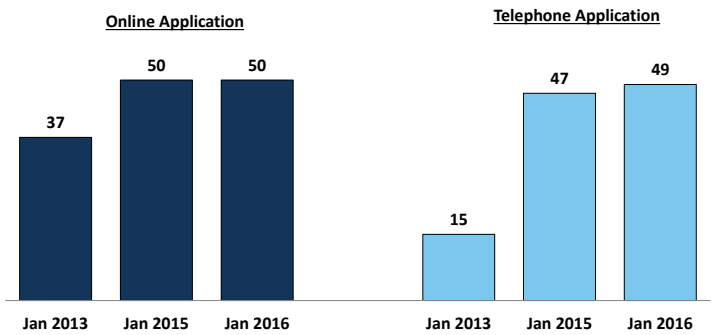
APPLICATIONS

Under the ACA, states must provide multiple methods for individuals to apply for health coverage, including online, by phone, by mail, and in person, using a single streamlined application for Medicaid, CHIP, and Marketplace coverage. The use of online applications, as well as online accounts, gives states new opportunities to offer features and functions that enhance individuals' enrollment experience and expand their ability to manage their ongoing Medicaid coverage, which may help eligible individuals enroll and retain coverage over time. The increased use of technology may also provide administrative efficiencies to states by reducing paperwork and manual input of information that enrollees can report online, such as an address change. This growth in the use of technology has been supported by the 90% federal match for systems development and 75% federal match for ongoing operations that are now permanently available to states.

As of January 2016, individuals can apply online or by phone for Medicaid in nearly all states. In all states, except Tennessee, there is an online Medicaid application available through the state Medicaid agency or, in SBM states, an integrated portal that provides access to Medicaid and the SBM. In addition, 24 states offer an integrated online application that allows individuals to apply for Medicaid and non-health programs, such as SNAP or TANF. These states largely align with those states that have Medicaid and non-health programs integrated into a single eligibility system, although a few states are using separate eligibility systems to process multi-benefit applications. With the addition of Arkansas and Florida during 2015, 49 states are accepting Medicaid applications by phone as of January 2016. The number of states providing online and telephone Medicaid applications has significantly increased since initial implementation of the ACA changes in 2014 (Figure 13).

Figure 13

Number of States with Online and Telephone Medicaid Applications Over Time

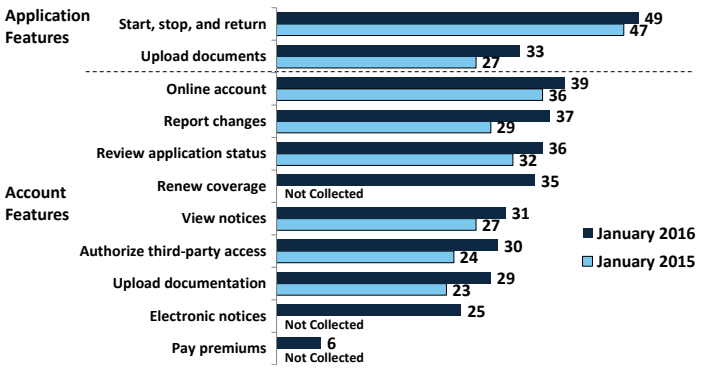


NOTE: Online applications refer to applications that can be submitted electronically, not those that may only be downloaded from websites.
SOURCE: Based on results from national surveys conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families in 2013, 2015, and 2016.

A number of states expanded the functionality of online applications and accounts during 2015. Between January 2015 and 2016, the number of states that provide applicants the option to start, stop, and return to complete their application at a later time increased from 47 to 49, while the number of states that allow applicants to upload electronic copies of documentation through the online application increased from 27 to 33 (Figure 14). In addition, the number of states that provide individuals the opportunity to create an online account for ongoing management of their Medicaid coverage rose from 36 to 39, with the addition of North Dakota, South Carolina, and South Dakota. A larger number of states added features to existing online accounts. Specifically, there were increases in the number of states that allow individuals to use their online account to report changes (29 to 37 states), review the status of their application (32 to 36 states), view notices (27 to 31 states), authorize third-party access (24 to 30 states), and upload documentation (23 to 29 states). This year's survey also asked about additional account functionalities and found that individuals can use their account to renew coverage in 35 states, go paperless and receive electronic notices in 25 states, and pay premiums in 6 of the 32 states that charge premiums in Medicaid or CHIP. Additional states plan to add online accounts in 2016 or beyond, while states with online accounts plan to continue to add features. These online functions provide timely and convenient access to account information that is commonplace in today's digital age, and may lead to administrative efficiencies by reducing mailing costs, call volume, and manual processing of updates. The ability for consumers to see and manage their application and information online also may contribute to increased enrollment and retention levels over time.

Figure 14

Number of States with Selected Features for Online Applications and Accounts, 2015-2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families in 2015 and 2016.

Nearly half of the states (24 states) provide a web portal or secure login for authorized consumer assisters to submit applications they have facilitated on behalf of consumers. In some cases, these portals provide additional administrative features that support the work of assisters, such as the ability to check a renewal date or update an address. Providing better tools for assisters may reduce state administrative workloads and free resources for other consumer services. This functionality may also allow the agency to track, monitor and report application activity by assister more thoroughly, accurately, and efficiently.

Verification of Eligibility Criteria

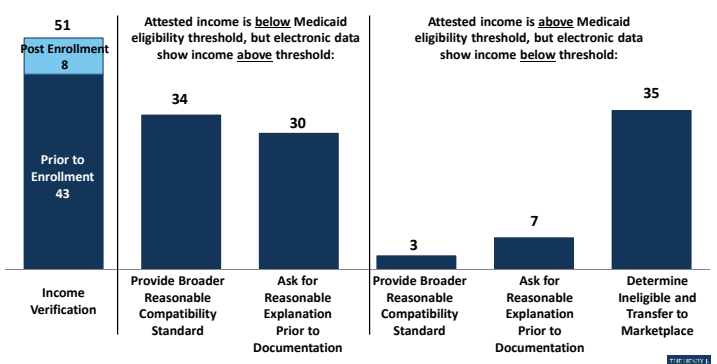
Under the ACA, all states must verify income eligibility and citizenship or immigrant status but they have flexibility to accept self-attestation for other criteria such as age/date of birth, state residency, and household composition. If verification is required, states are expected to use electronic data sources to the extent possible. Verifying eligibility criteria electronically is not only technically complicated, but requires the establishment of data sharing agreements between agencies to ensure that the privacy and security of personally identifiable information is protected. These challenges in accessing electronic data sources can slow state progress in implementing or maximizing real-time eligibility determinations and automated renewals without the intervention of an eligibility worker. However, as of 2016, a number of states are reporting success completing real-time eligibility determinations and automatic renewals that are facilitated through electronic data matches.

States are relying on a mix of data sources to electronically verify eligibility criteria. To facilitate electronic verification, a federal data hub was established that allows states to access information from multiple federal agencies, including the Internal Revenue Service, the Social Security Administration (SSA), and the Department of Homeland Security (DHS), which is used by almost three quarters of states. States not using the federal hub rely on pre-ACA linkages to SSA and DHS databases. Nearly all states also use state databases that collect quarterly state wage information or unemployment compensation, which may contain more current income information. About half of the states also use information from their state vital records while a smaller number of states access information from other state databases, such as the Department of Motor Vehicles or State Tax Department.

As of January 2016, 43 states use electronic data sources to verify income prior to enrollment, while 8 states verify after enrollment (Figure 15). States are required to verify income electronically either prior to or after enrollment and may apply "reasonable compatibility standards" to account for differences in self-reported income and data from electronic sources. If self-reported income and the data from the electronic source are both above or below the Medicaid or CHIP eligibility threshold, states must disregard the discrepancy since it does not impact eligibility. States have the option to establish broader reasonable compatibility standards, which 34 states have adopted for cases in which self-attested income is below but electronic data sources show income above the Medicaid or CHIP eligibility limit. If the difference is within this reasonable compatibility standard, which is most often 10%, states accept the self-reported income. In contrast, only three states (Colorado, Florida and New Jersey) have adopted a reasonable compatibility standard for when self-reported income is above the income standard but the electronic data source is below. In these circumstances, 35 states deny Medicaid or CHIP eligibility and transfer the account for an assessment of Marketplace eligibility. Regardless of whether they have set broader reasonable compatibility standards, states may accept a reasonable explanation of the difference (e.g., the individual lost a job) in lieu of requiring paper documentation.

Figure 15

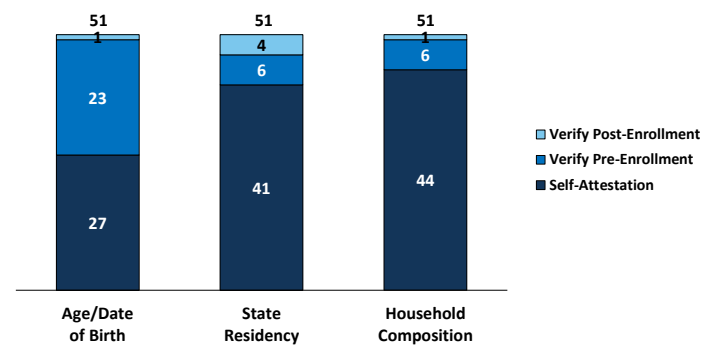
Income Verification Policies and Procedures in Medicaid, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Figure 16

Non-Financial Verification Procedures Used by Medicaid Agencies at Application, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

States' procedures to verify non-financial eligibility criteria continue to evolve as their systems and electronic verification capacity develop. For non-financial eligibility criteria, including age/date of birth, state residency, and household composition, states may accept self-attestation or verify either before or after enrollment. Accepting self-attestation expedites the process for states and applicants, particularly when the state lacks access to trusted data sources that can be used for verification purposes. For states that rely

on self-attestation, verification is required if a state has any information on file that conflicts with the self-attestation. As of January 2016, just over half of the states accept self–attestation of age/date of birth (27 states), while a majority of states do so for state residency (41 states) and household size (44 states) (Figure 16). The remaining states verify these eligibility criteria either prior to enrollment or post-enrollment, and about half of those states re-verify the information at renewal.

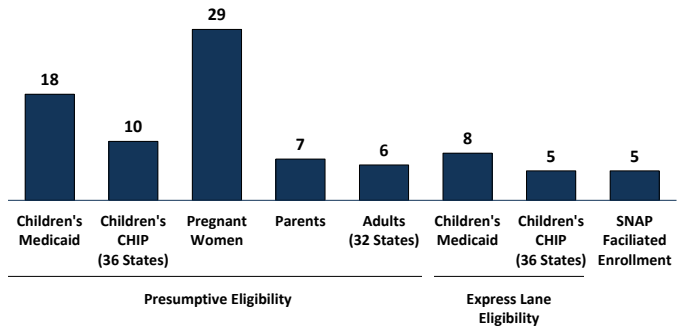
Facilitated Enrollment Options

States vary in their use of policy options to streamline enrollment. As states achieve high rates of real time eligibility determinations, the reliance on facilitated enrollment options may decline. However, there will always be some individuals who may benefit from expedited paths to enrollment since not all individuals will be able to have eligibility verified in real time. As of January 2016, states continue to rely on a range of these policy options to provide facilitated access to coverage as discussed below.

- ***Presumptive eligibility.*** Presumptive eligibility is a longstanding option in Medicaid and CHIP, which allows states to authorize qualified entities—such as community health centers or schools—to make a temporary eligibility determination to expedite access to care for children and pregnant women while the regular application is being processed. The ACA broadened the use of presumptive eligibility in two ways. First, the law allows states that use qualified entities to presumptively enroll children or pregnant women to extend the policy to parents, adults, and other groups. As of January 2016, 18 states use presumptive eligibility for children in Medicaid, 10 for children in CHIP, 29 for pregnant women, 7 for parents, and 6 for other adults (Figure 17). This count reflects expansion of the use of presumptive eligibility to parents and adults in Colorado and Montana; to children in Medicaid and CHIP, parents, and adults in Indiana; and to pregnant women in Kansas during 2015. Second, the ACA gives hospitals nationwide the authority to determine eligibility presumptively for Medicaid for all non-elderly, non-disabled individuals. Hospital-based presumptive eligibility has been implemented in 45 states as of January 2016.

Figure 17

Number of States Adopting Targeted Strategies to Streamline Enrollment of Eligible Individuals, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

- ***Express Lane Eligibility.*** Express Lane Eligibility (ELE) is another pre-ACA option that allows states to enroll children in Medicaid or CHIP based on findings from other programs, like SNAP. During 2015, Oregon discontinued the use of ELE, while Iowa began using ELE to enroll CHIP eligible children. Following this state action, eight states (Alabama, Colorado, Georgia, Iowa, Louisiana, New Jersey, New York, and South Carolina) use ELE to enroll children in Medicaid, and five states (Colorado, Georgia, Iowa, New Jersey, and Pennsylvania) use ELE to enroll CHIP eligible children as of January 2016.

- ***Facilitated enrollment using SNAP data.*** In 2013, CMS offered states new temporary facilitated enrollment options, including using SNAP data to identify and enroll eligible individuals and using child enrollment data to expedite parent enrollment. In 2015, CMS made the SNAP facilitated enrollment option permanent.[8] As of January 2016, five states (Arkansas, California, New Jersey, Oregon, and South Dakota)

are using the facilitated SNAP enrollment strategy. Given that analysis has shown that facilitated enrollment strategies contribute to success enrolling newly eligible adults and children and reducing administrative costs,[9] other states may consider adopting the SNAP enrollment practice now that it is a permanent state option.

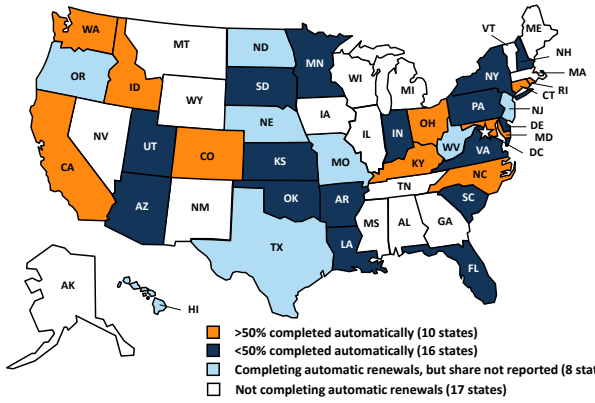
Renewal Processes

Many states eliminated delays in renewals during 2015. When the ACA was initially implemented, states and the federal government focused heavily on implementing streamlined enrollment processes and establishing coordination between Medicaid and Marketplace coverage. As a result, most states were delayed in implementing the new renewal procedures and 36 states took up a temporary option to postpone renewals for existing Medicaid or CHIP enrollees during 2014.[10] During 2015, most states caught up on renewals. As of January 2015, 47 states reported that they are up to date in processing Medicaid renewals.

States continued to implement streamlined renewal processes, with 34 states using automated renewal processes as of January 2016, including 10 states that automatically verify ongoing eligibility for more than half of MAGI-based renewals. Similar to data-driven enrollment processes, the ACA requires states to first use available data to determine if ongoing eligibility can be established without requiring the individual to fill out a renewal form or provide paper documentation. As of January 1, 2016, 34 states are using this automated renewal process—known as ex parte. Not all of these states were able to report the share of renewals that are automatically renewed through this process. However, among the 26 states that did report this data, 10 states reported that they are successfully renewing more than 50% of enrollees automatically, with 3 achieving automatic renewals rates above 75% (Figure 18). Under ACA policies, if a renewal cannot be completed automatically based on data, states must send the enrollee a pre-populated notice or renewal form. As of January 2016, 41 states report they are able to send forms or notices that are pre-populated with information (beyond demographics), and 14 states use updated sources of data to populate the form. As is the case with enrollment, the ACA also requires states to provide individuals the option to renew their coverage by telephone. As of January 2016, 41 states provide this renewal option.

Figure 18

Automated/Ex Parte Renewals for MAGI-Based Medicaid, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

States continue to use other policy tools to boost retention.

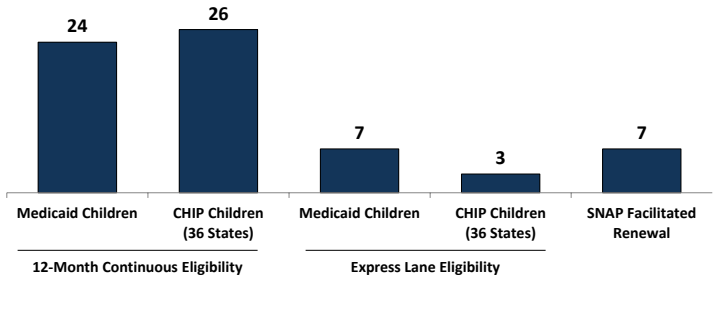
- ***12-month continuous eligibility.*** The ACA established a new policy that requires states to renew coverage no more frequently than once every 12 months. However, enrollees still are required to report changes and will lose coverage if these changes make them ineligible. One way states can provide more stable coverage over time is to provide 12-month continuous eligibility, which provides a full year of coverage regardless of changes in income or household size. This policy promotes retention and improves the ability of states to measure quality. It also reduces the number of people moving on and off of coverage due to small changes in income and lowers state administrative costs that result from processing small

changes in income. States have an option to adopt 12-month continuous eligibility for children, but must obtain a waiver to provide it to other groups. As of January 2016, 24 states provide 12-month continuous eligibility to children in Medicaid, while 26 of 36 states with a separate CHIP program have adopted the policy, including Arkansas for its newly established separate CHIP program (Figure 19). In addition, as of January 2016, New York and Montana provide 12-month continuous eligibility to parents and other adults under Section 1115 waiver authority.

- ***Express Lane Eligibility and Facilitated Renewal Using SNAP data.*** As is the case at enrollment, states can use ELE to streamline renewals. With the addition of Colorado, as of January 2016, 7 states (Alabama, Colorado, Iowa, Louisiana, Massachusetts, New York, and South Carolina) use ELE at renewal for children in Medicaid, and 3 of the 36 states with separate CHIP programs (Colorado, Massachusetts, and Pennsylvania) use ELE for CHIP renewals. In addition, Massachusetts uses ELE to renew parents and other adults in Medicaid under Section 1115 waiver authority. The new option or waiver to use SNAP data to expedite enrollment of eligible individuals also applies to using SNAP data to renew coverage for enrollees. As of January 2016, seven states (Alaska, Arkansas, New Jersey, Oregon, South Dakota, Tennessee, and Virginia) are using SNAP data to renew Medicaid coverage under the waiver or option.

Figure 19

Number of States Adopting Selected Strategies to Streamline Renewals, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Premiums and Cost-Sharing

Given that additional expenses can strain the budgets of low-income individuals and families, federal rules in Medicaid and CHIP set limits on the amounts that states can charge for premiums and cost-sharing, including copayments, coinsurance, and deductibles (see Box 1). In light of this, premiums and cost-sharing generally remain low in Medicaid and CHIP as of January 1, 2016, with few changes in 2015. However, under Section 1115 waiver authority, several states have implemented monthly contributions or premiums for adults that would not otherwise be allowed under federal rules.

Box 1: Premium and Cost-sharing Rules for Medicaid and CHIP

States have flexibility to impose premiums and cost-sharing in Medicaid. The maximum allowable charges vary by income and coverage group within federal rules:

Premiums in Medicaid. Medicaid enrollees, including children, pregnant women, parents and the adult expansion group, with incomes below 150% FPL may not be charged premiums. Premiums are allowed for Medicaid enrollees (both children and adults) with incomes above 150% FPL.

Cost-sharing in Medicaid. Children with incomes below 133% FPL generally cannot be charged cost-sharing. Cost-sharing is allowed for adults enrolled in Medicaid, but charges for those with incomes below 100% FPL are limited to nominal amounts. Cost-sharing cannot be charged for preventive services for children or emergency, family planning, or pregnancy-related services in Medicaid. Under the ACA, preventive services defined as essential health benefits in Alternative Benefit Plans (ABP) in Medicaid also are exempt from cost-sharing for any individual enrolled in an ABP.

Out-of-pocket limit in Medicaid. Overall premium and cost-sharing amounts for family members enrolled in Medicaid may not exceed five percent of household income.

Premiums and Cost-sharing in CHIP. States have somewhat greater flexibility to charge premiums and cost-sharing for children covered by CHIP, although there remain federal limits on the amounts that can be charged, including an overall cap of five percent of household income.

See: Premiums, Copayments, and other Cost-Sharing at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing.html

Premiums and Cost-Sharing For Children

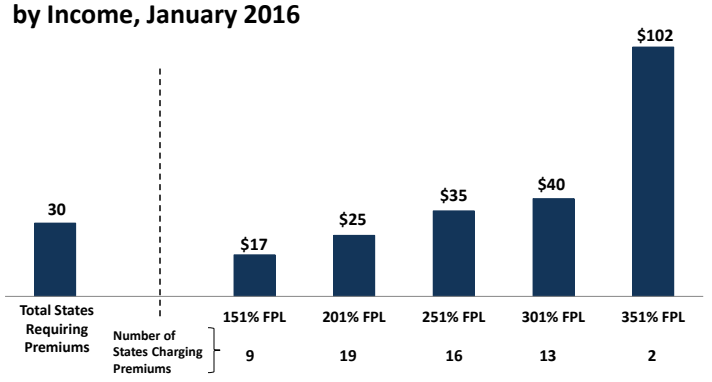
As of January 2016, 30 states charge premiums or enrollment fees for children in Medicaid or CHIP. Reflecting the ACA eligibility protections for children that extend through 2019, this count remained steady during 2015 as did most premium amounts. Under the ACA protections, states generally cannot increase premium amounts. One exception to this protection is if a state had a routine premium adjustment approved in its state Medicaid or CHIP plan prior to the enactment of the ACA on March 23, 2010. During 2015, two states (Maryland and Pennsylvania) increased premiums under such routine annual adjustments. Other changes included Michigan joining the three other states (California, Maryland and Vermont) that charge monthly premiums to children in Medicaid when it shifted all children from its separate CHIP program to Medicaid. Premiums and enrollment fees are more prevalent in CHIP than Medicaid due to the relatively higher incomes of families with children covered under CHIP and the program's more flexible premium rules.[11] Overall, 26

states charge monthly or quarterly premiums and 4 charge annual enrollment fees for children in Medicaid or CHIP. In the 26 states charging monthly or quarterly premiums, charges begin for families above 150% FPL in 19 states, including 8 states in which charges begin above 200% FPL. Median monthly premium amounts range from $17 at 151% FPL to $102 at 351% FPL, although only two states extend eligibility up to this level (Figure 20).

States vary in their policies for nonpayment of premiums. States must provide a minimum 60-day grace period in Medicaid before cancelling coverage for nonpayment of premiums and cannot require enrollees to repay outstanding premiums as a condition of reenrollment, nor can they delay reenrollment. In contrast, CHIP programs are required to provide only a minimum 30-day grace period and may impose up to a 90-day lockout period during which time a child is not allowed to reenroll. Among the 22 states that charge monthly or quarterly premiums or enrollment fees in CHIP, only 4 states limit the grace period to the minimum 30 days, while 17 states provide a 60-day or longer grace period. With the addition of New Jersey in 2015, 14 CHIP programs have a lock-out period after a child is disenrolled for nonpayment of premiums, which range from 1 month to the maximum 90 days. Sixteen states that charge monthly or quarterly payments in Medicaid or CHIP require children who have been disenrolled due to nonpayment of premiums to reapply for coverage. However, seven states reinstate coverage retroactively if outstanding premiums are repaid.

Figure 20

Median Monthly Premiums for Children in Medicaid/CHIP by Income, January 2016

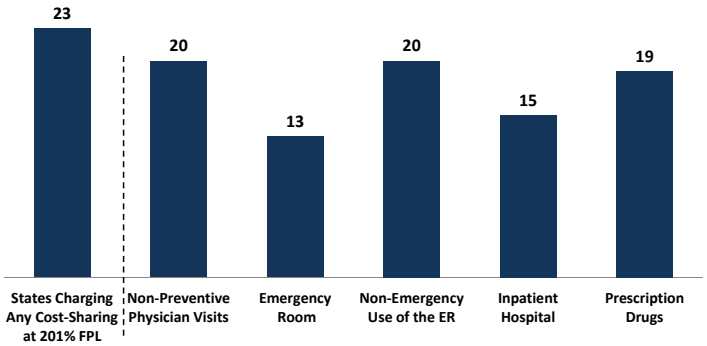


NOTE: Premiums listed at 201%, 251%, 301%, and 351% include states whose upper income levels are 200%, 250%, 300%, and 351% FPL. NV and UT require quarterly premiums that have been calculated to be monthly equivalents. Data exclude four states charging annual enrollment fees (AL, CO, NC, and TX).
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

The number of states (26 states) charging cost-sharing for children in Medicaid or CHIP, as well as the amounts of copayments remained largely constant in 2015. As of January 2016, only three states charge cost-sharing for children in Medicaid, while 25 of the 36 states with separate CHIP programs charge cost-sharing. The number of states charging cost-sharing for children did not change in 2015; however, the data reflect Arkansas' transition of children who were subject to cost-sharing in Medicaid to its new separate CHIP program. Only Tennessee charges cost-sharing for children in families with incomes below 133% FPL; under Section 1115 waiver authority, cost-sharing for children starts at the poverty level in the state. Copayments vary by service type. For example, for a child with family income at 201% FPL, 20 states charge cost-sharing for a physician visit, 13 charge for an emergency room visit, 20 charge for non-emergency use of the emergency room, 15 charge for an inpatient hospital visit, and 19 have charges for prescription drugs, although, in some cases, charges only apply to brand name or non-preferred brand name drugs (Figure 21).

Figure 21

Number of States with Cost-Sharing for Selected Services for Children at 201% FPL, January 2016



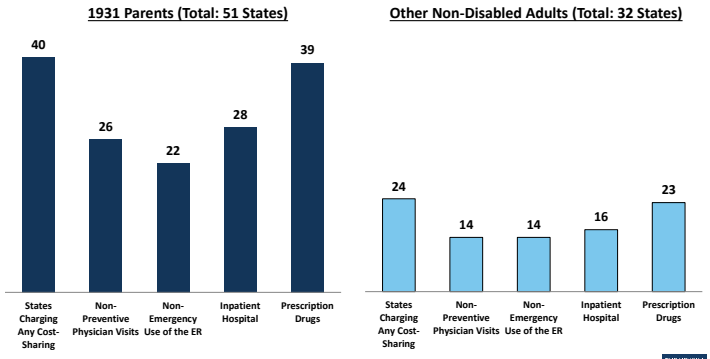
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Premiums and Cost-Sharing for Parents and Other Adults

As of January 2016, states generally do not charge premiums for low-income parents in Medicaid, but many do have cost-sharing for these parents. Because most parents covered through the Section 1931 eligibility pathway that existed pre-ACA have incomes below poverty, states generally do not charge them monthly premiums. However, during 2015, Indiana implemented monthly contributions for Section 1931 parents under waiver authority, although enrollees cannot be disenrolled due to nonpayment. Forty states charge nominal cost-sharing for Section 1931 parents in Medicaid which varies by service. As of January 2016, 26 states charge parents cost-sharing for a physician visit, 22 charge for non-emergency use of the emergency room, 28 charge for an inpatient hospital visit, and 39 charge for prescription drugs, which may be limited to brand name drugs in some cases (Figure 22). Indiana is the only state to obtain Section 1916(f) waiver authority to charge parents higher cost-sharing than otherwise allowed, which applies to non-emergency use of the emergency room. Cost-sharing for parents remained stable in 2015 with a few exceptions: Florida and Oklahoma increased and Montana decreased cost-sharing for some services, and New York raised the income level at which cost-sharing begins from 0% to 100% FPL.

Figure 22

Number of States with Cost-Sharing for Selected Services for Adults, January 2016



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

There are no premiums for expansion adults in 26 of the 31 states that have implemented the ACA Medicaid expansion, but 5 states charge premiums or monthly contributions under Section 1115 waiver authority as of January 2016. Specifically, Arkansas, Indiana, Iowa, Michigan, and Montana charge premiums and/or monthly contributions for adults with incomes above poverty. The consequences of nonpayment of these charges vary across these states. Indiana and Montana can disenroll adults above poverty due to unpaid amounts and impose a lock-out period for those disenrolled. Iowa can also disenroll adults with incomes above poverty; however, it must waive the charges for individuals who self-attest to financial hardship and individuals can reenroll at any time. In Arkansas, monthly contributions are in lieu of point-of-service copayments; adults who do not make monthly contributions are responsible for point-of-service cost-sharing charges. The waivers in Arkansas, Iowa, Indiana, and Montana also allow the states to collect monthly contributions from individuals with incomes below poverty, although Arkansas has not implemented monthly contributions at this income level as of January 2016. Individuals with incomes below poverty cannot be disenrolled due to nonpayment. (See Box 2 for more details).

As of January 2016, 23 of the 31 states that have expanded Medicaid charge expansion adults cost-sharing. In addition, Wisconsin charges the adults it covers up to 100% FPL cost-sharing. Most states have aligned cost-sharing policies for adults and Section 1931 parents, although there are differences in some states. Cost-sharing amounts are generally nominal reflecting the low incomes of adults. Overall, 14 states charge cost-sharing for a physician visit, 14 charge for non-emergency use of the emergency room, 16 charge for an inpatient hospital visit, and 23 charge for prescription drugs as of January 2016. There were few changes in cost-sharing in the past year. These changes included some increases in copayments in New Hampshire and New York raising the income at which cost-sharing begins from 0% to 100% FPL.

Box 2: Premiums/Monthly Contributions for Adults Under Section 1115 Waiver Authority

Arkansas received waiver approval to require certain enrollees to make monthly income-based contributions to health savings accounts (HSAs) to be used in lieu of paying point-of-service copayments and co-insurance. Medically-frail individuals, including those with disabilities or complex health conditions, are exempt from these payments. Monthly contributions are $10 for expansion adults with incomes between 101% - 115%, and $15 for individuals with incomes between 116% - 138%. Under the waiver, Arkansas can charge monthly HSA contributions for expansion adults with incomes down to 50% FPL, but the state is not currently charging those with incomes below poverty. Adults with incomes above poverty who fail to make monthly HSA contributions are responsible for copayments and co-insurance at the point of service, and providers can deny services for failure to pay cost-sharing. Cost-sharing charges are at amounts otherwise allowed under federal law.

In **Iowa**, the waiver allows the state to impose monthly contributions of $5 per month for non-medically frail beneficiaries with incomes between 50% and 100% FPL and $10 per month for non-medically frail beneficiaries with incomes above poverty beginning as of the second year of enrollment. The state cannot disenroll individuals below poverty due to unpaid premiums. Individuals above poverty have a 90-day grace period to pay past-due premiums before they are disenrolled, and the state must waive premiums for enrollees who self-attest to financial hardship. Individuals who are disenrolled for nonpayment can reenroll at any time.

The waiver in **Indiana** imposes monthly contributions at 2% of income for most newly eligible adults and Section 1931 parents. Those with incomes between 0% and 5% FPL must pay $1.00 per month. Individuals with incomes below poverty cannot be disenrolled due to nonpayment but receive a more limited benefit package and are subject to copayments at the point of service. (Medically frail individuals are not placed in the more limited benefit package.) Individuals above poverty are not enrolled in coverage until they make their first monthly payment. In addition, non-medically frail individuals above poverty can be disenrolled due to nonpayment after a 60-day grace period and are subject to a 6-month lock-out period.

Michigan's waiver provides for monthly premiums of 2% of income for enrollees with incomes above poverty, as well as monthly payments into HSAs based on their prior six months of copayments for services used. The copayments are at the same level as what would have been collected without the waiver. Enrollees cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copayments or premiums.[12]

In **Montana**, non-medically frail expansion adults with incomes above 50% FPL are subject to monthly premiums of 2% of income. Enrollees receive a credit in the amount of their premiums toward copayments incurred, so that they effectively only have to pay copayments that exceed 2% of income. Those with incomes above poverty can be disenrolled for nonpayment after notice and a 90-day grace period and can reenroll upon payment of arrears or after the debt is assessed against their state income taxes, no later than the end of the calendar quarter. Reenrollment does not require a new application, and the state must establish a process to exempt beneficiaries from disenrollment for good cause. Individuals below poverty cannot be disenrolled for nonpayment of premiums.

Source: M. Musumeci and R. Rudowitz, "The ACA and Medicaid Expansion Waivers," The Kaiser Commission on Medicaid and the Uninsured, November 2015, available at http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers

Looking Ahead

States' Medicaid and CHIP eligibility policies and enrollment and renewal processes will play a key role in reaching the remaining low-income uninsured population and keeping eligible individuals enrolled over time. Together, these survey findings show that:

Medicaid and CHIP continue to be central sources of coverage for the low-income population, but access to coverage varies widely across groups and states. Medicaid and CHIP offer a base of coverage to low-income children and pregnant women nationwide. Eligibility for adults has grown under the Medicaid expansion, but remains low in states that have not expanded. Overall, eligibility continues to vary significantly by group, with coverage available to children and pregnant women at higher income levels relative to parents and other adults. Eligibility also varies across states, and these differences have increased as a result of state Medicaid expansion decisions. Given this variation, there are substantial differences in individuals' access to coverage based on their eligibility group and where they live.

Upgraded state Medicaid systems help eligible individuals connect to and retain coverage over time, provide gains in administrative efficiencies, and offer new options to support program management. One key outcome of the ACA has been the significant modernization of states' Medicaid eligibility and enrollment systems. Although state implementation of new eligibility systems got off to a rocky start in 2014, as of 2016, states have implemented system enhancements and processes to increasingly support real-time, data driven eligibility determinations and automatic, paperless renewals of coverage as envisioned by the ACA. The higher-functioning systems in states help eligible individuals connect to coverage more quickly and easily, keep eligible individuals enrolled over time, reduce paperwork burdens, and lead to increased administrative efficiencies as paper-based processes move to an electronic, automated environment. Moreover, the modernized systems offer new options to support program management. For example, states may have increased data reporting capabilities and expanded options to connect Medicaid with other systems and programs. Further, as systems and processes become more refined over time, states may be able to manage enrollment more efficiently, allowing for resources to be refocused on other activities. Looking ahead, states will continue to fully operationalize the streamlined enrollment and renewal processes outlined in the ACA and build on their developments to date to increase the use of technology, expand functionality, smooth out coordination across coverage programs, and integrate non-health programs into their new systems.

There remain key questions about how recent changes in eligibility and enrollment may be affected by a range of factors moving forward. Funding for CHIP is set to expire in 2017, raising key questions about the future of the program and what might happen in its absence. In addition, the ACA maintenance of effort provisions for children's coverage end in 2019. State Medicaid expansion decisions will likely continue to evolve over time, and it remains to be seen how they might be affected by the gradual reduction in federal funding for newly eligible expansion adults, which begins to phase down in 2017 when it reduces to 95%. Pending proposals in current budget reconciliation legislation would roll back the Medicaid expansion to adults and eliminate the maintenance of effort requirements in 2017. Outside of these potential changes, it also will be important to examine how the Section 1115 waivers that allow states to charge adults premiums and monthly contributions are affecting coverage and program administration, particularly given that waiver authority is provided for research and demonstration purposes.

Endnotes

[1] Iowa also used state funds to cover immigrant children in foster care.

[2] This group of adults may include some adults with disabilities who are not eligible for Medicare.

[3] MaryBeth Musumeci and Robin Rudowitz, *The ACA and Medicaid Expansion Waivers* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2015), http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/.

[4] Stan Dorn and Jennifer Tolbert, *The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2014), http://kff.org/health-reform/report/the-acas-basic-health-program-option-federal-requirements-and-state-trade-offs/.

[5] Rachel Garfield and Anthony Damico*, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2015), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

[6] 80 *Fed. Reg*. 75817-75843 (December 4, 2015). Available at https://www.federalregister.gov/articles/2015/12/04/2015-30591/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010.

[7] Kevin Concannon, Kevin Counihan, Mark Greenberg and Victoria Wachino, Tri-Agency Letter on *Additional Guidance to States on the OMB Circular A-87 Cost Allocation Exception*, July 20, 2015. Available at http://www.medicaid.gov/federal-policy-guidance/downloads/SMD072015.pdf.

[8] Vikki Wachino, CMS Letter to State Medicaid Directors and State Health Officials, SHO # 15-001; ACA #34 *Re: Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies*, August 31, 2015. Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-15-001.pdf.

[9] Jocelyn Guyer, Tanya Schwartz, and Samantha Artiga, *Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2013), http://kff.org/medicaid/issue-brief/fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion/.

[10] "Targeted Enrollment Strategies," CMS, accessed December 2015, http://www.medicaid.gov/medicaid-chip-program-information/program-information/targeted-enrollment-strategies/targeted-enrollment-strategies.html.

[11] The Medicaid and CHIP Payment and Access Commission (MACPAC) has indicated that the prevalent use of premiums in CHIP leads to the problem of 'premium stacking' for families, in which families have to pay both premiums for children enrolled in CHIP and for adults enrolled in Marketplace coverage. MACPAC notes that these combined premiums could constitute a percentage of a family's income that is higher than the limits established by the ACA. For more information see Medicaid and CHIP Payment and Access Commission, "Chapter 5: Children's Coverage under CHIP and Exchange Plans," in *Report to the Congress on Medicaid and CHIP* (Washington, DC: March 2014), 150-182, https://www.macpac.gov/wp-content/uploads/2015/01/2014-03-14_Macpac_Report.pdf.

[12] On December 17, 2015, Michigan received approval for a waiver amendment. Under the approved waiver amendment, beneficiaries between 100% and 138% FPL who are not medically frail could choose between two coverage options as of April 2018: continued coverage through Medicaid managed care or the Healthy Michigan Plan or Marketplace coverage through a Qualified Health Plan (QHP) or the Marketplace Option. If beneficiaries choose Medicaid managed care, they will be required to meet a healthy behavior requirement or they could be transitioned to a QHP plan. Beneficiaries above 100% FPL would face monthly premiums of up to 2% of income in both Healthy Michigan and QHPs, but failure to pay would not result in termination of eligibility. See, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Michigan* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2016), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/.

Trend and State-by-State Tables

Table A
Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies[1]
July 2000 to January 2016

	Program	July 2000	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013	January 2015	January 2016
ELIGIBILITY															
Cover children ≥200% FPL	**N/A**	36	40	39	39	41	41	45	44	47	47	47	47	48	48
Cover children ≥300% FPL	**N/A**	5	6	6	6	6	8	9	10	16	16	17	17	19	19
Cover lawfully-residing immigrant children without five-year wait	**Medicaid**	Option Not Available								17	21	24	25	28	29
	CHIP														19
Cover pregnant women ≥200% FPL	**N/A**	Not Collected		17	16	17	17	20	21	24	25	25	25	33	33
Cover lawfully-residing immigrant pregnant women without five-year wait	**Medicaid**	Option Not Available								14	17	18	20	23	23
	CHIP														4
Cover parents ≥100% FPL[2]	**N/A**	Not Collected	20	16	17	17	16	18	18	17	18	18	18	31	34
Cover childless adults[2]	**N/A**	Not Collected									7	8	25	29	32
Asset test not required	**Medicaid**	42	45	45	46	47	47	47	47	48	48	48	48	51*	51*
	CHIP	31	34	34	33	33	34	35	36	37	36	37	36		
	Parents	Not Collected	19	21	22	22	21	22	23	24	24	24	24		
STREAMLINED ENROLLMENT PROCESSES															
Online Medicaid application[3]	**Medicaid**	Not Collected									32	34	36	50	50
Telephone Medicaid application[3]	**Medicaid**	Not Collected											17	47	49
Presumptive eligiblity for children	**Medicaid**	8	9	7	8	9	9	14	14	14	16	16	17	15	18
	CHIP	4	5	4	6	6	6	9	9	9	10	11	12	9	10
Presumptive eligibility for pregnant women	**Medicaid**	Not Collected		29	29	30	31	30	30	30	31	31	32	27	29
	CHIP														2
No face-to-face interview at enrollment[3]	**Medicaid**	40	47	46	45	45	46	46	48	48	49	49	49	51*	51*
	CHIP	31	34	33	33	33	33	34	38	38	37	38	37		
	Parents	Not Collected	35	36	36	36	39	40	41	41	44	45	45		
STREAMLINED RENEWAL PROCESSES															
Ex parte renewals	**N/A**	Not Collected													34
Telephone Medicaid renewal	**N/A**	Not Collected													41
No face-to-face interview at renewal[3]	**Medicaid**	43	48	49	48	48	48	48	49	50	50	50	50	51*	51*
	CHIP	32	34	35	35	35	35	36	38	38	37	38	37		
	Parents		35	42	42	43	45	46	46	46	46	48	48		
12-month eligibility period[3]	**Medicaid**	39	42	42	41	42	44	45	44	47	49	49	49	51*	51*
	CHIP	23	33	33	32	34	34	37	39	39	38	28	38		
	Parents		38	38	36	36	39	40	40	43	45	46	46		
12-month continuous eligibility	**Medicaid**	14	18	15	15	17	16	16	18	22	23	23	23	21	24
	CHIP	22	23	21	21	24	25	27	30	30	28	28	27	25	26

SOURCES: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 2000-2009; and with the Georgetown University Center for Children and Families, 2011-2015.

*See S. Artiga, M. Musumeci, and R. Rudowitz, "Medicaid Eligibility, Enrollment Simplification, and Coordination Under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule," December 2012

1. The numbers in this table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year.

2. These counts do not include states that may have provided coverage above the levels shown using state-only funding or provide a more limited benefit package.

3. Required across all states under the Affordable Care Act (ACA). States are in varied stages of implementing the new streamlined enrollment and renewal processes under the ACA, and mitigation strategies are in place in cases in which requirements have not been met.

Table 1

Upper Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level (FPL)[1]

January 2016

State	Upper Income Limit	Medicaid for Infants Ages 0-1[2]		Medicaid for Children Ages 1-5[2]		Medicaid for Children Ages 6-18[2]		Separate CHIP for Uninsured Children Ages 0-18[3]
		Medicaid Funded	CHIP-Funded	Medicaid Funded	CHIP-Funded	Medicaid Funded	CHIP-Funded	
Alabama	317%	146%		146%		146%	146%	317%
Alaska	208%	177%	208%	177%	208%	177%	208%	
Arizona[4]	152%	152%		146%		138%	138%	200% (closed)
Arkansas[5]	216%	147%		147%		147%	147%	216%
California[6]	266%	208%	266%	142%	266%	133%	266%	
Colorado	265%	147%		147%		147%	147%	265%
Connecticut	323%	201%		201%		201%		323%
Delaware	217%	194%	217%	147%		138%	138%	217%
District of Columbia	324%	324%	324%	324%	324%	324%	324%	
Florida[7,8]	215%	211%	211%	145%		138%	138%	215%
Georgia	252%	210%		154%		138%	138%	252%
Hawaii	313%	191%	313%	139%	313%	133%	313%	
Idaho	190%	147%		147%		138%	138%	190%
Illinois[9]	318%	147%		147%		147%	147%	318%
Indiana[10]	263%	218%		165%	165%	165%	165%	262%
Iowa	380%	380%	380%	172%		172%	172%	307%
Kansas[11]	244%	171%		154%		138%	138%	244%
Kentucky	218%	200%		142%	164%	142%	164%	218%
Louisiana	255%	142%	217%	142%	217%	142%	217%	255%
Maine[8,12]	213%	196%		162%	162%	162%	162%	213%
Maryland	322%	194%	322%	138%	322%	133%	322%	
Massachusetts[13]	305%	205%	205%	155%	155%	155%	155%	305%
Michigan[14]	217%	195%	217%	160%	217%	160%	217%	
Minnesota[15]	288%	275%	288%	280%		280%		
Mississippi	214%	199%		148%		138%	138%	214%
Missouri	305%	201%		155%	155%	155%	155%	305%
Montana	266%	148%		148%		148%		266%
Nebraska	218%	162%	218%	145%	218%	133%	218%	
Nevada	205%	165%		165%		138%	138%	205%
New Hampshire	323%	196%	323%	196%	323%	196%	323%	
New Jersey	355%	199%		147%		147%	147%	355%
New Mexico	305%	240%	305%	240%	305%	190%	245%	
New York[8]	405%	223%		154%		154%	154%	405%
North Carolina[8]	216%	215%	215%	215%	215%	138%	138%	216%
North Dakota	175%	152%		152%		138%	138%	175%
Ohio	211%	156%	211%	156%	211%	156%	211%	
Oklahoma[16]	210%	210%	210%	210%	210%	210%	210%	
Oregon	305%	190%	190%	138%		138%	138%	305%
Pennsylvania[8]	319%	220%		162%		138%	138%	319%
Rhode Island	266%	190%	266%	142%	266%	133%	266%	
South Carolina	213%	194%	213%	143%	213%	133%	213%	
South Dakota	209%	187%	187%	187%	187%	187%	187%	209%
Tennessee[17]	255%	195%	216%	142%	216%	133%	216%	255%
Texas	206%	203%		149%		138%	138%	206%
Utah	205%	144%		144%		138%	138%	205%
Vermont	317%	317%	317%	317%	317%	317%	317%	
Virginia	205%	148%		148%		148%	148%	205%
Washington	317%	215%		215%		215%		317%
West Virginia	305%	163%		146%		138%	138%	305%
Wisconsin[18]	306%	306%		191%		133%	156%	306%
Wyoming	205%	159%		159%		138%	138%	205%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 1 Notes

1. January 2016 income limits reflect MAGI-converted income standards and include a disregard equal to five percentage points of the federal poverty level (FPL) applied at the highest income level for Medicaid and separate CHIP coverage. Eligibility levels are reported as percentage of the FPL. The 2015 FPL for a family of three was $20,090.
2. States may use Title XXI CHIP funds to cover children through CHIP-funded Medicaid expansion programs and/or separate child health insurance programs for children not eligible for Medicaid. Use of Title XXI CHIP funds is limited to uninsured children. The Medicaid income eligibility levels listed indicate thresholds for children covered with Title XIX Medicaid funds and uninsured children covered with Title XXI funds through CHIP-funded Medicaid expansion programs. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may either provide benefits similar to Medicaid or a somewhat more limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children. These programs typically provide coverage for uninsured children until the child's 19th birthday.
4. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009, prior to the ACA's maintenance of effort requirement. A temporary successor program, KidsCare II, was eliminated on January 31, 2014. As of April 2015, less than 1,300 children remain enrolled in the original KidsCare program.
5. Arkansas converted its CHIP-funded Medicaid expansion program to a separate CHIP program in 2015.
6. In California, children with higher incomes may be eligible for separate CHIP coverage in certain counties.
7. Florida operates three CHIP-funded separate programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations; MediKids covers children ages 1 through 4; and the Children's Medical Service Network serves children with special health care needs from birth through age 18.
8. Florida, Maine, New York, North Carolina, and Pennsylvania allow families with incomes above the levels shown to buy into Medicaid/CHIP. For details, see Table 3.
9. In Illinois, infants born to non-Medicaid covered mothers are covered up to 147% FPL in Medicaid, and up to 318% FPL under CHIP. Infants born to mothers enrolled in Medicaid coverage are deemed eligible for Medicaid until age 1.
10. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
11. Kansas covers children in a separate CHIP program at an income level equal to 238% FPL in 2008. In 2016, the equivalent eligibility level adjusted for the conversion to Modified Adjusted Gross Income and reflecting the five percentage point of income disregard is 244% FPL.
12. In Maine, children ages 0-1 not born to mothers covered under Medicaid are eligible up to 196% FPL.
13. Massachusetts also covers insured children up to its separate CHIP program income limit under a Section 1115 waiver.
14. Michigan converted its separate CHIP program to a CHIP-funded Medicaid expansion program as of January 2016.
15. In Minnesota, the infant category under Title XIX-funded Medicaid includes insured and uninsured children up to age two with incomes up to 275% FPL. Under Title XXI-funded coverage for uninsured children, eligibility for infants is up to 288% FPL.
16. Oklahoma offers a premium assistance program to children ages 0 - 18 with income up to 222% FPL with access to employer sponsored insurance through its Insure Oklahoma program.

17. In Tennessee, Title XXI funds are used for two programs, TennCare Standard and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 216% FPL or are medically eligible.
18. In Wisconsin, a child is not eligible for CHIP if they have access to health insurance coverage through a job where the employer covers at least 80% of the cost.

Table 2
Waiting Period for CHIP Enrollment
January 2016

State	Waiting Period[1]	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total No Waiting Period	**34**	
Alabama	None	
Alaska	None	
Arizona[2]	Enrollment closed	
Arkansas	90 days	
California	None	
Colorado	None	
Connecticut	None	
Delaware	None	
District of Columbia	None	
Florida	2 months	
Georgia	2 months	
Hawaii	None	
Idaho	None	
Illinois	90 days	Below 209%
Indiana	90 days	
Iowa	1 month	Below 200%
Kansas	90 days	Below 200%
Kentucky	None	
Louisiana	90 days	Below 212%
Maine	90 days	
Maryland	None	
Massachusetts	None	
Michigan[3]	None	
Minnesota	None	
Mississippi	None	
Missouri	None	
Montana	None	
Nebraska	None	
Nevada	None	
New Hampshire	None	
New Jersey	90 days	Below 200%
New Mexico	None	
New York	90 days	Below 250%
North Carolina	None	
North Dakota	90 days	
Ohio	None	
Oklahoma	None	
Oregon	None	
Pennsylvania	None	
Rhode Island	None	
South Carolina	None	
South Dakota	90 days	
Tennessee	None	
Texas	90 days	
Utah	90 days	
Vermont	None	
Virginia	None	
Washington	None	
West Virginia	None	
Wisconsin[4]	None	
Wyoming	1 month	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.
Table presents rules in effect as of January 1, 2016.

Table 2 Notes

1. "Waiting period" refers to the length of time a child is required to be without group coverage prior to enrolling in CHIP coverage. Waiting periods generally apply to separate CHIP programs only, as they are not permitted in Medicaid without a waiver. The ACA limits waiting periods to no more than 90 days, and states must waive the waiting period for specific good causes established in federal regulations. States may adopt additional exceptions to the waiting period, which vary by state. In addition to the income exemptions shown, specific categories of children such as newborns may be exempt from the waiting periods.
2. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009, prior to the ACA's maintenance of effort requirement.
3. In Michigan, the waiting period was eliminated effective January 1, 2016, as children transitioned from separate CHIP to Medicaid expansion coverage.
4. Wisconsin eliminated its income-based exemption from the CHIP waiting period in July 2015.

Table 3
Optional Medicaid and CHIP Coverage for Children
January 2016

State	Buy-In Program (Income Eligibility as a Percent of the FPL)[1]	Coverage for Dependents of State Employees in CHIP (Total =36)[2]	Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]		Medicaid Coverage of Former Foster Youth up to Age 26 Extends to Youth from Other States[4]
			Medicaid	CHIP (Total = 36)	
Total	**5**	**15**	**29**	**19**	**13**
Alabama		Y			
Alaska		N/A (M-CHIP)		N/A (M-CHIP)	
Arizona					
Arkansas		Y			
California[7]		N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
Colorado[5]		Y	Y	Y	
Connecticut[6]		Y	Y	Y	
Delaware			Y	Y	
District of Columbia[7]		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Florida[8]	>215%	Y			
Georgia		Y			Y
Hawaii		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Idaho					
Illinois[7]			Y	Y	
Indiana					
Iowa[7]			Y	Y	
Kansas					
Kentucky		Y	Y	Y	Y
Louisiana					Y
Maine[9]	>213%		Y	Y	
Maryland		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Massachusetts[7,10]			Y	Y	Y
Michigan		N/A (M-CHIP)		N/A (M-CHIP)	Y
Minnesota		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Mississippi		Y			
Missouri					
Montana		Y	Y	Y	Y
Nebraska		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Nevada[11]		Y			
New Hampshire		N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey			Y	Y	
New Mexico[12]		N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
New York[7]	>405%		Y	Y	Y
North Carolina[13]	>216%	Y	Y	Y	
North Dakota					
Ohio		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)		N/A (M-CHIP)	
Oregon			Y	Y	
Pennsylvania[14]	>319%	Y	Y	Y	Y
Rhode Island		N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Carolina		N/A (M-CHIP)		N/A (M-CHIP)	
South Dakota					Y
Tennessee					
Texas		Y	Y	Y	
Utah					
Vermont		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Virginia[11]		Y	Y	Y	Y
Washington[7]			Y	Y	
West Virginia		Y	Y	Y	
Wisconsin			Y	Y	Y
Wyoming					

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.
Table presents rules in effect as of January 1, 2016.

Table 3 Notes

1. States with a buy-in program allow families with incomes over the upper income eligibility limit for children's coverage (including the 5 percentage point disregard), to buy into Medicaid or CHIP for their children.
2. This column indicates whether the state has adopted the option to cover otherwise eligible children of state employees in a separate CHIP program. Under the option, states may receive federal funding to extend CHIP eligibility where the state has maintained its contribution levels for health coverage for employees with dependent coverage or where it can demonstrate that the state employees' out-of-pocket health care costs pose a financial hardship for families.
3. This column indicates whether the state has received approval through a State Plan Amendment and implemented coverage for immigrant children who have been lawfully residing in the U.S. for less than five years, otherwise known as the Immigrant Children's Health Improvement Act (ICHIA) option.
4. Under the ACA, all states must provide Medicaid coverage to youth up to age 26 who were in foster care in the state as of their 18th birthday and enrolled in Medicaid. This column indicates whether the state has elected the option to also provide Medicaid coverage to former foster youth up to age 26 who were enrolled in Medicaid in another state as of their 18th birthday.
5. Colorado passed legislation authorizing coverage of lawfully residing immigrant children in 2012; it implemented this coverage in July 2015.
6. Connecticut eliminated its buy-in program as of August 1, 2015.
7. The District of Columbia, Illinois, Massachusetts, New York, and Washington cover income-eligible children regardless of immigration status using state-only funds. In California, some local programs cover immigrant children regardless of immigration status. Legislation was approved in 2015 to cover all income-eligible children regardless of immigration status statewide; implementation is planned for 2016. Iowa also uses state-only funds to cover immigrant children in foster care.
8. In Florida, families can buy into Healthy Kids coverage for children ages 5 to 19 and into MediKids coverage for children ages 1 to 4.
9. Maine has a buy-in program called the Health Insurance Purchase Option. The program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 18 months.
10. Massachusetts offers more limited state-subsidized coverage to children at any income through its Children's Medical Security Plan program; premiums vary based on income. Massachusetts also has buy-in coverage limited to children with disabilities with no income limit.
11. Nevada and Virginia began using CHIP funds to cover some dependents of state employees as January 2016.
12. New Mexico began covering former foster children from other states as of October 2015.
13. In North Carolina, eligibility for the buy-in program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 12 months. The upper limit for the buy-in program was eliminated during 2015.
14. In Pennsylvania, CHIP coverage for dependents of state employees is limited to part-time and seasonal employees who meet a hardship exemption.

Table 4
Medicaid and CHIP Coverage for Pregnant Women
January 2016

State	Income Eligibility Limits (Percent of the FPL)[1]			Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]		Full Medicaid/CHIP Benefit Package for Pregnant Women[4]	
	Medicaid (Title XIX)	CHIP (Title XXI)	Unborn Child Option (Title XXI)[2]	Medicaid	CHIP (Total = 5)	Medicaid	CHIP (Total = 5)
Total	**51**	**5**	**15**	**23**	**4**	**45**	**5**
Alabama[5]	146%				N/A	Y	N/A
Alaska[5]	205%				N/A	Y	N/A
Arizona	161%				N/A	Y	N/A
Arkansas[6]	214%		214%		N/A		N/A
California	213%		322%	Y	N/A		N/A
Colorado[7]	200%	265%		Y	Y	Y	Y
Connecticut	263%			Y	N/A	Y	N/A
Delaware	217%			Y	N/A	Y	N/A
District of Columbia[8]	211%	324%		Y	Y	Y	Y
Florida	196%				N/A	Y	N/A
Georgia	225%				N/A	Y	N/A
Hawaii	196%			Y	N/A	Y	N/A
Idaho	138%				N/A		N/A
Illinois	213%		213%		N/A	Y	N/A
Indiana[9]	218%				N/A	Y	N/A
Iowa	380%				N/A	Y	N/A
Kansas	171%				N/A	Y	N/A
Kentucky	200%				N/A		N/A
Louisiana	138%		214%		N/A	Y	N/A
Maine	214%			Y	N/A	Y	N/A
Maryland	264%			Y	N/A	Y	N/A
Massachusetts	205%		205%	Y	N/A	Y	N/A
Michigan	200%		200%		N/A	Y	N/A
Minnesota	283%		283%	Y	N/A	Y	N/A
Mississippi	199%				N/A	Y	N/A
Missouri	201%				N/A	Y	N/A
Montana	162%				N/A	Y	N/A
Nebraska	199%		202%	Y	N/A	Y	N/A
Nevada	165%				N/A	Y	N/A
New Hampshire	201%				N/A	Y	N/A
New Jersey[8]	199%	205%		Y	Y	Y	Y
New Mexico	255%			Y	N/A		N/A
New York[5,8]	223%			Y	N/A	Y	N/A
North Carolina	201%			Y	N/A	Y	N/A
North Dakota	152%				N/A	Y	N/A
Ohio	205%			Y	N/A	Y	N/A
Oklahoma[10]	138%		190%		N/A	Y	N/A
Oregon	190%		190%		N/A	Y	N/A
Pennsylvania	220%			Y	N/A	Y	N/A
Rhode Island	195%	258%	258%			Y	Y
South Carolina	199%				N/A	Y	N/A
South Dakota[11]	138%				N/A		N/A
Tennessee	200%		255%		N/A	Y	N/A
Texas	203%		207%		N/A	Y	N/A
Utah	144%				N/A	Y	N/A
Vermont	213%			Y	N/A	Y	N/A
Virginia	148%	205%		Y	Y	Y	Y
Washington	198%		198%	Y	N/A	Y	N/A
West Virginia	163%			Y	N/A	Y	N/A
Wisconsin	306%		306%	Y	N/A	Y	N/A
Wyoming	159%			Y	N/A	Y	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.
Table presents rules in effect as of January 1, 2016.

Table 4 Notes

1. January 2016 income limits reflect MAGI converted income standards, and include a disregard equal to five percentage points of the federal poverty level (FPL). As of 2015, the FPL for a family of three in 2015 was $20,090.
2. The unborn child option permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
3. These columns indicate whether the state received approval through a State Plan Amendment to adopt and has implemented the option to cover immigrant pregnant women who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option.
4. These columns indicate whether pregnant beneficiaries in the state receive the full Medicaid or CHIP benefit package. During a presumptive eligibility period, pregnant women receive only prenatal and pregnancy-related benefits. Pregnant women who are covered through the unborn child option may receive more limited pregnancy-related benefits. N/A responses indicate that the state does not provide CHIP coverage to pregnant women.
5. In 2015, Alabama, Alaska and New York implemented full Medicaid benefits for pregnant women.
6. Arkansas provides the full Medicaid benefits to pregnant women with incomes up to levels established for the old Aid to Families with Dependent Children (AFDC) program, which is $124 per month. Above those levels, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid and the unborn child option in CHIP with incomes up to 209% FPL.
7. Colorado passed legislation authorizing coverage of lawfully residing immigrant pregnant women in CHIP during 2012; it implemented this coverage in July 2015.
8. The District of Columbia, New Jersey, and New York provide pregnancy-related services not covered through emergency Medicaid for some income-eligible pregnant women regardless of immigration status using state-only funds.
9. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
10. Oklahoma offers a premium assistance program to pregnant women with incomes up to 205% FPL who have access to employer sponsored insurance through its Insure Oklahoma program.
11. South Dakota provides full Medicaid benefits to pregnant women with incomes up to $591 per month (for a family of three). Above those levels, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid.

Table 5
Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level[1]
January 2016

State	Parents (in a family of three)		Childless Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Alabama	18%	18%	0%
Alaska[2]	143%	143%	138%
Arizona	106%	138%	138%
Arkansas	16%	138%	138%
California	109%	138%	138%
Colorado	68%	138%	138%
Connecticut[3]	155%	155%	138%
Delaware	87%	138%	138%
District of Columbia[4]	221%	221%	215%
Florida	34%	34%	0%
Georgia	37%	37%	0%
Hawaii[4]	100%	138%	138%
Idaho	26%	26%	0%
Illinois	25%	138%	138%
Indiana[5]	18%	139%	139%
Iowa	52%	138%	138%
Kansas	38%	38%	0%
Kentucky	20%	138%	138%
Louisiana	24%	24%	0%
Maine	105%	105%	0%
Maryland	123%	138%	138%
Massachusetts[4,6]	138%	138%	138%
Michigan	54%	138%	138%
Minnesota[7]	138%	138%	138%
Mississippi	27%	27%	0%
Missouri	22%	22%	0%
Montana[8]	45%	138%	138%
Nebraska[9]	63%	63%	0%
Nevada	29%	138%	138%
New Hampshire[10]	57%	138%	138%
New Jersey	30%	138%	138%
New Mexico	45%	138%	138%
New York[4,7]	90%	138%	138%
North Carolina	44%	44%	0%
North Dakota	52%	138%	138%
Ohio	90%	138%	138%
Oklahoma[11]	44%	44%	0%
Oregon	36%	138%	138%
Pennsylvania[4,12]	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	52%	52%	0%
Tennessee	101%	101%	0%
Texas[13]	18%	18%	0%
Utah[14]	45%	45%	0%
Vermont[15]	45%	138%	138%
Virginia[16]	39%	39%	0%
Washington	48%	138%	138%
West Virginia	18%	138%	138%
Wisconsin[17]	100%	100%	100%
Wyoming	57%	57%	0%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 5 Notes

1. January 2016 income limits reflect MAGI-converted income standards, and include a disregard equal to five percentage points of the federal poverty level (FPL) applied to the highest income limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. Eligibility levels for parents are presented as a percentage of the 2015 FPL for a family of three, which is $20,090. Eligibility limits for other adults are presented as a percentage of the 2015 FPL for an individual, which is $11,770.
2. Alaska expanded Medicaid to adults as a state plan option during 2015.
3. Connecticut reduced parent eligibility from 201% to 155% FPL during 2015.
4. The District of Columbia, Hawaii, Massachusetts, New York, and Pennsylvania cover some income-eligible adults, regardless of immigration status using state-only funds.
5. Indiana expanded Medicaid to adults in February 2015 under Section 1115 waiver authority. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
6. Massachusetts also provides subsidies for Marketplace coverage for parents and childless adults with incomes up to 300% through its Connector Care program. The state's Section 1115 waiver also authorizes MassHealth coverage for HIV-positive individuals with incomes up to 200% FPL, uninsured individuals with breast or cervical cancer with incomes up to 250% FPL, and individuals who work for a small employer and purchase ESI with incomes up to 300% FPL, as well as coverage through MassHealth CommonHealth for adults with disabilities with no income limit.
7. Minnesota and New York received approval to implement a Basic Health Program (BHP) established by the ACA. Minnesota received approval in December 2014, and transferred coverage for Medicaid enrollees with incomes between 138% - 200% FPL to the BHP as of January 1, 2015. New York began phasing in its BHP during 2015 and will complete the phased-in implementation as of January 1, 2016.
8. Montana expanded Medicaid to adults under Section 1115 waiver authority as of January 1, 2016. When the state implemented the expansion, it reduced Section 1931 eligibility for parents to the minimum level allowed under federal rules.
9. Nebraska converted the basis of 1931 parent eligibility from a dollar threshold to a percent of the FPL during 2015, which resulted in a small increase in the income eligibility limit.
10. New Hampshire converted its Medicaid expansion to low-income adults from state option to under Section 1115 waiver authority effective January 1, 2016.
11. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance though the Insure Oklahoma Section 1115 waiver program. Individuals working for certain qualified employers with incomes at or below 200% FPL are eligible for premium assistance for employer-sponsored insurance.
12. Pennsylvania converted its Medicaid expansion to low-income adults from under Section 1115 waiver authority to the state option during 2015.
13. In Texas, the income limit for parents and other caretaker relatives is based on monthly dollar amounts which vary based on whether it is a one-parent family or a two-parent family and the family size. The eligibility level shown is for a single parent household and a family size of three.
14. In Utah, adults with incomes up to 100% FPL are eligible for coverage of primary care services under the Primary Care Network Section 1115 waiver program. Enrollment is opened periodically when there is capacity to accept new enrollees.

15. Vermont also provides a 1.5% reduction in the federal applicable percentage of the share of premium costs for individuals who qualify for advance premium tax credits to purchase Marketplace coverage with income up to 300% FPL.
16. In Virginia, eligibility levels for 1931 parents vary by region. The value shown is the eligibility level for Region 2, the most populous region.
17. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA Medicaid expansion.

Table 6
MAGI Eligibility Systems
January 2016

State	Able to Make Real-Time Determinations (<24 Hours)[1]	Share of MAGI-Based Applications With a Determination Completed in Real-Time[1]				Integrated with CHIP (Total = 36)[2]	Integrated with Non-MAGI Medicaid[2]	Integrated with:[2]		
		<25%	25%-50%	50%-75%	75%+			SNAP	TANF	Child Care Subsidy
Total	**37**	**12**	**4**	**2**	**9**	**34**	**24**	**17**	**17**	**7**
Alabama	Y				Y	Y				
Alaska						N/A (M-CHIP)				
Arizona	Y	Y				Y	Y			
Arkansas	Y	Y				Y				
California[3]	Y		Y			N/A (M-CHIP)				
Colorado[4]	Y				Y	Y	Y			
Connecticut	Y				Y	Y				
Delaware	Y	Y				Y	Y	Y	Y	Y
District of Columbia	Y	Y				N/A (M-CHIP)				
Florida[5]	Y		Y			Y	Y			
Georgia							Y	Y	Y	
Hawaii	Y		Not Reported			N/A (M-CHIP)	Y			
Idaho						Y	Y	Y	Y	
Illinois						Y	Y	Y	Y	
Indiana						Y	Y	Y	Y	
Iowa	Y		Not Reported			Y				
Kansas	Y	Y				Y	Y			
Kentucky	Y			Y		Y				
Louisiana	Y	Y				Y	Y			
Maine						Y	Y	Y	Y	Y
Maryland	Y		Not reported			N/A (M-CHIP)				
Massachusetts[6]	Y				Y	Y				
Michigan	Y		Y			N/A (M-CHIP)				
Minnesota	Y		Y			N/A (M-CHIP)				
Mississippi						Y				
Missouri	Y		Not Reported			Y				
Montana	Y				Y	Y	Y	Y	Y	
Nebraska[5]	Y		Not Reported			N/A (M-CHIP)	Y	Y	Y	Y
Nevada	Y		Not Reported			Y	Y	Y	Y	
New Hampshire	Y	Y				N/A (M-CHIP)	Y	Y	Y	Y
New Jersey						Y				
New Mexico						N/A (M-CHIP)	Y	Y	Y	
New York	Y				Y	Y				
North Carolina	Y		Not Reported			Y	Y	Y	Y	
North Dakota	Y		Not Reported			Y				
Ohio	Y	Y				N/A (M-CHIP)				
Oklahoma	Y				Y	N/A (M-CHIP)				
Oregon	Y			Y		Y				
Pennsylvania	Y	Y				Y	Y	Y	Y	
Rhode Island	Y				Y	N/A (M-CHIP)				
South Carolina	Y	Y				N/A (M-CHIP)				
South Dakota						Y				
Tennessee										
Texas						Y	Y	Y	Y	
Utah						Y	Y	Y	Y	Y
Vermont	Y		Not Reported			N/A (M-CHIP)				
Virginia[5]	Y	Y				Y	Y			Y
Washington	Y				Y	Y				
West Virginia						Y	Y	Y	Y	
Wisconsin	Y		Not Reported			Y	Y	Y	Y	Y
Wyoming	Y	Y				Y				

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 6 Notes

1. Under the ACA, states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. These columns reflect whether the state system is able to make real-time eligibility determinations, defined as within 24 hours, and the share of MAGI-based applications that are determined eligible in real-time.
2. These columns indicate whether the state MAGI-based Medicaid eligibility system is integrated with CHIP, non-MAGI Medicaid, and certain non-health programs.
3. California's statewide-integrated Marketplace and Medicaid system, CALHEERs, is not integrated with other programs. However, counties in California use different Medicaid eligibility systems that are integrated with non-health programs.
4. Colorado integrated its Medicaid eligibility with its SBM system and delinked the Medicaid eligibility system from other non-health programs during 2015.
5. Florida, Nebraska and Virginia integrated non-MAGI Medicaid eligibility into their MAGI–based system during 2015.
6. In Massachusetts, the share of applications completed in real-time is among online applications.

Table 7
Coordination between Medicaid and Marketplace Systems
January 2016

State	Marketplace Structure[1]	FFM Conducts Assessment or Final Determination for Medicaid Eligibility[2]	State is Receiving Electronic Account Transfers from FFM[3] (Total = 38)	State is Sending Electronic Account Transfers to FFM[3]	State is Experiencing Delays or Problems with Transfers[3]
Total	**FFM: 28 Partnership: 6 SBM: 17**	**Assessment: 30 Determination: 8**	**38**	**36**	**20**
Alabama	FFM	Determination	Y	Y	Y
Alaska[5]	FFM	Determination	Y	Y	Y
Arizona	FFM	Assessment	Y	Y	Y
Arkansas	Partnership	Determination	Y	Y	Y
California	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Colorado	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Connecticut	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Delaware	Partnership	Assessment	Y	Y	
District of Columbia	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Florida	FFM	Assessment	Y	Y	Y
Georgia	FFM	Assessment	Y	Y	
Hawaii[4]	Federally-supported SBM	Assessment	Y	Y	Not reported
Idaho	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Illinois	Partnership	Assessment	Y	Y	Y
Indiana	FFM	Assessment	Y	Y	
Iowa	FFM	Assessment	Y	Y	Y
Kansas	FFM	Assessment	Y	Y	Y
Kentucky	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Louisiana[5]	FFM	Assessment	Y	Y	
Maine	FFM	Assessment	Y	Y	Y
Maryland	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Massachusetts	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Michigan	Partnership	Assessment	Y	Y	
Minnesota	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Mississippi	FFM	Assessment	Y	Y	
Missouri	FFM	Assessment	Y	Y	Y
Montana	FFM	Determination	Y	Y	
Nebraska	FFM	Assessment	Y	Y	
Nevada	Federally-supported SBM	Assessment	Y	Y	Y
New Hampshire	Partnership	Assessment	Y	Y	Y
New Jersey	FFM	Determination	Y		
New Mexico	Federally-supported SBM	Assessment	Y	Y	
New York	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
North Carolina	FFM	Assessment	Y	Y	Y
North Dakota[5]	FFM	Assessment	Y	Y	Y
Ohio	FFM	Assessment	Y	Y	Y
Oklahoma	FFM	Assessment	Y	Y	
Oregon[5]	Federally-supported SBM	Assessment	Y	Y	Y
Pennsylvania	FFM	Assessment	Y	Y	Y
Rhode Island	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
South Carolina	FFM	Assessment	Y	Y	Y
South Dakota	FFM	Assessment	Y	Y	
Tennessee	FFM	Determination	Y		
Texas	FFM	Assessment	Y	Y	
Utah	FFM	Assessment	Y	Y	
Vermont	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Virginia	FFM	Assessment	Y	Y	
Washington	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
West Virginia	Partnership	Determination	Y	Y	Y
Wisconsin	FFM	Assessment	Y	Y	Y
Wyoming	FFM	Determination	Y	Y	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 7 Notes

1. This column indicates whether a state has elected to establish and operate its own State-based Marketplace (SBM), establish a State-based Marketplace with federal support, use the Federally-facilitated Marketplace (FFM), or establish a Marketplace in partnership with the federal government (Partnership). States running a SBM are responsible for performing all Marketplace functions, except for four SBM states (Hawaii, Nevada, New Mexico, and Oregon) that rely on the FFM information technology (IT) platform for application processing and certain eligibility and enrollment activities. In a Federally-facilitated Marketplace (FFM), the US Department of Health and Human Services (HHS) conducts all Marketplace functions. States with a Partnership Marketplace may administer plan management functions, in-person consumer assistance functions, or both, and HHS is responsible for the remaining Marketplace functions.
2. This column indicates whether states using the FFM IT platform for eligibility activities (including FFM, Partnership, and Federally-supported SBM states) have elected to allow the FFM to make assessments or final determinations of Medicaid/CHIP eligibility for MAGI-based groups. In assessment states, applicants' accounts must be transferred to the state Medicaid/CHIP agency for a final determination. In determination states, the FFM makes a final Medicaid/CHIP eligibility determination and transfers the account to the state Medicaid/CHIP agency for enrollment. States marked as N/A do not rely on the FFM for eligibility functions.
3. These columns indicate whether states are receiving and sending electronic accounts transfers from and to the FFM, and whether they are experiencing delays or problems with the account transfer process.
4. Hawaii transitioned from a SBM to a Federally-Supported SBM during 2015. Hawaii did not report whether it is experiencing problems or delays with transfers to and from the FFM because it had not begun transfers at the time of the survey interview.
5. During 2015, Louisiana, North Dakota, and Oregon transitioned to rely on the FFM to make assessments rather than final determinations for Medicaid eligibility, while Alaska transitioned to rely on the FFM to make final determinations rather than assessments.

Table 8
Online and Telephone Medicaid Applications
January 2016

State	Applications Can be Submitted Online at the State Level[1]	Online Application for Medicaid Allows Individuals to:		Separate Online Portal for Application Assisters[2]	Online Multi-Benefit Application for MAGI-Based Medicaid and Non-Health Programs[3]	Telephone Applications at the State Level[4]
		Start, Stop, and Return to an Application	Scan and Upload Documentation			
Total	**50**	**49**	**33**	**24**	**24**	**49**
Alabama	Y	Y				Y
Alaska	Y	Y				Y
Arizona	Y	Y	Y	Y	Y	Y
Arkansas[5]	Y	Y				Y
California	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y		Y	Y
Connecticut	Y	Y	Y			Y
Delaware[6]	Y	Y		Y	Y	Y
District of Columbia	Y	Y	Y	Y		Y
Florida[5]	Y	Y	Y	Y	Y	Y
Georgia[7]	Y	Y	Y		Y	Y
Hawaii[7]	Y	Y	Y	Y		Y
Idaho[7]	Y	Y	Y	Y		Y
Illinois	Y	Y	Y	Y	Y	Y
Indiana	Y	Y				Y
Iowa	Y	Y				Y
Kansas[7]	Y	Y	Y			Y
Kentucky	Y	Y	Y	Y		Y
Louisiana	Y	Y		Y		Y
Maine	Y	Y			Y	Y
Maryland	Y	Y	Y		Y	Y
Massachusetts	Y	Y				Y
Michigan	Y	Y	Y		Y	Y
Minnesota	Y	Y		Y		
Mississippi	Y		Y			Y
Missouri	Y	Y				Y
Montana	Y	Y	Y		Y	Y
Nebraska[8]	Y	Y	Y			Y
Nevada	Y	Y	Y		Y	Y
New Hampshire	Y	Y	Y		Y	Y
New Jersey[9]	Y	Y				Y
New Mexico	Y	Y	Y	Y	Y	Y
New York	Y	Y	Y	Y		Y
North Carolina	Y	Y			Y	Y
North Dakota	Y	Y	Y	Y	Y	Y
Ohio	Y	Y	Y	Y		Y
Oklahoma	Y	Y	Y	Y		Y
Oregon[7,9]	Y	Y	Y	Y		Y
Pennsylvania	Y	Y	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y	Y	Y
South Carolina	Y	Y				Y
South Dakota	Y	Y	Y		Y	Y
Tennessee						
Texas	Y	Y	Y	Y	Y	Y
Utah	Y	Y			Y	Y
Vermont	Y	Y		Y		Y
Virginia	Y	Y	Y		Y	Y
Washington	Y	Y	Y	Y		Y
West Virginia	Y	Y		Y	Y	Y
Wisconsin	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y	Y			Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 8 Notes

1. This column indicates whether individuals can complete and submit an online application for Medicaid through a state-level portal. For State-based Marketplace (SBM) states, such a portal may be either exclusive to Medicaid or integrated with the Marketplace. For Federally-facilitated Marketplace (FFM) and Partnership Marketplace states, state Medicaid agency portals are indicated.
2. This column indicates whether the MAGI-based Medicaid eligibility system provides either a separate online portal for application assisters or a secure log-in for assisters to submit facilitated applications. Some states are able to identify and collect information about assister-facilitated applications although they do not have a separate portal or secure log-in for assisters to submit facilitated applications.
3. In these states, a combined online multi-benefit application is available that allows applicants to apply for MAGI-based Medicaid and one or more non-health programs, such as SNAP (food stamps) or cash assistance.
4. This column indicates whether individuals can complete MAGI-based Medicaid applications over the telephone at the state level, either through the Medicaid agency or the State-based Marketplace.
5. Arkansas and Florida began accepting telephone applications in 2015.
6. In Delaware, families can call an eligibility worker to complete a Medicaid application; the application is then mailed to the applicant for signature.
7. Georgia, Hawaii, Idaho, Kansas, and Oregon added functionality to allow scan and upload of documentation through the online application during 2015.
8. In Nebraska, applicants can return to and restart an application for 30 days only.
9. New Jersey and Oregon added the ability to start, stop, and return to an application during 2015.

Table 9
Online Account Capabilities for Medicaid
January 2016

State	Online Medicaid Account[1]	Online Account Allows Individuals to: Report Changes	Review Application Status	Renew Coverage	View Notices	Authorize Third-Party Access	Upload Verification Documentation	Go Paperless and Receive Notices Electronically	Pay Premiums
Total	**39**	**37**	**36**	**35**	**31**	**30**	**29**	**25**	**6**
Alabama	Y	Y	Y	Y		Y			
Alaska									N/A
Arizona	Y	Y	Y	Y	Y	Y	Y	Y	Y
Arkansas									
California	Y	Y	Y	Y	Y	Y	Y		
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y	Y	
Delaware[2]	Y	Y	Y	Y	Y	Y			
District of Columbia	Y	Y	Y		Y	Y	Y	Y	N/A
Florida	Y	Y	Y	Y	Y		Y	Y	N/A
Georgia[3]	Y	Y	Y	Y	Y	Y	Y		Y
Hawaii[2,3,4,5,6]	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Idaho[3,4,5]	Y	Y	Y	Y	Y	Y	Y		
Illinois									
Indiana[7]	Y	Y	Y			Y			
Iowa									
Kansas									
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Louisiana[4]	Y	Y		Y					
Maine	Y	Y	Y	Y	Y			Y	
Maryland	Y	Y	Y	Y	Y	Y	Y	Y	
Massachusetts[4]	Y	Y	Y	Y	Y				
Michigan	Y	Y	Y	Y	Y	Y	Y		
Minnesota									N/A
Mississippi									N/A
Missouri									
Montana	Y	Y	Y	Y	Y	Y	Y	Y	
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Nevada									
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y	N/A
New Jersey									
New Mexico	Y	Y	Y	Y			Y		N/A
New York	Y	Y	Y	Y	Y	Y	Y	Y	
North Carolina									
North Dakota[2,3,4,5,6,8]	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Ohio	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Oklahoma	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Pennsylvania	Y	Y	Y	Y	Y		Y	Y	
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y	N/A
South Carolina[6,8]	Y		Y						N/A
South Dakota[3,4,8]	Y	Y		Y			Y		N/A
Tennessee									N/A
Texas[9]	Y	Y	Y	Y		Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y		Y	Y
Vermont[4]	Y	Y	Y		Y	Y			Y
Virginia	Y	Y	Y	Y		Y	Y		N/A
Washington[2,3,4]	Y	Y	Y	Y	Y	Y	Y	Y	
West Virginia	Y		Y	Y	Y			Y	
Wisconsin[2,5]	Y	Y	Y	Y	Y	Y	Y	Y	
Wyoming	Y	Y		Y	Y	Y	Y	Y	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 9 Notes

1. This column indicates whether individuals can create an online account for ongoing management of their MAGI-based Medicaid coverage at the state level, either through the Medicaid agency or a case management system that is integrated with the SBM.
2. Delaware, Hawaii, North Dakota, Washington, and Wisconsin added functionality to allow enrollees to authorize third party access to their account during 2015.
3. Georgia, Hawaii, Idaho, North Dakota, South Dakota, and Washington added functionality to allow enrollees to upload verification documents if needed during 2015.
4. Hawaii, Idaho, Louisiana, Massachusetts, North Dakota, South Dakota, Vermont, and Washington added functionality to allow enrollees to report changes through their online account during 2015.
5. Hawaii, Idaho, North Dakota, and Wisconsin added functionality to allow enrollees to view notices during 2015.
6. Hawaii, North Dakota, and South Carolina added functionality to allow applicants to review their application status during 2015.
7. In Indiana, individuals can manage their case online, but there is no account to set up.
8. North Dakota, South Carolina, and South Dakota implemented online accounts during 2015 or as of January 1, 2016.
9. In Texas, only certain notices can be viewed from a client's online account if the client does not elect to receive electronic notices.

Table 10
Income Verification Procedures Used by Medicaid Agencies at Application
January 2016

State	Pre-Enrollment Verification[1]	Post-Enrollment Verification[1]	If attestation is below and data are above the income standard[2]			If attestation is above and data are below the income standard[2]			
			Reasonable Compatibility Standard	*If not reasonably compatible, state first:*		Reasonable Compatibility Standard	*If not reasonably compatible, state first:*		
				Asks for a Reasonable Explanation	Requires Paper Documentation		Asks for a Reasonable Explanation	Requires Paper Documentation	Transfers to Marketplace
Total	**43**	**8**	**34**	**30**	**21**	**3**	**7**	**9**	**35**
Alabama	Y		10%	Y		None			Y
Alaska	Y		10%	Y		None			Y
Arizona	Y		None		Y	None			Y
Arkansas	Y		10%		Y	None			Y
California	Y		None		Y	None		Y	
Colorado[3]		Y	10%	Y		10%			Y
Connecticut[4,5]	Y		10%	Y		None			Y
Delaware		Y	10%	Y		None			Y
District of Columbia	Y		10%		Y	None		Y	
Florida[3,6]	Y		10%	Y		10%	Y		
Georgia	Y		None		Y	None			Y
Hawaii		Y	10%	Y		None			Y
Idaho	Y		None		Y	None		Y	
Illinois	Y		5%	Y		None			Y
Indiana	Y		None		Y	None			Y
Iowa	Y		10%	Y		None			Y
Kansas	Y		20%	Y		None			Y
Kentucky	Y		10%	Y		None			Y
Louisiana	Y		25%	Y		None			Y
Maine	Y		None	Y		None			Y
Maryland	Y		10%		Y	None			Y
Massachusetts[4]	Y		10%		Y	None			Y
Michigan	Y		10%	Y		None			Y
Minnesota	Y		10%	Y		None			Y
Mississippi	Y		$50	Y		None	Y		
Missouri[7]	Y		10%		Y	None	Y		
Montana		Y	10%	Y		None			Y
Nebraska	Y		10%		Y	None			Y
Nevada	Y		None	Y		None			Y
New Hampshire		Y	10%	Y		None			Y
New Jersey[6]	Y		10%	Y		10%	Y		
New Mexico	Y		None		Y	None		Y	
New York	Y		10%		Y	None			Y
North Carolina	Y		None	Y		None	Y		
North Dakota	Y		None	Y		None	Y		
Ohio	Y		5%		Y	None			Y
Oklahoma		Y	5%		Y	None			Y
Oregon[5,8]	Y		10%	Y		None			Y
Pennsylvania	Y		5%	Y		None		Y	
Rhode Island	Y		10%	Y		None			Y
South Carolina	Y		10%	Y		None			Y
South Dakota[6]	Y		None	Y		None	Y		
Tennessee	Y		10%		Y	None			Y
Texas	Y		None		Y	None		Y	
Utah[9]	Y		None		Y	None		Y	
Vermont		Y	None		Y	None		Y	
Virginia	Y		10%	Y		None			Y
Washington		Y	None	Y		None			Y
West Virginia	Y		10%	Y		None			Y
Wisconsin	Y		None		Y	None			Y
Wyoming	Y		None		Y	None		Y	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.
Table presents rules in effect as of January 1, 2016.

TABLE 10 NOTES

1. States are expected to attempt to verify income through an electronic source; they can verify information prior to enrollment or enroll based on an individual's self-attestation and conduct a post-enrollment verification. Only in cases where there is no electronic data source for a type of income are states able to accept self-attestation of income without verification.
2. If the information obtained from electronic data sources and the information provided by or on behalf of the individual are both above, at, or below the applicable income standard, the state must determine the applicant eligible or ineligible for Medicaid/CHIP. In these cases, any difference does not impact eligibility. If the data are not consistent, states have the option to apply a reasonable compatibility standard by establishing a threshold (e.g., a percentage or dollar figure) in which they will still consider the data to be reasonably compatible. States have the option to set different standards based on whether the applicant's attestation is above or below the eligibility threshold. In both cases, if the difference between the attested income and the electronic data source are within the reasonable compatibility standard, the state will process eligibility based on the individual's attestation. If the applicant reports income below the standard and the electronic source indicates income above the standard, and the difference is not reasonably compatible, the state may accept a reasonable explanation and/or request paper documentation. If the applicant reports income above the Medicaid or CHIP limit but the electronic source reflects income below, and the data are not reasonably compatible, the state may accept a reasonable explanation, request paper documentation, or determine the individual ineligible and transfer the application to the Marketplace.
3. Colorado and Florida implemented a reasonable compatibility standard of 10% when the applicant's income attestation is above but the data source reflects income below the Medicaid standard during 2015.
4. In Connecticut and Massachusetts, if the state is not able to verify income with electronic data, an individual will be enrolled based on self-attestation and income will be verified post-enrollment.
5. Connecticut and Oregon transitioned to verifying income prior to enrollment rather than relying on post-enrollment verification during 2015.
6. Florida, New Jersey, and South Dakota transitioned to rely on a reasonable explanation rather than transferring the account to the Marketplace when self-attested income is above the Medicaid standard but electronic data show income below the standard and the data are not reasonably compatible.
7. Missouri changed to request paper documentation when an individual's self-attestation is below the Medicaid income standard but electronic data show income above the standard during 2015.
8. Oregon added a reasonable compatibility standard of 10% when the applicant's income attestation is below but the data source reflects income above the Medicaid standard during 2015. Oregon also transitioned to rely on a reasonable explanation rather than paper documentation when data are not reasonably compatible.
9. In Utah, if an individual reports income above the Medicaid cutoff but a reliable data source qualifies the individual, Utah will approve the application.

Table 11

Non-Financial Eligibility Criteria Verification Procedures Used by Medicaid Agencies[1,2]

January 2016

State	Age/Date of Birth			State Residency				Household Composition			
				At Application				At Application			
	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	If Do Not Use Self-Attestation, Verify at Renewal	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	If Do Not Use Self-Attestation, Verify at Renewal
Total	**27**	**23**	**1**	**41**	**6**	**4**	**4**	**44**	**6**	**1**	**4**
Alabama	Y			Y				Y			
Alaska	Y			Y				Y			
Arizona	Y				Y			Y			
Arkansas		Y		Y				Y			
California		Y		Y				Y			
Colorado	Y			Y				Y			
Connecticut	Y			Y				Y			
Delaware	Y			Y				Y			
District of Columbia	Y			Y				Y			
Florida	Y			Y				Y			
Georgia	Y			Y				Y			
Hawaii	Y			Y				Y			
Idaho	Y				Y				Y		
Illinois		Y			Y		Y	Y			
Indiana		Y			Y		Y		Y		Y
Iowa		Y		Y					Y		Y
Kansas	Y			Y				Y			
Kentucky		Y			Y				Y		
Louisiana	Y			Y				Y			
Maine	Y			Y				Y			
Maryland		Y		Y				Y			
Massachusetts	Y					Y		Y			
Michigan	Y			Y				Y			
Minnesota		Y		Y				Y			
Mississippi		Y		Y				Y			
Missouri	Y			Y				Y			
Montana	Y			Y				Y			
Nebraska		Y		Y				Y			
Nevada		Y		Y				Y			
New Hampshire			Y	Y				Y			
New Jersey	Y			Y				Y			
New Mexico		Y		Y				Y			
New York	Y			Y				Y			
North Carolina	Y				Y			Y			
North Dakota		Y		Y				Y			
Ohio	Y			Y				Y			
Oklahoma		Y		Y				Y			
Oregon	Y			Y				Y			
Pennsylvania		Y		Y				Y			
Rhode Island		Y		Y					Y		
South Carolina		Y		Y				Y			
South Dakota	Y			Y				Y			
Tennessee		Y				Y		Y			
Texas[3]		Y		Y				Y			
Utah	Y			Y				Y			
Vermont	Y			Y				Y			
Virginia	Y			Y				Y			
Washington		Y		Y				Y			
West Virginia		Y		Y				Y			
Wisconsin		Y				Y	Y			Y	Y
Wyoming		Y				Y	Y		Y		Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016. Table presents rules in effect as of January 1, 2016.

TABLE 11 NOTES

1. In addition to the eligibility criteria shown in the table, all states must verify citizenship and immigration status through electronic data matches with the Social Security Administration (SSA) or the Department of Homeland Security (DHS).
2. States have the option to accept self-attestation for the non-financial eligibility criteria listed. If states verify non-financial eligibility criteria at application or renewal, they are expected to use electronic data and eliminate or minimize requirements for paper documentation. In states accepting self-attestation without further verification, the state may have access to electronic data for some applicants (for example, if the consumer is also enrolled in SNAP), which may be used to confirm eligibility. Verification is required if a state has any information on file that conflicts with the self-attestation. In states noted as conducting pre-enrollment verification, the state will confirm eligibility prior to enrolling an individual into coverage. States conducting post-enrollment verification enroll an individual based on their self-attested information and confirm the criteria after enrollment.
3. Texas accepts self-attestation for children, but verifies state residency for parents.

Table 12
Use of Selected Options to Facilitate Enrollment in Medicaid and CHIP
January 2016

	Hospital-based Presumptive Eligibility[1]	Broader Presumptive Eligibility Using Qualified Entities[2]						Express Lane Eligibility[3]		Use of SNAP Data to Facilitate Enrollment[4]
		Children		Pregnant Women						
		Medicaid	CHIP (Total =36)	Medicaid	CHIP (Total = 5)	Parents	Adults (Total = 32)	Medicaid Children	CHIP Children (Total = 36)	
Total	**45**	**18**	**10**	**29**	**2**	**7**	**6**	**8**	**5**	**5**
Alabama	Y				N/A		N/A	Y		
Alaska	Y		N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Arizona[5]	Y				N/A					
Arkansas					N/A					Y
California[6]	Y	Y	N/A (M-CHIP)	Y	N/A				N/A (M-CHIP)	Y
Colorado[7]	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Connecticut	Y	Y	Y	Y	N/A					
Delaware[5]	Y				N/A					
District of Columbia	Y		N/A (M-CHIP)	Y					N/A (M-CHIP)	
Florida	Y			Y	N/A		N/A			
Georgia	Y			Y	N/A		N/A	Y	Y	
Hawaii			N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Idaho	Y	Y	Y	Y	N/A	Y	N/A			
Illinois[8]		Y	Y	Y	N/A					
Indiana[9]	Y	Y	Y	Y	N/A	Y	Y			
Iowa[10]	Y	Y	Y	Y	N/A			Y	Y	
Kansas[11]	Y	Y	Y	Y	N/A		N/A			
Kentucky	Y			Y	N/A					
Louisiana	Y				N/A		N/A	Y		
Maine	Y			Y	N/A		N/A			
Maryland	Y		N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Massachusetts	Y				N/A					
Michigan	Y	Y	N/A (M-CHIP)	Y	N/A				N/A (M-CHIP)	
Minnesota	Y		N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Mississippi	Y				N/A		N/A			
Missouri	Y	Y		Y	N/A		N/A			
Montana[12]	Y	Y	Y	Y	N/A	Y	Y			
Nebraska	Y		N/A (M-CHIP)	Y	N/A		N/A		N/A (M-CHIP)	
Nevada	Y				N/A					
New Hampshire	Y	Y	N/A (M-CHIP)	Y	N/A	Y	Y		N/A (M-CHIP)	
New Jersey[5]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Mexico[13]	Y	Y	N/A (M-CHIP)	Y	N/A				N/A (M-CHIP)	
New York[14]		Y	Y	Y	N/A			Y		
North Carolina	Y			Y	N/A		N/A			
North Dakota	Y				N/A					
Ohio	Y	Y	N/A (M-CHIP)	Y	N/A	Y	Y		N/A (M-CHIP)	
Oklahoma	Y		N/A (M-CHIP)		N/A		N/A		N/A (M-CHIP)	
Oregon[15]	Y				N/A					Y
Pennsylvania[16]	Y			Y	N/A				Y	
Rhode Island	Y		N/A (M-CHIP)						N/A (M-CHIP)	
South Carolina	Y		N/A (M-CHIP)		N/A		N/A	Y	N/A (M-CHIP)	
South Dakota[5]	Y				N/A		N/A			Y
Tennessee		Y		Y	N/A		N/A			
Texas	Y			Y	N/A		N/A			
Utah	Y			Y	N/A		N/A			
Vermont			N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Virginia	Y						N/A			
Washington	Y				N/A					
West Virginia[8]	Y				N/A					
Wisconsin	Y	Y		Y	N/A					
Wyoming	Y			Y	N/A		N/A			

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 12 Notes

1. This column indicates whether a state has implemented the hospital-based presumptive eligibility process required by the ACA. This process allows hospitals to conduct presumptive eligibility determinations to expedite access to Medicaid coverage, regardless of whether a state has otherwise adopted presumptive eligibility.
2. These columns indicate whether a state has elected to implement the broader presumptive eligibility option, under which a state can authorize qualified entities such as hospitals, community health centers, and schools to make presumptive eligibility determinations for Medicaid and/or CHIP and extend coverage to individuals temporarily until a full eligibility determination is made.
3. The Express Lane Eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs to determine children eligible for Medicaid and CHIP at application or renewal. States are designated as having ELE if they have an approved and implemented State Plan Amendment from CMS.
4. In May 2013 guidance, CMS offered states several temporary targeted enrollment strategies, including the ability to use to SNAP data to facilitate enrollment of eligible individuals (see SHO #13-003, May 17, 2013). In August 2015, CMS issued new guidance allowing states to adopt the SNAP targeted strategy at enrollment and renewal as a state plan option, or to continue using the strategy under temporary waiver authority. For details, see V. Wachino, Director of Centers for Medicaid and CHIP Services, letter to State Health Officials and State Medicaid Directors (SHO #15-001/ACA #34, August 31, 2015). States are designated as adopting a strategy if they have a CMS-approved waiver or are in the process of applying for a SPA to use this the strategy.
5. In Arizona, Delaware, New Jersey, and South Dakota, the SPA for hospital presumptive eligibility is approved but no hospitals have implemented.
6. California is evaluating whether to seek a temporary waiver or submit a state plan amendment to continue using SNAP as a targeted enrollment strategy.
7. Colorado implemented presumptive eligibility for parents and adults in 2015.
8. Illinois and West Virginia will no longer use the SNAP facilitated enrollment strategy in Medicaid as of January 2016.
9. Indiana implemented presumptive eligibility for children, parents, and expansion adults in 2015.
10. Iowa implemented Express Lane Eligibility for CHIP children in 2015.
11. Kansas implemented presumptive eligibility for pregnant women in 2015.
12. Montana implemented presumptive eligibility for expansion adults effective January 2016.
13. New Mexico has presumptive eligibility for parents and other adults in Medicaid, but it is limited to those in correctional facilities (state prisons/county jails) and health facilities operated by the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian Organization.
14. New York uses Express Lane Eligibility to enroll parents in Medicaid (based on enrollment in TANF).
15. Oregon has temporarily discontinued use of Express Lane Eligibility for children in Medicaid and CHIP, but intends to reinstate in the future.
16. Pennsylvania uses Express Lane Eligibility to transition children between Medicaid and CHIP.

Table 13
Renewal Processes for MAGI-Based Medicaid Groups
January 2016

State	Processing Ex Parte Renewals[1]	Percentage of Renewals Completed via Ex Parte[1]				Prepopulated Renewal Form[2]	Populate Form with Updated Data[2]	Telephone Renewals at State Level[3]	Up-to-Date on Renewals[4]	
		<25%	25%-50%	50%-75%	75%+				Medicaid	CHIP (Total = 36)
Total	**34**	**5**	**11**	**7**	**3**	**41**	**14**	**41**	**47**	**34**
Alabama						Y		Y	Y	Y
Alaska[5]						Y			Y	N/A (M-CHIP)
Arizona	Y		Y			Y	Y	Y	Y	Y
Arkansas	Y	Y							Y	Y
California	Y			Y		Y	Y	Y	Y	N/A (M-CHIP)
Colorado	Y				Y	Y	Y	Y	Y	Y
Connecticut	Y			Y		Y		Y	Y	Y
Delaware	Y	Y				Y	Y	Y	Y	Y
District of Columbia						Y	Y	Y	Y	N/A (M-CHIP)
Florida[6]	Y		Y					Y	Y	Y
Georgia[7]						Y		Y	Y	Y
Hawaii	Y		Not Reported			Y	Y	Y	Y	N/A (M-CHIP)
Idaho	Y			Y		Y	Y	Y	Y	Y
Illinois						Y			Y	Y
Indiana	Y		Y			Y		Y	Y	Y
Iowa						Y	Y	Y	Y	Y
Kansas[8]	Y		Y			Y	Y		Y	Y
Kentucky	Y			Y				Y	Y	Y
Louisiana[9]	Y		Y					Y	Y	Y
Maine						Y		Y	Y	Y
Maryland	Y			Y		Y		Y	Y	N/A (M-CHIP)
Massachusetts								Y	Y	Y
Michigan[10]									Y	N/A (M-CHIP)
Minnesota	Y		Y			Y	Y		Y	N/A (M-CHIP)
Mississippi						Y		Y	Y	Y
Missouri	Y		Not Reported			Y	Y	Y	Y	Y
Montana						Y		Y	Y	Y
Nebraska	Y		Not Reported			Y		Y	Y	N/A (M-CHIP)
Nevada						Y		Y	Y	Y
New Hampshire	Y	Y				Y	Y	Y	Y	N/A (M-CHIP)
New Jersey	Y		Not Reported			Y		Y	Y	Y
New Mexico						Y		Y	Y	N/A (M-CHIP)
New York	Y		Y			Y		Y	Y	Y
North Carolina	Y				Y				Y	Y
North Dakota	Y		Not Reported			Y		Y	Y	Y
Ohio	Y				Y	Y		Y	Y	N/A (M-CHIP)
Oklahoma	Y		Y					Y	Y	N/A (M-CHIP)
Oregon	Y		Not Reported			Y		Y	Y	Y
Pennsylvania	Y	Y				Y		Y	Y	Y
Rhode Island	Y			Y		Y	Y	Y	Y	N/A (M-CHIP)
South Carolina	Y		Y			Y				N/A (M-CHIP)
South Dakota	Y		Y			Y		Y	Y	Y
Tennessee										
Texas	Y		Not Reported			Y	Y		Y	Y
Utah[8]	Y		Y			Y		Y	Y	Y
Vermont[11]								Y		N/A (M-CHIP)
Virginia	Y	Y				Y		Y		
Washington	Y			Y		Y		Y	Y	Y
West Virginia	Y		Not Reported			Y		Y	Y	Y
Wisconsin						Y		Y	Y	Y
Wyoming						Y		Y	Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 13 Notes

1. Under the ACA, states must seek to re-determine eligibility at renewal using electronic data matches with reliable sources of data, a process known as ex parte, prior to requiring enrollees to complete a renewal form. These columns reflect whether the state system is able to make ex parte re-determinations and reports the share of MAGI-based renewals that are successfully completed via ex parte.
2. Under the ACA, when a state is unable to determine ongoing eligibility at renewal via ex parte, it is expected to send the enrollee a renewal notice or form pre-populated with data on file. These columns indicate if a state is able to produce prepopulated renewal forms and whether the pre-populated information is updated with information accessed from electronic sources of data.
3. This column indicates whether enrollees are able to complete a MAGI-based Medicaid renewal over the phone at the state level, either through the Medicaid agency or a SBM call center.
4. These columns indicate whether states report any delays in processing 2015 renewals.
5. In Alaska, the state conducts ex parte review before closing a case after a non-response to renewal.
6. Florida's online renewal application is prepopulated when the enrollee completes an online renewal, but the state does not mail prepopulated forms.
7. Georgia has not implemented its new MAGI-based eligibility system but is sending pre-populated renewal forms through its older system.
8. In Kansas and Utah, families may report changes by phone but still need to sign and return the pre-populated renewal form.
9. Louisiana is procuring a new MAGI-based system, but conducts ex parte renewals through its existing system, which has been modified to be MAGI-enabled.
10. In Michigan, there may be some delays in renewals for children transitioning from separate CHIP to Medicaid expansion coverage as of January 2016.
11. Vermont has an approved renewal plan that allows delays of renewals until November 2016. Vermont began using a pre-populated renewal form as of January 2016 that includes name, address, phone number, and active Medicaid members due for renewal.

Table 14
Targeted Strategies to Streamline Renewals
January 2016

State	12-Month Continuous Eligibility for Children[1]		Express Lane Eligibility for Children at Renewal[2]		SNAP Data Used at Renewal[3]
	Medicaid	CHIP (Total = 36)	Medicaid	CHIP (Total = 36)	
Total	**24**	**26**	**7**	**3**	**7**
Alabama	Y	Y	Y		
Alaska	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Arizona					
Arkansas[4]		Y			Y
California	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Colorado[5]	Y	Y	Y	Y	
Connecticut					
Delaware		Y			
District of Columbia		N/A (M-CHIP)		N/A (M-CHIP)	
Florida[6]		Y			
Georgia					
Hawaii		N/A (M-CHIP)		N/A (M-CHIP)	
Idaho	Y	Y			
Illinois	Y	Y			
Indiana[7]					
Iowa	Y	Y	Y		
Kansas	Y	Y			
Kentucky					
Louisiana	Y	Y	Y		
Maine	Y	Y			
Maryland[8]		N/A (M-CHIP)		N/A (M-CHIP)	
Massachusetts[9]			Y	Y	
Michigan	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Minnesota		N/A (M-CHIP)		N/A (M-CHIP)	
Mississippi	Y	Y			
Missouri					
Montana[10]	Y	Y			
Nebraska		N/A (M-CHIP)		N/A (M-CHIP)	
Nevada		Y			
New Hampshire		N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey	Y	Y			Y
New Mexico	Y	N/A (M-CHIP)		N/A (M-CHIP)	
New York[11]	Y	Y	Y		
North Carolina	Y	Y			
North Dakota	Y	Y			
Ohio	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)		N/A (M-CHIP)	
Oregon	Y	Y			Y
Pennsylvania		Y		Y	
Rhode Island		N/A (M-CHIP)		N/A (M-CHIP)	
South Carolina	Y	N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Dakota					Y
Tennessee		Y			Y
Texas[12]		Y			
Utah		Y			
Vermont		N/A (M-CHIP)		N/A (M-CHIP)	
Virginia					Y
Washington	Y	Y			
West Virginia	Y	Y			
Wisconsin					
Wyoming	Y	Y			

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

Table 14 Notes

1. Under state option, states may provide 12-month continuous eligibility for children, allowing them to remain enrolled regardless of changes in income or household size. States must obtain a waiver to provide 12-month continuous eligibility to adults.
2. The Express Lane Eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs to determine children eligible for Medicaid and CHIP at enrollment or renewal. States are designated as having ELE at renewal if they have an approved and implemented State Plan Amendment from CMS.
3. In August 2015, CMS issued new guidance allowing states to adopt the SNAP targeted strategy at enrollment and renewal as a state plan option or under temporary waiver authority. For details, see V. Wachino, Director of Centers for Medicaid and CHIP Services, letter to State Health Officials and State Medicaid Directors (SHO #15-001/ACA #34, August 31, 2015). States are designated as adopting a strategy if they have a CMS-approved waiver or are in the process of applying for a SPA to use this the strategy.
4. Arkansas adopted 12-month continuous eligibility in CHIP when it transitioned its CHIP-funded Medicaid expansion to a separate CHIP program in 2015.
5. Colorado implemented Express Lane Eligibility for renewals in CHIP in 2015.
6. In Florida, children younger than age five receive 12-month continuous eligibility and children ages five and older receive 6 months of continuous eligibility.
7. In Indiana, continuous eligibility is only provided to children under age 3.
8. In Maryland, newborns are provided 12-month continuous eligibility.
9. Massachusetts extends ELE to pregnant women, childless adults, and parents through a Section 1115 waiver.
10. Montana adopted 12-month continuous eligibility for parents and other adults as of January 2016.
11. New York implemented 12-month continuous eligibility for adults in 2015.
12. In Texas, a child in CHIP with income at or above 185% FPL receives 12 months of continuous eligibility unless there is an indication of a change at a six-month income check that would make the child ineligible for CHIP.

Table 15
Premium, Enrollment Fee, and Cost-Sharing Requirements for Children
January 2016

State	Premiums/Enrollment Fees			Cost-Sharing		
	Required in Medicaid	Required in CHIP (Total = 36)	Lowest Income at Which Premiums Begin (Percent of the FPL)[1]	Required in Medicaid	Required in CHIP (Total = 36)	Lowest Income at Which Cost-Sharing Begins (Percent of the FPL)[1]
Total	**4**	**26**		**3**	**25**	
Alabama		Y	>141%		Y	>141%
Alaska		N/A (M-CHIP)			N/A (M-CHIP)	
Arizona		Y	>133%			
Arkansas					Y	>142%
California	Y	N/A (M-CHIP)	>160%		N/A (M-CHIP)	
Colorado		Y	>157%		Y	>142%
Connecticut		Y	>249%		Y	>196%
Delaware[2]		Y	>142%		Y	>142%
District of Columbia		N/A (M-CHIP)			N/A (M-CHIP)	
Florida		Y	>133%		Y	>133%
Georgia		Y	>133%		Y	>133%
Hawaii		N/A (M-CHIP)			N/A (M-CHIP)	
Idaho		Y	>142%		Y	>142%
Illinois		Y	>157%		Y	>142%
Indiana		Y	>158%		Y	>158%
Iowa		Y	>182%		Y	>182%
Kansas		Y	>166%			
Kentucky					Y	>139%
Louisiana		Y	>212%			
Maine		Y	>157%			
Maryland	Y	N/A (M-CHIP)	>211%		N/A (M-CHIP)	
Massachusetts		Y	>150%			
Michigan[3]	Y	N/A (M-CHIP)	>160%		N/A (M-CHIP)	
Minnesota		N/A (M-CHIP)			N/A (M-CHIP)	
Mississippi					Y	>150%
Missouri		Y	>150%			
Montana					Y	>142%
Nebraska		N/A (M-CHIP)			N/A (M-CHIP)	
Nevada		Y	>133%			
New Hampshire		N/A (M-CHIP)			N/A (M-CHIP)	
New Jersey		Y	>200%		Y	>150%
New Mexico[4]		N/A (M-CHIP)		Y	N/A (M-CHIP)	>190%
New York		Y	>160%			
North Carolina		Y	>159%		Y	>133%
North Dakota					Y	>133%
Ohio		N/A (M-CHIP)			N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)			N/A (M-CHIP)	
Oregon						
Pennsylvania		Y	>208%		Y	>208%
Rhode Island		N/A (M-CHIP)			N/A (M-CHIP)	
South Carolina		N/A (M-CHIP)			N/A (M-CHIP)	
South Dakota						
Tennessee[5]				Y	Y	>100%
Texas		Y	>150%		Y	>133%
Utah		Y	>133%		Y	>133%
Vermont	Y	N/A (M-CHIP)	>195%		N/A (M-CHIP)	
Virginia					Y	>143%
Washington		Y	>210%			
West Virginia		Y	>211%		Y	>133%
Wisconsin		Y	>200%	Y	Y	>133%
Wyoming					Y	>133%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 15 NOTES

1. In a number of states, the income at which premiums or cost-sharing begin may vary by the child's age since Medicaid and CHIP eligibility levels vary by age and some states exempt younger children from cost-sharing. The reported income eligibility limits at which premiums and cost-sharing begin do not reflect the five percentage points of FPL disregard that applies to eligibility determinations, although this disregard may apply when the income level at which premiums or cost-sharing applies aligns with the eligibility cutoff between Medicaid and separate CHIP programs.
2. Delaware increased the income level at which premiums and cost-sharing begin from 133% FPL to 143% FPL effective January 2016.
3. Michigan implemented premiums for children in Medicaid when it transitioned all children from its separate CHIP program to a CHIP-funded Medicaid expansion program effective January 2016.
4. In New Mexico, most cost-sharing applies to children covered through the CHIP-funded Medicaid expansion, which begins at 190% FPL. For children with income below this income limit, the only cost-sharing that applies is the $3 per brand name drug when there is a less expensive drug available and the $8 for non-emergent use of the emergency room.
5. Tennessee has waiver authority to charge cost-sharing for children between 100% and 133% FPL.

Table 16
Premiums and Enrollment Fees for Children at Selected Income Levels
January 2016

State	Premiums/Enrollment Fees at:[1,2]				
	151% FPL (or 150% if upper limit)	201% (or 200% if upper limit)	251% FPL (or 251% if upper limit)	301% FPL (or 300% if upper limit)	351% FPL (or 350% if upper limit)
MONTHLY PAYMENTS (24 states)					
Arizona[3]	$40|$60	$50|$70	N/A	N/A	N/A
California[3]	$0	$13|$26|$39	$13|$26|$39	N/A	N/A
Connecticut[3]	$0	$0	$30|$50	$30|$50	N/A
Delaware[4,5]	$15	$25	N/A	N/A	N/A
Florida	$15	$20	N/A	N/A	N/A
Georgia	$20	$29	N/A	N/A	N/A
Idaho	$15	N/A	N/A	N/A	N/A
Illinois[3,6]	$0	$15|$25	$40|$80	$40|$80	N/A
Indiana[3]	$0	$33|$50	$53|$70	N/A	N/A
Iowa[3]	$0	$10|$20	$20|$40	$20|$40	N/A
Kansas	$0	$30	N/A	N/A	N/A
Louisiana[4]	$0	$0	$50	N/A	N/A
Maine	$0	$32	N/A	N/A	N/A
Maryland[4]	$0	$0	$66	$66	N/A
Massachusetts	$12	$20	$28	$28	N/A
Michigan[4]	$0	$10	N/A	N/A	N/A
Missouri[3,7]	$19|$23|$28	$61|$77|$93	$148|$186|$224	$148|$186|$224	N/A
New Jersey	$0	$43	$86	$144.50	$144.50
New York	$0	$9	$30	$45	$60
Pennsylvania[8]	$0	$0	$70	$80	N/A
Vermont[4,9]	$0	$15	$20/$60	$20/$60	N/A
Washington	$0	$0	$20	$30	N/A
West Virginia[3]	$0	$0	$35|$71	$35|$71	N/A
Wisconsin	$0	$10	$34	$97	N/A
QUARTERLY PAYMENTS (2 states)					
Nevada	$50	$80	N/A	N/A	N/A
Utah[4]	$75	$75	N/A	N/A	N/A
ANNUAL PAYMENTS (4 states)					
Alabama[10]	$104	$104	$104	$104	N/A
Colorado[3]	$0	$25|$35	$75|$105	N/A	N/A
North Carolina[3]	$0	$50|$100	N/A	N/A	N/A
Texas	$35	$50	N/A	N/A	N/A
NO PREMIUMS OR ENROLLMENT FEES (21 states)					
Alaska	--	--	--	--	--
Arkansas	--	--	--	--	--
District of Columbia	--	--	--	--	--
Hawaii	--	--	--	--	--
Kentucky	--	--	--	--	--
Minnesota	--	--	--	--	--
Mississippi	--	--	--	--	--
Montana	--	--	--	--	--
Nebraska	--	--	--	--	--
New Hampshire	--	--	--	--	--
New Mexico	--	--	--	--	--
North Dakota	--	--	--	--	--
Ohio	--	--	--	--	--
Oklahoma	--	--	--	--	--
Oregon	--	--	--	--	--
Rhode Island	--	--	--	--	--
South Carolina	--	--	--	--	--
South Dakota	--	--	--	--	--
Tennessee	--	--	--	--	--
Virginia	--	--	--	--	--
Wyoming	--	--	--	--	--

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 16 NOTES

1. N/A indicates that coverage is not available at the specified income level. If a state does not charge premiums at all, it is noted as "- -".
2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.
3. In Arizona, California, Connecticut, Illinois, Indiana, Iowa, Missouri, West Virginia, Colorado, and North Carolina the values before the vertical line represent premiums or enrollment fees for one child. Those after the line represent premiums for two or more children.
4. In Delaware, Louisiana, Maryland, Michigan, Vermont, and Utah, premiums are family-based and not based on costs per child.
5. Delaware has an incentive system for premiums where families can pay three months and get one premium-free month, pay six months and get two premium-free months, and pay nine months and get three premium-free months.
6. In Illinois, CHIP premiums are $15 per child, $25 for two children, and $5 for each additional child up to a $40 maximum for families with incomes below 208% FPL. Above 208% FPL, families pay $40 per child or $80 for two or more children.
7. In Missouri premiums vary by family size. Amounts shown are for 2-person, 3-person, and 4-person family. Rates increase based on family size with no cap.
8. In Pennsylvania, premiums vary by contractor. The average amount is shown.
9. In Vermont, for those above 238% FPL, the monthly charge is $20 if the family has other health insurance and $60 if there is no other health insurance.
10. Alabama's annual fee is not required before a child enrolls in coverage, nor is a child disenrolled for nonpayment in the first year. Following the annual renewal, families have 30 days to pay the annual enrollment fee to avoid disenrollment.

Table 17
Disenrollment Policies for Non-Payment of Premiums in Children's Coverage
January 2016

State	Grace Period (amount of time) Before a Child Loses Coverage for Nonpayment of Premiums[1]	After Disenrollment for Failure to Pay Premiums: Lock-Out Period in Separate CHIP Program[2]	Families Must Reapply for Coverage to Reenroll	Retroactive Reinstatement of Coverage if Family Pays Outstanding Premiums
Total		**14**	**16**	**7**
MONTHLY PAYMENTS (24 states)				
Arizona	60 days	Enrollment Closed	Enrollment Closed	Enrollment Closed
California	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Connecticut[3,4]	Until Renewal	None		N/A
Delaware	60 days	None		Y
Florida[5]	30 days	1 month		
Georgia[6]	60 days	1 month		Y
Idaho[3]	Until Renewal	None	Y	N/A
Illinois	60 days	None		Y
Indiana	60 days	90 days		
Iowa	44 days	None	Y	
Kansas	60 days	90 days	Y	
Louisiana[7]	60 days	90 days	Y	
Maine[8]	12 months	up to 90 days	Y	
Maryland	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Massachusetts[9]	60 days	90 days		
Michigan[10]	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Missouri[11]	30 days	90 days	Y	
New Jersey[12]	60 days	90 days		
New York[13]	30 days	None	Y	
Pennsylvania[14]	90 days	90 days	Y	Y
Vermont[15]	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Washington[16]	90 days	90 days	Y	Y
West Virginia[3,17]	Until Renewal	None		N/A
Wisconsin[18]	60 days	90 days	Y	Y
QUARTERLY PAYMENTS (2 states)				
Nevada[19]	60 days	90 days	Y	
Utah	30 days	90 days	Y	Y
ANNUAL PAYMENTS (4 states)				
Alabama[20]	--	--	--	--
Colorado	--	--	--	--
North Carolina	--	--	--	--
Texas	--	--	--	--
NO PREMIUMS OR ENROLLMENT FEES (21 states)				
Alaska	--	--	--	--
Arkansas	--	--	--	--
District of Columbia	--	--	--	--
Hawaii	--	--	--	--
Kentucky	--	--	--	--
Minnesota	--	--	--	--
Mississippi	--	--	--	--
Montana	--	--	--	--
Nebraska	--	--	--	--
New Hampshire	--	--	--	--
New Mexico	--	--	--	--
North Dakota	--	--	--	--
Ohio	--	--	--	--
Oklahoma	--	--	--	--
Oregon	--	--	--	--
Rhode Island	--	--	--	--
South Carolina	--	--	--	--
South Dakota	--	--	--	--
Tennessee	--	--	--	--
Virginia	--	--	--	--
Wyoming	--	--	--	--

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.
Table presents rules in effect as of January 1, 2016.

TABLE 17 NOTES

1. This column indicates the grace period for payment of Medicaid or CHIP premiums before a child is disenrolled from coverage. If premiums are charged in Medicaid, a state must provide a 60-day grace period. CHIPRA required states to provide a minimum 30-day premium payment grace period under CHIP before cancelling a child's coverage.
2. A lock-out period is a period of time during which the disenrolled person is prohibited from returning to the CHIP program. Lock-outs are not permitted in Medicaid and the ACA limited such lock-out periods in CHIP to no more than 90 days.
3. Connecticut, Idaho and West Virginia do not disenroll children for unpaid premiums in CHIP. Renewal is considered a new application, and families need to pay the initial month to continue coverage at renewal. Retroactive coverage does not apply because there are no gaps in coverage since a child is not disenrolled until renewal.
4. Connecticut stopped disenrolling children for unpaid premiums in CHIP during 2015.
5. In Florida, children are locked out for one month for nonpayment of the premium but they do not need to reapply if the child is within the 12-month continuous eligibility period.
6. In Georgia, if a child who is disenrolled for nonpayment of premium re-enrolls within 90 days, eligibility must be re-verified but no new application is needed.
7. In Louisiana, children in the 12-month continuous eligibility period do not need to reapply for coverage.
8. In Maine, for each month there is an unpaid premium, there is a month of ineligibility up to a maximum of 3 months. The penalty period begins in the first month following the enrollment period in which the premium was overdue. For example, if a family does not pay the last 2 months of premiums, they will have a 2-month penalty. If they do not pay 3 or more months, they will have a 3-month lock-out period. Families can re-enroll if they pay back-owed premiums.
9. In Massachusetts, families must reapply for coverage if their application is more than 12 months old. Premiums that are more than 24 months overdue are waived. After the 90-day lock-out period children may re-enroll for prospective coverage without paying the past due premiums. Children may re-enroll for prospective coverage during the 90-day lock-out period if the past due premiums are paid, if a payment plan is set up, or if the family is determined eligible for a premium waiver.
10. In Michigan, the grace period increased from 30 days to 60 days as a result of the transition from a separate CHIP program to a CHIP-funded Medicaid expansion program effective January 2016.
11. In Missouri, only children in families with incomes above 225% FPL are subject to the lock-out period.
12. New Jersey implemented a 90-day lock out period in its CHIP program in 2015.
13. In New York, if the family pays the premium within 30 days of cancellation they do not need to reapply for coverage.
14. In Pennsylvania, if the family pays past due premiums prior to the end of the renewal period, they do not have to re-apply for coverage.
15. In Vermont, if the premium is paid in the calendar month after the child lost coverage, the family does not have to reapply.
16. In Washington, the family must reapply only if they do not pay the past due premium. If they pay the premium then coverage is automatically reinstated back to the month coverage ended for non-payment of premiums.
17. In West Virginia, children are not disenrolled for non-payment of premiums, but past due amounts are subject to third-party collections after 120 days.
18. In Wisconsin, only families that reapply within 3 months after losing coverage are required to repay past due premiums.
19. In Nevada, if a family pays during the lockout period, they are enrolled effective the next month. If they do not during the lockout period, they must reapply.

20. Alabama's annual enrollment fee is not required before a child enrolls in coverage, nor is a child disenrolled for nonpayment in the first year. Following the annual renewal, families have 30 days to pay the annual enrollment fee to avoid disenrollment.

Table 18

Cost-Sharing Amounts for Selected Services for Children at Selected Income Levels[1]

January 2016

State	Family Income at 151% FPL (or 150% if upper eligibility limit)				Family Income at 201% FPL (or 200% if upper eligibility limit)			
	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER	Inpatient Hospital Visit
Total	**19**	**13**	**20**	**15**	**20**	**13**	**20**	**15**
Alabama	$13	$60	$60	$200	$13	$60	$60	$200
Alaska	--	--	--	--	--	--	--	--
Arizona	--	--	--	--	--	--	--	--
Arkansas	$10	$10	$10	20% of reimbursement rate for first day	$10	$10	$10	20% of reimbursement rate for first day
California	--	--	--	--	--	--	--	--
Colorado	$5	$30	$30	$20	$10	$50	$50	$50
Connecticut	$0	$0	$0	$0	$10	$0	$0	$0
Delaware	$0	$0	$10	$0	$0	$0	$10	$0
District of Columbia	--	--	--	--	--	--	--	--
Florida[2]	$5	$10	$10	$0	$5	$10	$10	$0
Georgia	$0.50-$3	$0	$10	$12.50	$0.50-$3	$0	$10	$12.50
Hawaii	--	--	--	--	--	--	--	--
Idaho	$4	$0	$4	$0	N/A	N/A	N/A	N/A
Illinois	$3.90	$0	$0	$3.90/day	$5	$5	$25	$5/day
Indiana	$0	$0	$0	$0	$0	$0	$0	$0
Iowa	$0	$0	$0	$0	$0	$0	$25	$0
Kansas	--	--	--	--	--	--	--	--
Kentucky[3]	$3	$0	$8	$50	$3	$0	$8	$50
Louisiana	--	--	--	--	--	--	--	--
Maine	--	--	--	--	--	--	--	--
Maryland	--	--	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--	--	--
Michigan	--	--	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--	--	--
Mississippi	$5	$15	$15	$0	$5	$15	$15	$0
Missouri	--	--	--	--	--	--	--	--
Montana[4]	$3	$5	$5	$25	$3	$5	$5	$25
Nebraska	--	--	--	--	--	--	--	--
Nevada	--	--	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--	--	--
New Jersey	$5	$10	$10	$0	$5	$35	$35	$0
New Mexico[5]	$0	$0	$8	$0	$5	$0	$8	$25
New York	--	--	--	--	--	--	--	--
North Carolina	$5	$0	$10	$0	$5	$0	$25	$0
North Dakota	$0	$5	$5	$50	N/A	N/A	N/A	N/A
Ohio	--	--	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--	--	--
Oregon	--	--	--	--	--	--	--	--
Pennsylvania[2, 6]	$0	$0	$0	$0	$0	$0	$0	$0
Rhode Island	--	--	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--	--	--
Tennessee[2,7]	$5 | $15/$20	$5 | $50	$10 | $50	$5 | $100	$15/$20	$50	$50	$100
Texas	$20	$0	$75	$75	$25	$0	$75	$125
Utah[8]	$25/$40	$300	$100-$200	20% daily reimbursement rate	$25/$40	$300	$100-$200	20% daily reimbursement rate
Vermont	--	--	--	--	--	--	--	--
Virginia	$5	$5	$25	$25	$5	$5	$25	$25
Washington	--	--	--	--	--	--	--	--
West Virginia[2,9]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin	$0.50-$3	$0	$0	$3	$0.50-$3	$0	$0	$3
Wyoming[2]	$10	$25	$25	$50	$10	$25	$25	$50

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 18 NOTES

1. If a state charges cost-sharing for selected services or drugs shown in Tables 18 and 19, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level, it is noted as "N/A;" if a state does not charge copayments at all, it is noted as "- -". Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
2. In Florida, Pennsylvania, Tennessee, West Virginia, and Wyoming, the emergency room copayment is waived if the child is admitted.
3. In Kentucky, enrollees are charged 5% coinsurance for non-emergency use of the emergency room, which is capped at $8.
4. In Montana, cost-sharing is limited to $215 per family.
5. In New Mexico, most cost-sharing applies to children covered through the CHIP-funded Medicaid expansion, which begins at 190% FPL. For children with incomes below this income limit, the only cost-sharing that applies is the $3 for unnecessary use of a brand name drug and $8 for non-emergent use of the emergency room.
6. Pennsylvania charges cost-sharing but it does not begin charging until >208% FPL, so no charges are reported in the table.
7. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% FPL for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the "|" represent copayments for children enrolled in TennCare Standard, whereas the values after the "|" represent copayments for children enrolled in Cover Kids. The values shown before a "/" represent copayments for a primary care provider, whereas the values after the "/" represent copayments for a provider that is a specialist.
8. Utah has a $300 deductible in CHIP. In Utah, for a non-preventive physician visit, the value before the "/" is the copayment amount for a visit with a primary care doctor, the value after the "/" is the copayment for a visit with a specialist.
9. In West Virginia, the copayment for a non-preventive physician visit is waived if the child goes to his or her medical home.

Table 19
Cost-Sharing Amounts for Prescription Drugs for Children at Selected Income Levels[1]
January 2016

State	Family Income at 151% FPL (or 150% if upper limit)			Family Income at 201% FPL (or 200% if upper limit)		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Total	**16**	**17**	**15**	**18**	**19**	**16**
Alabama	$5	$25	$28	$5	$25	$28
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$5	$5	$5	$5	$5	$5
California	--	--	--	--	--	--
Colorado	$3	$10	N/C	$5	$15	N/C
Connecticut	$0	$0	$0	$5	$10	$10
Delaware	$0	$0	$0	$0	$0	$0
District of Columbia	--	--	--	--	--	--
Florida	$5	$5	$5	$5	$5	$5
Georgia	$0.50	$0.50-$3	$0.50-$3	$0.50	$0.50-$3	$0.50-$3
Hawaii	--	--	--	--	--	--
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$2	$3.90	$3.90	$3	$5	$5
Indiana	$0	$0	$0	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky	$1	$4	$8	$1	$4	$8
Louisiana	--	--	--	--	--	--
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	--	--	--	--	--	--
Montana[2]	$0	$0	$0	$0	$0	$0
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico[3]	$0	$0	$3	$2	$3	$3
New York	--	--	--	--	--	--
North Carolina[4]	$1	$1	$3	$1	$1	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania[5]	$0	$0	N/C	$0	$0	N/C
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[6]	$1.50 | $5	$3 | $20	$3 | $40	$1.50 | $5	$3 | $20	$3 | $40
Texas	$10	$35	N/C	$10	$35	N/C
Utah[7]	$15	25% of cost	50% of cost	$15	25% of cost	50% of cost
Vermont	--	--	--	--	--	--
Virginia	$5	$5	$5	$5	$5	$5
Washington	--	--	--	--	--	--
West Virginia	$0	$10	$15	$0	$10	$15
Wisconsin	$1	$3	$3	$1	$3	$3
Wyoming	$5	$10	N/C	$5	$10	N/C

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 19 NOTES

1. If a state charges cost-sharing for selected services or drugs shown in Tables 18 and 19, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level, it is noted as "N/A;" if a state does not charge copayments at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "N/C". Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
2. In Montana, if families order prescriptions through the mail, they pay $6 for a 3-month supply of a generic drug and $10 for a 3-month supply of a brand-name drug.
3. In New Mexico, most cost-sharing applies to children covered through the CHIP-funded Medicaid expansion, which begins at 190% FPL. For children with incomes below this income limit, the only cost-sharing that applies is the $3 for unnecessary use of a brand name drug and $8 for non-emergent use of the emergency room.
4. In North Carolina, the copayment for brand-name drugs only applies if a generic version is available.
5. Pennsylvania charges cost-sharing but it does not begin charging until >208% FPL, so no charges are reported in the table.
6. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% FPL for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the "|" represent copayments for children enrolled in TennCare Standard, whereas the values after the "|" represent copayments for children enrolled in Cover Kids. The values shown before a "/" represent copayments for a primary care provider, whereas the values after the "/" represent copayments for a provider that is a specialist.
7. Utah charges a $300 deductible.

Table 20

Premium and Cost-Sharing Requirements for Section 1931 Parents[1]

January 2016

State	Monthly Contribution/ Premiums	Cost-Sharing	Income at Which Cost-Sharing Begins (%FPL)	Cost-Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Total	**1**	**40**		**26**	**22**	**28**	**37**	**39**	**38**
Alabama		Y	0%	$1.30-$3.90	$3.90	$50	$0.65-$3.90	$0.65-$3.90	$0.65-$3.90
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona		Y	0%	$3.40	$0	$0	$2.30	$2.30	$2.30
Arkansas		Y	0%	$0	$0	10% cost of first day	$0.50-$3.90	$0.50-$3.90	$0.50-$3.90
California		Y	0%	$1	$5	$0	$1	$1	$1
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Florida[2]		Y	0%	$2	5% of first $300	$3	$0	$0	$0
Georgia		Y	0%	$0	$0	$12.50	$0.50-$3	$0.50-$3	$0.50-$3
Hawaii			--	--	--	--	--	--	--
Idaho			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[3]	Y, >0%	Y	0%	$4	$8/$25 subsequent visits	$75	$4	$4	$8
Iowa[4]		Y	0%	$3	$3	$0	$1	$1	$2-$3
Kansas			--	--	--	--	--	--	--
Kentucky[5]		Y	0%	$3	$8	$50	$1	$4	$8
Louisiana		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
Maine[6]		Y	0%	$0	$3	up to $3/day	$3	$3	$3
Maryland		Y	0%	$0	$0	$3	$1-$3	$1-$5	$1-$5
Massachusetts[7]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan		Y	0%	$0	$0	$0	$1	$1	$1
Minnesota		Y	0%	$3	$3.50	$0	$1	$3	$3
Mississippi		Y	0%	$3	$0	$10	$3	$3	$3
Missouri		Y	0%	$1	$3	$10	$0.50-$2	$0.50-$2	$0.50-$2
Montana[8]		Y	0%	$4	$4	$75	$1-$4	$1-$4	$1-$4
Nebraska		Y	0%	$2	$0	$15	$2	$2	$3
Nevada			--	--	--	--	--	--	--
New Hampshire		Y	0%	$0	$0	$0	$1	$2	$2
New Jersey			--	--	--	--	--	--	--
New Mexico			--	--	--	--	--	--	--
New York[9]		Y	100%	$0	$3	$25/discharge	$1	$3	$3
North Carolina		Y	0%	$3	$0	$3/day	$3	$3	$3
North Dakota		Y	0%	$2	$3	$75	$0	$3	$3
Ohio		Y	0%	$0	$3	$0	$0	$2	$3
Oklahoma[10]		Y	0%	$4	$4	$10/day; $90 max	$4	$4	$4
Oregon[11]		Y	0%	$0	$3	$0	$2	$3	$3
Pennsylvania[12]		Y	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
South Carolina		Y	0%	$2.30	$0	$25	$3.40	$3.40	$3.40
South Dakota		Y	0%	$3	full amount	$50	$1	$3.30	N/C
Tennessee		Y	0%	$0	$0	$0	$1.50	$3	$3
Texas			--	--	--	--	--	--	--
Utah[13]		Y	>40%	$3	$6	$220	$3	$3	$3
Vermont		Y	0%	$0	$0	$75	$1-$3	$1-$3	$1-$3
Virginia		Y	0%	$1	$0	$100	$1	$3	$3
Washington			--	--	--	--	--	--	--
West Virginia[14]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
Wisconsin[15]		Y	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming		Y	0%	$2.45	$3.65	$0	$0.65	$3.65	$3.65

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 20 NOTES

1. Data in the table present premiums or other monthly contributions and cost-sharing requirements for Section 1931 parents. If a state charges cost-sharing, but does not charge for the specific service, it is recorded as $0; if a state does not charge cost-sharing at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "N/C". In some states, copayments vary based on the cost of the drug.
2. Florida increased copayments for some services during 2015.
3. Indiana implemented monthly contributions in 2015. In Indiana, Section 1931 parents who fail to pay monthly contributions will not be disenrolled but will receive HIP Basic, a more limited benefit package with state plan level copayments. In Indiana, copayments are only required if enrolled in HIP Basic. In the Plus plan, there are no copayments except for $8 for first time use and $25 for second time use of emergency room for a non-emergency.
4. In Iowa, charges are $2 for non-preferred name brand drugs that cost between $25.01 and $50; and $3 for non-preferred brand name drugs that cost >$50.
5. In Kentucky, enrollees are charged 5% coinsurance for non-preferred brand-name drugs, capped at $20.
6. In Maine, there are separate $30 monthly maximums for inpatient hospital and drug copayments.
7. In Massachusetts, generic drugs for diabetes, high blood pressure and high cholesterol have a $1 copayment. There is a cap of $36 per year for non-pharmacy copayments and a cap of $250 per year for pharmacy copayments.
8. Montana decreased copayments for some services during 2015.
9. New York eliminated copayments for parents and adults with incomes below 100% FPL in 2015.
10. Oklahoma increased copayments for prescription drugs during 2015.
11. In Oregon, there are no copayments for drugs ordered through home-delivery pharmacy programs.
12. In Pennsylvania, copayments vary based on the cost of service. The inpatient hospital copayment is subject to a maximum of $21 per stay.
13. In Utah, enrollees under the TANF payment limit are exempt from paying copayments.
14. In West Virginia, drug copayments range from $.50 to $3 depending on the cost of the drug, while other copayment amounts vary by income. Enrollees have a quarterly out-of-pocket maximum of $8 up to 50% FPL; $71 between 50% and 100%; and $143 above 100%.
15. In Wisconsin, emergency room copayments are waived if admitted.

Table 21

Premium and Cost-Sharing Requirements for Medicaid Adults[1]

January 2016

State	Monthly Contributions/ Premiums	Cost-Sharing	Income at Which Cost-Sharing Begins (%FPL)	Cost-Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
ADOPTED MEDICAID EXPANSION (31 States)									
Total	**5**	**23**		**13**	**14**	**15**	**18**	**21**	**22**
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona			--	--	--	--	--	--	--
Arkansas[2]	Y, >100% FPL	Y	100%	$10	$0	$140/day	$4	$4	$8
California[3]		Y	0%	$1	$5	$0	$1	$1	$1
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware[4]		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Hawaii			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[5]	Y, >0%	Y	0%	$4	$8/ $25 subsequent visits	$75	$4	$4	$8
Iowa[6]	Y, >50% FPL	Y	50%	$0	$8	$0	$0	$0	$0
Kentucky		Y	0%	$3	$8	$50	$1	$4	$8
Maryland		Y	0%	$0	$0	$3	$1-$3	$1-$5	$1-$5
Massachusetts[7]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[8]	Y, >100% FPL	Y	0%	$0	$0	$0	$1	$1	$1
Minnesota		Y	0%	$3	$4	$0	$1	$3	$3
Montana[9]	Y, >50% FPL	Y	0%	$4/10% of state payment	$8	$75/10% of state peyment	$0	$4	$8
Nevada			--	--	--	--	--	--	--
New Hampshire[10]		Y	>100%	$3	$0	$125	$4	$8	$8
New Jersey			--	--	--	--	--	--	--
New Mexico		Y	0%	$0	$8	$0	$0	$3	$3
New York		Y	100%	$0	$3	$25/discharge	$1	$3	$3
North Dakota		Y	0%	$2	$3	$75	$0	$3	$3
Ohio		Y	0%	$0	$0	$0	$0	$0	$3
Oregon		Y	0%	$0	$3	$0	$2	$3	$3
Pennsylvania		Y	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
Vermont		Y	0%	$0	$0	$75	$1-$3	$1-$3	$1-$3
Washington			--	--	--	--	--	--	--
West Virginia[11]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
NOT ADOPTING THE MEDICAID EXPANSION AT THIS TIME (20 States)									
Total		**1**		**1**	**0**	**1**	**1**	**1**	**1**
Alabama									
Florida									
Georgia									
Idaho									
Kansas									
Louisiana									
Maine									
Mississippi									
Missouri									
Nebraska									
North Carolina									
Oklahoma									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah									
Virginia									
Wisconsin[12]		Y	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming									

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 21 NOTES

1. Data in the table represent premium or other monthly contributions and cost-sharing requirements for non-disabled adults. This group also includes parents above Section 1931 limits. If a state charges cost-sharing, but does not charge for the specific service or drug, it is recorded as $0; if a state does not charge cost-sharing at all, it is noted as "- -."
2. Arkansas received waiver approval to require certain non-medically frail enrollees to make monthly income-based contributions to health savings accounts (HSAs) to be used in lieu of paying point-of-service copayments and coinsurance. Arkansas can charge monthly HSA contributions for expansion adults with incomes down to 50% FPL, but the state is not currently charging individuals with incomes below poverty. Adults with incomes above poverty who fail to make monthly HSA contributions are responsible for copayments and coinsurance at the point of service, and providers can deny services for failure to pay cost-sharing. Cost-sharing is not a condition of Medicaid eligibility and is limited to 5% of monthly or quarterly income.
3. In California, inpatient visits are $100 per day, $200 max.
4. In Delaware, copayments vary based on cost of drug.
5. In Indiana, under Section 1115 waiver authority, adults with incomes above poverty who fail to pay monthly contributions will be disenrolled from coverage after a 60-day grace period and barred from re-enrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay monthly contributions will receive HIP Basic, a more limited benefit package with state plan level copayments. In Indiana, copayments are only required if enrolled in HIP Basic. In the Plus plan, there are no copayments except for $8 for first time use and $25 for second time use of emergency room for a non-emergency.
6. In Iowa, under Section 1115 waiver authority, Medicaid expansion beneficiaries above 100% FPL pay contributions of $10 per month. Beneficiaries from 50-100% FPL pay $5 per month and cannot be disenrolled for non-payment. Contributions are waived for the first year of enrollment. In subsequent years, contributions are waived if beneficiaries complete specified healthy behaviors. The state must grant waivers of payment to beneficiaries who self-attest to a financial hardship. Beneficiaries have the opportunity to self-attest to hardship on each monthly invoice.
7. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 copayment. There is a $36 annual cap for non-pharmacy copayments and a $250 annual cap for pharmacy copayments.
8. In Michigan, under Section 1115 waiver authority, expansion adults with incomes above 100% FPL are charged monthly premiums that are equal to 2% of income. Expansion adults have cost-sharing contributions based on their prior 6 months of copayments incurred, billed at the end of each quarter. There is no cost-sharing for the first six months of enrollment in the plan. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment or be denied access to services, and providers may not deny services for failure to pay copayments or premiums. Cost-sharing can be reduced through compliance with healthy behaviors. Cost-sharing and premiums cannot exceed 5% of household income.
9. In Montana, individuals with incomes at or below 100% FPL will not be disenrolled due to unpaid premiums. Individuals with incomes above 100% FPL will be disenrolled for unpaid premiums after notice and a 90-day grace period. Disenrollment lasts until arrears are paid or until the state assesses debt against income taxes, which must happen by the end of the calendar quarter (maximum disenrollment period is 3 months). The state must establish a process to exempt beneficiaries from disenrollment for good cause. Reenrollment does not require a new application. Combined premiums and copayment charges may not exceed 5% of household income. Enrollees will receive a credit toward their copayment obligations in the amount of their premiums. For copayments, amounts before the slash are for adults with incomes at or below 100% FPL; amounts after the slash are for adults with incomes above 100% FPL.
10. New Hampshire increased copayments for some services during 2015.

11. In West Virginia, drug copayments range from $.50 to $3 depending on the cost of the drug, while other copayment amounts vary by income. Enrollees have a quarterly out-of-pocket maximum of $8 up to 50% FPL; $71 between 50% and 100%; and $143 above 100%.
12. Wisconsin offers Medicaid coverage to childless adults up to 100% FPL, but has not adopted the ACA Medicaid expansion. Enrollees pay cost-sharing equal to those reported for parents in Table 20.

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Medicaid and the Uninsured

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New Estimates of Eligibility for ACA Coverage among the Uninsured

Rachel Garfield, Anthony Damico, Cynthia Cox, Gary Claxton, Larry Levitt

The Affordable Care Act (ACA) extends health insurance coverage to people who lack access to an affordable coverage option. Under the ACA, as of 2014, Medicaid coverage is extended to low-income adults in states that have opted to expand eligibility, and tax credits are available for middle-income people who purchase coverage through a health insurance Marketplace. Millions of people have enrolled in these new coverage options, but millions of others are still uninsured. Some remain ineligible for coverage, and others may be unaware of the availability of new coverage options or still find coverage unaffordable even with financial assistance.

This analysis provides national and state-by-state estimates of eligibility for ACA coverage options among those who remained uninsured. It is based on Kaiser Family Foundation analysis of the 2015 Current Population Survey, combined with other data sources. We estimate coverage and eligibility as of early 2015, which is prior to the end of the 2015 Marketplace open enrollment period, but have updated this brief to reflect state Medicaid expansion decisions as of January 2016. An overview of the methodology underlying the analysis can be found in the Methods box at the end of the data note, and more detail is available in the Technical Appendices available here.

Background: How Does the ACA Expand Health Coverage?

The ACA fills historical gaps in Medicaid eligibility by extending Medicaid to nearly all nonelderly adults with incomes at or below 138% of the federal poverty level (FPL) ($27,724 for a family of three in 2015[1]). With the June 2012 Supreme Court ruling, the Medicaid expansion essentially became optional for states, and as of January 2016, 31 states and DC had expanded Medicaid eligibility under the ACA. Under rules in place before the ACA, all states already extended public coverage to poor and low-income children, with a median income eligibility level of 255% of poverty in 2016.[2] The ACA also established Health Insurance Marketplaces where individuals can purchase insurance and allows for federal tax credits for such coverage for people with incomes from 100% to 400% FPL ($19,790 to $79,160 for a family of three in 2015).[3, 4] Tax credits are generally only available to people who are not eligible for other coverage.

Because the ACA envisioned low-income people receiving coverage through Medicaid, people with incomes below poverty are not eligible for Marketplace subsidies. Thus, in the 19 states not implementing the Medicaid expansion, some adults fall into a “coverage gap” of earning too much to qualify for Medicaid but not enough to qualify for premium tax credits. In addition, undocumented immigrants are ineligible for Medicaid coverage and barred from purchasing coverage through a Marketplace. In most cases, lawfully present immigrants are

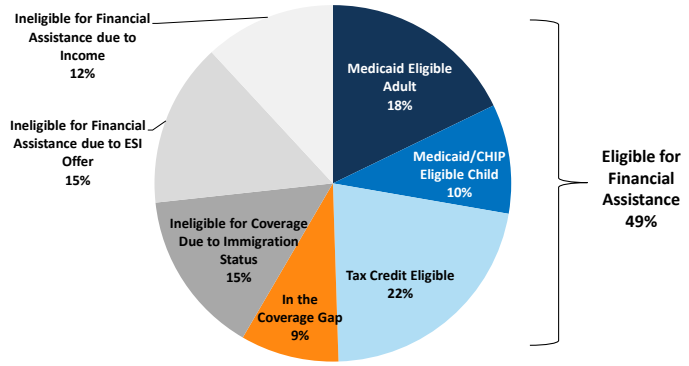
subject to a five-year waiting period before they may enroll in Medicaid, though they can purchase coverage through a Marketplace and may receive tax credits for such coverage.

How Many Uninsured Are Eligible for Assistance under the ACA?

As of the beginning of 2015, 32.3 million nonelderly people lacked health coverage in the U.S. Nationally, we estimate that nearly half (15.9 million, or 49%) of this population is eligible for financial assistance to gain coverage through either Medicaid or subsidized Marketplace coverage (Figure 1 and Tables 1 and 2). More than a quarter are either adults eligible for Medicaid (5.7 million, or 18%) or children eligible for Medicaid or the Children's Health Insurance Program (CHIP) (3.2 million, or 10%). Those who are Medicaid eligible include people who were previously eligible as well as those newly eligible under the ACA. About one in five (7.0 million, or 22%) of the nonelderly uninsured are eligible for premium tax credits to purchase coverage through the Marketplace.[5]

Figure 1

Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2015



Total = 32.3 Million Nonelderly Uninsured

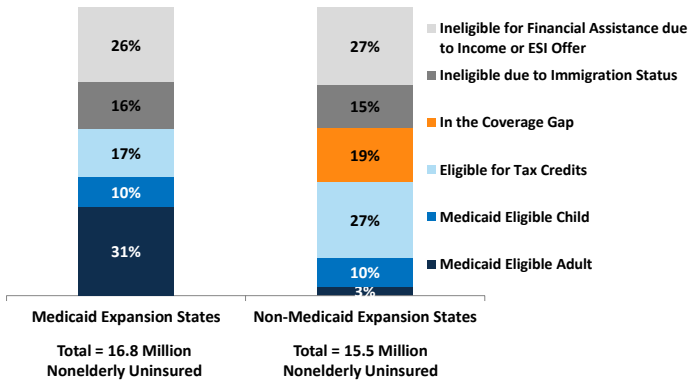
NOTES: Numbers may not sum to subtotals or 100% due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Nearly one in ten uninsured people (2.9 million) fall into the coverage gap due to their state's decision not to expand Medicaid, and 15% of the uninsured (4.9 million) are undocumented immigrants who are ineligible for ACA coverage under federal law.

The remainder of the uninsured either has an offer of ESI (4.9 million, or 15%) or has an income above the limit for premium tax credits but could purchase unsubsidized Marketplace coverage (3.7 million, or 12%). We cannot determine from available survey data if the offer of ESI would be considered affordable under the law, which would make the individual ineligible for a Marketplace premium subsidy.

Figure 2

Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2015, by State Medicaid Expansion Status



NOTES: Totals may not sum to 100% due to rounding. Tax Credit Eligible share in expansion states includes adults in MN and NY who are eligible for coverage through the Basic Health Plan.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Patterns of eligibility vary by state (Tables 1 and 2), depending on state decisions about expanding Medicaid, premiums in the exchange, and underlying demographic factors such as poverty rates and access to employer coverage. In states that expanded Medicaid, 41% of the nonelderly uninsured population is eligible for Medicaid, versus just 13% in states that have not expanded Medicaid (Figure 2). No one in Medicaid expansion states falls into a coverage gap; in non-expansion states, nearly one in five (19%) uninsured people falls into

the coverage gap, while about two-thirds as many are eligible for Medicaid under pathways in place before the ACA. Because adults with incomes from 100% to 138% of poverty in non-expansion states can receive tax credits for Marketplace coverage, a larger share of the uninsured population in those states is eligible for Marketplace tax credits than in expansion states (27% versus 17%).

Discussion

Though millions of people have gained coverage under the ACA, many remain uninsured. The ACA provides new coverage options across the income spectrum for low and moderate-income people, and nearly half of the uninsured population appear to be eligible for Medicaid or subsidized Marketplace coverage. For these individuals, outreach and education about coverage and financial assistance may be important to continuing coverage gains that were seen in the first two years of full ACA implementation. Data from other sources indicates that misperceptions about cost, lack of awareness of financial assistance, and confusion about eligibility rules were barriers to some eligible uninsured gaining coverage.[6] Others report that they found coverage to be too expensive, even with the availability of financial assistance.[7]

Nearly a quarter of the remaining uninsured population is outside the reach of the ACA due to either their immigration status or their state's decision not to expand Medicaid. People in the coverage gap would be eligible for Medicaid should their state opt to expand Medicaid but are otherwise likely to remain uninsured, as they have limited incomes, are unlikely to have an affordable offer of coverage from an employer, and do not have access to affordable coverage options under the ACA. Many undocumented immigrants also will likely remain uninsured.[8]

Approximately a quarter of the uninsured population is not eligible for any assistance under the ACA because they have access to employer coverage that may be considered affordable or have incomes too high to qualify for Medicaid or Marketplace subsidies. Increased penalties under the ACA's so-called "individual mandate" in 2016 may encourage some of them to obtain coverage.

As of 2016, there are still substantial opportunities to increase coverage by reaching those who are eligible for help under the ACA. However, the breakdown of who the remaining uninsured are suggests that many may be difficult to reach and will still remain uninsured.

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Table 1: Number of Nonelderly People Eligible for ACA Coverage Among those Remaining Uninsured as of 2015					
State	Total Uninsured	Medicaid Eligible	Tax Credit Eligible	Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship	In Medicaid Coverage Gap
US Total	**32,339,000**	**8,850,000**	**7,022,000**	**13,572,000**	**2,895,000**
Alabama	513,000	75,000	160,000	139,000	139,000
Alaska	100,000	51,000	20,000	29,000	-
Arizona	808,000	368,000	100,000	341,000	-
Arkansas	285,000	127,000	60,000	98,000	-
California	3,845,000	1,428,000	623,000	1,795,000	-
Colorado	593,000	223,000	104,000	266,000	-
Connecticut	247,000	69,000	62,000	116,000	-
Delaware	63,000	22,000	15,000	25,000	-
DC	42,000	20,000	N/A	19,000	-
Florida	2,788,000	306,000	825,000	1,091,000	567,000
Georgia	1,524,000	201,000	406,000	612,000	305,000
Hawaii	70,000	35,000	N/A	28,000	-
Idaho	166,000	21,000	43,000	72,000	30,000
Illinois	1,122,000	397,000	166,000	559,000	-
Indiana	686,000	310,000	128,000	248,000	-
Iowa	188,000	88,000	30,000	71,000	-
Kansas	302,000	38,000	83,000	131,000	49,000
Kentucky	285,000	121,000	N/A	119,000	-
Louisiana*	582,000	311,000	117,000	154,000	-
Maine	121,000	18,000	40,000	39,000	24,000
Maryland	336,000	133,000	43,000	160,000	-
Massachusetts	288,000	93,000	N/A	147,000	-
Michigan	685,000	320,000	147,000	218,000	-
Minnesota	364,000	126,000	45,000^	193,000	-
Mississippi	359,000	42,000	104,000	106,000	108,000
Missouri	516,000	52,000	156,000	198,000	109,000
Montana	126,000	59,000	27,000	40,000	-
Nebraska	178,000	16,000	46,000	90,000	27,000
Nevada	350,000	147,000	61,000	143,000	-
New Hampshire	94,000	37,000	17,000	41,000	-
New Jersey	940,000	335,000	131,000	473,000	-
New Mexico	233,000	109,000	31,000	94,000	-
New York	1,476,000	548,000	317,000^	611,000	-
North Carolina	1,138,000	152,000	289,000	452,000	244,000
North Dakota	64,000	24,000	16,000	24,000	-
Ohio	834,000	404,000	165,000	264,000	-
Oklahoma	581,000	109,000	144,000	236,000	91,000
Oregon	307,000	122,000	N/A	150,000	-
Pennsylvania	994,000	477,000	180,000	338,000	-
Rhode Island	55,000	27,000	13,000	15,000	-
South Carolina	604,000	100,000	186,000	195,000	123,000
South Dakota	77,000	12,000	22,000	30,000	13,000
Tennessee	605,000	104,000	127,000	257,000	118,000
Texas	4,425,000	493,000	1,035,000	2,132,000	766,000
Utah	337,000	66,000	92,000	138,000	41,000
Vermont	34,000	8,000	11,000	15,000	-
Virginia	804,000	77,000	235,000	361,000	131,000
Washington	621,000	238,000	116,000	267,000	-
West Virginia	116,000	56,000	31,000	29,000	-
Wisconsin	410,000	129,000	100,000	181,000	†
Wyoming	56,000	6,000	19,000	20,000	11,000

NOTES: Numbers may not sum to totals due to rounding. * LA's Governor signed an Executive Order to adopt the Medicaid expansion on 1/12/16, but coverage under the expansion is not yet in effect. For purposes of this analysis, LA is considered an expansion state. ^ Tax credit-eligible population in Minnesota and New York include uninsured adults who are eligible for coverage through the Basic Health Plan. † Wisconsin covers adults up to 100% FPL in Medicaid under a waiver but did not adopt the ACA expansion. Estimates of subsidy eligibility of uninsured nonelderly in DC, HI, KY, MA, and OR are "N/A" because point estimates do not meet minimum standards for statistical reliability.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Table 2: Distribution of Nonelderly Eligibility for ACA Coverage Among those Remaining Uninsured as of 2015					
State	Total Uninsured	Medicaid Eligible	Tax Credit Eligible	Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship	In Medicaid Coverage Gap
US Total	**32,339,000**	**27%**	**22%**	**42%**	**9%**
Alabama	513,000	15%	31%	27%	27%
Alaska	100,000	51%	20%	29%	-
Arizona	808,000	46%	12%	42%	-
Arkansas	285,000	44%	21%	34%	-
California	3,845,000	37%	16%	47%	-
Colorado	593,000	38%	18%	45%	-
Connecticut	247,000	28%	25%	47%	-
Delaware	63,000	35%	24%	40%	-
DC	42,000	48%	N/A	45%	-
Florida	2,788,000	11%	30%	39%	20%
Georgia	1,524,000	13%	27%	40%	20%
Hawaii	70,000	50%	N/A	39%	-
Idaho	166,000	13%	26%	44%	18%
Illinois	1,122,000	35%	15%	50%	-
Indiana	686,000	45%	19%	36%	-
Iowa	188,000	47%	16%	38%	-
Kansas	302,000	13%	28%	43%	16%
Kentucky	285,000	43%	N/A	42%	-
Louisiana*	582,000	53%	20%	26%	-
Maine	121,000	15%	33%	32%	20%
Maryland	336,000	40%	13%	48%	-
Massachusetts	288,000	32%	N/A	51%	-
Michigan	685,000	47%	21%	32%	-
Minnesota	364,000	35%	12%^	53%	-
Mississippi	359,000	12%	29%	29%	30%
Missouri	516,000	10%	30%	38%	21%
Montana	126,000	47%	22%	32%	-
Nebraska	178,000	9%	26%	50%	15%
Nevada	350,000	42%	17%	41%	-
New Hampshire	94,000	39%	18%	43%	-
New Jersey	940,000	36%	14%	50%	-
New Mexico	233,000	47%	13%	40%	-
New York	1,476,000	37%	21%^	41%	-
North Carolina	1,138,000	13%	25%	40%	21%
North Dakota	64,000	37%	25%	38%	-
Ohio	834,000	48%	20%	32%	-
Oklahoma	581,000	19%	25%	41%	16%
Oregon	307,000	40%	N/A	49%	-
Pennsylvania	994,000	48%	18%	34%	-
Rhode Island	55,000	49%	23%	27%	-
South Carolina	604,000	17%	31%	32%	20%
South Dakota	77,000	16%	29%	39%	17%
Tennessee	605,000	17%	21%	42%	19%
Texas	4,425,000	11%	23%	48%	17%
Utah	337,000	20%	27%	41%	12%
Vermont	34,000	24%	33%	43%	-
Virginia	804,000	10%	29%	45%	16%
Washington	621,000	38%	19%	43%	-
West Virginia	116,000	48%	27%	25%	-
Wisconsin	410,000	32%	24%	44%	†
Wyoming	56,000	11%	34%	36%	19%

NOTES: Numbers may not sum to 100% due to rounding. *LA's Governor signed an Executive Order to adopt the Medicaid expansion on 1/12/16, but coverage under the expansion is not yet in effect. For purposes of this analysis, LA is considered an expansion state. ^ Tax credit-eligible population in Minnesota and New York include uninsured adults who are eligible for coverage through the Basic Health Plan. † Wisconsin covers adults up to 100% FPL in Medicaid under a waiver but did not adopt the ACA expansion. Estimates of subsidy eligibility of uninsured nonelderly in DC, HI, KY, MA, and OR are "N/A" because point estimates do not meet minimum standards for statistical reliability.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Table 3: Number and Distribution of Nonelderly People Ineligible for Financial Assistance due to Income, Offers of Employer Coverage, or Citizenship Status as of 2015, in States with Sufficient Sample Size								
State	Number of Nonelderly People Ineligible due to:				% of Nonelderly Uninsured Ineligible due to:			
	Total Ineligible Due to Income, ESI Offer, or Citizenship	Income	Employer Offer	Citizenship	Total Ineligible Due to Income, ESI Offer, or Citizenship	Income	Employer Offer	Citizenship
US Total	**13,572,000**	**3,720,000**	**4,916,000**	**4,936,000**	**42%**	**12%**	**15%**	**15%**
Arizona	341,000	113,000	100,000	127,000	42%	14%	12%	16%
Arkansas	98,000	25,000	45,000	28,000	34%	9%	16%	10%
California	1,795,000	396,000	476,000	922,000	47%	10%	12%	24%
Colorado	266,000	72,000	95,000	99,000	45%	12%	16%	17%
Florida	1,091,000	290,000	417,000	384,000	39%	10%	15%	14%
Georgia	612,000	187,000	233,000	192,000	40%	12%	15%	13%
Illinois	559,000	173,000	151,000	235,000	50%	15%	13%	21%
Minnesota	193,000	66,000	73,000	55,000	53%	18%	20%	15%
Nebraska	90,000	31,000	33,000	26,000	50%	17%	18%	15%
Nevada	143,000	31,000	50,000	62,000	41%	9%	14%	18%
New Jersey	473,000	91,000	118,000	264,000	50%	10%	13%	28%
New Mexico	94,000	34,000	25,000	35,000	40%	14%	11%	15%
New York	611,000	150,000	242,000	220,000	41%	10%	16%	15%
North Carolina	452,000	119,000	190,000	143,000	40%	10%	17%	13%
Oklahoma	236,000	68,000	114,000	54,000	41%	12%	20%	9%
Oregon	150,000	45,000	50,000	56,000	49%	15%	16%	18%
Pennsylvania	338,000	123,000	149,000	66,000	34%	12%	15%	7%
Tennessee	257,000	88,000	99,000	69,000	42%	15%	16%	11%
Texas	2,132,000	416,000	652,000	1,064,000	48%	9%	15%	24%
Virginia	361,000	122,000	140,000	99,000	45%	15%	17%	12%
Washington	267,000	72,000	96,000	99,000	43%	12%	15%	16%

NOTES: States not included above do not have sufficient sample size to show distribution of uninsured nonelderly ineligible for financial assistance in at least one of the three categories (income, ESI, and/or citizenship). Numbers may not sum to totals due to rounding.
SOURCE: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Methods

This analysis uses data from the 2015 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes.

The CPS asks respondents about coverage at the time of the interview (for the 2015 CPS, February, March, or April 2015) as well as throughout the preceding calendar year. People who report any type of coverage throughout the preceding calendar year are counted as "insured." Thus, the calendar year measure of the uninsured population captures people who lacked coverage for the entirety of 2014 (and thus were uninsured at the start of 2015). We use this measure of insurance coverage, rather than the measure of coverage at the time of interview, because the latter lacks detail about coverage type that is used in our model. Based on other survey data, as well as administrative data on ACA enrollment, it is likely that a small number of people included in this analysis gained coverage in 2015.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax credits for each person individually, using the rules for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available here.

Undocumented immigrants are ineligible for Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. al.[9,10] This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available here.

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance are still potentially MAGI-eligible for Medicaid coverage, but they are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since CPS data do not directly indicate whether workers have access to ESI, we draw on the methods comparable to our imputation of authorization status and use SIPP to develop a model that predicts offer of ESI, then apply the model to CPS. For more detail on the offer imputation used in this analysis, see the technical Appendix C available here.

As of January 2014, Medicaid financial eligibility for most nonelderly adults is based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state's reported eligibility levels as of January 1, 2015, updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Federal Poverty Levels.[11] Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.[12]

An individual's income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move and out of the coverage gap as their income fluctuates.

Endnotes

[1] U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation, 2015 Poverty Guidelines. Available at: http://aspe.hhs.gov/2015-poverty-guidelines.

[2] Tricia Brooks, Sean Miskell, Samantha Artiga, Elizabeth Cornachione and Alexandra Gates, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2016), http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey.

[3] U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation, 2014 Poverty Guidelines. Available at: http://aspe.hhs.gov/2014-poverty-guidelines

[4] Tax credit eligibility in 2015 is based on 2014 poverty guidelines. In addition to the premium tax credits, the federal government also makes available cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty have to pay out-of-pocket to access health services. The cost-sharing subsidies are also available on a sliding scale based on income.

[5] Includes individuals in Minnesota and New York who are eligible for coverage through the Basic Health Plan. See table notes for more detail.

[6] Garfield, R. and K. Young. January 2015. *Adults who Remained Uninsured at the End of 2014.* (Washington, DC: Kaiser Family Foundation). Available at: http://kff.org/health-reform/issue-brief/adults-who-remained-uninsured-at-the-end-of-2014/.

[7] Ibid.

[8] Artiga, S. February 2013. *Immigration Reform and Access to Health Coverage: Key Issues to Consider*. (Washington, DC: Kaiser Family Foundation). Available at: http://kff.org/uninsured/issue-brief/immigration-reform-and-access-to-health-coverage-key-issues-to-consider/

[9] State Health Access Data Assistance Center. 2013. "State Estimates of the Low-income Uninsured Not Eligible for the ACA Medicaid Expansion." Issue Brief #35. Minneapolis, MN: University of Minnesota. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825

[10] Van Hook, J., Bachmeier, J., Coffman, D., and Harel, O. 2015. "Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches" *Demography*. 52(1):329-54.

[11] Based on state-reported eligibility levels as of January 1, 2015. Eligibility levels are updated to reflect state implementation of the Medicaid expansion as of September 2015 and 2015 Federal Poverty Levels, but may not reflect other eligibility policy changes since January 2015. The Kaiser Family Foundation State Health Facts. Data Source: Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families: Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015, Kaiser Family Foundation, January 20, 2015.

[12] Non-MAGI pathways for nonelderly adults include disability-related pathways, such as SSI beneficiary; Qualified Severely Impaired Individuals; Working Disabled; and Medically Needy. We are unable to assess disability status in the CPS sufficiently to model eligibility under these pathways. However, previous research indicates high current participation rates among individuals with disabilities (largely due to the automatic link between SSI and Medicaid in most states, see Kenney GM, V Lynch, J Haley, and M Huntress. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." *Inquiry*. 49:231-53 (Fall 2012)), indicating that there may be a small number of eligible uninsured individuals in this group. Further, many of these pathways (with the exception of SSI, which automatically links an individual to Medicaid in most states) are optional for states, and eligibility in states not implementing the ACA expansion is limited. For example, the median income eligibility level for coverage through the Medically Needy pathway is 15% of poverty in states that are not expanding Medicaid, and most states not expanding Medicaid do not provide coverage above SSI levels for individuals with disabilities. (See: O'Mally-Watts, M and K Young. *The Medicaid Medically Needy Program: Spending and Enrollment Update.* (Washington, DC: Kaiser Family Foundation), December 2012. Available at: http://www.kff.org/medicaid/issue-brief/the-medicaid-medically-needy-program-spending-and/. And Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010. Available at: http://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-primary-pathways-for-the-elderly-and-people-with-disabilities/.

The Implications of a Finding for the Plaintiffs in *House v. Burwell*

$47 Billion More in Federal Spending over 10 years and Smaller Marketplaces

Linda J. Blumberg and Matthew Buettgens

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In 2016, the case *House v. Burwell* will be decided in the United States district court of the District of Columbia. In this case, the House of Representatives claims that the cost-sharing reductions (CSRs) the Obama administration paid to low-income enrollees (those with incomes below 250 percent of the federal poverty level [FPL]) in Marketplace coverage were inappropriate because Congress had not made a specific line-item appropriation to do so. We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the ramifications of eliminating federal reimbursement of CSRs. Given that the Affordable Care Act (ACA) requires insurers to provide low-income Marketplace enrollees with the reductions regardless of explicit funding, we assume that insurers would build the costs associated with them into the premiums for Marketplace silver plans (those with 70 percent actuarial value).

We find that premiums for silver Marketplace plans would increase $1,040 per person on average. This premium increase would, on average, make silver plan premiums higher than those of gold plans (plans with 80 percent actuarial value). The higher premiums would in turn lead to higher federal payments for Marketplace tax credits because such payments are tied to the second-lowest-cost silver plan premium. All tax credit–eligible Marketplace enrollees with incomes up to 400 percent of FPL would receive larger tax credits, not just those eligible for CSRs. On net, Marketplace enrollment would decrease by 1.0 million people because enrollees ineligible for tax credits could find less expensive coverage elsewhere, and federal government costs would increase $3.6 billion in 2016 ($47 billion over 10 years). We estimate that the change would also reduce the number of people uninsured by approximately 400,000.

However, there is substantial uncertainty around insurer decisions to continue to offer Marketplace coverage in the event of a finding for the plaintiff. The timing of such a change in policy could interfere with established, approved premiums, potentially creating financial losses for insurers

and chaos for enrollees. Even if insurers are allowed sufficient time to modify premiums, they may leave the Marketplaces in response to the continued litigation and associated policy changes, the lack of predictability such changes create, and the costs such changes impose on insurers.

Introduction

In 2016, Judge Rosemary Collyer of the United States district court of the District of Columbia will decide the case *House v. Burwell.* In this case, the US House of Representatives claims that the cost-sharing reductions (CSRs) the Obama administration paid to low-income enrollees (those with incomes below 250 percent of the federal poverty level [FPL]) in Marketplace coverage were inappropriate because Congress had not made a specific line-item appropriation for this expenditure. The House argues that although the premium tax credits in the ACA were permanently appropriated, the CSRs associated with them are subject to the annual appropriations process. The CSRs are available under the law to individuals and families eligible for advanced premium tax credits who enroll in silver plans (those with 70 percent actuarial value)[1] in the Marketplaces, and who have family income at or below 250 percent of FPL. These CSRs increase the actuarial value of silver plan coverage by lowering the deductibles, copayments, coinsurance, and out-of-pocket maximums faced by the low-income enrollees, making their use of medical services more affordable (table 1).

This brief explores the implications of a possible prohibition on the federal reimbursement of CSRs to Marketplace insurers. As the plaintiff in the case acknowledges, the law requires insurers to provide reduced cost-sharing plans to eligible enrollees regardless of whether the federal government makes the payment.[2] Consequently, one can expect that Marketplace insurers would build the expenses associated with these CSRs into their Marketplace premiums to avoid financial losses. Such an increase in premiums would increase federal payments for premium tax credits because tax credit amounts are tied to the second-lowest-cost silver plan premium available to the enrollee. Simultaneously, federal payments for CSRs would fall to zero. In addition, changes to premiums and tax credits will change some individuals' decisions about whether to buy inside or outside the Marketplace, which actuarial level of coverage to buy, and whether to buy coverage at all. All of these decisions have implications for the health insurance risk pool, premiums, federal spending, and household spending.

But the timing of such a potential change would be critical. If payments for CSRs are stopped in the middle of a plan year, insurers would face the choice of exiting the Marketplace or incurring losses by paying out CSRs without the expectation of reimbursement (because their premiums are already approved and fixed for the year). With many states requiring a minimum period of notice before insurers can exit a Marketplace, such a change in the middle of a policy year could create chaos for enrollees and significant financial losses for insurers. If a change in reimbursement policy is delayed until the start of a new plan year, insurers might be given sufficient time to recalculate and seek approval for premium rates that would incorporate the CSRs in them, although that process takes several months to complete. Even with sufficient time, insurers may leave the Marketplaces in response to the continued litigation and associated policy changes, the lack of predictability such changes create, and the costs such changes impose on insurers. This brief assumes a scenario in which insurers would

have sufficient time to adjust premiums before the federal reimbursement for cost-sharing is halted and would not exit the Marketplaces. However, the actual scenario is critical to the outcome for both insurers and enrollees, and the uncertainty around insurer decisions is substantial.

TABLE 1

Premium Tax Credit Caps as a Percentage of Income and CSRs under the ACA, 2016

Income (% of FPL)	Premium tax credit schedule: Household premium as a percentage of income[a]	CSR schedule: AV of plan provided to eligible individuals enrolling in silver coverage[b] (%)
≤ 100–138	2.03	94
138–150	3.05–4.07	94
150–200	4.07–6.41	87
200–250	6.41–8.18	73
250–300	8.18–9.66	70
300–400	9.66	70
≥ 400	NA	70

Source: 26 CFR 601.105, Rev. Proc. 2014-62. https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.
Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; NA = not applicable.
[a] Premium tax credit amounts are set to limit household premium contributions for the second-lowest-cost silver premium available to the given percentage of income. If enrollees choose a more expensive plan, they pay more; if they choose a less expensive plan, they pay less.
[b] Silver plan coverage has a standard AV of 70 percent.

What We Did

We use the Urban Institute's Health Insurance Policy Simulation Model—Current Population Survey version (HIPSM-CPS) to simulate the elimination of federal reimbursement for CSRs in the Marketplaces.[3] We simulate the ACA as if it were fully phased in in 2016, and we simulate the elimination of federal reimbursements in the same year, although we recognize that litigation and appellate litigation would render unlikely a final decision on this matter before 2017. All estimates are presented in long-run equilibrium; changes are likely to take more than one premium rating cycle to reach equilibrium, but we do not model that time path here.

We assume that insurers would continue to provide CSRs to eligible enrollees as both parties to the litigation agree would be required. Our simulations do not include an exit of insurers from the Marketplaces, although we recognize that a mid–plan year change in reimbursement policy, or other considerations related to a change occurring even at the beginning of a plan year, could lead to such exits. As such, we do not account for any effects on premiums related to insurers exiting the Marketplaces (e.g., if lower-cost insurers exit or if competition weakens in other ways that would affect the second-lowest-cost premium and the computation of tax credits).

We assume that insurers would recoup their full expenditures on CSRs by building those costs into all their silver plan premiums in the Marketplaces. We do not think that insurers would spread these

costs beyond their silver plan premiums or load them only into premiums for CSR plans, for several reasons. First, the ACA does not permit insurers to charge different premiums for enrollees in CSR silver plans than they do for those in standard silver plans. Second, if insurers spread the CSR costs across non–silver plan premiums, they would be charging those enrollees for a higher actuarial value of coverage than the enrollees would be provided. This would be a strong disincentive for individuals to enroll in these options through the Marketplaces; insurers would not want to create such disincentives. The effect of spreading the costs across all tiers would be particularly unprofitable for any one insurer if the other insurers did not do so: it would lead to those products being priced high relative to competitors because the one insurer would be recouping a portion of the CSRs through them. Third, the federal government, state-based Marketplace management, and state departments of insurance do not generally seem interested in actively managing insurers' pricing policies. Where the law allows, they appear strongly inclined to allow the insurers to determine their own policies; they are reluctant to interfere unless required to enforce specific provisions of the ACA. A few states, such as California, have actively negotiated Marketplace premiums with insurers, but there would be no clear incentive for a state to require that CSR costs be spread across all Marketplace products. Consequently, we believe the most likely scenario is that the Marketplace and regulators would allow the insurers to build the expenses into their silver plan premiums only, which insurers should strongly prefer.

In addition, we do not expect insurers to spread the costs of CSRs to coverage for silver plans sold outside the Marketplaces. Although section 1301(a)(1)(C)(iii) of the ACA requires that a qualified health plan sold inside and outside Marketplaces be assigned the same premiums, we believe elimination of federal CSR funding would create a strong incentive for insurers to offer ACA compliant but non–Qualified Health Plan options outside the Marketplaces, allowing the insurers to charge different premiums for them. Many insurers already offer different plans inside and outside the Marketplaces, so this should not be viewed as a significant burden to the insurers. If insurers did spread the costs associated with CSRs to their non-Marketplace plans, they would place themselves at a competitive disadvantage with insurers only selling non-Marketplace coverage, those that would have no such costs to cover. Thus, in our simulations and consistent with federal law, the health care risk of the nongroup market inside and outside the Marketplace is shared broadly, although the additional premium associated with CSRs is included in the Marketplace silver plan premiums alone, effectively as a premium surcharge.

HIPSM-CPS computes the costs associated with providing CSRs, calculates the premium "add-on" necessary to cover those costs, and increases the Marketplace silver plan premiums accordingly. Premium tax credits are recomputed because they are tied to the now-higher second-lowest-cost silver plan premium, individual and household decisions are made, the costs associated with the CSRs are recomputed, and the process iterates until it reaches equilibrium (i.e., until there are few or no additional changes under additional iterations of the model).

Results

Three types of changes occur once the expenses associated with CSRs are incorporated into silver plan premiums: changes to premiums, changes to tax credits, and changes in individual and household decisions.

Changes to Premiums

Silver plan premiums increase in equilibrium $1,040 on average (table 2). For a 40-year-old, silver plan premiums for single coverage would be $4,640 per year ($387 per month) in 2016, exceeding the cost of gold plan premiums, which would be $4,560 per year ($380 per month) on average.[4]

Changes to Tax Credits

Given the rise of the silver plan premiums to which they are pegged, premium tax credits increase $1,040 on average. Although CSRs are only available to enrollees in Marketplace coverage using tax credits who have income below 250 percent of FPL, the tax credits apply to all eligible individuals up to 400 percent of FPL, regardless of the actuarial tier of coverage they purchase. So as the silver plan premium increases once CSR costs are incorporated, increasing the tax credit calculations, all tax credit–eligible individuals have larger tax credits available to them.

Changes to Individual and Household Decisions about Purchasing Insurance Coverage

The changes in premiums and tax credits change many Marketplace enrollees' preferences for coverage. These changes in preferences and enrollee behavior are summarized in box 1.

First, given the increase in silver plan premiums in the Marketplace, those purchasing silver plan coverage without a tax credit under current implementation of the ACA are strongly disincentivized to continue to do so. HIPSM-CPS calculates that there would be 1.7 million fewer people ineligible for tax credits enrolled in the Marketplace. A small minority (roughly 100,000) previously enrolled in the Marketplace without tax credits would gain eligibility for tax credits as their premiums increased; the remainder of those not receiving financial assistance would exit the Marketplaces and enroll in silver plan coverage in the non-Marketplace nongroup insurance market.

In addition, as discussed, the increase in silver plan premiums means that the premium for silver plan (70 percent actuarial value) coverage becomes higher than the premium for gold plan (80 percent actuarial value) coverage. This means that individuals above 200 percent of FPL can obtain higher-value plans at a lower cost if they shift from silver to gold plans. Consequently, virtually all tax credit–eligible individuals with incomes above 200 percent of FPL move to gold plans; their tax credit, computed using the second-lowest-cost silver plan, goes further when used for a gold plan. Even those between 200 and 250 percent of FPL, originally eligible for small CSRs that increase the actuarial value of their silver

plans to 73 percent, can increase the value of their coverage by moving to gold plans without paying more.

Those tax credit–eligible individuals with incomes below 200 percent of FPL who receive the largest CSRs (94 percent actuarial value and 87 percent actuarial value) remain in silver plan coverage because their subsidized actuarial value is still greater than that of gold plan coverage. They do not face a disincentive to remain, because their tax credits limit the share of income they pay toward their premiums as long as they enroll in the lowest- or second-lowest-cost silver option available to them. These low-income enrollees are essentially the only individuals that remain in Marketplace silver plan coverage.

Finally, about 700,000 more individuals over 200 percent of FPL would enroll in Marketplace coverage with tax credits under the new scenario. Because their tax credits are more modest and because cost-sharing for plans without cost-sharing assistance are considerable, these individuals do not place sufficient value on the coverage to enroll under current conditions. However, when the tax credits increase and allow them to afford higher-value gold plans at a lower cost than current silver plans, some of them decide to enroll.

BOX 1

Nature of Shifts in Marketplace Enrollment Caused by Increased Silver Plan Premiums and Consequent Larger Tax Credits

Those currently enrolled in silver marketplace coverage without tax credits would purchase their coverage outside the Marketplace instead (although a small number would become eligible for tax credits because of the premium increase and stay in the Marketplace with financial assistance); silver plan premiums in the outside market would be significantly lower.

Those with incomes above 200 percent of FPL currently enrolled in silver coverage using tax credits would shift to gold plan coverage; gold plan premiums would be lower than those of silver plans and offer higher actuarial value (lower out-of-pocket costs).

Those with incomes below 200 percent of FPL currently enrolled in silver coverage using tax credits would remain in silver plan coverage; their cost-sharing reductions mean their silver plan coverage has a higher actuarial value (lower out-of-pocket costs) than gold plans, and their now-larger tax credits absorb the increased premiums for their coverage.

Some **individuals between 200 and 400 percent of FPL eligible for tax credits** will enroll in Marketplace gold plans even though they remained outside of the Marketplace before; the value of the coverage they can obtain with their tax credits increases from 70 percent actuarial value to 80 percent, creating a stronger incentive for them to obtain coverage there.

Table 2 summarizes the magnitude of the implications of incorporating the costs of providing CSRs by incorporating these costs into silver plan premiums.

Because of these shifting household preferences and coverage decisions, Marketplace enrollment decreases by 1.0 million people. The number of people with incomes below 200 percent of FPL who enroll in coverage with tax credits remains largely unchanged at 5.7 million; their premium costs and plan actuarial value levels do not change. These lower-income tax credit recipients are virtually the only people who still enroll in silver Marketplace plans. As noted, 700,000 more people with incomes above 200 percent of FPL enroll in Marketplace coverage with tax credits because of the lower cost of gold plans available to them (about 100,000 of these people previously bought Marketplace coverage without tax credits but would now qualify for financial assistance because of the higher premiums), and 1.7 million people ineligible for tax credits under the current implementation of the ACA would no longer enroll in Marketplace coverage because they can obtain equivalent coverage less expensively outside the Marketplace.

TABLE 2

Changes to Marketplace Premiums, Enrollment, and the Uninsured, Assuming a Finding for the Plaintiffs in *House v. Burwell*, 2016

		Current ACA with CSRs	Finding for plaintiffs (no federal CSR funding)	Difference
Per capita value of cost-sharing reductions	< 150% of FPL	$1,070	$0	-$1,070
	150–200% of FPL	$770	$0	-$770
	200–250% of FPL	$150	$0	-150
Marketplace premium for single coverage, 40-year-old	Silver	$3,600	$4,640	$1,040
	Gold	$4,450	$4,560	$110
Marketplace enrollment (millions)	APTCs < 200% of FPL	5.7	5.7	0
	APTCs > 200% of FPL	2.8	3.5	0.7
	Other	3.4	1.7	-1.7
	Total	**11.9**	**10.9**	**-1.0**
Uninsured (millions)		29.7	29.3	-0.4
Federal costs ($ billions)	APTCs	$32.2	$41.1	$8.9
	CSRs	$5.2	$0.0	-$5.2
	Total	**$37.5**	**$41.1**	**$3.6**

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2016.
Notes: ACA = Affordable Care Act; APTC = Advanced Premium Tax Credit; CSR = cost-sharing reduction; FPL = federal poverty level.

The number of uninsured individuals falls about 400,000 as some tax credit eligible–individuals with incomes over 200 percent of FPL take advantage of the new ability to purchase higher-tier (gold) policies with their federal assistance. This change is smaller than the 700,000 tax credit eligible–individuals who newly enroll in Marketplace coverage, because some of these new enrollees switched from employer coverage or had nongroup coverage but newly became eligible for tax credits.

We estimate that federal government costs for Marketplace coverage financial assistance would increase $3.6 billion per year (computed in 2016 dollars) and $47 billion from 2016 to 2025. This increase in government cost accounts for the savings from eliminating federal spending on CSRs.

Discussion

An ultimate finding for the plaintiff in *House v. Burwell* would prohibit federal reimbursement of insurers for the CSRs they are required by law to provide to low-income Marketplace enrollees unless Congress specifically appropriates the funds to do so. In such a case, were there to be no explicit appropriation, a finding in favor of the House of Representatives could cause significant disruption to the ACA's nongroup insurance Marketplaces, depending upon the timing and notice provided to insurers. Without sufficient notice, insurers would be unable to change their approved premiums, causing them to choose among incurring significant near-term financial losses, abruptly leaving the Marketplaces, filing their own legal actions against the federal government, potentially violating notice requirements for exiting the Marketplaces, and causing enormous disruption to their enrollees. If, however, the courts find for the plaintiff but provide the insurers sufficient time to modify their Marketplace premiums through the customary rate review processes, the outcome would likely be quite different.

In this latter scenario, insurers choosing to remain in the nongroup Marketplaces would most likely increase their silver plan premiums to absorb the costs associated with providing eligible low-income enrollees with coverage meeting the actuarial value standards specified in the ACA. Although this would drive up the premiums for silver plan coverage approximately $1,040 per insured person, those eligible for premium tax credits would be protected from the increased costs because the tax credits limit their premiums as a share of their family income. Thus, premium tax credits would increase for all those eligible for them, including those not eligible for CSRs, increasing net government costs (after accounting for the elimination of cost-sharing assistance). However, financing the CSRs through a silver Marketplace premium surcharge would still allow those eligible for tax credits to continue to purchase coverage of equal or higher value than they would if the government directly financed the cost-sharing assistance.

Our best estimates indicate that federal government costs would increase $3.6 billion per year (computed in 2016 dollars) and $47 billion from 2016 to 2025 if there is a finding for the plaintiff. We also estimate an increase in the number of individuals insured because the value of insurance coverage that can be purchased with a given tax credit would increase for eligible individuals with incomes between 200 and 400 percent of FPL, making coverage more attractive for that group.

As noted, however, the importance of how such a change in policy is implemented cannot be overstated. In addition, continuing litigation and uncertainty in how Marketplace policy is implemented could increasingly affect private insurer decisions to participate in the Marketplaces. Insurers may tire both of the instability and inability to plan and of the costs associated with changing their approaches to predicting appropriate premiums and developing systems to ensure that they are making a sufficient return on their Marketplace business. If that is the case, insurers could begin to pull out of Marketplaces that they are only now beginning to understand and feel comfortable competing in.

Notes

1. A 70 percent actuarial value plan reimburses 70 percent of health expenditures for benefits covered by the plan, on average, for a typical population. The remaining 30 percent of expenditures are paid for by enrollees through cost-sharing requirements (e.g., deductibles, copayments, and coinsurance). The higher the actuarial value of a plan, the more generous the coverage for a given set of covered benefits.
2. "Plaintiff United States House of Representatives' Motion for Summary Judgment," at 6, December 12, 2015, ECF No. 53 (Case No. 14-cv-01967-RMC).
3. Buettgens (2011) provides the HIPSM-CPS methodology documentation.
4. The average gold premium rises by about $100 per year because of a modest change in the average health care risk of those enrolling in Marketplace coverage once the CSR payments are eliminated, tax credits increase, and households make different enrollment decisions.

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HealthAffairs | Robert Wood Johnson Foundation

Health Policy Brief

FEBRUARY 4, 2016

High-Deductible Health Plans. **As high-deductible health plans become increasingly prevalent in both group and individual markets, it remains to be seen how they will affect health care access and outcomes.**

WHAT'S THE ISSUE?

Over the past twenty-five years, health care spending growth overall has exceeded gross domestic product (GDP) growth, and total health care costs now account for more than 17 percent of GDP. A combination of factors—including technology, inefficiency, population health status, and insurance coverage rates—have historically been the major contributors to cost growth. Higher health care costs have translated into higher insurance costs, in both the individual and group markets.

Increasing plan deductibles has emerged as one potential solution to slowing health care cost growth by reducing use. A higher deductible reduces a plan's monthly premium payment, while increasing the amount consumers are responsible for paying for their care before their insurance pays for benefits. This effectively increases the price consumers face when deciding whether or not to seek care and may in turn reduce medical spending.

High-deductible health plans (HDHPs) are increasing in prevalence in both the group and individual markets. In the group market, rising insurance costs make HDHPs more attractive to employers. Employers now spend an average of $5,179 and $12,591 on health insurance premiums for their employees in individual and family plans, respectively. A recent Henry J. Kaiser Family Foundation survey of employers shows that deductibles have increased 67 percent since 2010. Nearly one-quarter of workers are enrolled in an HDHP, up from 4 percent in 2006. Nearly half of workers are covered by an insurance plan with a general annual deductible of at least $1,000 for individual coverage.

In the individual market, almost 90 percent of enrollees in Affordable Care Act (ACA) Marketplaces are in a plan with a deductible above the amount that qualifies a plan as an HDHP: $1,300 for an individual and $2,600 for a family (not including cost-sharing reductions) in 2015. The increasing number of enrollees in and prevalence of HDHPs raises a number of policy questions.

WHAT'S THE BACKGROUND?

HDHPs are plans with a minimum deductible and maximum out-of-pocket limits as defined by the Internal Revenue Service (IRS). Other than certain preventive services, all medical care must be paid for out of pocket until the deductible is met. Network plans such as preferred provider organization (PPO) plans can be HDHPs, as the designation of a plan as a PPO or point-of-service (POS) plan refers to preferred benefits for services provided by network providers.

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67%

In the employer market, deductibles have increased 67 percent since 2010.

"Increasing plan deductibles has emerged as one potential solution to slowing health care cost growth by reducing use."

HDHPs with a savings option (health savings account [HSA] or health reimbursement arrangement [HRA]) are also referred to commonly as consumer-driven health plans. This name connotes an increased role for consumers in shopping for services and reducing the use of unnecessary care.

Consumer-driven health plans were first offered by employers in 2001 but didn't experience large growth until after creation of HSAs through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The concept of consumer-driven health plans was to apply cost controls to the demand side of health care (instead of reducing provider costs, and so forth) by increasing consumers' exposure to the true costs of care. HDHPs can also be paired with a HRA, in which the employer contributes tax-free dollars to an account that workers can use to pay for out-of-pocket medical expenses. The key difference between HSAs and HRAs is that an HSA is a savings account that employees own, while an HRA is a reimbursement arrangement between employers and employees. HSAs are available to all qualified HDHP enrollees, not just those in an employer-sponsored plan. Employers can also contribute to an HSA.

More recently, the ACA created actuarial value tiers for all nongrandfathered plans sold in the individual and small-group markets and created a defined set of benefits (essential health benefits) for all nongrandfathered plans. These actuarial tiers—platinum, gold, silver, and bronze—correspond to the percentage of health costs that each plan covers. Platinum plans cover the most; and bronze plans the least. Another important provision of the ACA ties premium tax credits to the premium of the second-lowest-cost silver plan in each Marketplace. This means that consumers who are eligible for premium tax credits pay the least in premiums by selecting a silver or bronze plan. Cost-sharing reductions are available only to consumers who purchase a silver plan.

Because of these provisions, large portions of consumers in the Marketplaces are enrolling in silver and bronze plans. As of April 2014, 85 percent of enrollees were in a silver or bronze plan. As of March 2015, this number was nearly 90 percent. The average silver plan deductible nationally is more than $2,500 for an individual, although most silver plan enrollees are eligible for cost-sharing reductions. The average bronze plan deductible is more than $5,300 for an individual. While not all silver and bronze plans qualify as a HSA-eligible HDHP, about 25 percent of the plans offered nationally on the Marketplaces are HSA-qualified. For employer-sponsored coverage, the average deductible for individual coverage is $2,196 for HSA-qualified HDHPs.

WHAT'S THE LAW?

A high-deductible health plan is a legal designation for HSA eligibility. Enrollment in a plan with a deductible above the IRS-defined threshold is a prerequisite for HSA qualification. Each year the IRS determines the qualifying HDHP deductible, out-of-pocket limit, and maximum HSA contributions. HDHPs are often identified as HSA-eligible, signaling that they meet this set of requirements.

In 2015 the qualifying deductible was $1,300 for an individual and $2,600 for a family. The maximum out-of-pocket limit was $6,450 for an individual and $12,900 for a family. When consumers are enrolled in a qualified HDHP, HSAs allow them to put tax-preferred money into accounts to help pay for medical expenses. In 2015 this contribution was limited to $3,350 per year for an individual and $6,650 for a family. Unlike HSAs, enrollment in an HDHP isn't required for HRAs.

Section 2713 of the ACA requires all private, nongrandfathered plans to cover a set of preventive services without imposing any form of cost sharing, including a deductible. Services covered by this provision include those that have earned an "A" or "B" rating from the US Preventive Services Task Force such as disease screenings, routine immunizations, and counseling for drug and tobacco use. Enrollees in HDHPs should be able to access these services without having to meet their deductible.

WHAT'S THE DEBATE?

The central debate over HDHPs is whether or not the plans reduce health care costs and use in a way that could negatively affect health. The Institute of Medicine estimates that 30 percent of health spending is waste. HDHPs are designed to reduce unnecessary use. There is mounting evidence that HDHPs are successful at reducing costs and care use, but results are mixed on the impact of this reduced care use on health status. Cost sharing can reduce the use of beneficial as well as unnecessary services. Prior to the ACA's preventive service requirement, some HDHPs made preventive services free of cost sharing to provide consumers with incentives to continue using high-value care.

25%

Nearly one-quarter of workers are enrolled in a HDHP, up from 4 percent in 2006.

Reducing care use and costs

A number of studies have analyzed consumers' sensitivity to health care prices via cost sharing and how they respond.

The RAND Health Insurance Experiment is considered the seminal work on the impact of cost sharing on insurance use and costs. Running from 1974 to 1982, the study randomly assigned families to plans with various deductibles from $0 to $1,000. Ultimately, the study concluded that higher deductibles did reduce use of care. Those enrollees assigned to the 95 percent coinsurance plan (most comparable to today's HDHPs) reduced spending by 30 percent.

Subsequent studies have continued to confirm this central theory: Higher deductibles will result in less care use across the board and, in turn, lower costs. Actuaries from the Centers for Medicare and Medicaid Services project that the proliferation in HDHPs "may be significantly offsetting the effects of the coverage expansion in the Marketplaces on growth in the number of physician office visits made by consumers with private health insurance." A survey of New England HDHP enrollees published in *JAMA Internal Medicine* found high levels of delayed or forgone care for a period of six months across income levels, largely as a result of costs.

A recent study published by the National Bureau of Economic Research (NBER) followed a firm that switched its plan offering to employees from a non-HDHP PPO to an HDHP. Following this change, costs substantially decreased across a number of categories: preventive, emergency, outpatient, and pharmaceutical care. Overall spending decreased between 10 percent and 15 percent for the two years after the change. The decrease in spending was attributable entirely to reductions in care use.

Necessary or unnecessary care?

A number of studies have shown that increasing consumers' share of costs reduces their care use. But evidence is mixed on the health impact of this reduction. At least some of the research so far seems to indicate that high deductibles and out-of-pocket expenses reduce use of necessary as well as unnecessary care, particularly in specific populations. There are varying ways to measure this impact: Some studies, such as the RAND Health Insurance Experiment, look at health status. Others look at use by individuals with particular conditions.

The RAND study concluded that HDHPs reduce use of both effective and less effective care, but without a measurable impact on health status for most patients. However, there was an adverse impact on low-income patients and those with chronic conditions. Those populations on plans with no deductible or cost sharing had better outcomes on four of the thirty health conditions measured.

The increased prevalence of chronic conditions such as diabetes, hypertension, and so forth in the United States require medications or other regular interventions to remain under control. High cost sharing is of concern for people with chronic conditions, mental health disorders, and other conditions that require expensive prescription drugs or long-term service use. Among families in which members have chronic conditions, both adults and children are more likely to delay care when enrolled in an HDHP than in other plans. The NBER study found that the sickest enrollees decreased their medical spending by more than average, between 18 percent and 22 percent in the first year. These enrollees had relatively high incomes and even received a subsidy in the amount of the deductible in an HSA. Even if certain types of care for chronic conditions are desirable, HSA-qualified plans cannot pay for them in advance of the deductible.

The families with HDHPs who have family members with chronic conditions also have higher levels of financial burden, with nearly half reporting problems paying medical bills or other bills because of health care costs. Enrollees in HDHPs are also more likely to stop taking their medications for chronic illnesses. A 2013 analysis found decreased medication adherence for patients in HDHPs across four of five chronic conditions studied. Better adherence to taking prescribed medications for some chronic conditions results in less health care use, so this decreased adherence may not save money in the long term.

Low-income individuals and families are also disproportionately affected by high deductibles because they may not have sufficient assets to meet the out-of-pocket requirements. Individuals enrolled in high-deductible plans who live in areas with high poverty rates and low education rates reduced their "high-severity," emergency department visits (those with a high probability of needing

care within twelve hours) by 25–30 percent over two years. Individuals with higher socioeconomic status reduced only lower-severity visits, or those that can likely be substituted with a primary care visit. Other studies have echoed the finding that individuals with lower incomes are significantly more likely to forgo care than those with higher incomes when enrolled in an HDHP.

"Enrollees in high-deductible health plans are likely to reduce preventive care use and are largely unaware of the fact that preventive care is free or low cost."

Enrollees in HDHPs are also likely to reduce preventive care use, even when covered without cost sharing, and are largely unaware of the fact that preventive care is free or low cost. Even though a number of preventive care services are covered pre-deductible as required by the ACA, consumers may not be aware and take advantage because of fears of high out-of-pocket payments. Challenges remain to entice consumers to shop for health care and to use available information to do so. The NBER study found no evidence of consumers' shopping for care and substituting lower-cost services. Another recent study—surveying both those enrolled in an HDHP or a traditional plan—found similar results. Those enrolled in an HDHP were no more likely to compare costs or change providers despite having higher levels of cost sharing.

WHAT'S NEXT?

Coverage

With an increased health system focus on value, one policy to more specifically target unnecessary care use may be value-based insurance design. Plans using this design incentivize services that have a clinical evidence base and that can improve outcomes and reduce costs. Patients pay less for higher-value treatments and more for lower-value treatments. Value-based insurance design plans are more nuanced than the "blunt instrument" of HDHPs by better aligning deductibles and copayments with the value of health services. While HSA-qualified HDHPs do include high-value preventive services for free, other services are not covered in large part until the deductible is met.

Although more than ten million individuals have purchased Marketplace coverage, there are still ten million eligible people who have not, including seven million who would receive premium assistance. Surveys have indicated that a primary reason for not enrolling remains premium affordability. Some policy makers have proposed the creation of "copper" plans at a lower actuarial value to address this issue. These plans would have sizable deductibles, as they would cover even a smaller percentage of costs than bronze plans, but would also have lower premiums. To meet the health law's coverage requirements while reducing the proportion of medical expenses insurers pay to 50 percent, a plan would have a deductible of $9,000 per person, according to the Kaiser Family Foundation.

Costs

Another impending policy set to take effect in 2018 could have a major impact on deductibles in the employer-insurance market. The so-called Cadillac Tax is an excise tax of 40 percent on employer-sponsored plans valued at more than $10,200 for individual coverage and $27,500 for family coverage. Research indicates that employers may shift costs on to employees through deductibles as one way to keep plans below the level of taxation. This could further increase the share of employees enrolled in plans with high deductibles.

Initial modeling indicates that 16 percent of employers offering health benefits would have at least one health plan that would exceed the $10,200 individual coverage threshold in 2018, the first year that plans are subject to the tax. The percentage would increase to 22 percent in 2023 and to 36 percent in 2028. As employer-sponsored insurance remains the source of insurance for most individuals, this potential cost shifting could subject a large number of consumers to high deductibles.

Health care costs have slowed in recent years but are growing once again. Forecasting predicts that health spending will continue to grow faster than the GDP, at a rate of 5.8 percent from 2014 to 2024, and will rise to 19.6 percent of the GDP by 2024. As health care spending climbs, the prevalence of high-deductible plans will likely continue to increase. ■

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Most Regionally Ranked Hospitals Stay In-Network with Marketplace Plans, But Participation Declines

Analysis compares providers accessible through marketplace plans with those included on U.S. News & World Report's list of Best Regional Hospitals

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Top Findings:

- More than 95 percent of regionally ranked hospitals were in-network with at least one Affordable Care Act marketplace plan in both 2015 and 2016.
- Network participation decreases significantly, however, as more than half of hospitals reduce the number of networks in which they participate between 2015 and 2016.
- The percent of hospitals in-network with only one marketplace plan increased from 7 percent in 2015 to 20 percent in 2016.
- Network participation declined more in metro areas.
- Customers loyal to a particular hospital can in most cases still find a marketplace plan that includes it, but choices are narrowed in 2016 relative to 2015; plans with these hospitals may be more expensive.

Introduction & Methodology

Much attention has been paid to changes in marketplace plans between 2015 and 2016. Some of the most significant changes relate to provider networks and access to out-of-network providers. A number of prior reports have noted a decline in the number of broad network plans, or PPOs (Preferred Provider Organizations) offered in the marketplace in 2016. It has also been noted that PPOs newly offered on the marketplace in 2016 provide less comprehensive coverage, and in particular offer less financial access to out-of-network providers.

A closely related issue is the extent to which access to particular providers may have changed for enrollees in marketplace plans between 2015 and 2016. An increased use of narrow and/or restricted provider networks is suggested by the shift in plan types already observed, but this change may also occur within existing plan types. While provider directories are available for customers choosing health plans using healthcare.gov and in some of the state-based marketplaces, there has not yet been a release of provider network data in a machine-readable form that would permit a more comprehensive analysis of whether or how provider networks are changing.

In the absence of comprehensive data, one way to gain insight is to measure changes in network participation in marketplace plans by a fixed cohort of providers between 2015 and 2016. We selected a group of hospitals that are highly rated by one widely used measure, the *U.S. News and World Report's* list of Best Regional Hospitals in 2015. The Best Regional Hospital category is limited to general medical-surgical hospitals that provide a wide range of services. Hospitals that are regionally ranked must be categorized as "high performing" in terms of the quality of their clinical care in at least two out of five common care categories. Some Best Regional Hospitals are also nationally ranked and appear on the *U.S. News and World Report's* much shorter "Best Hospitals" list. The regional rankings included states and all metropolitan areas with a population that exceeded 1 million. However, not all metropolitan areas had a regionally ranked hospital, and rankings were not published for metropolitan areas or states where there was only one regionally ranked hospital. More information about the specific methodology used by *U.S. News and World Reports* in selecting and ranking hospitals can be found here.

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We chose the two most highly ranked regional hospitals in each area for which *U.S. News and World Reports* published ratings, which created a group of 156 hospitals. To identify network participation for our cohort of hospitals, we worked with Vericred, a health care technology company focused on transparency solutions for the insurance industry. Vericred has developed a centralized database of health care providers and the health insurance plans in which they participate. We used this database to identify the network affiliations of regionally ranked hospitals in marketplace plans in 2015 and 2016. These estimates are based on plans available to residents of the counties in which the hospitals were located. These data provide us with a point-in-time estimate of network affiliation in 2015 and 2016. However, since network participation changes throughout the year, these measures underestimate changes that may have occurred earlier in 2015, and other changes in network participation will inevitably take place during 2016.

Results

Looking at network participation by state, one of the most important results is that nearly all of the highly ranked hospitals were in-network with at least one marketplace plan in both 2015 and 2016. The percent participating stayed nearly the same at the very high rate of 97 percent in 2015 and 96 percent in 2016. The small number of hospitals that did not participate in marketplace networks changed between 2015 and 2016. Two of the four hospitals that did not participate in 2015 were in California and two were in Tennessee. In 2016, all but one of these four hospitals were in-network with at least one plan, but two hospitals from Texas and one each from Arizona, Florida, New York, and North Carolina were no longer in marketplace networks.

While the percent of these hospitals that were in-network with at least one plan changed very little since last year, the number of networks in which these hospitals participated declined quite a bit. Looking at changes in participation, only 43 percent of these hospitals maintained or increased the number of marketplace networks in which they participated, while 57 percent of hospitals participated in fewer networks in 2016. Nationally, the number of marketplace networks that included a regionally ranked hospital declined by 20 percent, from 597 to 476.

There was significant variation by state. Florida, for example, has 10 rated hospitals, and while all 10 continued to be in-network with at least one marketplace plan in 2016, the total number of networks in which these 10 hospitals participate fell by more than half. In Texas, as seen in Table 1, two of the 10 ranked hospitals exited marketplace network participation altogether, and seven of the remaining eight reduced the number of networks in which they participated. Other states with big declines included Arizona, Illinois, Kansas, Maine, Massachusetts, Minnesota, North Carolina, Pennsylvania, Utah, and Virginia. A number of states, including Arkansas, Iowa, Idaho, Oregon, and Rhode Island saw increases in the number of networks in which their ranked hospitals participated. The geographic pattern is mixed, although rural and smaller states tended to see fewer declines in network participation. Additionally, West Coast states—namely California, Washington, and Oregon all saw no change or increased participation.

Looking at plan participation regionally, the overall distribution shifted notably, in that the proportion of hospitals that were in only one network nearly tripled, from 11 in 2015 to 31 in 2016. In 2016, 24 percent of hospitals participated in one or zero networks, as compared with 10 percent in 2015. Similarly, there were fewer hospitals participating in large numbers of networks. In 2015, 50 percent of hospitals participated in four or more networks, which was only the case for 34 percent of hospitals in 2016. The average number of networks per top-rated hospital declined from 3.8 in 2015 to 3.1 in 2016.

Looking at changes in individual hospitals by state, it appears that exits from marketplace plans may be more likely in urbanized states and in more urban parts of states, although there are clearly many exceptions. Data on individual hospitals in specific metro areas shows where the overall reduction in network participation was higher, as nearly two-thirds of hospitals reduced the number of networks in which they participated in 2016.

Discussion

Changes in network participation can occur for a variety of reasons. One may be that a carrier exits the market, either because they become insolvent and fail, as did a number of the co-ops, or a carrier may choose not to sell marketplace plans in a particular state, such as Cigna's decision not to sell marketplace plans in Florida in 2016. Alternatively, carriers and providers may not be able to come to terms. Carriers creating narrow or tiered products may exclude certain providers, or may offer rates that providers are not willing to accept.

Recent research by Cooper, Gaynor, et al has provided an important new perspective on commercial prices paid to hospitals. Their results show there is significant variation both between and within hospital referral regions, and that among other factors, quality rating and market power are two significant determinants of negotiated hospital prices. Although based on an analysis of transaction prices in the group market, this research is clearly relevant. It may be the case that reductions in network participation in marketplace plans are more likely among top-rated hospitals that are relatively high priced for their market, and where carriers have other choices.

Carriers may not offer these hospitals rates that were sufficient to entice their participation, and the size of the non-group market may be small enough so that hospitals can afford to forgo this business, while carriers have opportunities with other hospitals. In less populated regions where there are fewer providers, hospitals may have more market power, and carriers may need to work harder to come to terms. There is also some research that suggests that patients loyal to highly rated hospitals may be more costly, and carriers are incentivized to exclude those hospitals to reduce their exposure to those patients (Shepard, 2015).

This reduction in network participation by top-rated hospitals is consistent with previously observed changes in plan types—i.e. movements away from broader network plans and the shrinking of out-of-network benefits. Many consumers returning to the marketplace in 2016 may find that their choices have changed in ways that limit their access to certain providers. Yet it is still the case that almost all of these highly rated hospitals are in-network with at least one marketplace plan.

These changes are best seen as a series of adjustments being made by carriers to both limit their exposure to high costs and to present an affordable product to consumers. Consumers have repeatedly indicated that they are willing to trade access to providers in exchange for lower health insurance prices. It remains to be seen to what extent they are willing to accept the products currently being offered, which are in many ways quite different from those of the previous year.

Table 1. Participation in Marketplace Plan Networks by Regionally Ranked Hospitals, 2015 to 2016, U.S. and States

		In-Network with at Least One Marketplace Plan				
		2015		2016		
	Regionally Ranked Hospitals	Yes	No	Yes	No	% Change in Network Participation
United States (N)	156	152	4	149	7	-2%
(%)	100%	97%	3%	96%	4%	
Alabama (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Arizona (N)	3	3	0	2	1	-33%
(%)	100%	100%	0%	67%	33%	
Arkansas (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
California (N)	12	10	2	11	1	10%
(%)	100%	83%	17%	92%	8%	
Colorado (N)	4	4	0	4	0	0%
(%)	100%	100%	0%	100%	0%	
Connecticut (N)	7	7	0	7	0	0%
(%)	100%	100%	0%	100%	0%	
District of Columbia (N)	1	1	0	1	0	0%
(%)	100%	100%	0%	100%	0%	
Florida (N)	10	10	0	9	1	-10%
(%)	100%	100 %	0%	90%	10%	
Georgia (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
Hawaii (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Idaho (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Illinois (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Indiana (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Iowa (N)	1	1	0	1	0	0%
(%)	100%	100%	0%	100%	0%	
Kansas (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Kentucky (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Louisiana (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
Maine (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Maryland (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Massachusetts (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	

Table 1 continued

		In-Network with at Least One Marketplace Plan				
		2015		2016		
	Regionally Ranked Hospitals	Yes	No	Yes	No	% Change in Network Participation
Michigan (N)	4	4	0	4	0	0%
(%)	100%	100%	0%	100%	0%	
Minnesota (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
Missouri (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
Nebraska (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
New York (N)	8	8	0	7	1	-13%
(%)	100%	100%	0%	88%	13%	
North Carolina (N)	7	7	0	6	1	-14%
(%)	100%	100%	0%	86%	14%	
Ohio (N)	15	15	0	15	0	0%
(%)	100%	100%	0%	100%	0%	
Oregon (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Pennsylvania (N)	10	10	0	10	0	0%
(%)	100%	100%	0%	100%	0%	
Rhode Island (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
South Carolina (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
Tennessee (N)	5	3	2	5	0	67%
(%)	100%	60%	40%	100%	0%	
Texas (N)	10	10	0	8	2	-20%
(%)	100%	100%	0%	80%	20%	
Utah (N)	3	3	0	3	0	0%
(%)	100%	100%	0%	100%	0%	
Virginia (N)	5	5	0	5	0	0%
(%)	100%	100%	0%	100%	0%	
Washington (N)	2	2	0	2	0	0%
(%)	100%	100%	0%	100%	0%	
Wisconsin (N)	4	4	0	4	0	0%
(%)	100%	100%	0%	100%	0%	
Total	**156**	**152**	**4**	**149**	**7**	

Table 2. Change in Marketplace Network Participation for Regionally Ranked Hospitals, 2015 to 2016, U.S. and States

		Marketplace Network Participation, 2016 v. 2015		Number of Networks		
	Hospitals	Same or More	Less	2015	2016	% Change
United States (n)	156	67	89	597	476	-20%
(%)	100%	43%	57%			
Alabama (N)	2	2	0	5	5	0%
(%)	100%	100%	0%			
Arizona (N)	3	0	3	8	3	-63%
(%)	100%	0%	100%			
Arkansas (N)	3	3	0	8	11	38%
(%)	100%	100%	0%			
California (N)	12	11	1	28	35	25%
(%)	100%	92%	8%			
Colorado (N)	4	0	4	25	20	-20%
(%)	100%	0%	100%			
Connecticut (N)	7	7	0	28	28	0%
(%)	100%	100%	0%			
District of Columbia (N)	1	1	0	2	2	0%
(%)	100%	100%	0%			
Florida (N)	10	0	10	44	21	-52%
(%)	100%	0%	100%			
Georgia (N)	3	3	0	11	13	18%
(%)	100%	100%	0%			
Hawaii (N)	2	2	0	3	3	0%
(%)	100%	100%	0%			
Idaho (N)	2	2	0	6	9	50%
(%)	100%	100%	0%			
Illinois (N)	2	0	2	8	3	-63%
(%)	100%	0%	100%			
Indiana (N)	2	1	1	10	9	-10%
(%)	100%	50%	50%			
Iowa (N)	1	1	0	1	2	100%
(%)	100%	100%	0%			
Kansas (N)	2	0	2	4	2	-50%
(%)	100%	0%	100%			
Kentucky (N)	2	1	1	6	6	0%
(%)	100%	50%	50%			
Louisiana (N)	3	3	0	11	11	0%
(%)	100%	100%	0%			
Maine (N)	2	0	2	6	4	-33%
(%)	100%	0%	100%			

Table 2 continued

		Marketplace Network Participation, 2016 v. 2015		Number of Networks		
	Hospitals	Same or More	Less	2015	2016	% Change
Maryland (N)	2	0	2	7	5	-29%
(%)	100%	0%	100%			
Massachusetts (N)	3	0	3	29	19	-34%
(%)	100%	0%	100%			
Michigan (N)	4	0	4	27	21	-22%
(%)	100%	0%	100%			
Minnesota (N)	3	0	3	12	6	-50%
(%)	100%	0%	100%			
Missouri (N)	3	3	0	8	9	13%
(%)	100%	100%	0%			
Nebraska (N)	2	2	0	4	4	0%
(%)	100%	100%	0%			
New York (N)	8	2	6	37	29	-22%
(%)	100%	25%	75%			
North Carolina (N)	7	0	7	23	12	-48%
(%)	100%	0%	100%			
Ohio (N)	15	7	8	90	82	-9%
(%)	100%	47%	53%			
Oregon (N)	2	2	0	6	8	33%
(%)	100%	100%	0%			
Pennsylvania (N)	10	1	9	49	30	-39%
(%)	100%	10%	90%			
Rhode Island (N)	2	2	0	4	6	50%
(%)	100%	100%	0%			
South Carolina (N)	3	3	0	4	5	25%
(%)	100%	100%	0%			
Tennessee (N)	5	3	2	6	6	0%
(%)	100%	60%	40%			
Texas (N)	10	1	9	37	18	-51%
(%)	100%	10%	90%			
Utah (N)	3	0	3	6	3	-50%
(%)	100%	0%	100%			
Virginia (N)	5	0	5	11	5	-55%
(%)	100%	0%	100%			
Washington (N)	2	2	0	13	13	0%
(%)	100%	100%	0%			
Wisconsin (N)	4	2	2	10	8	-20%
(%)	100%	50%	50%			
Totals	**156**	**67**	**89**	**597**	**476**	

Figure 1. Marketplace Plan Network Participation by Regionally Ranked Hospitals

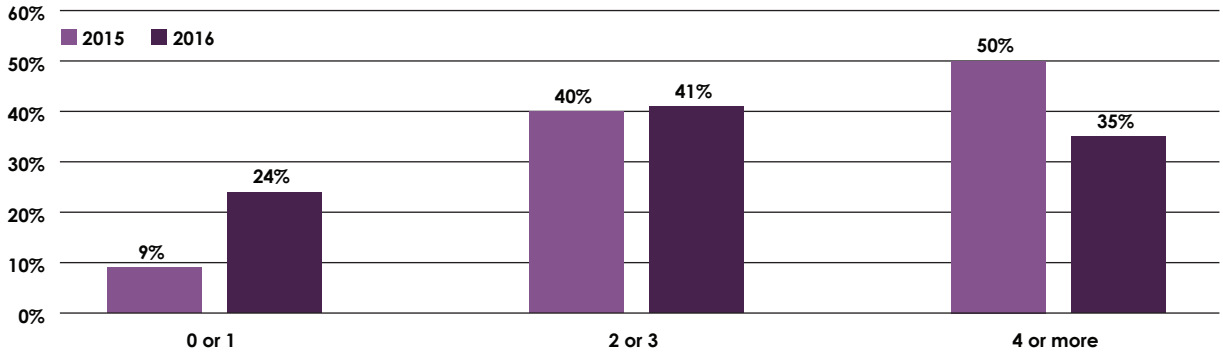


Table 3. Marketplace Plan Network Participation by Regionally Ranked Hospitals by State

	Number of Networks			
	2015	2016	Same or More	Less
Alabama				
Huntsville Hospital	3	3	1	
University of Alabama	2	2	1	
Arizona				
Banner Good Samaritan Phoenix	4	2		1
Mayo Phoenix	1	0		1
Banner–University Medical Center Tucson	3	1		1
Arkansas				
Arkansas Surgical Hospital	3	4	1	
CHI St. Vincent Infirmary	2	3	1	
Washington Regional Medical Center	3	4	1	
California				
El Camino Hospital	4	5	1	
Loma Linda University Medical Center	4	3		1
Scripps Mercy Hospital	3	4	1	
UC-Davis Medical Center	4	4	1	
UCSD Medical Center	3	4	1	
UCSF Medical Center	3	4	1	
Cedars-Sinai Medical Center	2	3	1	
KFH-Fontana	0	0	1	
KFH-South Sacramento	0	1	1	
LAC Olive View/UCLA Medical Center	1	2	1	
Stanford University Medical Center	1	1	1	
John Muir Medical Center	3	4	1	

Table 3 continued

	Number of Networks			
	2015	2016	Same or More	Less
Colorado				
Memorial Hospital	5	4		1
Penrose–St. Francis Health Services	8	7		1
Porter Adventist Hospital	7	6		1
University of Colorado Hospital	5	3		1
Connecticut				
Danbury Hospital	4	4	1	
Greenwich Hospital	4	4	1	
Hartford Hospital	4	4	1	
Middlesex Hospital	4	4	1	
Saint Francis Hospital and Medical Center	4	4	1	
Waterbury Hospital	4	4	1	
Yale-New Haven Hospital	4	4	1	
District of Columbia				
Washington Hospital Center	2	2	1	
Florida				
Baptist Hospital	4	2		1
Florida Hospital	5	2		1
Holy Cross Hospital	5	2		1
Holmes Regional Medical Center	6	3		1
Mayo Clinic Florida	3	1		1
Orlando Health	4	2		1
Sarasota Memorial Hospital	5	3		1
Tampa General Hospital	6	4		1
UF Hospital Jacksonville	2	0		1
Venice Regional Medical Center	4	2		1
Georgia				
Emory University Hospital	3	4	1	
Northside Hospital	5	6	1	
University Hospital	3	3	1	
Hawaii				
KFH Hawaii	1	1	1	
Queen's Medical Center	2	2	1	
Idaho				
Saint Alphonsus Regional Medical Center	3	4	1	
St. Luke's Regional Medical Center	3	5	1	
Illinois				
Northwestern Memorial Hospital	5	2		1
Rush University Medical Center	3	1		1

Table 3 continued

	Number of Networks			
	2015	2016	Same or More	Less
Indiana				
Indiana University Health	5	5	1	
St. Vincent Hospital and HCC	5	4		1
Iowa				
Iowa Lutheran Hospital	1	2	1	
Kansas				
Kansas Medical Center	2	1		1
University of Kansas Hospital	2	1		1
Kentucky				
Baptist Health Louisville	2	3	1	
Norton Hospital	4	3		1
Louisiana				
East Jefferson General Hospital	5	5	1	
Ochsner Baptist Medical Center	3	3	1	
Our Lady of the Lake	3	3	1	
Maine				
Maine Medical Center	3	2		1
Mid Coast Hospital	3	2		1
Maryland				
Johns Hopkins University Hospital	4	3		1
University of Maryland Medical System	3	2		1
Massachusetts				
Baystate Medical Center	9	5		1
Brigham and Women's	10	7		1
Massachusetts General Hospital	10	7		1
Michigan				
William Beaumont Hospitals–Royal Oak	12	10		1
Saint Mary's Health Care	5	3		1
University of Michigan Medical Center	6	5		1
Spectrum Health	4	3		1
Minnesota				
Abbott Northwestern Hospital	5	3		1
Mayo Clinic Methodist Hospital	2	1		1
University of Minnesota Medical Center	5	2		1
Missouri				
Barnes–Jewish Hospital	3	3	1	
Missouri Baptist Medical Center	2	3	1	
St. Luke's Hospital	3	3	1	

Table 3 continued

	Number of Networks			
	2015	2016	Same or More	Less
Nebraska				
CHI Health Immanuel	2	2	1	
CHI Creighton University	2	2	1	
New York				
Albany Medical Center Hospital	7	6		1
Ellis Hospital	6	6	1	
New York Presbyterian	3	2		1
Northern Dutchess Hospital	6	7	1	
New York University Langone Medical Center	3	0		1
Rochester General Hospital	5	3		1
St. Joseph's Hospital Health Center	3	2		1
Strong Memorial Hospital	4	3		1
North Carolina				
Carolinas Medical Center	3	2		1
Duke University Hospital	3	2		1
Moses H. Cone Memorial Hospital	4	3		1
Novant Health Matthews	4	3		1
Novant Health Presbyterian Medical Center	4	1		1
University of North Carolina Hospital	4	1		1
Wake Forest University Baptist Medical Center	1	0		1
Ohio				
Akron General Medical Center	6	5		1
Bethesda Hospital	8	7		1
Cleveland Clinic Hospital	5	3		1
Grandview Hospital	5	6	1	
Good Samaritan Hospital Cincinnati	8	7		1
Kettering Medical Center	5	5	1	
Promedica Toledo Hospital	1	1	1	
Riverside Methodist Hospital	3	3	1	
St. Elizabeth Boardman Health Center	9	8		1
St. Elizabeth Youngstown	9	8		1
Summa Akron City & St. Thomas Hospital	7	7	1	
The Christ Hospital	6	5		1
The Ohio State University Hospital	5	5	1	
UH Case Medical Center	6	6	1	
University of Toledo Medical Center	7	6		1
Oregon				
OHSU Hospital and Clinics	2	3	1	
Providence Portland Medical Center	4	5	1	

Table 3 continued

	Number of Networks			
	2015	2016	Same or More	Less
Pennsylvania				
Holy Spirit Hospital	7	5		1
Hospital of the University of Pennsylvania	4	1		1
Lancaster General Hospital	7	4		1
Lehigh Valley Hospital	8	5		1
Lehigh Valley Hospital Muhlenberg	7	5		1
The Milton S. Hershey Medical Center	5	2		1
Thomas Jefferson University	3	1		1
UPMC–Pittsburgh	2	3	1	
Western Pennsylvania Hospital	2	1		1
Wilkes-Barre General Hospital	4	3		1
Rhode Island				
Miriam Hospital	2	3	1	
Newport Hospital	2	3	1	
South Carolina				
Bon Secours St. Francis Downtown	1	1	1	
Medical University of South Carolina	1	1	1	
St. Francis Xavier Bon Secours	2	3	1	
Tennessee				
Memorial Health Care System	0	1	1	
Methodist Healthcare-Memphis	2	1		1
Saint Thomas Hospital	0	1	1	
University of Tennessee Memorial Hospital	2	2	1	
Vanderbilt University Hospitals	2	1		1
Texas				
Baylor University Medical Center	4	2		1
Doctors Hospital at Renaissance	6	4		1
Edinburg Regional Medical Center	2	2	1	
Houston Methodist Hospital	3	0		1
Methodist Stone Oak Hospital	4	2		1
Seton Medical Center	4	3		1
St. David's Medical Center	5	2		1
University Health System	4	1		1
UT Southwestern University Hospital	1	0		1
Memorial Herman	4	2		1
Utah				
Intermountain Medical Center	2	1		1
Utah Valley Regional Medical Center	2	1		1
University of Utah Hospitals and Clinic	2	1		1

Table 3 continued

	Number of Networks			
	2015	2016	Same or More	Less
Virginia				
Bon Secours St Mary's Hospital	2	1		1
Inova Fairfax Hospital	2	1		1
Sentara Norfolk General Hospital	2	1		1
Sentara Williamsburg Regional Medical Center	3	1		1
Virginia Commonwealth University Health System	2	1		1
Washington				
UW Medicine/Northwest Hospital	7	7	1	
Virginia Mason Medical Center	6	6	1	
Wisconsin				
Aurora Health Care Metro	3	2		1
Froedtert Hospital and the Medical College of Wisconsin	3	3	1	
Meriter Hospital	3	2		1
St. Mary's Hospital	1	1	1	
Total			**67**	**89**
			43%	**57%**

Table 4. Marketplace Plan Network Participation by Regionally Ranked Hospitals by Selected Metro Areas

	Number of Networks		Same or More	Less
	2015	2016		
New York City				
New York Presbyterian	3	2		1
New York University Langone Medical Center	3	0		1
Chicago				
Northwestern Memorial Hospital	5	2		1
Rush University Medical Center	3	1		1
Los Angeles				
Cedars–Sinai Medical Center	2	3	1	
LAC Olive View/UCLA Medical Center	1	2	1	
Dallas				
Baylor University Medical Center	4	2		1
UT Southwestern University Hospital	1	0		1
Houston				
Houston Methodist Hospital	3	0		1
Memorial Herman	4	2		1
Philadelphia				
Thomas Jefferson University	3	1		1
Hospital of the University of Pennsylvania	4	1		1
Washington DC/VA				
Inova Fairfax Hospital	2	1		1
Washington Hospital Center	2	2	1	
Miami				
Baptist Hospital	4	2		1
Atlanta				
Emory University Hospital	3	4	1	
Northside Hospital	5	6	1	
Boston				
Brigham and Women's	10	7		1
Massachusetts General Hospital	10	7		1
San Francisco				
UCSF Medical Center	3	4	1	
John Muir Medical Center	3	4	1	
Stanford University Medical Center	1	1	1	
Phoenix				
Banner Good Samaritan Phoenix	4	2		1
Mayo Phoenix	1	0		1
Riverside/San Bernardino				
Loma Linda University Medical Center	4	3		1

Table 4 continued

	Number of Networks		Same or More	Less
	2015	2016		
Detroit				
William Beaumont Hospitals–Royal Oak	12	10		1
Seattle				
UW Medicine/Northwest Hospital	7	7	1	
Virginia Mason Medical Center	6	6	1	
Minneapolis				
University of Minnesota Medical Center	5	2		1
Abbott Northwestern Hospital	5	3		1
San Diego				
Scripps Mercy Hospital	3	4	1	
UCSD Medical Center	3	4	1	
Tampa				
Tampa General Hospital	6	4		1
St. Louis				
Barnes-Jewish Hospital	3	3	1	
Missouri Baptist Medical Center	2	3	1	
Baltimore				
Johns Hopkins University Hospital	4	3		1
University of Maryland Medical System	3	2		1
Denver				
Porter Adventist Hospital	7	6		1
University of Colorado Hospital	5	3		1
Total			**14**	**25**
			36%	**64%**

Commonwealth Fund
Feb 8 · 13 min read

Designing More Affordable and Effective Health Care

by Lauren Hughes, Douglas McCarthy, Anne-Marie Audet, and Sarah Klein

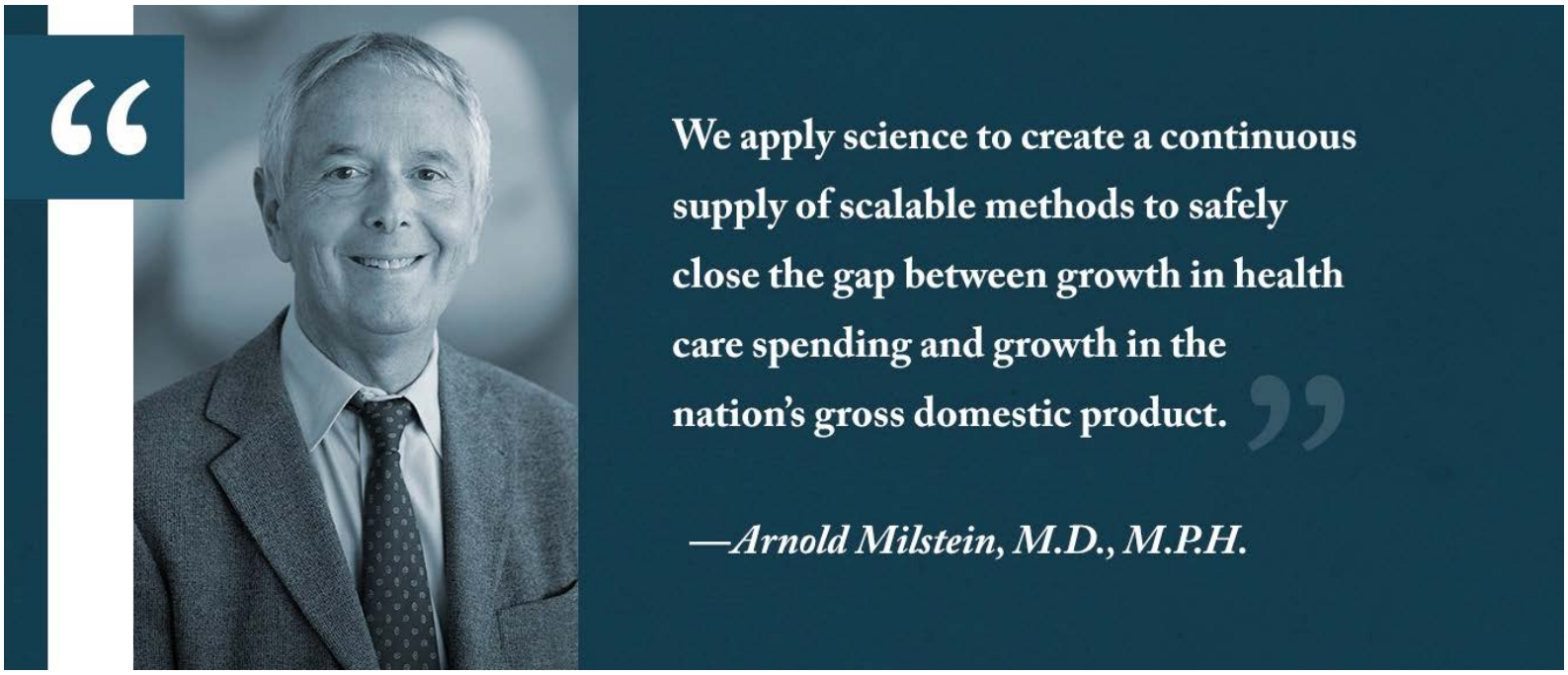
This case study is part of ongoing research by The Commonwealth Fund to track how health

systems are transforming care delivery, particularly to meet the needs of high-need, high-cost patients and other vulnerable populations. The first publication in the series profiled the Penn Medicine Center for Health Care Innovation.

• • •

Spiraling health care costs in the U.S. place untenable burdens on an increasing share of Americans and divert money from education, research, and economic development. In 2010, Stanford University launched its Clinical Excellence Research Center (CERC) to develop new ways of delivering health care that might slow this spending growth. “What we want is affordable clinical excellence, and that’s what is distinctive about what we’re doing,” says Arnold Milstein, M.D., M.P.H., CERC’s director, who was recruited to lead CERC in part because of his success redesigning ambulatory care for medically fragile patients. The center identifies diseases, conditions, and health care services for which spending could be lowered by 30 percent or more for certain populations while also improving patient health and care experiences.

The new care designs are developed by multidisciplinary teams of postdoctoral fellows, including physicians, systems engineers, and social scientists. Fellows spend one to three years at CERC and receive intensive training in its research and care redesign methods. The teams are assigned ambitious goals — for instance, cutting in half national spending on treatment for chronic musculoskeletal pain. Because real-world demonstrations are a key to spreading new care models, CERC partners with health systems and health plans across the United States to try out and test their approaches.



Structure and Approach

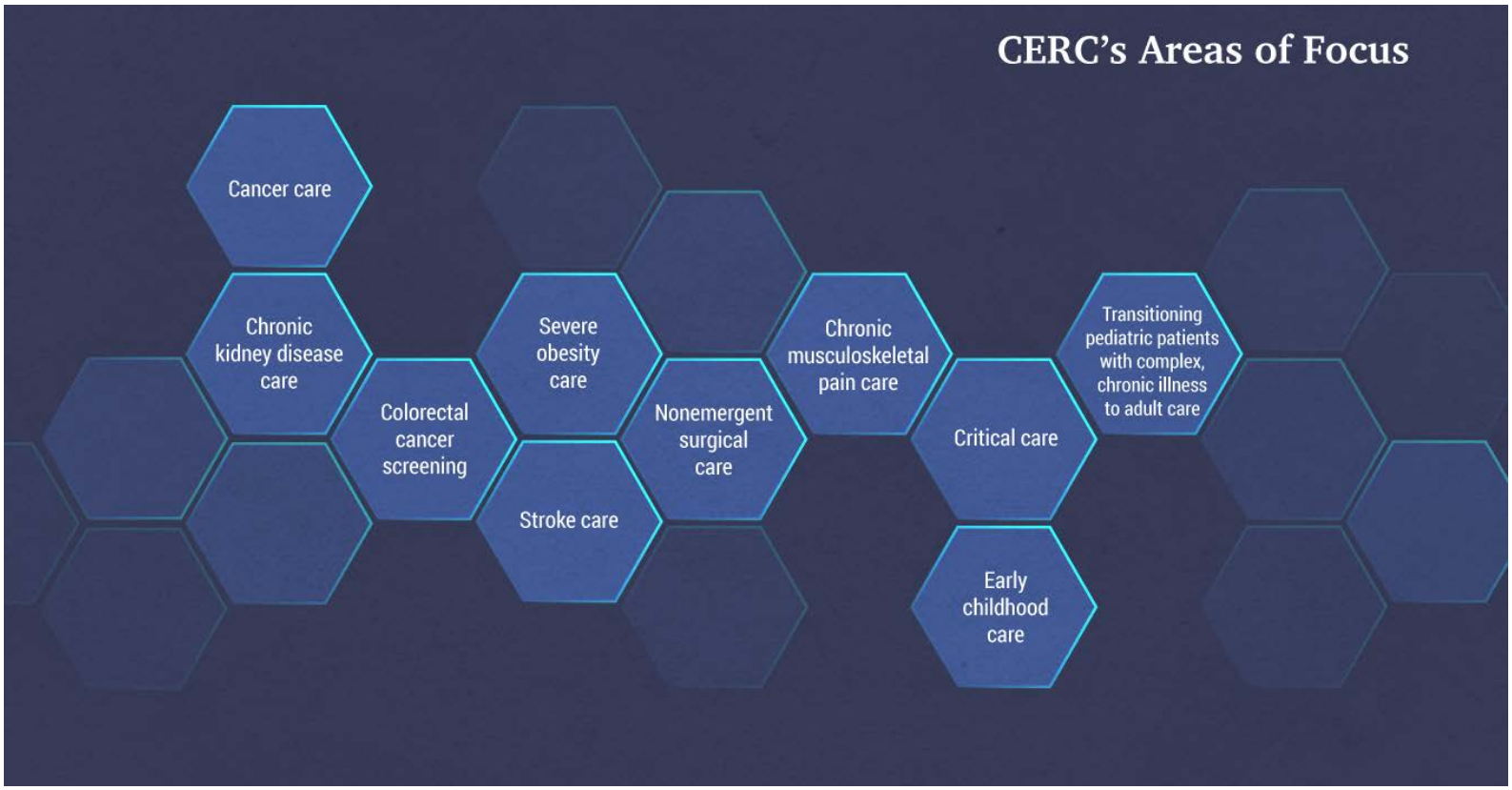
The Stanford University School of Medicine and its academic medical center cooperate with CERC in researching, designing, and refining new care approaches. The medical school provided half of the center's start-up funding and continues to provide administrative support and an academic home for CERC faculty. The center's annual operating budget of $3.5 million partially supports 21 full-time-equivalent staff members. Funding sources include private philanthropy, grants, and industry sponsors.

The center's work consists of four synergistic work streams:

- studying high-performing clinical teams to identify their replicable characteristics
- identifying the greatest sources of discontent among patients, families, and clinical teams
- collaborating with other Stanford researchers to identify new tools and knowledge from other disciplines that can be applied to health system redesign
- designing, implementing, and evaluating new care models that, if broadly implemented, would slow growth in health care spending.

CERC's initial areas of focus were selected by studying populationwide spending trends,

reviewing the current literature, and consulting with clinical experts. This approach identified promising opportunities to reduce needlessly costly or unnecessary care.

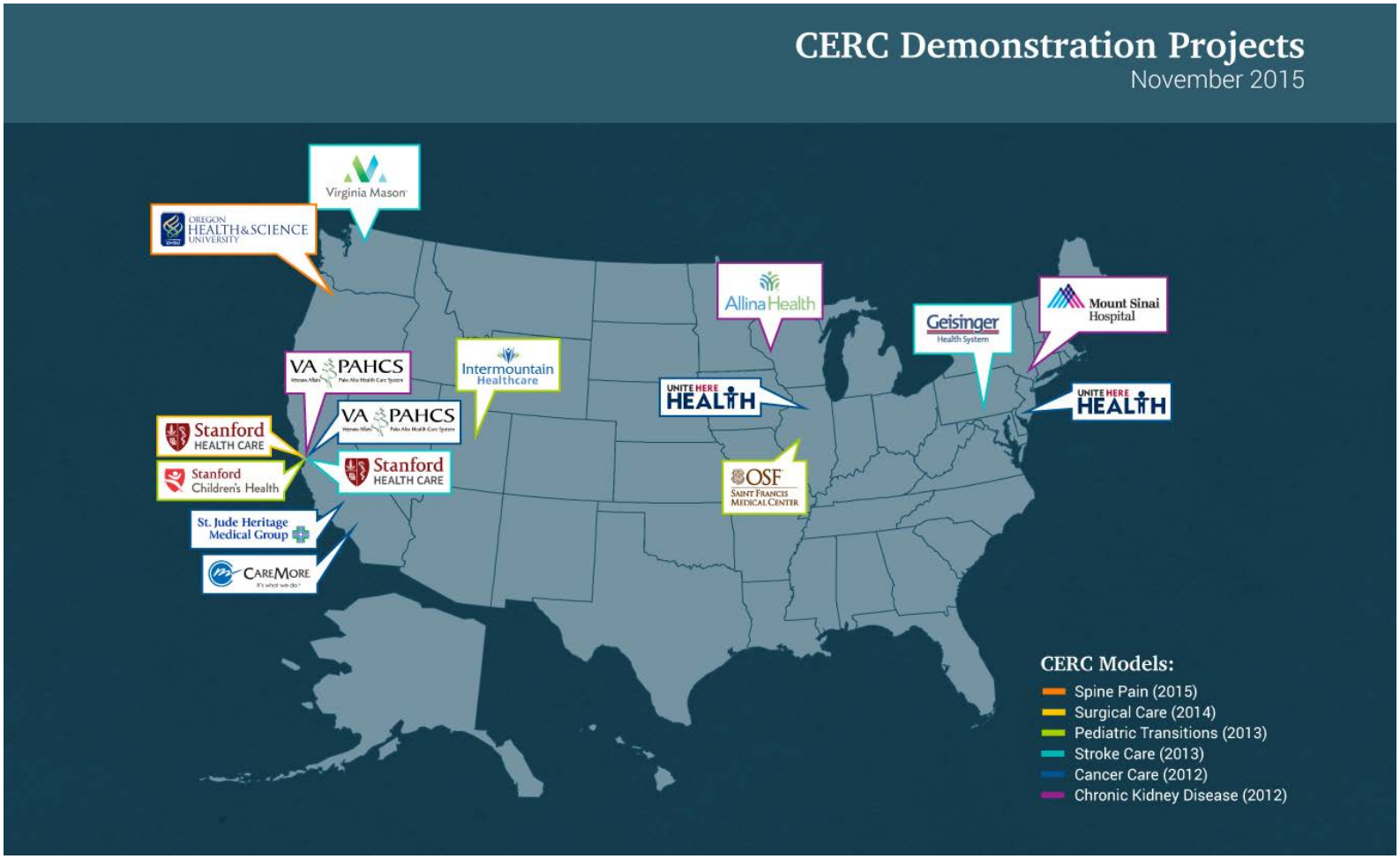


Once targets are identified, the center looks for key points in the trajectory of a condition or disease where changes in provider and patient behavior could slow the progression or make possible the use of less expensive but equally effective treatment methods. CERC's leaders refer to these windows of opportunity as "ambush points." For example, if a patient with chronic kidney disease begins to experience severely reduced kidney function, she could transition to either center-based or home-based dialysis. According to CERC's estimates, home-based dialysis, along with better management of early disease stages, could save the United States $63 billion per year while improving patients' experiences.

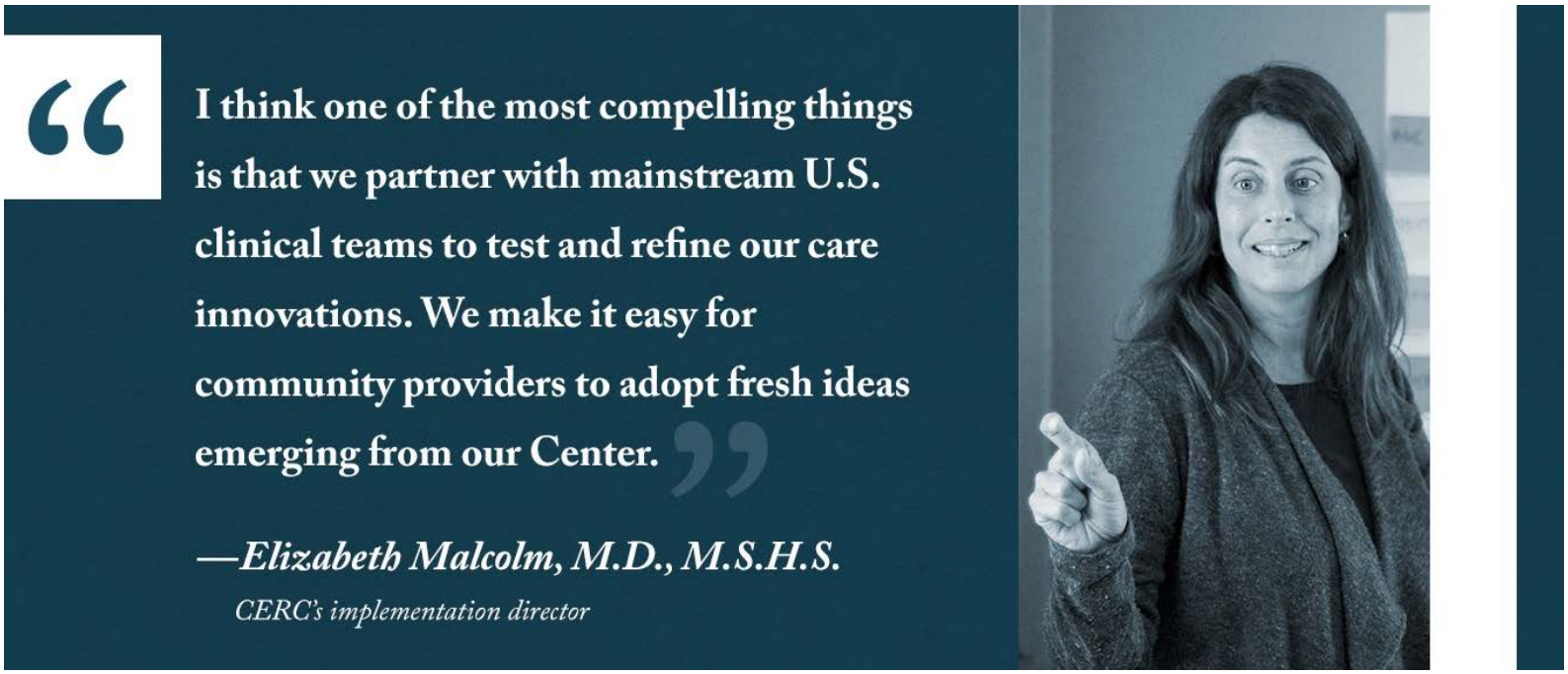
To identify new tools and techniques, CERC has fostered relationships with 16 other Stanford departments, including those focused on health behavior, management science, economics, and technological innovation. A collaboration with researchers working on artificial intelligence, for example, led to the idea of using computer vision technology to lower the cost

of continuous patient monitoring in intensive care units (ICUs) and senior housing. This technology could also be used to improve patient safety by detecting whether clinicians adhere to recommended infection prevention measures when entering the rooms of children with compromised immune systems, or by checking whether appropriate procedures are being followed in the ICU to prevent blood clots from forming in patients' legs.

Developing partnerships with other health systems and payers is another key strategy. CERC recruits partners with a population health focus and a history of taking on financial risk and then works with them to refine value-based care models.



As of October 2015, these partners included six insurance companies or self-insured health care purchasers and 11 integrated health systems. Several of the health systems support the center's fellowship program by helping fellows hone their new care models.



CERC's Efforts to Improve Care for Kidney Disease, Cancer, and Stroke

Chronic Kidney Disease

Problem: Patients with chronic kidney disease often do not receive optimal primary care treatment in the early stages. Those with late-stage disease, meanwhile, often struggle to follow the recommendations of the wide array of specialists involved in their care, including endocrinologists, neurologists, cardiologists, nutritionists, physical therapists, and social workers.

Solution: CERC found opportunities to improve outcomes and lower health care spending at critical junctures in care — after diagnosis and when patients begin to experience severely reduced kidney function. First, the center uses software to scan electronic medical records or lab reports to identify patients with early-stage chronic kidney disease whose loss of kidney function can be slowed. In those cases, a nephrologist remotely advises the patient's regular doctor on ways to alter therapy to meet key goals, like controlling blood pressure. Patients with late-stage disease are assigned a nurse care manager, who joins the patient in the

nephrologist's office for a videoconference with other specialists to create a coordinated care plan that reflects quality-of-life goals. This new care model, which also emphasizes shared decision-making to respect patients' preferences, is being tested to determine whether it can slow disease progression, reduce emergency department visits, and make greater use of safer and less costly home-based end-stage treatment methods.

Who is currently testing this model? VA Palo Alto Health Care System; New York's Mount Sinai Health System, in partnership with the Building Service 32BJ Health Fund.

CERC's estimate of savings if implemented nationally: $63 billion annually.

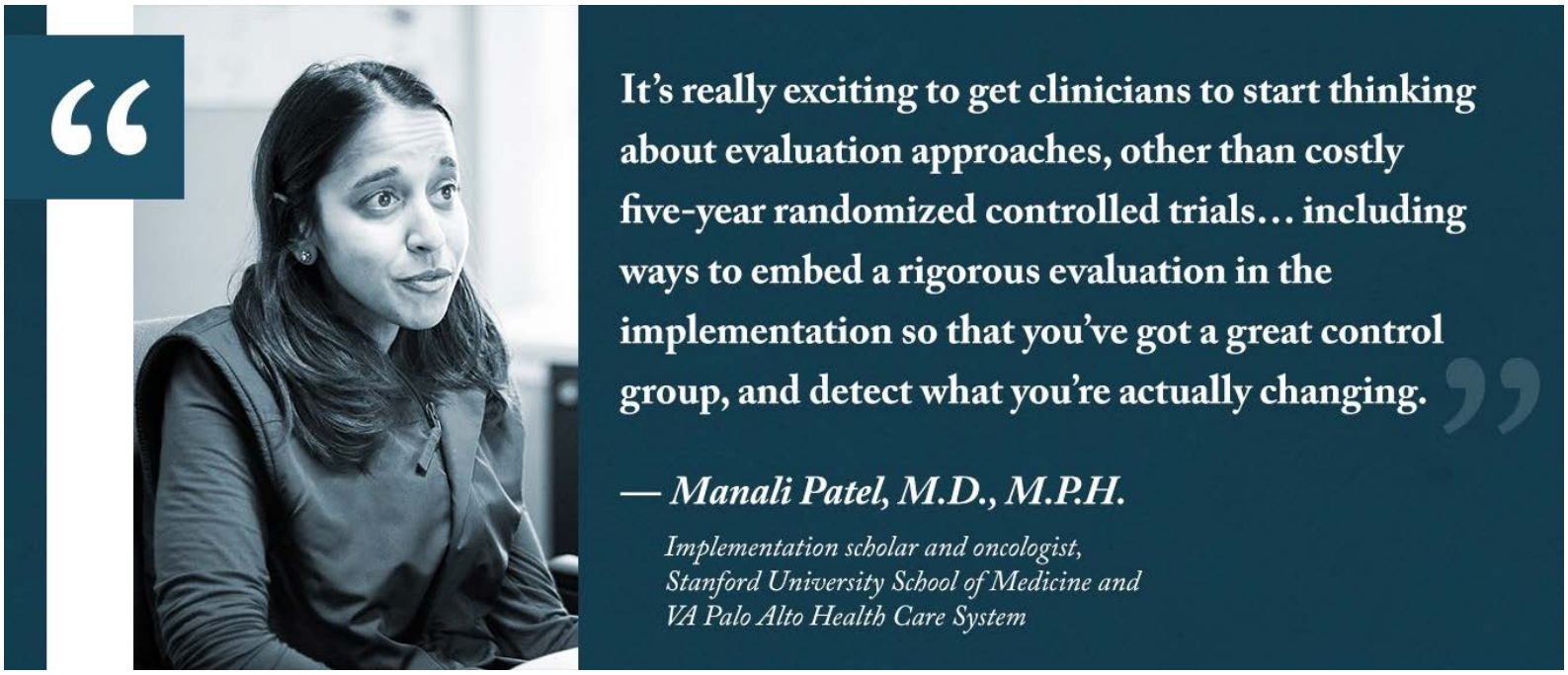
Enhancing Quality of Care for Patients with Advanced Cancer

Problem: Cancer patients with poor prognoses experience fluctuating emotions, great uncertainty, and evolving symptoms at the end of life. Treatment decisions are complex and often result in high-cost care that can worsen quality of life. Poor management of pain and nausea also leads some patients to turn to costly emergency department care for relief.

Solution: CERC's new care model for patients with advanced cancer relies on health coaches, who help talk to patients about their goals for their care and quality of life. Such conversations take place over time in patients' homes, in language free of technical jargon. Coaches also engage with family members whose goals may differ from the patient's — for example, grown children who aren't prepared to give up on treatment. These are difficult conversations that can be hard for busy providers to manage. Under the care model, patients also have the option of receiving chemotherapy at home, and they have access to emergency medication packets for immediate treatment of their pain and nausea while at home. In addition, a 24/7 symptom control call center is staffed by experienced cancer care nurses.

Who is currently testing this model? CareMore and St. Jude's Heritage Medical Group in Southern California; Unite Here Health in Chicago and Atlantic City; VA Palo Alto Health Care System.

CERC's estimate of savings if implemented nationally: $37 billion annually.



Advancing Stroke Prevention and Care

Problem: When it comes to treating a stroke, the time it takes to begin treatment has a significant effect on outcomes, quality of life, and subsequent costs to the health care system. Victims who are unaware of the signs of stroke may delay treatment, missing an opportunity to receive the clot-dissolving medication tPA, which must be administered within three-and-a-half hours to restore blood flow to affected parts of the brain.

Solution: CERC's approach to stroke care emphasizes patient behavior, using education and regular "stroke drills" to help at-risk patients and their families recognize symptoms and understand the importance of immediately calling an ambulance. On the way to the hospital, paramedics communicate with the neurologist about the patient's clinical history. Once at the hospital, patients who are likely experiencing a stroke are delivered directly to the computed tomography scanner, which reveals whether a clot exists. If so, a nurse is ready to administer tPA.

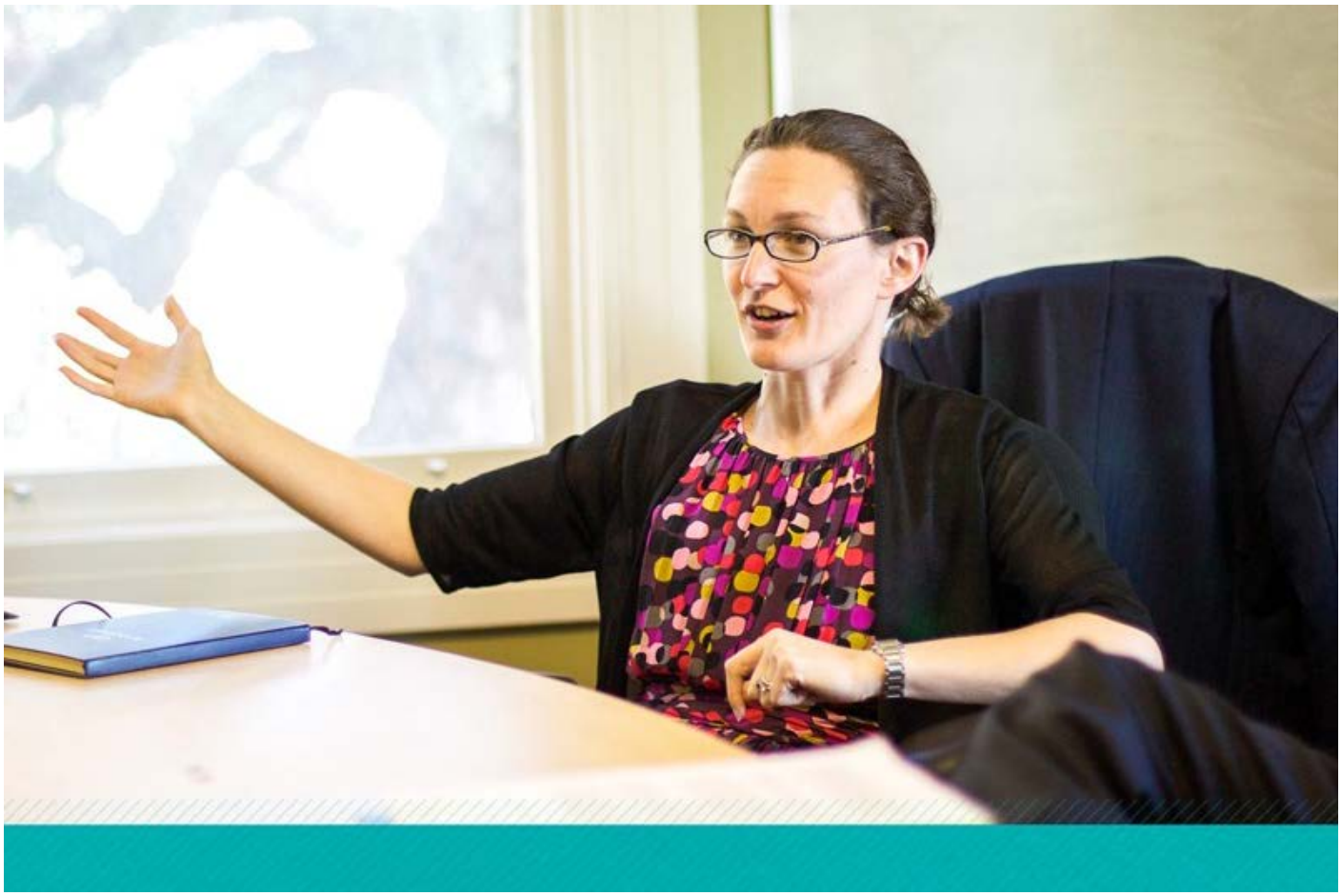
CERC has also developed innovations in stroke prevention and post-stroke care. Through lay coaching, which is supervised by a nurse, at-risk patients are encouraged to make lifestyle changes. Meanwhile, specialized outpatient clinics evaluate patients with transient ischemic attacks (mini-strokes), which may be a warning sign of an impending major stroke.

Who is currently testing this model? Stanford Health Care; Geisinger Health System in Pennsylvania; Allina Health in Minnesota; Virginia Mason in Washington. CERC is also collaborating with California Stroke Registry/California Coverdell Program through the California Department of Public Health to extend its model to two California regions.

CERC's estimate of savings if implemented nationally: $2.8 billion annually.

Providing High-Value Care

CERC has identified primary care sites, outside of well-studied large integrated health systems, that excel in delivering value. In assessing the factors that contribute to their higher performance, Melora Simon, M.P.H., and her colleagues looked at the total cost of care, as determined by market prices paid by private payers (rather than prices paid by Medicaid and Medicare) and quality measures like the Healthcare Effectiveness Data and Information Set (HEDIS). Their analysis, conducted with IMS Health, used claims data for some 40 million commercially insured Blue Cross Blue Shield patients, collectively seen by half of the physician practices in the United States.



Melora Simon, M.P.H., leader of America's Most Valuable Care Project

The team identified primary care practices that had at least two physicians and scored among the top 25 percent on quality measures. These practices were then narrowed down to only those within the lowest 25 percent of total annual per patient spending (after adjusting for disease severity). Less than 5 percent of the approximately 15,000 sites CERC assessed met both of these criteria.

After visiting 20 of these high-performing sites — a diverse mix in terms of geography, practice size, labor costs, market share, and practice arrangements — the clinical experts and CERC faculty described and ranked their distinguishing features with regard to cost impact, quality, and transferability of features to other practices. The team is developing a toolkit that practices can use to achieve similar results.

. . .

How CERC Describes the Ten Characteristics of High-Performing Primary Care Practices

1. They are "always on" and regard patients as individuals. Patients have a sense that their care team is always available and that they can quickly reach someone who knows them, whether the practice is open or closed. Practices offer same-day appointments, accommodate walk-in visits, and have extended evening and weekend hours.

2. Physicians adhere to quality guidelines and choose tests and treatments wisely. The care team has systems to ensure patients receive evidence-based tests and treatments. At the same time, the team conserves resources by tailoring care to align with patients' needs and values.

3. Patient complaints are treated like gold. Complaints from patients are considered as valuable as compliments, if not more so. High-value primary care providers take every opportunity to encourage feedback that can help to improve the patient experience.

4. They in-source, rather than outsource, needed tests and procedures. Primary care teams do as much as they can safely do themselves, within the scope of their expertise, rather than refer patients to external providers. This includes services that take more time than a visit usually allows: skin biopsies, insulin initiation and stabilization, joint injections, or suturing. If specialist supervision can be arranged, primary care teams will take on additional low-complexity services, like treadmill testing for cardiac patients.

5. They stay close to their patients after referring them to specialists. Physicians refer to carefully chosen specialists whom they trust to act in accordance with their patients' preferences and needs, and they stay in close communication as care decisions are made. Although physicians cannot always select the hospitalist or emergency department physician who cares for their patients, they do stay connected to ensure treatment plans respect patients' preferences and needs.

6. They close the loop for patients. The care team follows up to ensure that patients are seen rapidly after hospital discharge, are able to continue their prescribed medications, and can see specialists when needed.

7. They maximize the abilities of staff members. Physicians are supported by a team of nurse practitioners, physician assistants, nurses, and medical assistants — all of whom are working at the top of their licenses. This allows physicians to care for more patients and spend more time with each one.

8. They work in "hived workstations." Care teams work together in an open, collaborative environment that facilitates continuous communication among clinical and nonclinical staff alike.

9. They balance compensation. Rather than relying solely on fee-for-service reimbursement, pay typically also reflects quality of care, patients' experiences, use of resources, and contribution to practicewide improvement activities.

10. They invest in people, not space and equipment. Practices rent very modest offices and only invest in lab, imaging, and other equipment if doing so allows them to deliver care more cost-effectively in-house. Saving money this way eliminates the need to see more patients or order expensive tests to generate a competitive income.

Source: Stanford University Clinical Excellence Research Center

. . .

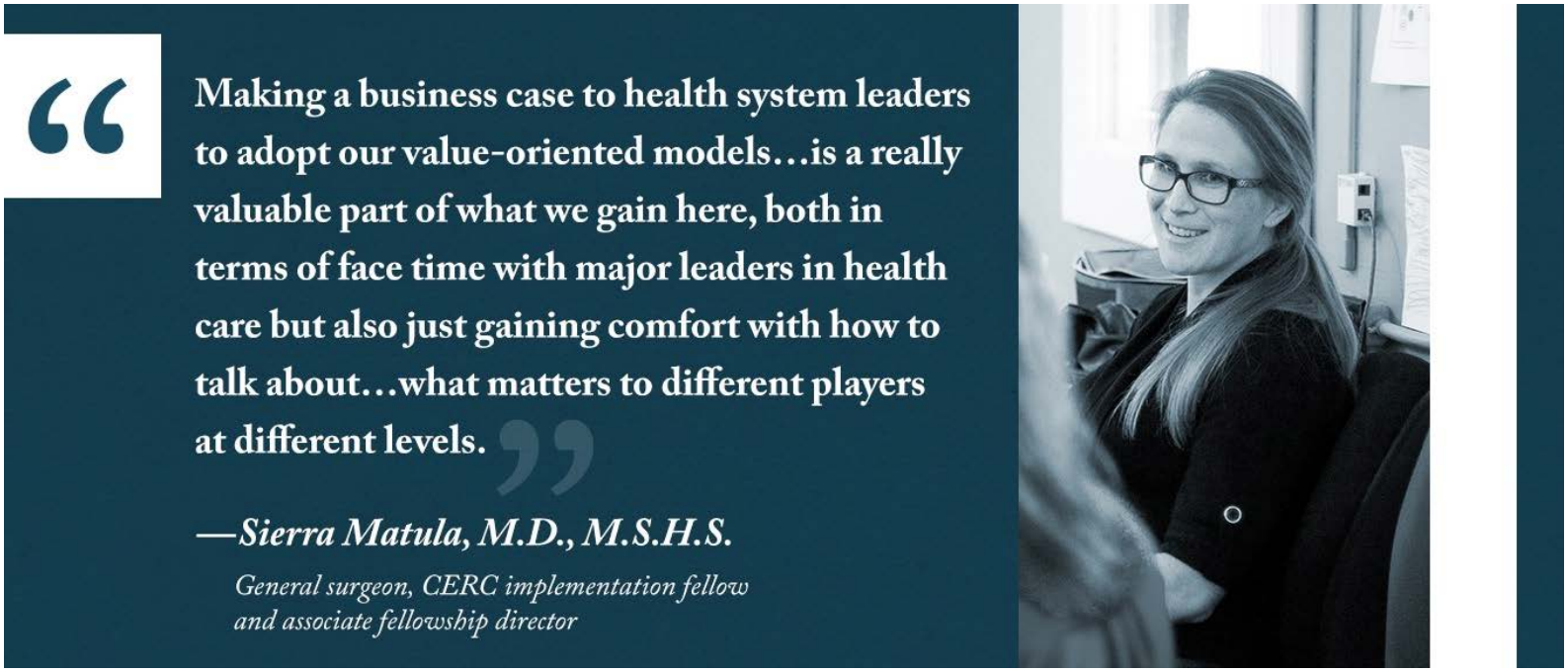
CERC is now performing a similar analysis to identify features of high-performing community hospitals and care practices in seven high-cost specialties: cardiology, endocrinology, nephrology, obstetrics, oncology, cardiothoracic surgery, and interventional cardiology.

CERC's Fellowship Program

In CERC's care innovation design fellowship program, participants develop new care models using multiple techniques: observing high-value clinical teams, studying emerging technology, such as automated clinical workflow support systems, and conducting interviews to identify patients' and clinicians' unmet needs.

The care models are refined through discussion with experts in industry and science, including leaders from health care systems and companies recognized for delivering high-value care. In their second year, fellows work with health systems to implement their new designs, assess their impact on cost and quality of care, and refine them.

Once they've developed a new approach, the teams practice explaining it to health system leaders, payers, and frontline clinicians — experiences that CERC hopes will prepare them to lead health system transformation elsewhere.



Jeffrey Jopling, M.D., M.S., a general surgery resident and CERC implementation fellow, explains the different approach required to redesign — rather than simply improve — health care systems.

> It takes a lot more thought and a lot more understanding of the environment, the context, the different components. You actually have to think about how you would finance it and what would the actual impact be to patients.
>
> *— Jeffrey Jopling, M.D., M.S.*
> *General surgery resident and CERC implementation fellow*

Lessons and Insights

Collaborate with health systems and purchasers as partners in care model design and implementation. To increase the likelihood of success, partners need to take ownership of and adapt the care models to their respective settings without compromising the integrity of design. That's why CERC develops innovations that can be tailored to each pilot site's level of capability and motivation to manage change.

CERC has yet to determine how it will progress from testing with a limited number of partner sites to reaching a broad cross-section of adopters. The size of the potential market for the center's innovations will depend on how quickly the country moves from volume-based, fee-for-service payment to value-based reimbursement, and on the willingness and readiness of clinicians to take on financial risk for lowering the total cost of care.

Develop policies that support rapid learning. When private payers and providers in a competitive market participate in collaborative research, there can be challenges related to ownership of data and intellectual property. To avoid these issues, CERC worked with

partners to define an open, nonproprietary innovation model that supports shared learning. To ease agreement on data use, the center does not collect protected health information from its partners or data suppliers, although it does help them perform relevant analyses.

Seek peer-reviewed publication to strengthen scientific standing and spur adoption. CERC strives to develop methods and approaches that meet the standards of peer-reviewed journals publishing early-stage research. The goal is to validate the credibility of the center's work with external audiences as well as the academic community. "In a university setting, published research is the 'coin of the realm,' and we have to find a way to make what we're doing relevant to the research mission as well as the teaching mission of the university," says Bob Rebitzer, M.B.A., CERC's chief operating officer.

Draw on the expertise of the university. The center's position within a leading research university allows it to tap scholarly resources and fund collaborative opportunities, like its work with the Stanford Artificial Intelligence Laboratory. This requires intellectual curiosity, disciplined inquiry, and the ability to identify partners willing to take calculated risks in testing new approaches.

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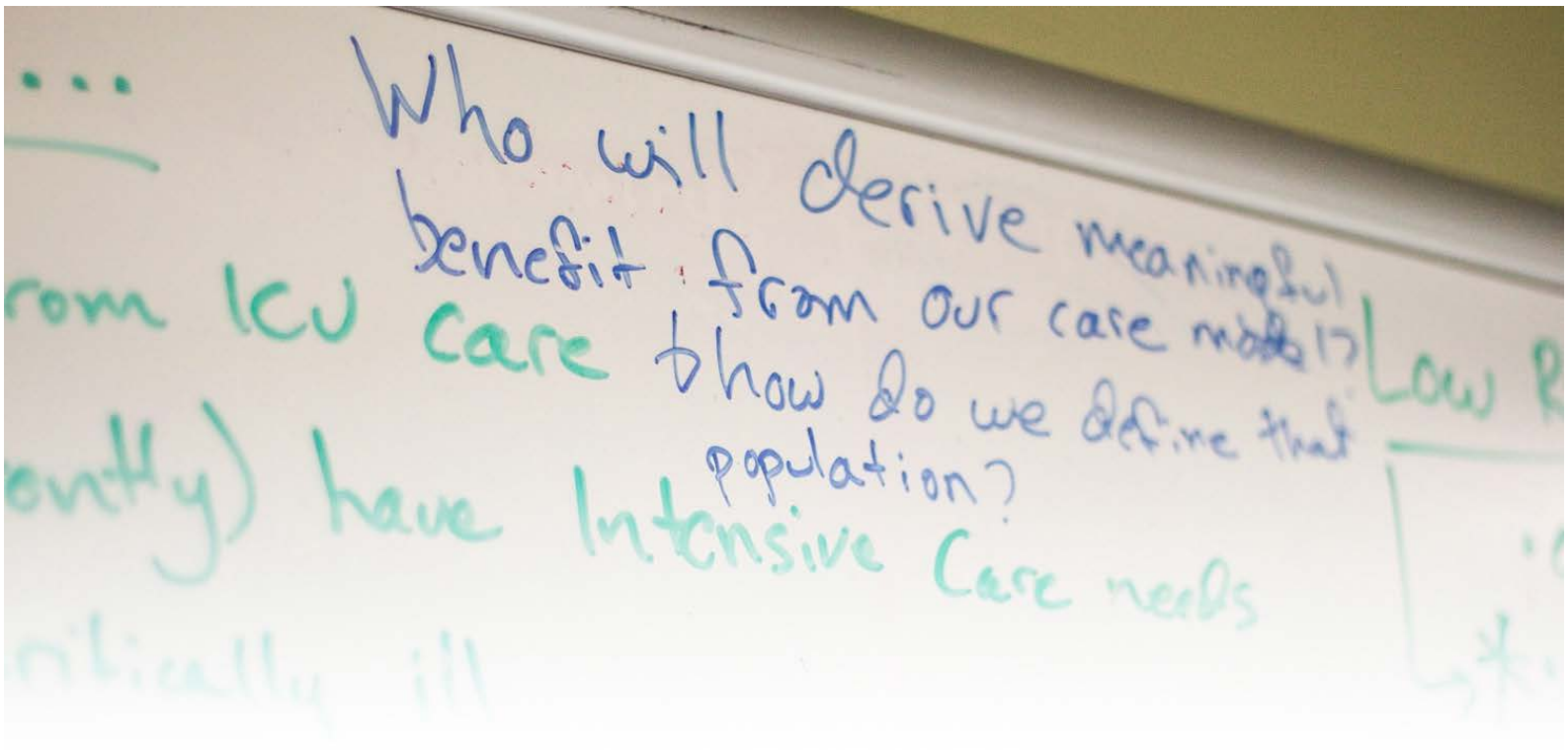
What Lies Ahead

Stanford University's Clinical Excellence Research Center focuses on care redesign aimed at improving the affordability of high-quality health care. It's a mission that distinguishes CERC from innovation centers pursuing commercialization ventures to sustain their operations or generate revenue.

As health care spending continues to grow unsustainably, CERC may become a national source of frugal clinical innovations for health systems facing increasing pressure to embrace higher-value care. The spread of its new care models, however, will ultimately depend on how easily they can be adopted, and whether policymakers increase incentives for the health care industry to do more with less.

At the same time, CERC's approach also can improve the care experience — and quality of life — for people with complex and costly medical conditions. Indeed, the patient is never far from

CERC director Arnold Milstein's mind. "If we don't design methods of care delivery that address the most deeply felt unmet human needs of patients, family members, and clinicians, our new models aren't going anywhere," he says.



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February 16, 2016

Commentary: Limiting Data-Matching Issues Could Help Stabilize Federal Marketplace Coverage

By Judith Solomon

The 2016 open enrollment period, during which people could enroll in private health insurance plans in the marketplaces, ended on January 31. As of February 1, some 9.6 million people had selected a health plan in the 38 states using the Federally Facilitated Marketplace (FFM).[1] Over the next few months, many of these individuals will need to submit documents proving their eligibility or risk losing coverage or the federal subsidies they receive to help pay for their premiums. In 2015, about 470,000 people lost FFM coverage and over 1 million households lost some or all of their subsidies because they had problems proving their eligibility.

Health insurers have made claims,[2] which haven't been substantiated, that too many people are inappropriately using special enrollment periods (SEPs) in the health insurance marketplaces to get care when they are sick and that this is weakening insurance markets and raising premiums.[3] Insurers have paid less attention to data-matching issues that present problems for both themselves and consumers.[4]

The vast majority of people who lose coverage or subsidies because of documentation issues are likely eligible. This should raise concerns for insurers, because when people are faced with repeated requests for additional documentation, those who give up on the process at some point — and

[1] "Health Insurance Marketplace Open Enrollment Snapshot – Week 13," Centers for Medicare & Medicaid Services, February 2, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html.

[2] Matthew Buettgens, Stan Dorn, and Hannah Recht, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," Urban Institute, November 20, 2015, http://www.urban.org/research/publication/more-10-million-uninsured-could-obtain-marketplace-coverage-through-special-enrollment-periods.

[3] Robert Pear, "Insurers Say Costs Are Climbing as More Enroll Past Health Act Deadline," *The New York Times*, January 9, 2016, http://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=1.

[4] Ricardo Alonso-Zaldivar, "Cancer patients snagged in health law's tangled paperwork," Associated Press, February 15, 2016, http://www.bigstory.ap.org/article/37825dc76a5b40b3ab0ef2f10028e400/cancer-patients-snagged-health-laws-tangled-paperwork.

consequently lose coverage — are likely to be healthier-than-average people rather than sicker ones. The result is that insurers end up with a less healthy, costlier group of enrollees. HHS has made some improvements in the processes for verifying eligibility in order to reduce the number of people who have to provide follow-up documents, but more can be done to limit the number of eligible people who lose coverage — and thereby to help in stabilizing insurance markets.

How People Prove They Are Eligible to Enroll in the Marketplace

The health reform law envisions a "real-time" eligibility system where people apply online, get an immediate decision on their eligibility, and enroll in coverage all in one sitting. The law also requires verification of eligibility factors such as citizenship or immigration status and income. Only citizens and people lawfully present in the United States are eligible to enroll in marketplace coverage, so everyone who wants to enroll must attest to and verify their citizenship or lawful presence. People seeking financial assistance in the form of advance payments of the premium tax credit and cost-sharing reductions must provide information on their income and household size to enable the marketplace to determine their eligibility for financial assistance and the amount of help they can receive.

The marketplace verifies citizenship through matches with Social Security Administration (SSA) information, and immigration status (and in some cases, citizenship for naturalized and derived citizens) through matches with information available through the Department of Homeland Security's Systematic Alien Verification for Entitlements program. If the marketplace cannot immediately verify citizenship or immigration status, applicants are given provisional eligibility and asked to send further documentation to verify their status within 95 days.

A match may not occur for a number of reasons. For example, consumers may not have Social Security numbers (SSNs) for all their family members readily available when they apply, an applicant's current legal name may not be the same as their name when they received their immigration status or SSN, or SSA may be unable to verify the citizenship of citizens born outside the United States.

Income is matched with Internal Revenue Service (IRS) information and data from a credit reporting agency. The tax information is from the most recently completed tax return, so 2014 tax returns are used to check information provided by people applying for coverage in 2016. The tax information is out-of-date for many people; for many others, no tax data are available. This may be because applicants were dependents in another tax household in prior years, they filed with a former spouse, or they didn't have a tax filing requirement. Young workers new to the workforce often don't have tax data that can be used as a comparison to their attestations of income. Many applicants are self-employed or seasonal workers, and no information on their income is available through the credit reporting agency the FFM uses. When electronic data on income aren't available, or when the application information isn't "reasonably compatible" with electronic data — which generally means that the applicant has listed income more than 10 percent lower than what the electronic data show — applicants receive financial assistance based on the income information they provided on the application. They have 90 days to provide documents to verify their income.

Consumers lose their coverage if they don't provide documents proving citizenship or immigration status, and their financial assistance is adjusted or terminated if they don't provide documents verifying their income. The amount of the financial adjustment depends on whether the

marketplace has IRS or other electronic data showing the applicant's income. If so, the marketplace sets the subsidy amount consistent with the electronic data. If no information is available, which is most often the case, subsidies are terminated.

In 2015, about 470,000 people enrolled through the FFM lost coverage for failure to prove citizenship or immigration status, and over 1 million households' subsidies were adjusted or terminated for failing to prove their income. This coverage disruption is likely the biggest reason that FFM enrollment fell by almost 11 percent between March and September 2015.

Some Improvements Have Been Made, But More Needs to Be Done

The FFM application now provides stronger prompts to all applicants to provide SSNs and immigration document numbers. This reportedly has decreased the number of people who have to follow up with documents to prove their citizenship or immigration status, but some continue to have problems obtaining the right documents or knowing which numbers they should put on the application.

Proving income also remains difficult for a substantial number of consumers, because many people relying on the individual insurance market don't have stable sources of income. The amount of premium tax credits that taxpayers are due isn't finally determined until they file their tax returns. Advance payments are based on taxpayers' estimates of income as a percentage of the poverty line, which entails projecting not only their income but also who will be in their household over the coming year. This is difficult for many families, especially people who are self-employed, working at seasonal jobs, juggling multiple part-time positions, or between jobs, as well as three-generation families and the like.

The best approach to keeping people from losing coverage is to prevent data-matching issues from occurring in the first place by increasing the number of cases with successful data matches. The President's 2017 budget would take a step in that direction by allowing the marketplaces to access the National Directory of New Hires, which includes more recent wage information than the IRS tax data. People also need more help in understanding how to estimate their income, and they should be given an opportunity to explain why their income has changed. Finalization of a proposed regulation[5] that would give the marketplace more flexibility to determine whether an applicant's listed income is "reasonably compatible" with electronic data would also help. The current 10 percent threshold makes it more likely that people with lower incomes will have to provide documents to verify their incomes. For example, if an individual whose income was $30,000 in 2014 projected his income for 2016 would be $26,500, he would have to submit documents, while an individual whose income was $40,000 in 2014 reporting the same $3,500 decrease would not. The proposed rule would allow the marketplace to use a larger percentage amount or a dollar threshold.

Even with measures designed to prevent data-matching issues from occurring, many people will have to provide follow-up documents to prove their eligibility, but there are ways to improve the process. Today, the notices the marketplace sends requesting proof of citizenship, immigration

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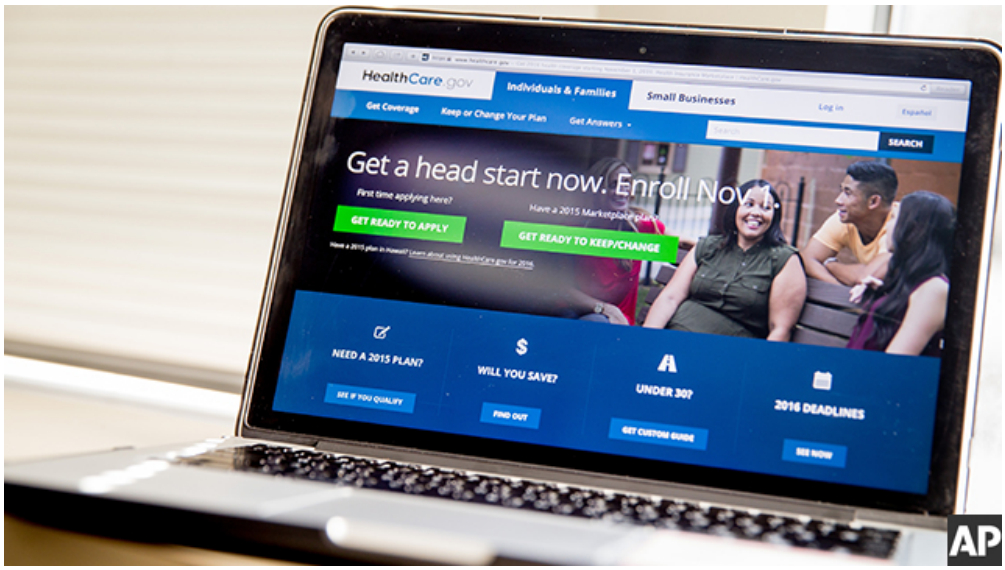
[5] *Federal Register,* Vol. 80, No. 231, December 2, 2015, https://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf.

status, or income are not specific to an individual's situation and instead provide general lists of the types of documents that applicants can use to resolve their data-matching issues. Consumers are also unable to get individualized help when they reach the marketplace call center to ask what documentation they need to provide. *Giving individuals specific information about how they can verify their eligibility would significantly limit the number of people who lose coverage or financial assistance*. Better training of application counselors, the call center, and insurers would also help steer people in the right direction.

Many people who signed up for 2016 coverage will be asked to prove their eligibility over coming weeks. Getting them the support they need so they provide the documents and information the marketplace is seeking will help them stay enrolled — and in so doing, help stabilize the marketplace risk pools.

Health Affairs Blog



The third annual Open Enrollment period for the Health Insurance Marketplaces ended [1] on January 31, but enrollment will continue year-round for individuals experiencing certain life or work transitions. Individuals who permanently move, get divorced, lose coverage due to job loss, job change, or an increase in income, or experience other qualifying changes in circumstances are eligible for a time-limited Special Enrollment Period (SEP) in the Marketplaces when their transition occurs.

These enrollment opportunities are a critical part of the health insurance safety net created under the Affordable Care Act (ACA). But the SEP safety net could be weakened if the Centers for Medicare and Medicaid Services (CMS) or Marketplaces take steps that would make it more difficult for individuals to enroll using Special Enrollment Periods, a policy change that insurers are advocating.

Insurers have alleged [2] that SEPs are being misused by consumers, but have not publicly provided data demonstrating misuse. Insurers concerns seem to stem in part from their surprise at the number of SEP enrollees, and those enrollees' shorter duration of coverage and higher costs compared to those who enroll during Open Enrollment.

However, research indicates that many more individuals are likely eligible for SEPs than have taken advantage of them, and that the individual market has always faced considerable turnover among enrollees. Marketplaces and insurers have been very aware that high enrollment during Open Enrollment is crucial for maintaining a balance of low- and high-risk enrollees, thereby helping to keep premiums sustainable. The same principle applies equally to SEP enrollment. The best way to reduce adverse selection and keep average premiums down is to achieve greater mid-year enrollment, including among healthier individuals.

Insurers are recommending changes that could have the opposite effect — reducing SEP enrollment. Insurers have asked CMS [3] to add verification requirements for SEP applicants and reduce or streamline the number of SEP categories. In January, CMS announced initial actions [4] that will eliminate six SEP categories that were likely intended as temporary, clarify SEP eligibility based on moving to an area in which different Marketplace plans are offered, and conduct an assessment of existing enrollment to evaluate whether misuse is occurring. This was intended as just a first step. CMS "will continue to make further adjustments in the future based on what we learn from continued monitoring and analysis of special enrollment period usage and compliance."

While CMS is considering further SEP policy changes, some insurers recently announced a decision that could also reduce SEP enrollment. In early February, Anthem, Aetna, and Cigna announced [5] that they will no longer pay brokers for applications completed outside of Open Enrollment.

SEP enrollment trends indicate under-use, not overuse, of the enrollment opportunities. A national study [6] by the Urban Institute estimated that fewer than 15 percent of consumers who are eligible for a SEP enroll.

his Urban Institute study and another study [7] by researchers at the University of Minnesota together indicate that between eight and 10 million Americans could be eligible for SEPs each year, a group of potential enrollees that is similar in size to the nearly 10 million [8] Americans enrolled in the Marketplaces as of June 2015. When

compared with actual SEP enrollment to-date (approximately 940,000 [9] in Healthcare.gov states in February through June 2015), these studies of SEP eligibility collectively demonstrate that there is still significant room for SEP enrollment growth.

Short duration of coverage is also not an indication of abuse because short stints in the individual market were quite common even prior to the ACA reforms. A study [10] by Kaiser Family Foundation found that among those enrolled in individual market in January 2010, only 62 percent remained in that coverage five months later.

The research also demonstrates the extent to which the uninsured—the primary target population for Marketplace enrollment—should not be thought of as a static population. In the late 1990s, one out of every three Americans had a lapse in coverage over a four year period, according to a study [11] published in *Health Affairs*. Twenty eight percent of those individuals were uninsured for between one and four months. Although the subsidies provided under the ACA may help to stabilize the individual market, the ACA continues the role of the individual market as a residual market, that is, the market consumers turn to when they lack employer-based coverage or are not eligible for Medicaid or other public programs.

Previous studies have predicted high levels of churn between Medicaid and Marketplace coverage. A national analysis [6] by the Urban Institute predicted that 1.8 million Americans would be eligible for an SEP when they lose Medicaid coverage each year and become newly eligible for tax credits. A California-specific analysis [12] by my UC Berkeley Labor Center colleagues estimated that 17 percent of non-elderly individuals enrolled in Medicaid at any point in time would be expected to become eligible for Marketplace coverage within 12 months due to an increase an income.

Given low SEP enrollment rates, it is no surprise that SEP enrollee costs are higher, on average. Enrollees with the greatest health care needs are the most likely to seek out information about mid-year enrollment opportunities, spend the time necessary to complete the application process, and enroll within the limited enrollment window permitted (typically 60 days after their life change). This does not mean that those enrollees are misusing SEPs; rather, it suggests that a large share of the SEP-eligible population is failing to enroll.

Greater SEP enrollment can be achieved by improving awareness of the ability to enroll mid-year. A national survey [13] by the Urban Institute found that fewer than 39 percent of adults were familiar with SEPs in the third quarter of 2014. In California, 49 percent of individuals surveyed [14] in 2015 were aware of the opportunity.

It is important that information about SEPs and enrollment assistance be targeted towards potential enrollees at the exact time they are eligible. Last year, Mary June Flores and I published a policy brief [15] that outlined strategies that Covered California and other Marketplaces could implement to maximize enrollment during work and life transitions.

We recommended that Covered California partner with public and private institutions that individuals interact with when they undergo transitions, in order to provide information about Marketplace coverage and connect individuals to enrollment assistance at the right time. For example, the California Employment Development Department could play a critical role in helping to connect individuals receiving unemployment insurance with health insurance, and the Department of Motor Vehicles could play the same role for individuals who permanently move.

Greater SEP enrollment not only depends on improving consumer awareness, but also on a smooth and easy enrollment process for applicants. One important aspect of achieving this is improving the transition processes between Medicaid and Marketplace coverage, which has been difficult [13] for applicants in some states in the initial years of the ACA.

Ensuring that the application process for all SEP eligible individuals is not overly burdensome can also ensure higher enrollment rates. Adding new verification requirements would only create another hurdle to enrollment, when no evidence of widespread abuse under the current processes has been publicly presented. Increased verification processes could especially deter enrollment among healthier individuals who may be less motivated to push through a difficult enrollment process, further increasing adverse selection, which is an effect that is opposite of the insurers' desire.

The Marketplaces have not only been critical for increasing coverage among those who would otherwise lack coverage over the longer-term, but they also play an important role as a safety net for individuals who are temporarily without coverage when they are undergoing transitions. It is in the best interest of Marketplaces, insurers, and potential

enrollees alike to maximize enrollment of eligible individuals who experience qualifying life events, which includes making mid-year enrollment processes for eligible individuals simple and easy.

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February 2016 | Issue Brief

Health Care Spending Among Low-Income Households With and Without Medicaid

Melissa Majerol, Jennifer Tolbert, and Anthony Damico

Medicaid provides coverage for over 70 million low-income families and adults.[1] The Affordable Care Act (ACA) sought to extend Medicaid's reach by expanding eligibility to nonelderly adults with incomes at or below 138% of the federal poverty level (FPL) ($27,310 for a family of three in 2014).[2] While the Medicaid expansion was intended to be national, the 2012 Supreme Court decision effectively made it optional for states, and as of January 2016, 19 states have not adopted the expansion.[3]

For low-income families and individuals not eligible for Medicaid, affordable health coverage options may be limited. Some low-income workers may be offered coverage by their employers, and those in states that have not expanded Medicaid who do not have coverage through their jobs may be eligible for premium subsidies in the Marketplaces if their income is above the poverty level. These private insurance options, however, often require consumers to pay premiums and may also require cost sharing in the form of deductibles, copayments, and co-insurance when they access care.

To gain a better understanding of the impact of insurance on the health care spending and budgets of low-income households, we use data from the 2014 Consumer Expenditure Survey to compare health care spending among low-income households (those with income below 138% FPL or $27,310 for a family of three in 2014) covered by Medicaid to those households not covered by Medicaid. Spending on health care as a share of total household spending, and the distribution of health spending on premiums and out-of-pocket costs for medical services, supplies and prescription drugs are assessed.

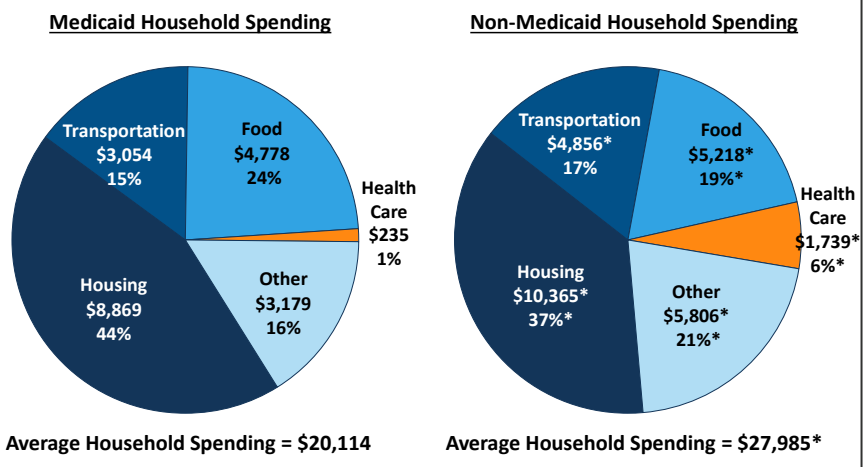
HEALTH CARE SPENDING AMONG LOW- INCOME HOUSEHOLDS

Low-income households allocate limited resources to competing necessities. The majority of spending among low-income households is devoted to housing, food, and transportation (Figure 1). In addition, average spending among low-income households greatly exceeds average income,[4] suggesting that they accrue debt, even as they earn. As a result, spending even small amounts on health care can crowd out other necessities or require low-income families to go further into debt.

Low-income households with Medicaid spend a smaller portion of their annual budget on health care compared to non-Medicaid households. Despite having smaller household budgets overall, low-income households in which all members are covered by Medicaid devote a much smaller portion of their annual budget to health care expenses compared to households in which no members are covered by Medicaid—(1% vs. 6%, respectively). On average, health spending by Medicaid households was about one-fifth that of non-Medicaid households ($235 vs. $1,739) (Figure 1). The absence of premiums and only nominal copayments for services in Medicaid likely explain the differences in spending. In addition, low-income non-Medicaid households spent a smaller share of their budget on food (19% vs. 24%) and housing (37% vs. 44%) than did Medicaid households, suggesting that health care spending may be crowding out what non-Medicaid households are able to allocate to other necessities.

Figure 1

Distribution of Average Household Spending Among Low-Income Medicaid and Non-Medicaid Households, 2014

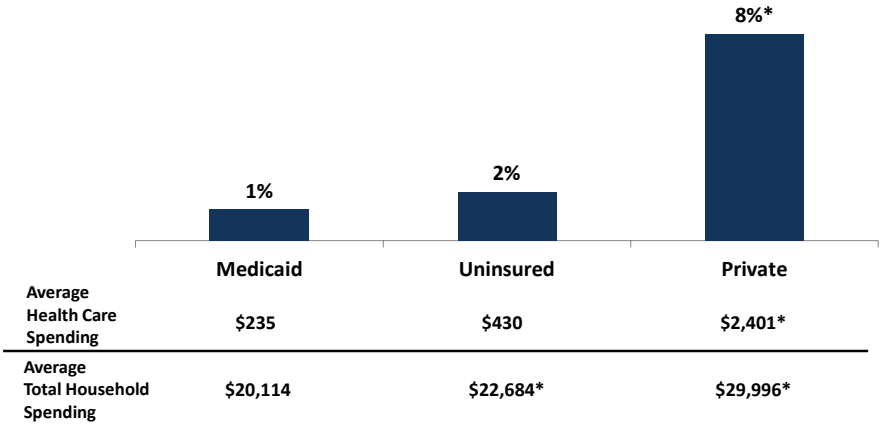


NOTES: Low-income households are defined here as having incomes below 138% FPL. Medicaid Households refer to households in which all members are enrolled in Medicaid. Non-Medicaid Households refer to households in which no members are enrolled in Medicaid. *Indicates statistically significant difference from Medicaid at p<0.05 level.
SOURCE: Kaiser Family Foundation analysis of 2014 Consumer Expenditure Survey.

The differences in health spending are starker when comparing low-income Medicaid households to those with private insurance. Compared to low-income households with Medicaid, those in which every family member is covered by private insurance spend ten times more on health care ($2,401 vs. $235) and devote a greater share of their household budgets to health care spending (8% vs. 1%). Low-income households in which every family member is uninsured also spend less on health care compared with households in which all members are covered by private insurance (Figure 2). However, other research indicates that uninsured individuals are less likely than those covered by private insurance or Medicaid to use health care services, and more likely to postpone or go without care due to cost.[5]

Figure 2

Average Health Spending as a Share of Total Spending Among Low-Income Households, by Insurance Coverage, 2014



	Medicaid	Uninsured	Private
Average Health Care Spending	$235	$430	$2,401*
Average Total Household Spending	$20,114	$22,684*	$29,996*

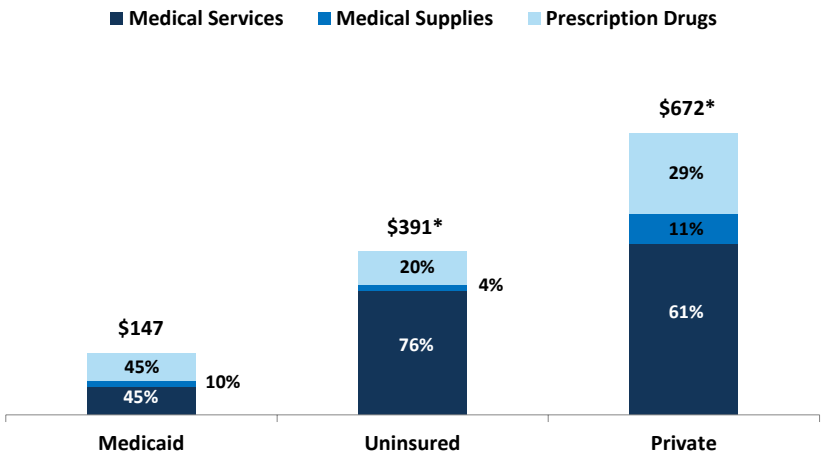
NOTES: Low-income households are defined here as those below 138% FPL. For each group, all members in the household have the same insurance status.*Indicates statistically significant difference from Medicaid at p<0.05 level.
SOURCE: Kaiser Family Foundation analysis of 2014 Consumer Expenditure Survey.

Low-income households are particularly vulnerable to the rising cost of health insurance premiums and the increasing use of deductibles and other cost-sharing requirements in private health plans that shift a greater share of health costs to consumers.[6] Focusing on premiums specifically, low-income households with private insurance spend an average of $1,729 on premiums or nearly 6% of their total household budgets. In comparison, Medicaid households spend an average of $88 on premiums or 0.4% of their total household budgets (data not shown). Although it is somewhat surprising that Medicaid households report any spending on premiums, these premiums may be for limited dental or vision coverage or for a family member who may have private coverage in addition to Medicaid.

Out-of-pocket (OOP) health care spending among low-income Medicaid households is a fraction of what it is among their uninsured and privately insured counterparts. Low-income households in which all members are covered by Medicaid spend less than half on OOP expenses as those households in which all members are uninsured ($147 vs. $391), and less than a quarter as those households in which all members have private coverage ($147 vs. $672) (Figure 3). Again, this difference is likely explained by Medicaid rules that permit only nominal copayments for benefits and services for individuals with incomes less than 150% FPL. A closer examination of OOP spending shows the distribution of spending on medical services and prescription drugs differs for Medicaid households compared to households with private insurance. For Medicaid households, OOP spending is divided equally between medical services and prescription drugs (45%), while households with private insurance spend twice as much on medical services as on prescription drugs (61% vs. 29%) (Figure 3).[7] This difference suggests Medicaid beneficiaries may be more likely to face copayments for prescription drugs than for other services,[8] or may reflect the higher share of Medicaid enrollees taking prescription drugs, as compared to those with private insurance.[9]

Figure 3

Distribution of Out-of-Pocket Health Spending among Low-Income Households, by Insurance Coverage, 2014



NOTES: Out-of-Pocket Health Spending does not include health insurance premiums. Low-income households are defined here as those below 138% FPL. For each group, all members in the household have the same insurance status.*Indicates statistically significant difference from Medicaid at p<0.05 level. Distributions may not equal 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of 2014 Consumer Expenditure Survey.

Conclusion

Low-income households allocate the majority of their budgets to necessities such as food, housing, transportation, and health care and often spend more than they earn. Health care spending varies considerably across low-income households with different health coverage. Those households with private insurance dedicate a substantial share of their modest budgets to premium and out-of-pocket health care costs—nearly one in every ten dollars (8%). Those households in which all members are covered by Medicaid spend about a tenth of what their counterparts with private coverage spend on health care costs, and devote a much smaller share of their total household budget to health-related expenses. As such, for the lowest income families, Medicaid enables beneficiaries to access health care services without placing additional strain on their resources, in comparison to the health spending faced by families with private insurance or among the uninsured.

Melissa Majerol and Jennifer Tolbert are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Methods

Our analysis is based on the 2014 Consumer Expenditure Survey, which is the primary source of data on national consumer spending. We limited the analysis to households with income below 138% of the poverty level or $27,310 for a family of three in 2014. In order to ensure that the Medicaid, Private, and Uninsured groups were mutually exclusive, we limited our analysis to households in which *all* members had the same insurance status. However, some Medicaid and uninsured households may also have some form of private coverage, such as dental, prescription, or vision insurance, and some households with private coverage may also have Medicaid, but instances of such overlap are few. In addition, we excluded households with one or more family members over age 65 to focus the analysis on populations targeted by the ACA Medicaid expansion. Household spending includes food; housing; transportation; health care; entertainment; personal care products and services; reading; education; tobacco products and smoking supplies; cash contributions; life, endowment, annuities, and other personal insurance; contributions to retirement pensions and Social Security. Health care spending includes health insurance premiums, medical services, medical supplies, and prescription drugs. Estimates were derived by summing household expenditures across components (housing, food, transportation, health care, etc.) and dividing this total amount by the aggregate amount for each component to calculate the share of total spending. The analysis focuses on average rather than median values to show the distribution of household spending across all components, which sums to 100%.

ENDNOTES

[1] "Medicaid and CHIP Program Information", CMS. Accessed December 17, 2015, http://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html.

[2] "2014 Poverty Guidelines," U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, http://aspe.hhs.gov/2014-poverty-guidelines.

[3] Kaiser Family Foundation State Health Facts, "Status of State Action on the Medicaid Expansion Decision," accessed January 13, 2016, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

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[5] Melissa Majerol, Vann Newkirk, and Rachel Garfield, *The Uninsured: A Primer Key Facts about Health Insurance and the Uninsured in the Era of Health Reform* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2015), http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-era-of-health-reform/.

[6] Gary Claxton, Matthew Rae, Michelle Long, Nirmita Panchal, Anthony Damico, Kevin Kenward, Heidi Whitmore, *2015 Kaiser/HRET Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation and Health Research & Educational Trust, 2013), http://kff.org/health-costs/report/2015-employer-health-benefits-survey/.

[7] Although the total absolute dollar value of OOP health spending statistically significantly differs between Medicaid beneficiaries and the low-income uninsured, the distribution of such spending between these two groups does not vary to a detectable extent. This may be partially attributed to the high degree of variation of the components of healthcare spending within these two groups.

[8] In 2012, 43 states required copayments for prescription drugs, while only 31 states required copayments for physician services, 28 required copayments for Federally Qualified Health Center services, and 24 required copayments for nurse practitioner services. Kaiser Family Foundation State Health Facts. Data source: KCMU Medicaid Benefits Database, prepared by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured (KCMU), available at: http://kff.org/data-collection/medicaid-benefits/

[9] 2014 Kaiser Family Foundation Survey of Low-Income Americans and the ACA.

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Realizing Health Reform's Potential

FEBRUARY 2016

Implementing the Affordable Care Act: Promoting Competition in the Individual Marketplaces

David Cusano and Kevin Lucia

Abstract A main goal of the Affordable Care Act is to provide Americans with access to affordable coverage in the individual market, achieved in part by promoting competition among insurers on premium price and value. One primary mechanism for meeting that goal is the establishment of new individual health insurance marketplaces where consumers can shop for, compare, and purchase plans, with subsidies if they are eligible. In this issue brief, we explore how the Affordable Care Act is influencing competition in the individual marketplaces in four states—Kansas, Nevada, Rhode Island, and Washington. Strategies include: educating consumers and providing coverage information in one place to ease decision-making; promoting competition among insurers; and ensuring a level playing field for premium rate development through the rate review process

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BACKGROUND

Prior to the passage of the Affordable Care Act, consumers who bought coverage in the individual market faced a host of issues. Insurers could refuse to issue a policy if an individual had a specific health condition or could exclude coverage of a condition. For many people, premiums were prohibitively expensive because rates varied based on an individual's health status, age, and other factors, with average yearly premium increases of 10.8 percent nationally from 2008 to 2010.[1] Now, insurers offering coverage in the individual market must offer coverage to all individuals regardless of health status, and may only vary premiums based on age, family size, geographic location, and tobacco use. In addition to a number of other consumer protections, the Affordable Care Act also established the new individual health insurance marketplaces where consumers can shop for, compare, and purchase plans, with subsidies if they are eligible.

The law encourages insurers in the individual market to compete in a variety of ways. For instance, to obtain federal subsidies, eligible

consumers must purchase coverage through the marketplaces. This provides an incentive for insurers who want to gain access to those potential customers to offer marketplace coverage. Additionally, the tax credits offered are based on a benchmark plan—that is, the second-lowest-cost silver plan available on the marketplace—and consumers shop for plans by comparing the benchmark plan to other plans. This ability to comparison shop encourages insurers to compete on price and value. Finally, as a safeguard against unreasonable premium hikes, the states are required to review premium rate increases to ensure that such increases are reasonable.[2]

Early indications suggest that the Affordable Care Act's approach to developing a competitive environment in the individual marketplaces is working. A national survey found that the number of insurers offering health insurance coverage through the marketplaces increased from 2014 to 2015.[3] In addition, there was generally no increase in average premiums for marketplace plans from 2014 to 2015, including the average benchmark premium.[4] Finally, although not the focus of this study, recent analysis suggests only a modest increase in average premiums for lowest-cost silver plans from 2015 to 2016.[5]

This issue brief explores some of the ways in which the Affordable Care Act is influencing competition in the individual marketplaces in four states are promoting competition: educating consumers and providing coverage information in one place to ease decision-making; encouraging insurer participation; and ensuring a level playing field through the rate review process.

METHODS

We conducted interviews with stakeholders in Kansas, Nevada, Rhode Island, and Washington, based on the following criteria: insurers offering silver plans at or below the national monthly premium average of $314, premium increases from 2014 to 2015 of 1 percent or less for such plans, and at least one new insurer offering coverage on the marketplace in 2015.[6] These four states are also geographically diverse and have different individual marketplace models (i.e., federally facilitated vs. state-based). Stakeholders included representatives from insurers participating in the marketplaces, senior officials from the state departments of insurance, and senior staff members at the state-based marketplaces. Between January and March 2015, we conducted 15 interviews using standard protocol questions developed for this issue brief.[7]

FINDINGS

Marketplaces Promote Price Competition Through Comparison Shopping

One way the marketplaces encourage competition among insurers is by providing information to consumers—allowing them to see their coverage options in one place and make educated decisions. State officials and insurers in all four states said that the marketplaces have made progress toward this goal by providing a platform to make it easier to compare and purchase plans. Stakeholders across the study states suggested that the marketplaces have been most adept at promoting competition based on price.[8] One insurer noted that the marketplace has forced carriers to be more strategic from a pricing perspective when it comes to setting rates because consumers now can use the shopping portal to

quickly hone in on plans with low premiums.[9] However, insurers and state officials cautioned that shopping based solely on price has its limitations. Regulators and insurers consistently stated that consumers should consider other factors, including quality, cost-sharing structures, and provider networks. However, this information is not as easily comparable (or in some cases, not yet available) through the marketplace. For example, one insurer noted the importance of distinguishing innovative plans that may be attractive to consumers, like patient-centered medical home plans, from other plans offered on the marketplace. Some stakeholders expressed concern that consumers might have too many plans to wade through and suggested that marketplaces limit the number of offerings so consumers are not overwhelmed by choice and can meaningfully differentiate among their options.[10]

Promoting Marketplace Competition Through Insurer Participation

Stakeholders indicated that the marketplaces are trying to encourage more insurers to participate. Regulators and marketplace officials in all four states expressly stated that they encouraged new insurers to enter the marketplace in 2015 and were willing to work directly with insurers to ensure a smooth entry process. That said, as one stakeholder indicated, an insurer ultimately must make the business decision as to whether it's worth the time, effort, and cost to enter the marketplace. Regulators and marketplaces can facilitate the entry process, but the ultimate decision rests with the insurer and depends on its assessment of the competitive landscape. Even if an insurer does participate in the marketplace, there is significant flexibility under federal and most state laws in terms of where the insurer markets and sells coverage. Of the study states, only Rhode Island requires insurers to offer marketplace coverage across the entire state.[11] In the larger study states (i.e., Kansas, Nevada, and Washington), insurers can limit their marketplace offerings to a single county (Exhibit 1), leading to significant within-state variation in the number of available plans on a county-by-county basis.[12] For example, in Nevada, only two of five insurers participating in the marketplace offer products in every county within the state.

Exhibit 1. Insurer Participation by County and Rating Area in the Individual Health Insurance Marketplaces, Plan Year 2015

State		Number of rating areas participating	Number of counties covered
Kansas	**Total**	**7**	**105**
	Coventry Health and Life	7	105
	Blue Cross and Blue Shield of Kansas	7	103
	Blue Cross and Blue Shield of Kansas Solutions	7	103
	Coventry Health Care of Kansas	4	21
	Blue Cross and Blue Shield of Kansas City	1	2
Nevada	**Total**	**4**	**17**
	Anthem Blue Cross Blue Shield	4	17
	Nevada Health Co-op	4	17
	Assurant Health	3	7
	Prominence	2	5
	Health Plan of Nevada	2	3
Rhode Island	**Total**	**1**	**5**
	Blue Cross and Blue Shield of Rhode Island	1	5
	Neighborhood	1	5
	UnitedHealthcare	1	5
Washington	**Total**	**5**	**39**
	Lifewise Health Plan of WA	5	39
	Moda Health Plan	5	39
	Premera Blue Cross	5	38
	Community Health Plan of WA	5	26
	Group Health Cooperative	4	19
	BridgeSpan Health Company	4	12
	Molina Health Care of WA	4	7
	Coordinated Care	3	13
	Kaiser Foundation Health Plan of the Northwest	2	2
	Columbia United Providers	1	1

Sources: Federal HealthCare.Gov 2015 Health Plan Information for Individuals and Families, https://www.healthcare.gov/health-plan-information-2015/; Washington State Office of the Insurance Commissioner, "2015 Individual Health Plans and Rates," http://www.insurance.wa.gov/your-insurance/health-insurance/individuals-families/health-plans-rates/; and Value Penguin, "Affordable Care Act (Obamacare) Health Insurance Exchanges," http://www.valuepenguin.com/ppaca/exchanges.

Insurers Are Competing on Premiums in the Marketplaces for 2014 and 2015

Premium tax credits and cost-sharing subsidies are tied to the benchmark plan (i.e., the second-lowest-cost silver plan).[13] In their second year of operation, many health insurance marketplaces saw either a change in the insurer offering the lowest- or second-lowest-cost silver plan or a decrease in premium in at least one rating area.[14] This finding suggests that insurers are competing to offer the lowest-cost silver plans to attract consumers who are shopping for coverage based on price and premium subsidies tied to those plans.[15]

In fact, from 2014 to 2015, the insurer offering the lowest-cost silver plan changed in Rhode Island (statewide), Washington (in at least one rating area), Nevada (in at least two rating areas), and Kansas (in at least three rating areas).[16] Additionally, the insurer offering the second-lowest-cost silver plan changed in Rhode Island (statewide) and Washington (in at least three rating areas). In Kansas, in the three rating areas examined, either Coventry Health and Life Insurance Company or Coventry Health Care of Kansas, Inc. offered the lowest-cost silver plan in 2014.[17]

Marketplace Uncertainty May Be Driving Competitive Premiums

Insurers and state regulators noted that during the first two years of the ACA marketplaces, insurers have had greater flexibility to price plans more competitively because of uncertainty in the marketplaces. Specifically, interviewees pointed out that insurers did not yet have the actual underlying claims data to substantiate 2015 premium rates. Because they lacked knowledge of the risk profiles of marketplaces enrollees, insurers had the flexibility to price aggressively or conservatively. As insurers acquire more data over time, their ability to compete on price may become more limited. For instance, medical loss ratio requirements will dictate the amount of premiums they must use to pay for medical services. Additional limitations include regulations against overpricing products, guaranteed issue and community rating requirements that regulate how premiums must be set, and actuarial value and essential health benefit requirements.

Once these uncertainties are eliminated, the real pressure point for premium pricing may shift to medical management and the reimbursement rates negotiated between providers and insurers. For instance, both state regulators and insurers said that it is much easier to leverage more favorable reimbursement rates with providers in urban areas, where provider competition tends to be more robust. An insurer in Nevada noted that in more rural areas, providers are able to extract higher reimbursement rates because of lack of competition. This results in higher medical costs, which translates to higher premiums. Rhode Island has addressed this issue by requiring insurers to include a specific provision in each hospital contract that limits yearly hospital reimbursement increases. Stakeholders generally agreed this requirement provides insurers with the necessary leverage to negotiate competitive reimbursement rates with hospitals.[18] Other respondents suggested that insurers are looking to establish long-term relationships with providers and develop networks and marketplace offerings around those relationships, but indicated that robust network adequacy requirements might stifle innovation around strategic provider–insurer partnerships.

Rate Review Plays a Role in Ensuring Fair Competition

To promote fair competition among insurers, the Affordable Care Act requires states to have an effective rate review program. Regulators review premium rate increases in the individual and small-group markets within and outside the marketplaces to ensure that such increases comply with the law's requirements and are not excessive, unjustified, or unfairly discriminatory.[19] In states that do not have an effective rate review program, the federal government reviews rates. All four study states are considered effective rate review states under federal law, as defined by the U.S. Department of Health and Human Services.[20] Additionally, they have the authority to approve or disapprove an insurer's premium rates.[21] Despite some similarities, stakeholders held varied opinions on the role of the rate review process itself.

State regulators, marketplace officials, and insurers uniformly agreed that a key function of effective rate review is to ensure that insurers remain solvent and can continue to pay claims for enrollees when they come due. Respondents in all four states believed their regulators were competently performing this function, but had different perspectives on rate review in other areas. In Kansas and Nevada, stakeholders generally agreed that the insurance department should not be in the business of setting premium rates, but rather should review them for adequacy and reasonableness. This is a critical role for state regulators, especially in an environment like the health insurance marketplace where insurers are incentivized to complete on price. In some cases, state regulators may need to push insurers to increase their rates so that their efforts to compete will not compromise solvency. In Washington and Rhode Island, stakeholders indicated that insurance regulators generally take a more aggressive approach and push back on the initial rates filed by insurers and try to extract lower ones, if appropriate. In Rhode Island and Nevada, regulators publicly post the insurers' initial filings and then allow insurers to revise their rates within a specified time frame after reviewing competitors' rates. Stakeholders said this practice resulted in lower premiums.

Despite varying perspectives, the final approved rates in all four study states in 2015 were lower than the rates initially filed. In some cases, the final rates were significantly lower (Exhibit 2). For example, in Rhode Island, the final approved base rate for individual market polices offered by Blue Cross and Blue Shield was 4.3 percentage points lower than originally requested.[22] This represents an average annual savings of $161 per year on premiums for consumers before accounting for federal premium subsidies. This suggests that regulators have the ability to put downward pressure on rates during the review process.

Exhibit 2. Proposed and Approved Health Insurance Rate Increases from 2014 to 2015

Company	Plan(s)	Proposed rate increase	Accepted rate increase
Kansas			
Coventry Health and Life Insurance Company	Individual PPO plan–Kansas City	16.38%	16.30%
	Individual PPO plan–outside of Kansas City	13.66%	13.00%
Nevada			
Assurant Health (Time Insurance Co.)	Individual PPO plan	18%	16%
Health Plan of Nevada	Individual HMO plan	8.90%	6.60%
HMO Colorado (Anthem Blue Cross Blue Shield)	Individual HMO plan	-3.90%	-6.90%
Rhode Island			
Blue Cross and Blue Shield of Rhode Island	Individual plan*	8.8%	4.5%
Washington			
Coordinated Care	Average across all individual plans	11.20%	7.20%
Group Health Cooperative	Average across all individual plans	11.20%	0%
Lifewise Health Plan of Washington	Average across all individual plans	8.90%	2.30%
Community Health Plan of Washington	Average across all individual plans	8.40%	0%
Premera Blue Cross	Average across all individual plans	8.10%	2.60%
Bridgespan Health Company	Average across all individual plans	1.70%	-2.90%
Molina Health Plan of Washington	Average across all individual plans	-6.80%	0%

* Base individual plan–no cost sharing plan issued to a 21 year-old.
Sources: Healthcare.gov, "Rate Review," https://ratereview.healthcare.gov/; "Health Insurance Rate Change Search Results," http://doi.nv.gov/rate-filings/results.aspx?action=search&status=&type=&cid; State of Rhode Island Office of the Health Insurance Commissioner, Press Release: OHIC Approves Commercial Health Insurance Rates for 2015, http://www.ohic.ri.gov/documents/Press-Release-rate-review-2014.pdf; and Washington State Office of the Health Insurance Commissioner, Search Health Insurance Rate Increases, http://www.insurance.wa.gov/health-rates/Search.aspx.

DISCUSSION

A main goal of the Affordable Care Act is to provide Americans with access to affordable coverage in the individual market. This will be achieved in part by promoting competition among insurers on premium price and value. Our research suggests that the individual marketplaces are creating an environment in which insurers are participating and competing for consumers. To foster this competitive environment, regulators in the four study states indicated they are encouraging new entrants to increase participation within the marketplaces and using the rate review process to ensure a level playing field.

State regulators, marketplace officials, and insurers agreed that in these early days of full implementation, competition was largely focused on premium price and not on improving value and quality for enrollees. For example, innovation in plan design—when it existed—appeared to be largely focused on features that would lower premiums rather than improve quality. In fact, one insurer introduced a narrow network plan that eliminated enrollees' access to out-of-state in-network providers solely to lower premium prices.

Stakeholders also agreed that although marketplaces are providing a platform to shop for and compare plans on price and other basic features, consumers lack the sophisticated decision-making tools to allow them to fully evaluate a plan in terms of quality, network design, and cost structures.

It may simply be a question of time before consumers can shop based on both price and value. Insurers may be better positioned to compete on value once the individual marketplaces stabilize. They need complete claims data to evaluate enrollee risk and a stable regulatory and competitive environment. This could take several years, but insurers will then be better positioned to identify real opportunities to compete on value, in addition to price.

In the meantime, state marketplaces can continue to foster a competitive environment by encouraging new entrants and enhancing marketplace platforms to assist enrollees in decision-making. In addition, federal officials recently reaffirmed the authority of marketplaces to selectively contract with insurers that provide quality and affordable coverage to individuals—this is also known as active purchasing. Regulators are exploring how best to use this authority in the federal marketplace to ensure that health plans "provide quality coverage to consumers to meet the Affordable Care Act's goals."[23] The early efforts of state-based marketplaces that have embraced selective purchasing may help to identify policies that show promise in promoting quality, value, and robust competition.[24]

Notes

[1] J. Gruber, *Growth and Variability in Health Plan Premiums in the Individual Insurance Market Before the Affordable Care Act* (New York: The Commonwealth Fund, June 2014).

[2] See 45 C.F.R. Part 154.

[3] J. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

[4] Ibid.

[5] J. Gabel, H. Whitmore, A. Call et al., "Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation," *The Commonwealth Fund Blog,* Jan. 28, 2016.

[6] J. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

[7] Please note that Kansas is not a state-based marketplace, therefore, an interview was not conducted with a marketplace representative.

[8] More than half of the 2.2 million active re-enrollees who selected 2015 plans through the marketplaces in the HealthCare.gov states switched plans between the 2014 and 2015 plan years. See ASPE, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, issue brief (Washington, D.C.: U.S. DHHS, Assistant Secretary for Planning and Evaluation, March 10, 2015).

[9] Recognizing that comparison shopping, whatever its limits, has been driving competition, some stakeholders identified a tension in states' approaches to coverage renewals. Marketplaces in Kansas and Washington used a "passive" renewal process that sought to minimize coverage gaps by allowing most individuals to be automatically re-enrolled in a marketplace plan for 2015. In Rhode Island, enrollees were required to return to the marketplace and re-enroll in a marketplace plan, or else lose their coverage entirely. One regulator in Rhode Island indicated that active renewal benefited consumers because it spurred them to go back to the marketplaces and shop, where they found more affordable plans to choose from in 2015 as compared with 2014. See Health Source RI, "Ready to Enroll, or Renew Your Coverage?" (Providence, R.I.: Nov. 15, 2014).

[10] See also C. H. Monahan, S. J. Dash, K. W. Lucia et al., *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013).

[11] J. Holahan, R. Peters, K. Lucia et al., *Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States* (Princeton, N.J., and Washington, D.C.: Robert Wood Johnson Foundation and Urban Institute, July 2013).

[12] See State of Kansas Qualified Health Plan Submission Attestation Form, last updated Feb. 22, 2015, http://www.ksinsurance.org/documents/company/ah-life/2016-state-dental-attestations.pdf; Silver State Health Insurance Exchange, Current Policy to Align Service Areas with Rating Areas, May 9, 2013, http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Meetings/08_-_Service_Areas.pdf; State Health Insurance Exchange, 2016 QHP Certification, April 16, 2015, http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Resources/Carrier_2016/April16Webinar_finaldraft.pdf; and Washington Health Benefit Exchange, Guidance for Participation in the Washington Health Benefit Exchange, April 10, 2014.

[13] Eighty-seven percent of individuals that obtained coverage in the individual market in 2015 were eligible for premium tax credits and/or cost sharing reductions. See ASPE, *Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report for the Period: Nov. 15, 2014–Jan. 16, 2015* (Washington, D.C.: U.S. DHHS, Assistant Secretary for Planning and Evaluation, Jan. 29, 2015).

[14] C. Cox, L. Levitt, G. Claxton et al., *Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces,* issue brief (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

[15] See also K. Swartz, M. Hall, and T. S. Jost, *How Insurers Competed in the Affordable Care Act's First Year* (New York: The Commonwealth Fund, June 2015).

[16] J. Gabel, NORC at the University of Chicago internal data set, Dec. 2014.

[17] Ibid.

[18] See R.I. Code R. 02-031-002, Section (10)(d)(3) (2015), which states:

> Hospital contracts shall include a provision that agrees on rates, and quality incentive payments for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if either:
>
> (i) the average rate increase, including estimated quality incentive payments, is greater than the U.S. All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (determined by the Commissioner as soon as practicable for calendar year 2015, and by October 1 each year thereafter, based on the most recently published U.S. Department of Labor data). Such percentage increase shall be plus 1% between July 1, 2015 and December 31, 2015, plus 0.75% during calendar year 2016, plus 0.50% during calendar year 2017, 0.25% during calendar year 2018, and plus 0.0% following calendar year 2018, or
>
> (ii) less than 50% of the average rate increase is for expected quality incentive payments.

[19] See 45 C.F.R. Part 154.

[20] Center for Consumer Information and Insurance Oversight, "State Effective Rate Review Programs," fact sheet (Washington, D.C.: Centers for Medicare and Medicaid Services, CCIIO).

[21] See Kan. Stat. Ann. § 40-2215 (2015); Nev. Rev. Stat. Ann. § 686B.070 & .110 (2015); Nev. Rev. Stat. Ann. § 695B.230 (2015); R.I. Code R. 02-031-017 (2015); WAC 284-170-870; and Washington State SERFF Health and Disability Rate Filing General Instructions, March 9 , 2015, http://www.insurance.wa.gov/for%2Dinsurers/filing%2Dinstructions/file%2Dhealth%2Dcare%2Ddisability/rate%2Dfiling%2Dinstructions/documents/rates-hd-general-filing-instructions.pdf.

[22] State of Rhode Island Office of the Health Insurance Commissioner, "OHIC Approves Commercial Health Insurance Rates for 2015," press release (Providence, R.I.: July 17, 2014).

[23] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75488, 75541 (Dec. 2, 2015).

[24] S. Dash, K. W. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

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The Affordable Care Act and the U.S. Economy

A Five-Year Perspective

Cathy Schoen

FEBRUARY 2016

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The COMMONWEALTH FUND

The Affordable Care Act and the U.S. Economy: A Five-Year Perspective

Cathy Schoen

FEBRUARY 2016

ABSTRACT

Despite fears that the Affordable Care Act's health coverage expansions and market reforms would cost jobs or accelerate health care inflation, the U.S. economy has grown steadily, if slowly, since the law's passage in 2010. The level of overall economic output and employment is currently well above the peaks prior to the 2008–09 recession. Jobs have increased by more than 13 million since 2010—5 million more than at the pre-recession peak. All of the net gain has been in full-time, private-sector jobs. Furthermore, the marked slowdown in health care cost growth that started during the recession has continued, although recent indicators show this trend may be waning. In reviewing evidence over the past five years, this report concludes that the ACA has had no net negative economic impact and, in fact, has likely helped to stimulate growth by contributing to the slower rise in health care costs.

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EXECUTIVE SUMMARY

This report provides a five-year perspective on the impact the Affordable Care Act (ACA) has had on the U.S. economy since the law's enactment. It discusses trends in economic growth, employment, and health care costs since 2010, as well as the national experience prior to that time, and compares the recovery in the United States with that in other high-income countries.

Although it is impossible to state with absolute certainty the full extent to which the ACA's reforms have contributed to the nation's recovery from one of the worst economic crises of recent decades, the news has been, on balance, positive. To date, there is no evidence that the ACA has had a negative impact on economic growth or jobs or that its reforms have undermined full-time employment—effects that the law's opponents had warned about. To the contrary, evidence indicates that the ACA has likely acted as an economic stimulus, in part by freeing up private and public resources for investment in jobs and production capacity. Moreover, the law's payment and other cost-related reforms appear to have contributed to the marked slowdown in health spending growth seen in recent years.

Following are highlights of this report's review of economic, job, and health cost trends since the ACA's enactment:

- The U.S. economy has gained nearly 14 million private sector jobs over five years. All of the net gain in employment has been in full-time work.
- There are 5 million more people working now than during the peak level prior to the recession, and the unemployment rate has plummeted. Recent annual gains in jobs have been faster than gains in any year since the 1990s.
- Still, labor force participation rates have yet to return to their pre-recession peak.
- Inflation-adjusted economic growth in the United States in recent years has rivaled or exceeded that of many other high-income nations.
- Health care spending growth per person—both public and private—has slowed for five years.
- A number of ACA reforms, particularly related to Medicare, have likely contributed to the slowdown in health care spending growth by tightening provider payment rates and introducing incentives to reduce excess costs.
- Faster-than-expected economic growth and slower-than-expected health care spending have led to multiple downward revisions of the federal deficit and projected deficits.
- These trends have also been a boon to state and local government budgets, as job growth has improved state tax revenues while cost growth in health care programs has slowed. At the same time, expanding insurance to millions of people who were previously uninsured has supported local health systems and enhanced families' ability to pay for necessities, including health care.

The accrued savings in health care spending relative to their projected growth prior to the ACA are substantial: Medicare alone is now projected to spend $1 trillion less between 2010 and 2020.

However, without targeted efforts to sustain slow growth, in the near future market forces could reverse these positive trends. In particular, rising drug costs, higher prices resulting from consolidation among providers and insurers, and rising administrative complexity could put the United States back on a path where costs increase faster than the economy and people's incomes, further undermining the affordability of insurance and health care.

Five years after passage of the ACA, we have evidence that it is possible to secure affordable coverage for all citizens, improve health outcomes, and slow cost growth—all to the benefit of families, businesses, and the economy. Looking to the future, the trillion-dollar question is this: What actions will be necessary to keep health spending growth at the same level as or below economic growth, while also maintaining health care access and quality?

The Affordable Care Act and the U.S. Economy: A Five-Year Perspective

BACKGROUND

At the time of the Affordable Care Act's (ACA) enactment in 2010, policymakers were grappling with the effects of the most severe recession in the United States since the Great Depression. Some feared that by undertaking an ambitious expansion of health insurance coverage and setting new requirements for health benefits provided by employers, the new law might limit job growth and economic recovery. Others predicted that ACA provisions targeted at slowing growth in health care costs, coupled with reforms to increase the number of people with health insurance, would instead stimulate the economy—by freeing up resources to add jobs and increase wages and by expanding consumer demand for goods and services beyond health care.[1]

To provide a five-year perspective on the ACA's impact on the U.S. economy, this report summarizes trends in economic growth, job creation, and health care costs from 2010 through 2015 and compares them with the national experience prior to that time. The analysis also compares U.S. economic growth to the recovery in other high-income countries.

U.S. ECONOMIC GROWTH SINCE 2010: SLOW BUT STEADY

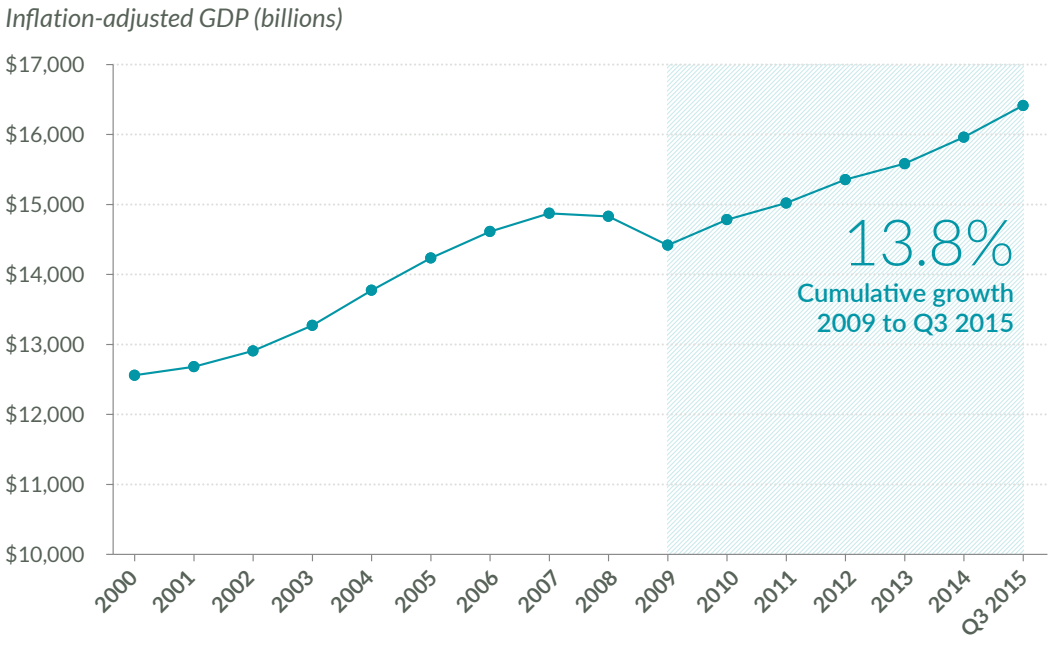
Since 2010, the U.S. economy has been growing—slowly but steadily. Especially in light of continued global economic turmoil, the news has been quite positive indeed. In terms of change in gross domestic product (GDP), the nation's economy grew by 21 percent over the five years through 2015, with inflation-adjusted cumulative "real" growth exceeding 13 percent by the third quarter of 2015. Total economic output is now well above the peak levels reached before start of the recession. (Exhibit 1).

Adjusted for inflation, gross private domestic investment through 2015, including factory and building expansion, has continued to grow faster than GDP (Exhibit 2). Such investment—an important signal that views of the economy remain positive—could pave the way for continued growth.

Notably, GDP growth rates accelerated from 2012 through 2014, the years during which the ACA's major

Exhibit 1

Steady U.S. Economic Growth After a Severe Recession



Data Source: Bureau of Economic Analysis, Annual to Q3 2015 revised Dec 22, 2015

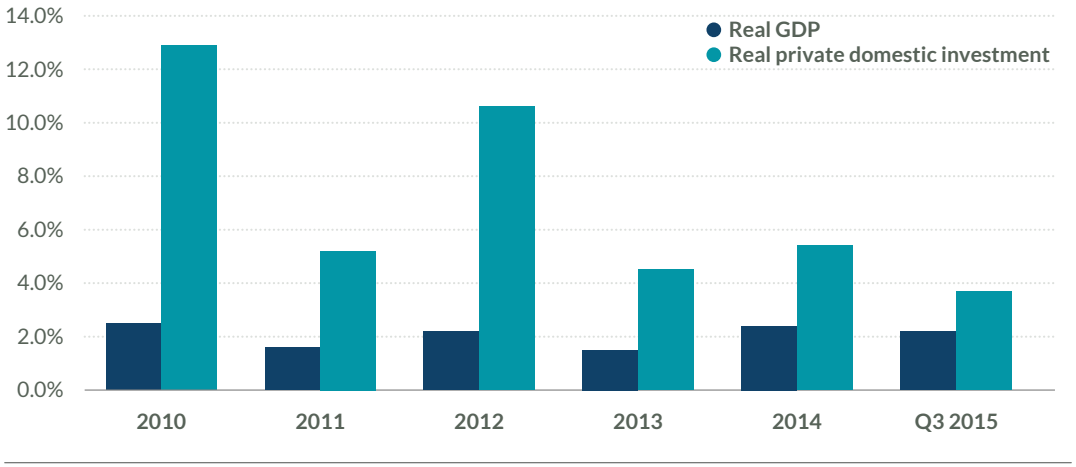
health insurance provisions, including the marketplaces and the Medicaid expansion, took hold. In fact, U.S. economic growth rates since 2011 have rivaled or exceeded those of other high-income countries struggling to recover from the worldwide recession (Exhibit 3). To gain access to the faster-growing North American market, foreign corporations have been increasing their acquisitions in the United States in recent years.[2]

Given the positive indicators for U.S. production capacity as well as job growth (see below), the Congressional Budget Office (CBO) now projects that, over the next few years and next decade, actual GDP will reach its potential levels.[3]

Exhibit 2

Annual Inflation-Adjusted Growth in U.S. Economy and Private Investment, 2010 to 2015

Inflation-adjusted growth (percent)

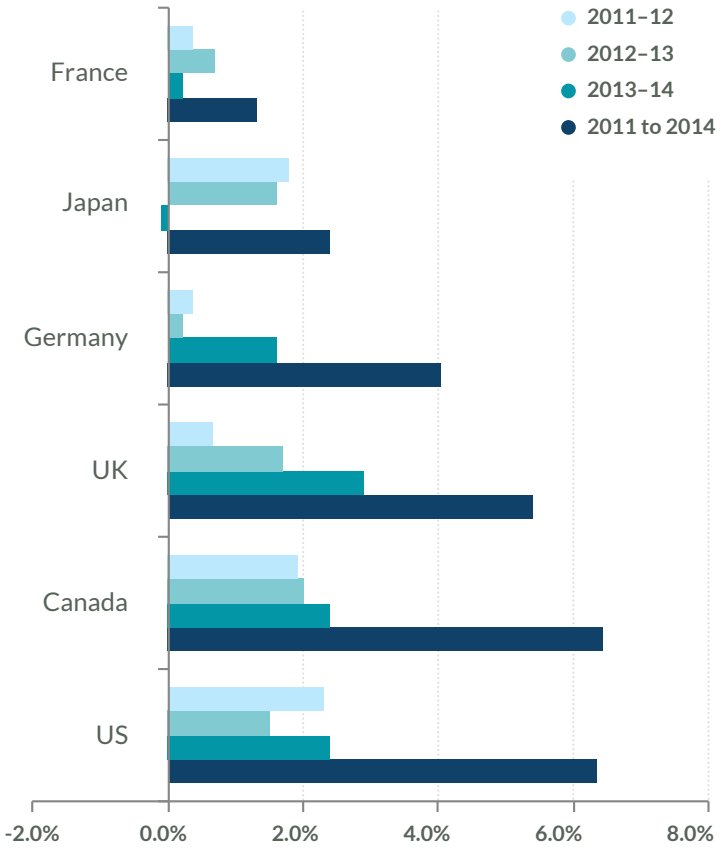


Source: U.S. Bureau of Economic Analysis. Inflation-adjusted. Dec. 22, 2015.
Notes: GDP = gross domestic product. Annual rate 2010 to 2014; Q3/Q3 2014/15 annual.

Exhibit 3

U.S. Economic Growth Rivals or Exceeds Other High-Income Countries

Real GDP growth rates, 2011–14



Source: World Bank database; accessed Sept. 2015.
Real GDP = Inflation-adjusted gross domestic product. U.S. GDP is revised.

EMPLOYMENT GROWTH UP MORE THAN 13 MILLION SINCE 2010; FULL-TIME PRIVATE-SECTOR JOBS ACCOUNT FOR ALL OF NET GAIN

By December 2015, 13.4 million more people were employed than in March 2010, when the ACA was enacted. Total nonfarm employment now stands well above the peak levels seen before the recession, with 5.3 million additional people now working. The job expansion was particularly strong in 2014 and 2015, with the economy adding an average of 200,000 jobs a month for two years—an annual increase of 3 million jobs that exceeds the gains seen in any single year since the 1990s (Exhibit 4). The five-year cumulative increase is more than double the eight-year growth in employment from 2000 to 2008.

With these job gains, the unemployment rate has fallen from 9.9 percent to 5 percent (Exhibit 5). It must be noted, however, that the percentage of people who are no longer seeking employment—and thus not counted as unemployed—remains above pre-recession levels. Despite many more people working now than before the recession, labor force participation rates for women and men age 20 and older have not returned to their earlier highs.[4]

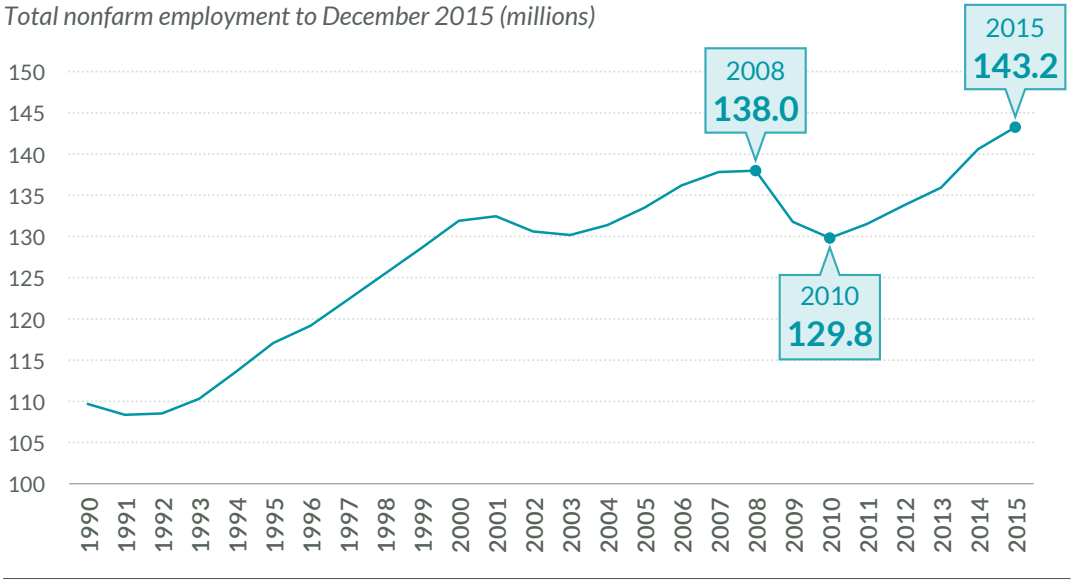
All Job Gains Private and Full-Time Employment

All of the net gain in employment has been in the

Exhibit 4

U.S. Jobs Up More than 13 Million Since 2010, 5 Million Above Pre-Recession Peak

Total nonfarm employment to December 2015 (millions)

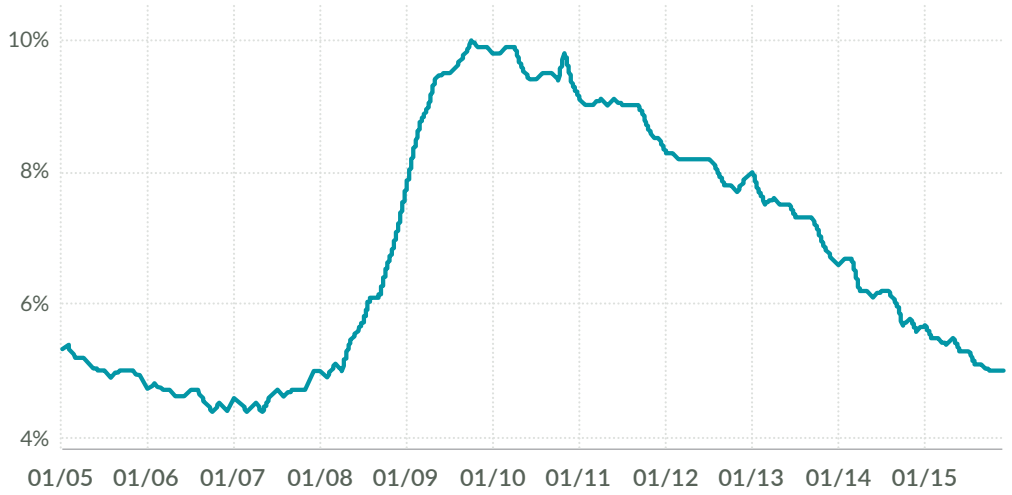


Source: U.S. Bureau of Labor Statistics. Seasonally adjusted. Establishment, Release 1/8/16.

Exhibit 5

Unemployment Rate Drops from 9.9% to 5% by 2015

U.S. unemployment rate (percent)



Source: U.S. Bureau of Labor Statistics. Monthly seasonally adjusted household to Dec. 2015. Released Jan. 8, 2015.
Figure generated online, http://www.bls.gov/ces/data.htm.

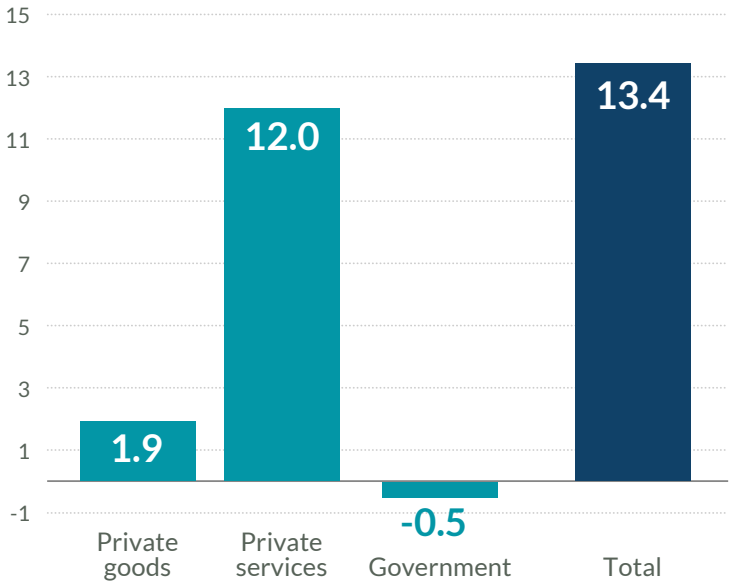
private sector. As private firms invested in new production capacity, they added nearly 14 million jobs between March 2010 and December 2015 (Exhibit 6). Despite concerns that the ACA would expand government, public-sector employment is down since 2010.

Full-time jobs have accounted for all of net job growth since March 2010 (Exhibit 7). Although some critics feared that employers would convert full-time positions to part-time ones to avoid the health insurance requirements that apply to full-time employees, the share of the workforce with full-time jobs has improved markedly. Moreover, the number of people working part-time who would prefer full-time work has declined by 3 million since 2010. By the end of 2015, 1 million fewer people were working part-time involuntarily than a year earlier. The continued decline in this population is notable, since 2015 was the year the ACA's employer mandate for firms with 50 or more workers began to take hold.

Exhibit 6

U.S. Private Jobs Increased by Nearly 14 Million, While Public Employment Declined

Change in employment, March 2010 to December 2015 (millions)

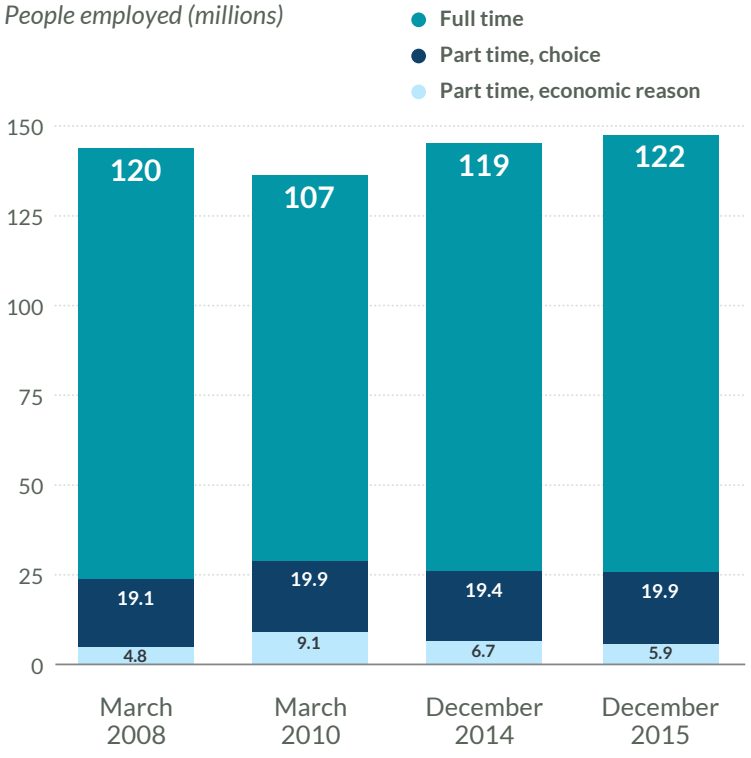


Source: U.S. Bureau of Labor Statistics. Nonfarm employment, seasonally adjusted. Released Jan 8, 2016.

Exhibit 7

Full-Time Jobs Account for All Net Job Growth from March 2010 to End of 2015

People employed (millions)



Source: U.S. Bureau of Labor Statistics. Household series, nonfarm employment, seasonally adjusted, Release Jan 2016.
Notes: Part-time work is 34 hours or less. "Part-time economic reason" includes unable to find full-time work or poor business conditions.

There has also been concern that the ACA's employer mandate might induce firms to reduce the number of people they employ directly—particularly firms just above the 50-employee threshold.[5] The ACA requires employers with 50 or more workers to provide health benefits to all full-time workers or pay a penalty if an employee becomes eligible for a marketplace plan tax credit. Firms with fewer than 50 workers are exempt from the mandate. (The ACA also provides premium tax credits for low-wage firms that have fewer than 25 employees.)

To date, however, job growth has been about equal across firms of all sizes (Exhibit 8). Firms employing from 50 to 99 workers have hired at a rate similar to that for smaller and larger employers. Indeed, rather than jobs shifting to small firms, or from permanent to contract workers, employment at large firms (500 employees or more) has expanded slightly—by 1 percent—as a share of the private, nonfarm workforce, with 6 million people joining their ranks. Meanwhile, the

percentage of U.S. workers employed by the smallest firms (those with nine or fewer employees) has declined.[6]

SLOW WAGE GROWTH: CONTINUATION OF A LONG-TERM TREND

Although the number of people working full-time has risen well above pre-recession levels, there has been little improvement in average weekly pay or income for working families. Average wages in the private sector have barely kept up with inflation over the past five years. More recently, inflation-adjusted pay has picked up—with a one-year gain of 2.1 percent through October 2015—but this likely reflects lower energy costs for consumers (Exhibit 9).[7]

With no significant increases in wages for the majority of the nation's workforce, particularly middle- and low-wage employees, there has been little or no improvement in median incomes since 2010.[8,9] This represents a continuation of a longer-term pattern that began well before the recession. By 2007, before the recession hit, median income adjusted for inflation was below the level in 1999.[10] Even in relatively tight labor markets, median incomes have for two decades failed to keep up with inflation. The gains from economic growth have instead accrued mainly to the top 5 percent of the income distribution.[11]

By 2015, a spreading movement to increase the minimum wage has started to raise the wage floor in labor markets. Reflecting this and perceived mounting upward pressures on wages, the CBO, among other forecasters, predicts that wages will pick up in future years as employers compete for new workers.[12]

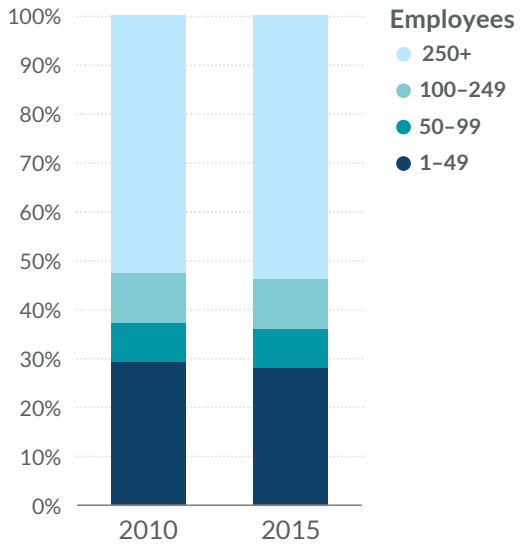
HEALTH CARE COSTS: SLOWDOWN IN GROWTH EXTENDS TO A FIFTH YEAR

A key goal of the Affordable Care Act is to slow growth in the costs of health care while enhancing access and health outcomes. With abundant evidence of waste and inefficiency throughout the U.S. health system, the ACA's framers looked to incentivize providers and payers to achieve better health outcomes at lower cost.[13] Lower cost inflation would reduce the federal government's costs for Medicare and the insurance expansion, make private insurance more affordable, and free up private and public resources for other needs. Critics worried, however, that ACA's tools for addressing cost were relatively weak and that setting

Exhibit 8

Job Growth Has Been Similar for Firms of All Sizes

Percent distribution of private jobs, by number of employees

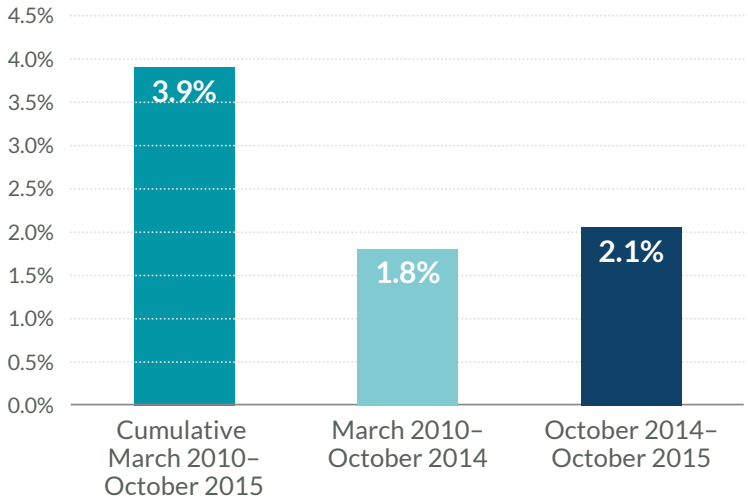


Source: U.S. Bureau of Labor Statistics. Business Employment Dynamics through Q1 2015. Modified Nov 2015. Distribution of private sector employees by firm size.

Exhibit 9

Little Growth Seen in Inflation-Adjusted Average Weekly Wages, but 2015 Pace Picks Up

Change in real weekly wages (percent)



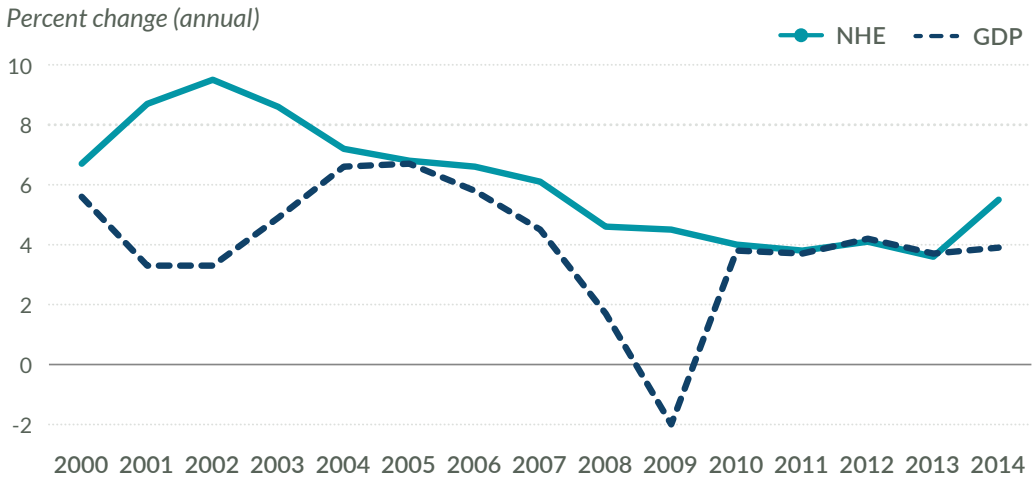
Source: U.S. Bureau of Labor Statistics. Real weekly earnings, seasonally adjusted for private nonfarm employment. Series uses urban consumer price index to adjust wages for inflation. Data released Nov. 17, 2015.

standards for health insurance benefits might increase the cost of coverage.

Contrary to critics' fears, the slowdown in health care spending that began during the recession, before passage of the ACA, has continued well into the economic recovery. As illustrated by Exhibit 10, growth in national health expenditures slowed to the rate of overall economic growth for four years, from 2009–10 through 2013–14. This represents a break from the pattern seen when the economy has emerged from past recessions.

Exhibit 10

Annual Health Spending Growth Slows to Rate of GDP Growth for Four Years (2010–13), But Rises in 2014



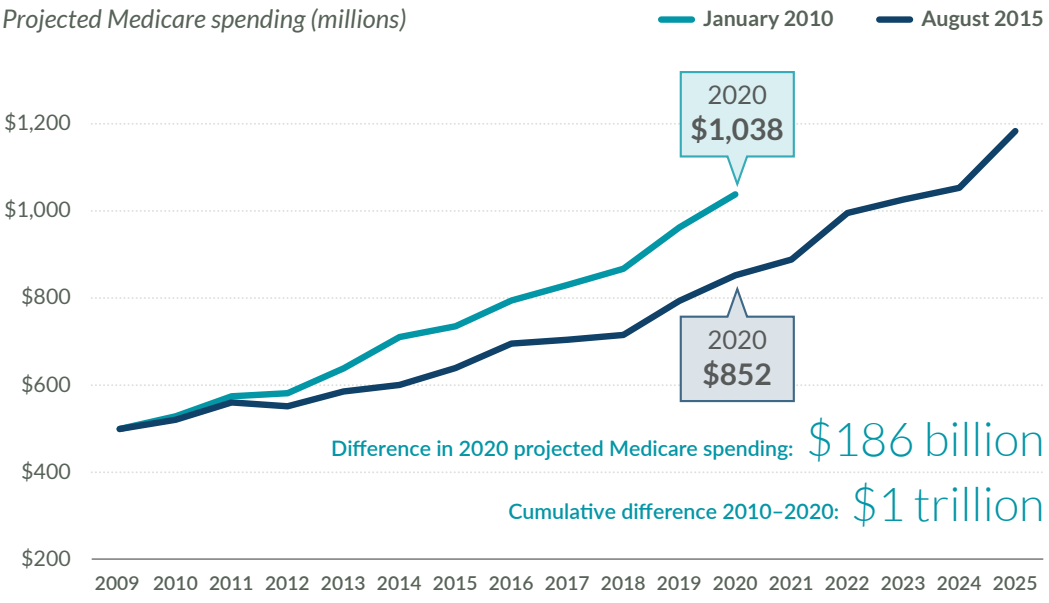
NHE = national health expenditures.
Source: Centers for Medicare and Medicaid Services, Historic and Projected National Health Expenditures. Updated July 2015.

Indeed, the slower pace of private as well as Medicare spending through 2014 has led to multiple revisions of the CBO's federal budget projections. As employers have spent more on jobs and less on health benefits than initially forecast, and as Medicare and insurance expansion costs have come in lower than expected, the CBO has revised upward its federal revenue projections and lowered its projections of federal health care spending. This in turn has led to downward revisions of projected federal deficits (March 2015 and August 2015).

Of special significance is the reduction in Medicare spending per beneficiary, which is now below the rate of inflation. According to the CBO's most recently revised projection, Medicare spending by 2020 will be $186 billion below the level projected in January 2010, for a 10-year cumulative savings of $1 trillion (Exhibit 11). And because actual Medicare costs through 2014 came in well below 2013

Exhibit 11

Lower 10-Year CBO Medicare Projections, August 2015 vs. January 2010



Sources: Congressional Budget Office (CBO), The Budget and Economic Outlook: 2010 to 2020, Jan. 2010; *CBO, An Update to the Budget and Economic Outlook: 2015 to 2025*, updated Aug. 25, 2015.

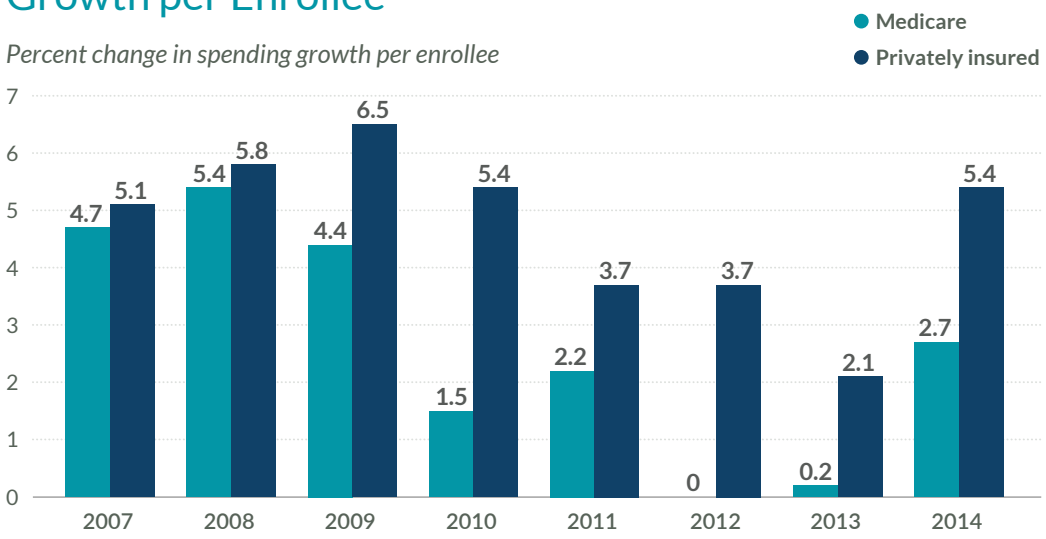
projections, the CBO also recently revised downward its 10-year federal spending projection for 2015–2025.[14]

Spending for privately insured enrollees in marketplace plans also has slowed markedly, although growth rates per person have continued to exceed Medicare's (Exhibit 12). This slower-than-expected growth has led the CBO in each of the past two years to lower its estimates of the federal cost of providing insurance subsidies. The slowdown has also benefited employers. Because of lower insurance cost growth in 2013 and 2014, the CBO in March 2015 revised its January 2015 10-year estimate of federal budget deficits downward by $431 billion. The agency explained that the revisions reflected increased revenues expected from taxable wage and salary growth—as employers spent less on health benefits and shifted a portion of employee compensation to salaries—as well as the decreased cost of federal marketplace subsidies.[15] In August 2015, the CBO revised its 10-year deficit projection downward by another $200 billion, largely based on positive economic news.[16]

Exhibit 12

Marked Slowdown in Medicare and Private Spending Growth per Enrollee

Percent change in spending growth per enrollee



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, Table 17, July 30, 2015, with projections.

IMPACT OF PROVIDER PAYMENT REFORMS AND NEW INCENTIVES

Analysis of the decline in health care spending growth indicates it has been driven partly by changes in the way health care is being delivered and paid for. Although it remains unclear how much of this phenomenon can be attributed to the Affordable Care Act, it seems clear that payment and delivery system changes set in motion by the ACA have made a significant contribution to lower cost growth as well as improvements in care.

Among the ACA reforms that appear to be contributing to recent trends are:

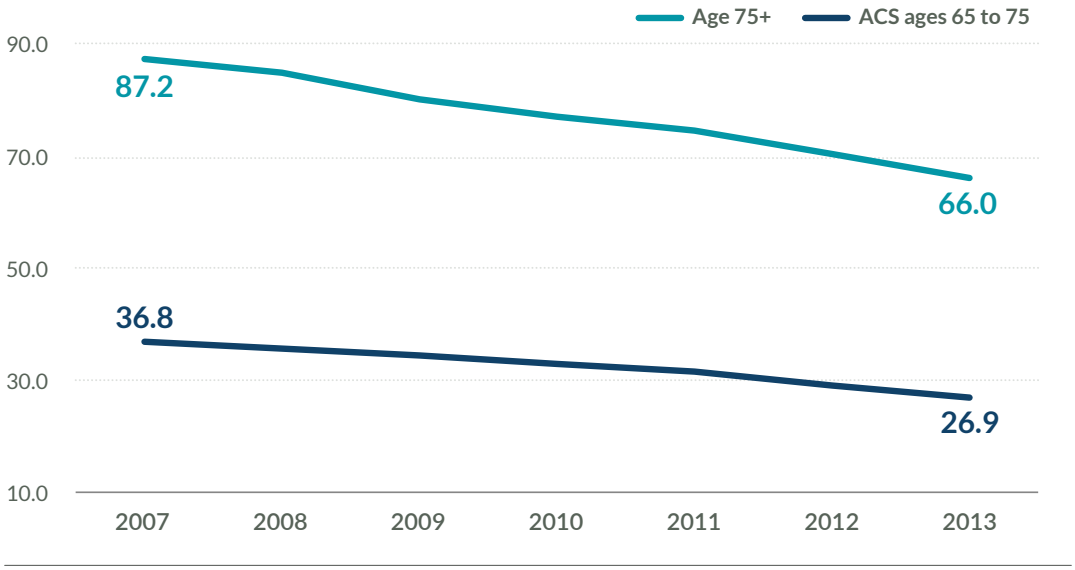
- A tightening of Medicare's hospital "productivity adjustment," which lowered the prices paid by the program.
- Adjustments to Medicare's annual updates of provider payment rates.
- Lower payment rates for private Medicare Advantage plans.
- Strong incentives to reduce hospital readmission rates and infections.
- New payment methods for holding health care providers and systems more accountable for the quality and cost of care they provide.

The ACA's reforms targeting Medicare, including a tightening of payments to hospitals and lower excess payments to private plans participating in Medicare, have directly contributed to lower program spending. Other reforms created incentives for providers to redesign their care delivery systems.

Exhibit 13

Medicare Hospital Admissions for Potentially Preventable Conditions Down 25 Percent

Ambulatory care–sensitive hospital admissions per 1,000 beneficiaries



Source: Centers for Medicare and Medicaid Services, Public Use File.

Providing evidence that tighter payment rates are not the only factor in Medicare's lower rate of spending are the significant reductions in hospitalizations for conditions that can be treated with timely primary care and lower hospital readmisson rates. For Medicare beneficiaries, such "ambulatory care–sensitive" admissions have fallen 25 percent since 2010, continuing a decline that began prior to the ACA (Exhibit 13). Meanwhile, rates of hospital readmission within 30 days have fallen from more than 19 percent to 17 percent, after years of failing to improve.[17] Tighter payments along with incentives have together contributed to the remarkable Medicare spending slowdown. Indeed, in 2012 and 2013, there was essentially no increase in spending per beneficiary (Exhibit 12).

Early participants in a Medicare accountable care organization (ACO) program known as the Pioneer ACOs achieved $385 million savings for Medicare over the first two years (2012–13) relative to fee-for-service-based medical groups, according to published analyses.[18] To lower hospital readmissions for patients discharged to postacute care settings, incentives provided to ACOs, along with other targeted incentives, have led hospitals in communities around the country to select nursing homes that have a track record of lower infection rates and higher quality.[19] Readmissions for medical conditions that could have been avoided with appropriate care drive up health costs and put elderly patients at risk.[20]

Emphasis on Primary Care

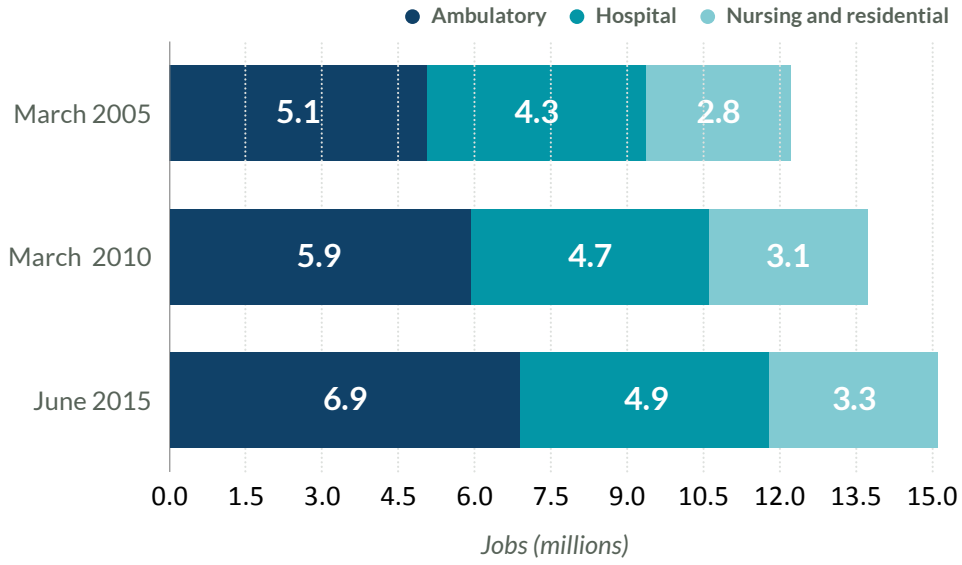
Other ACA payment provisions create incentives to strengthen primary care, particularly for people with chronic illnesses and complex conditions.[21] The goal is improved management of health conditions and complex prescription drug regimens, as well as prevention of complications that lead to hospital and nursing home stays. For example, Medicare and Medicaid, along with many private insurers, are promoting "patient-centered medical homes" and the use of care teams, with expanded roles for nurses and nurse aides.

With these and other changes to medical care practice, the bulk of new jobs in health care delivery since 2010 has been in ambulatory care settings, not in hospitals—a reflection of longer-term shifts in care delivery[22] as well as recent coverage and payment reforms (Exhibit 14). To the extent that physicians and hospitals continue to respond to the new incentives, potentially entire communities could benefit from the availability of more timely, more coordinated care and reduced acute care spending.

Many state Medicaid programs are following suit and adopting similar payment and delivery system changes. With Medicaid and Medicare accounting for nearly 40 percent of total national health care spending and 43 percent of hospital spending, their policies have the potential to leverage further health system change across the country.[23]

Exhibit 14

Health Care Sector Gained 1.4 Million Jobs Since March 2010, Mainly in Ambulatory Care



Source: U.S. Bureau of Labor Statistics. Seasonally adjusted establishment, June 2015 Preliminary, July 5, 2015.

Change in the Private Sector

In the private sector, payers have embraced many of the same reforms the ACA has instituted in Medicare, including bundled or episode-based payments, ACOs, and enhanced payment for primary care medical homes. (The ACA, in fact, specifically encourages the private sector to join in Medicare's payment initiatives.) Notably, private hospital use also has been in decline, a trend that has helped to moderate increases in health insurance costs.[24] Indeed, studies show that reforms in the public and private health care markets have had positive spillover effects—in both directions.[25,26]

Also of note is the ACA's "minimum loss ratio" requirement, which caps the portion of insurance premiums that can allocated for administrative costs and profits. The rule has yielded more than $5 billion in benefits to consumers from 2011 through 2013, either through the rebates paid by insurance companies or through reduced spending on overhead.[27]

In sum, the moderation in health costs growth through 2014 has benefited federal, state, and local governments, private employers, and workers and their families. Yet, as discussed later in this paper, the slowdown is unlikely to continue without further action to address the market forces that drive costs higher.

POTENTIAL IMPACT OF LOWER COST GROWTH ON LABOR MARKETS AND WORKFORCE PRODUCTIVITY

In most of the years leading up to the ACA's enactment, health care spending and private health insurance costs rose faster than economic growth, often exceeding it by 2 percent or more. As a result, for people with employer-based insurance, rising health care costs consumed a larger share of their total compensation—suppressing wages and providing strong incentives for employers to avoid adding full-time workers to their payrolls. Studies indicate that this "excess inflation" cost jobs, suppressed wages, and expanded reliance on employee overtime. One study estimated that every 10 percent increase in health insurance costs reduced the likelihood of being employed by 1.6 percent and, for workers with health benefits, decreased wages by 2.3 percent.[28] Another study found that to retain their company-provided health coverage, employees had to surrender wages (or forgo wage increases) or other benefits.[29]

The reversal of this trend over the past five years has likely stimulated economic growth. With payments for employee health insurance premiums rising more slowly than before, businesses have had additional resources to invest in production and jobs—even if this has yet to be matched by rising wages and salaries for the majority of the workforce.

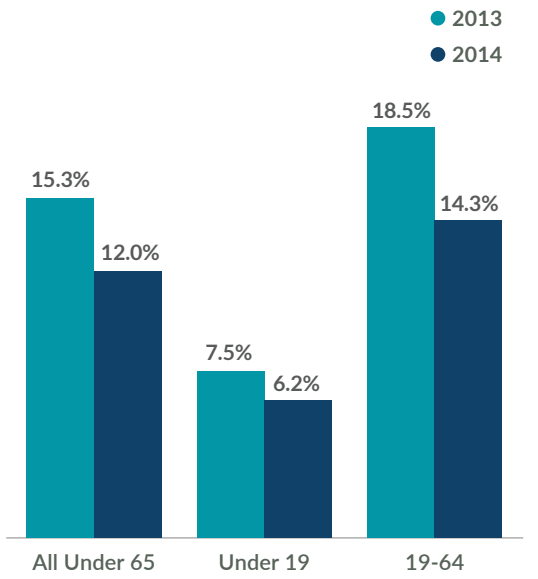
Over the longer term, the ACA's changes to the standards governing health insurance markets, including guaranteed access to coverage and a ban on preexisting condition exclusions, hold promise to enhance the ability of people to make career decisions, change jobs, or take the risk of opening a new business without fear that coverage will be unavailable or unaffordable because of age, gender, or health. Assured that health coverage will always be available to them, people can now more easily make the move from one job to another, reduce their hours, or take time off to obtain new skills. Entrepreneurs, no longer tethered to a job for need of its health benefits, have more freedom to start a new business. This reduction in "job lock" should benefit people throughout their work lives and may benefit the economy over the long term.[30]

For many working women, men, and families who previously were uninsured or experienced frequent gaps in coverage, the ACA's coverage expansions provide a new level of access to preventive and primary care and the potential for improved health, quality of life, and economic productivity. Since marketplaces opened in 2014 and Medicaid expanded in 31 states, 16 million to 17 million people have gained coverage—this in addition to the 1 million to 3 million young adults who have gained coverage under their parents' plans since 2012.[31] Between 2013 and 2014, the proportion of the nonelderly population without insurance dropped sharply, from 15.3 percent to 12 percent, with 8.8 million fewer people uninsured, according to the U.S. Census Bureau (Exhibit 15). Uninsured rates decreased in every state and for all age groups under 65, as both public and private insurance expanded. Moreover, each of the major studies tracking trends into 2015 finds continued decreases in the numbers of uninsured.[32]

Finally, recent studies by the Institute of Medicine find that the United States lags other high-income countries in population health despite spending far more than any other country.[33] If the ACA is able to reduce barriers to people receiving timely care and improve the safety and effectiveness of care, this health gap may finally begin to close.

Exhibit 15

Sharp Drop in Uninsured in All Nonelderly Age Groups Following Affordable Care Act's Insurance Expansions



Source: U.S. Bureau of the Census, *Health Insurance Coverage in the U.S.: 2014*, Current Population Reports, Sept. 2015.

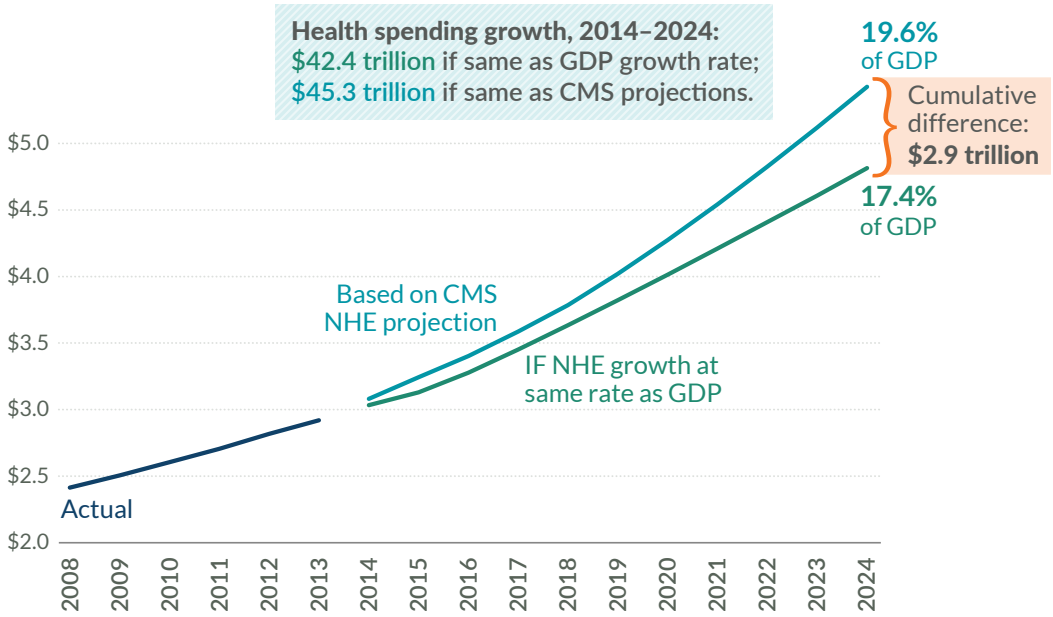
THE TRILLION DOLLAR QUESTION: WILL THE SLOW RISE IN HEALTH CARE COSTS CONTINUE?

Looking forward, the key concern is whether and how the nation will sustain the slow growth in health care expenditures while maintaining access to quality care. For four years, national health spending has risen at the same pace as, or slightly lower than, growth in the economy as measured by GDP. The most recent projections, however, have health expenditures returning to their previous levels, rising 1.1 percent faster than GDP through 2024.[34] If the country were instead able to hold the rate of increase to no more than GDP growth, the cumulative savings would amount to $2.9 trillion over the decade (Exhibit 16). The challenge is how to design payment and other policies to sustain slow health care cost growth rates.

Exhibit 16

What if Future Increases in U.S. National Health Expenditures Are Limited to Rate of Economic Growth?

National health expenditures (trillions)



Source: Author's analysis based on data from Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, 2014-2024 National Health Expenditures (NHE), projected July 2015; http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

Across the country, there is a shift away from payment based on the volume of services provided to payment based on the value of care delivered, along with a renewed commitment to eliminating the provision of duplicative, excessive, and unsafe care. Still, several market developments could increase health care prices and costs and offset savings from improved access to care and a better-functioning delivery and payment system. These developments include:

- *Rising costs of prescription drugs.* A lull in development of new breakthrough prescription drugs and the expiration of patents for several high-cost medications during recent years have both contributed to the spending slowdown in the first part of this decade.[35] But there are multiple warning signs that this trend may be ending, including the $82,000 price tag for treatment with an effective new drug for hepatitis C, the availability of new cancer drugs, and rapid increases in prices for even generic medications.[36,37] A key question is whether the United States will be able to implement more value-pricing for existing and new drugs while also promoting innovation and limiting monopolistic pricing.
- *Consolidation of providers and insurers though mergers and acquisitions.* Vertical or horizontal provider consolidation—for example, mergers of hospitals or drug companies—could push prices up, even if use of health services decreases. This is especially true in markets with multiple, nondominant payers. The greater market power achieved through consolidation also could help providers maintain the higher prices from private insurers gained in previous years.[38] At the same time, mergers of insurers pose the danger of raising premiums and the prices paid for care.[39]
- *Administrative layers and complexity.* Public and private health care payers and regulatory agencies use different, often changing payment methods and require separate reporting on an expanding array of metrics. There is concern that the proliferation of payment changes and reporting requirements are adding to administrative costs

and diverting time and resources away from the delivery of care.[40] The U.S. health system already has among the highest administrative costs in the world; the challenge is how to reduce the excess costs stemming from the U.S. health insurance system's inherent fragmentation.[41]

Although Medicare has the purchasing power to influence the prices it pays for medical and hospital services, it is currently barred from negotiating prices with prescription drug companies. However, private insurers must contend with both the market power of increasingly consolidated providers and the rising costs of prescription drugs.

Moreover, fragmented payment policies make it difficult to convey consistent pricing signals to markets and providers. Payment reforms undertaken by any one payer may be undermined by the lack of haromonization of incentives among Medicare, Medicaid, and private insurers. Looking forward, coherent, targeted efforts across payers aimed at the common factors contributing to high or rising costs will likely be necessary to sustain slow cost growth in ways that benefit all families and businesses.

With creative action to address these and other underlying factors driving up costs, the nation has the potential to hold health care cost growth to growth in the overall economy. Still to be determined are the types of actions at the private, state, or national level that will be needed to achieve this aspirational goal.

The Affordable Care Act affirmed a national commitment to expanding the availability of affordable health insurance to all citizens. The law aimed to finance and sustain this commitment by building a platform to lower health care costs and reduce future increases. Five years after its passage, there are strong indicators that the ACA has had a postive impact on the economy as well as insurance coverage. The longer-term impact on the economy and the nation's ability to maintain the ACA's achievements will likely depend on what happens to health care costs and whether effective policies evolve to sustain slow cost growth.

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[7] G. Burtless, "Payroll Gains Cool in March But Real Wages Edge Up," *Brookings on Job Numbers* (Washington, D.C.: Brookings Institution, April 3, 2015). Note that employment rebounded in April 2015.

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[14] Congressional Budget Office, *Updated Budget Projections 2015 to 2025* (Washington, D.C.: March 9, 2015).

[15] Congressional Budget Office, *Updated Budget Projections 2015 to 2025* (Washington, D.C.: March 9, 2015). CBO noted of the revision of its January deficit estimate (p. 1): "The largest factor underlying that reduction is a downward revision to projected growth in private health insurance spending, which is estimated to lower the net cost of the provisions of the Affordable Care Act (ACA) that are related to insurance coverage and to increase overall revenues from income and payroll taxes (because a larger share of employees' compensation over the coming decade is now projected to be paid in the form of taxable wages and salaries)."

[16] Congressional Budget Office, *An Update to the Budget and Economic Outlook, 2015 to 2025* (Washington, D.C.: CBO, Aug. 25, 2015).

[17] D. Blumenthal, M. K. Abrams, and R. Nuzum, "The Affordable Care Act at 5 Years," *New England Journal of Medicine,* published online May 6, 2015. See also online supplementary appendix with detailed list of payment and reporting and incentives reforms.

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[22] From 2010 to 2015, the health care sector added 1.2 million jobs. Of these, 900,000 were in ambulatory care settings. Bureau of Labor Statistics, employment by industry, through April 2015.

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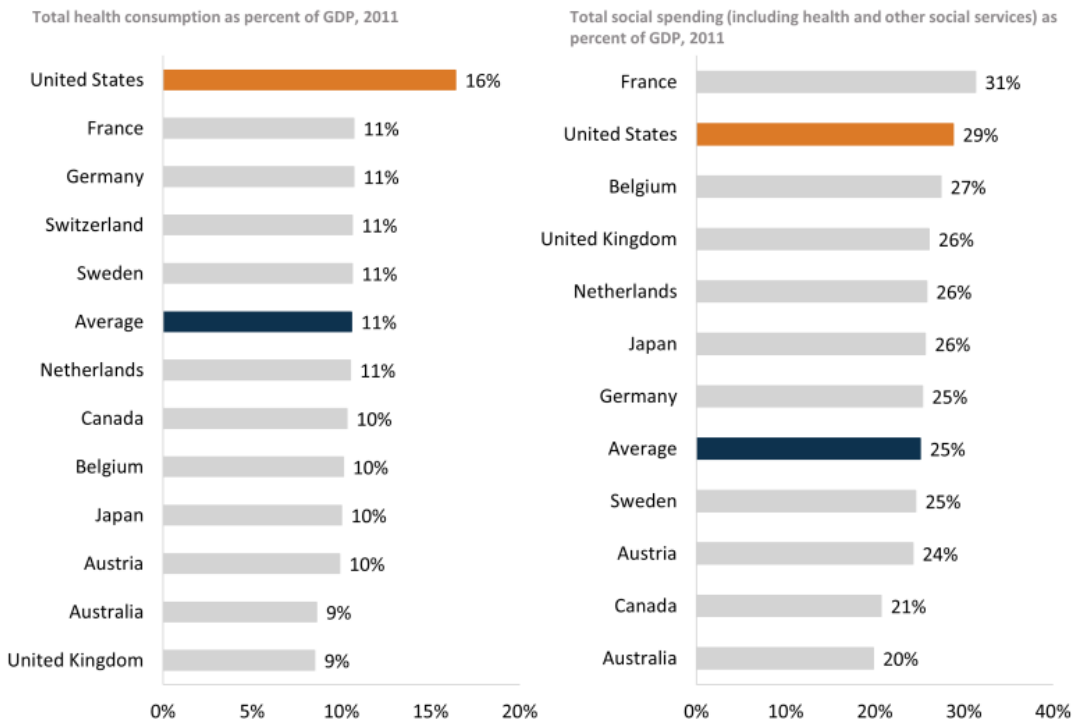
Peterson-Kaiser Health System Tracker

Measuring The Performance Of The U.S. Health System

Chart Collection

What do we know about social determinants of health in the U.S. and comparable countries?

The U.S. is an outlier for health spending, but when combined with other social services, spending is similar to other countries



Source: Kaiser Family Foundation analysis of data from OECD (2016), "Health expenditure and financing: Health expenditure indicators", *OECD Health Statistics* (database). doi: http://dx.doi.org/10.1787/data-00349-en (Accessed on 08 February 2016); and OECD (2016), Social spending (indicator). doi: 10.1787/7497563b-en (Accessed on 08 February 2016) **Note:** Social spending includes cash assistance. Total net social spending data unavailable for Switzerland.

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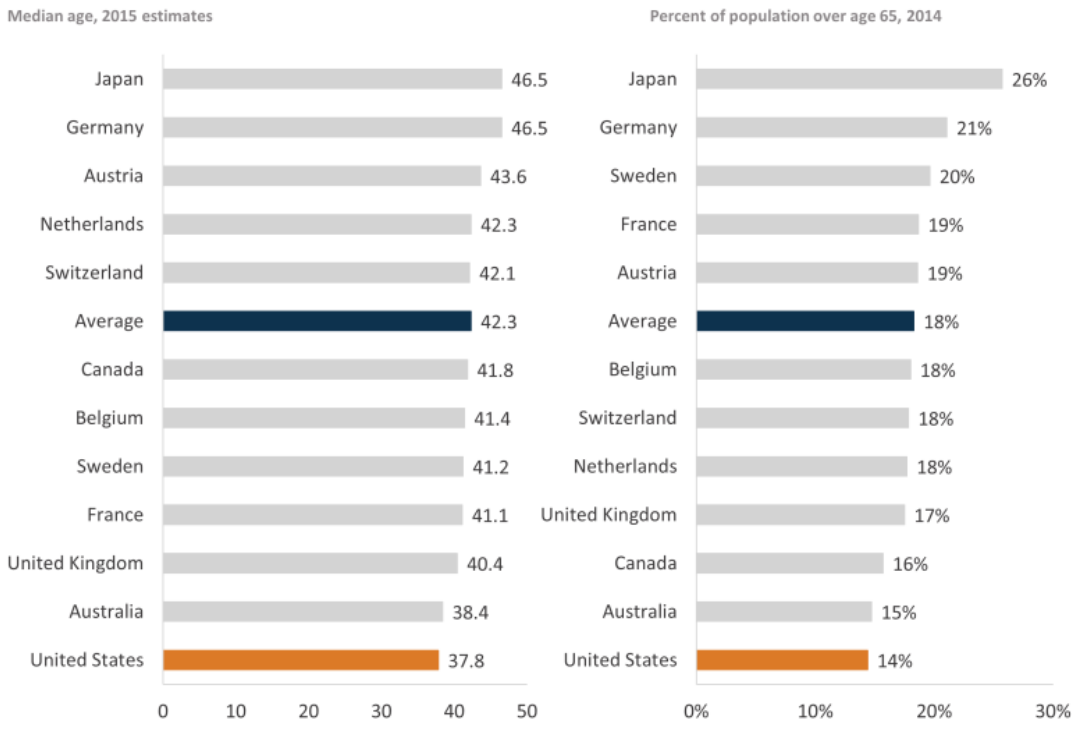
The U.S. spends significantly more on healthcare than do comparably wealthy and sizable countries (countries with above median total GDP and GDP per

capita for at least one of the past ten years), yet the U.S. lags behind these other countries in several measures of health outcomes. The U.S. has worse life expectancy, mortality, and disease burden rates. Some of this difference in outcomes could be due to quality of care provided (a comparative chart collection is available here). Though unknown to what degree, some of the difference in costs and outcomes could also be due to societal, economic, and environmental factors that influence health but are largely outside the control of the health system. Researchers have pointed out that while the U.S. spends much more on healthcare than other countries, it also spends significantly less on other social services, which could also support health in the long run. When combining health spending with other social spending, both public and private (which includes cash assistance, such as social security and pensions), the U.S. actually has similar costs as other countries. This series of charts explores international comparisons of some of these factors, broadly referred to as social determinants.

Though the U.S. population is aging, it has a younger average age and smaller elderly population than comparable countries



Source: Data on median age from the CIA World Fact Book , available at https://www.cia.gov/library/publications/the-world-factbook/fields/2177.html; data on the percent of population over age 65 from the World Bank, available at http://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS.

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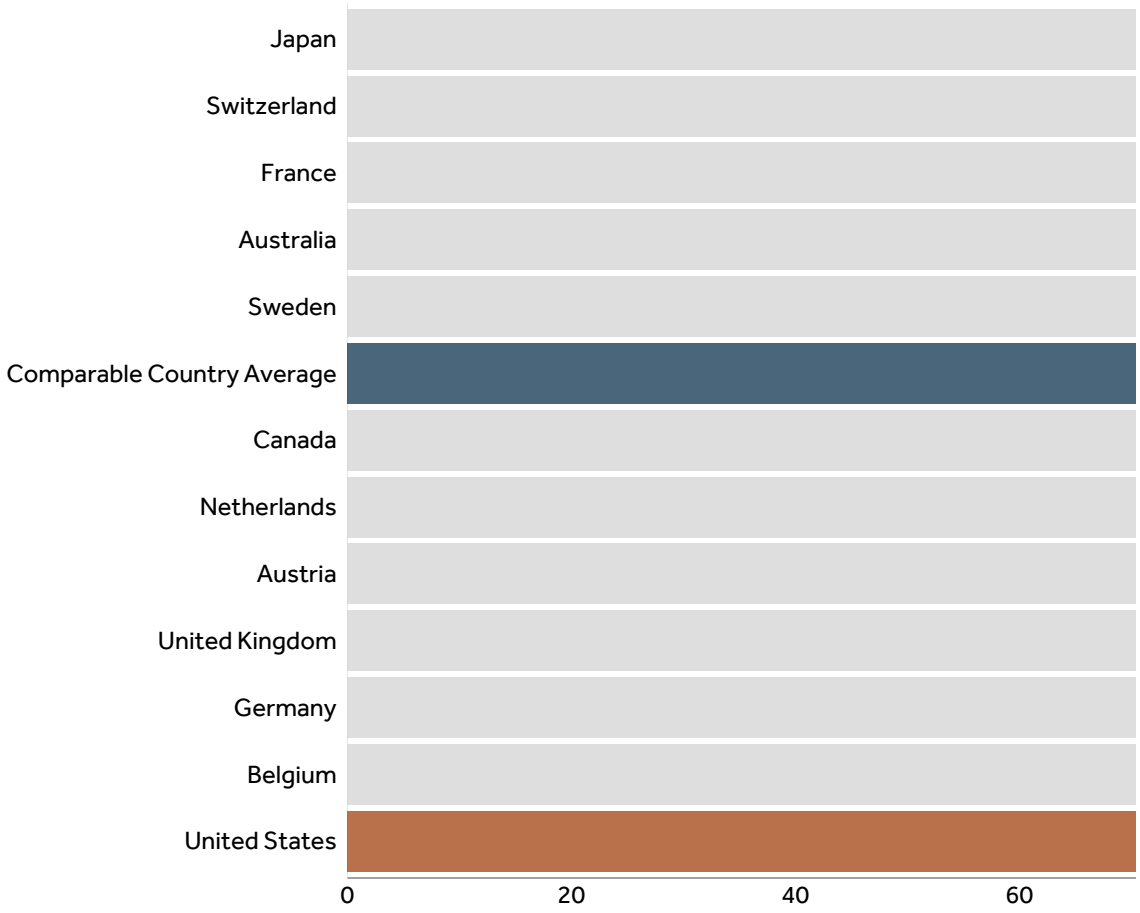
The aging population in the U.S. may help explain why the U.S. medical costs are rising, but it likely does not explain the difference in outcomes and spending between the U.S and other countries. The populations of comparably sizable and wealthy countries are aging more rapidly, with larger percentages of their populations over the age of 65.

The U.S. has the shortest life expectancy among comparable countries

Life expectancy at birth in years, 2013



Source: Kaiser Family Foundation analysis of data from OECD (2016), Life expectancy at birth (indicator). doi: 10.1787/27e0fc9d-en (Accessed on 12 January 2016). Note: Data for Canada are from 2011.

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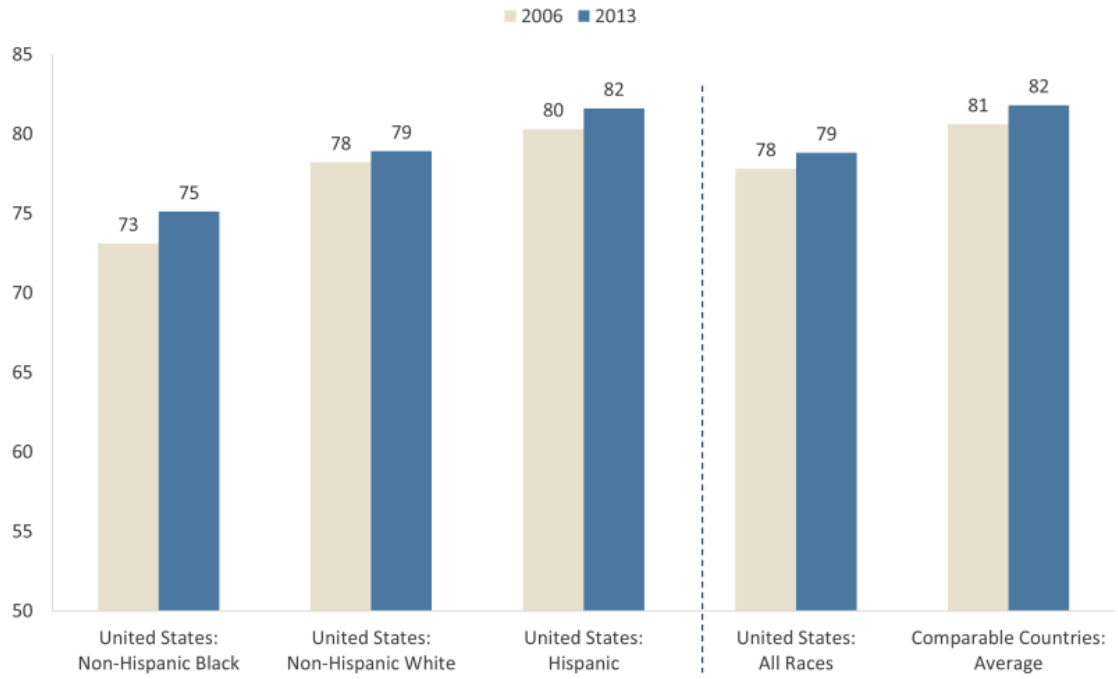
Life expectancy can be influenced by a number of factors, including those within the domain of the health system (e.g., quality of care, access to preventive health services) as well economic, behavioral, and environmental factors that may be outside the control of the health system (e.g. poverty, lifestyle, violence, and accidents). Life expectancy at birth in the U.S is lower than comparable OECD countries. In 2011, U.S. life expectancy was just under 79 years, compared to an average of just under 82 years for comparable OECD countries.

In the U.S., both blacks and whites have shorter average life expectancies than the average of comparable countries

Life expectancy at birth in years, 2006 and 2013



Source: Data by race are from the Centers for Disease Control, available at: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf (Accessed on 12 January 2016); comparable country data are from OECD (2016), Life expectancy at birth (indicator). doi: 10.1787/27e0fc9d-en (Accessed on 12 January 2016).

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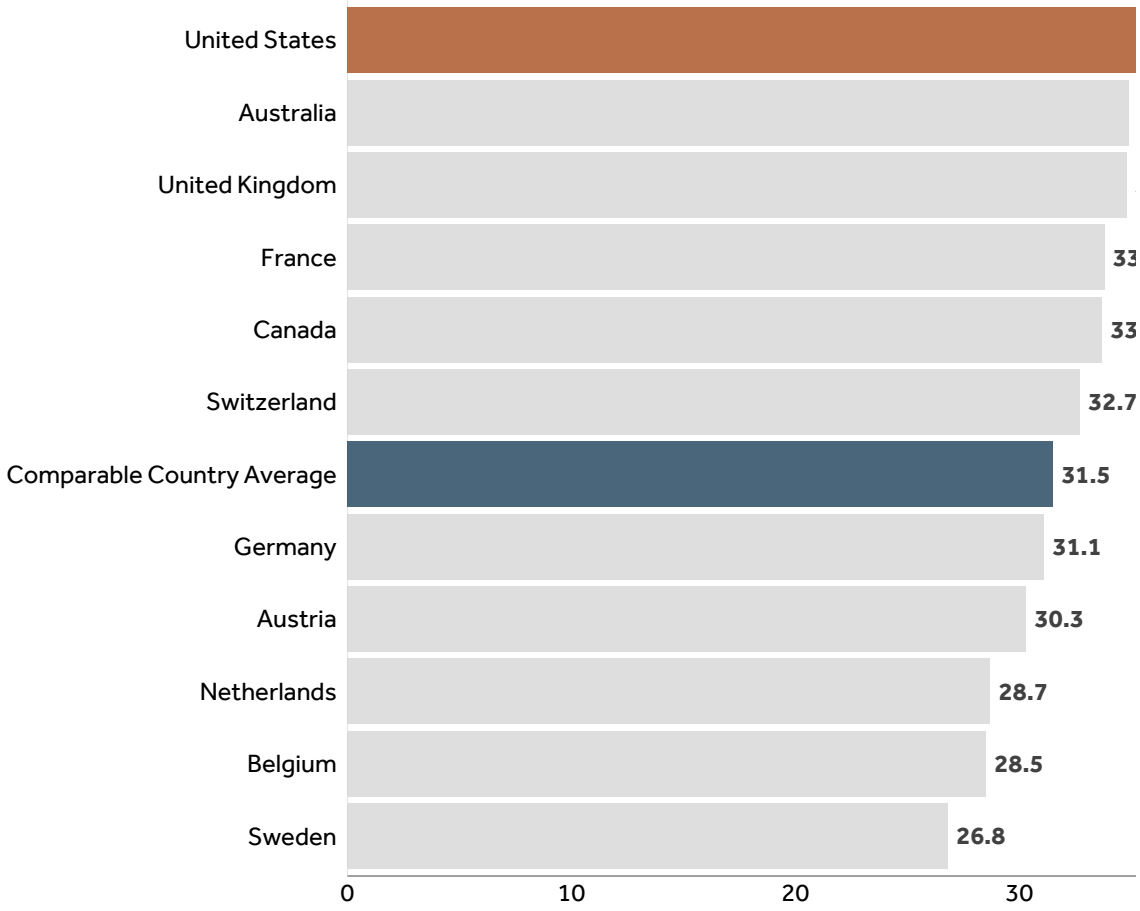
Although the racial gap in life expectancy has improved in recent years, recent data from the Centers for Disease Control indicate that black Americans continue to have shorter life expectancies than whites and Hispanics. Both black and white Americans have shorter average life expectancies than the average of comparably wealthy and sizable countries. However, people of Hispanic origin in the U.S. have average life expectancies that are similar to other large and wealthy nations.

The U.S. has a higher degree of income inequality than comparably wealthy countries

Gini coeffcient, 2010



Source: Kaiser Family Foundation Analysis of data from The World Bank, World Development Indicators (database). Available at http://data.worldbank.org/indicator/SI.POV.GINI/countries?cid=DEC_SS_WBGDataEmail_EXT&display=default (Accessed on December 16, 2015). Note: Data for Japan are unavailable.

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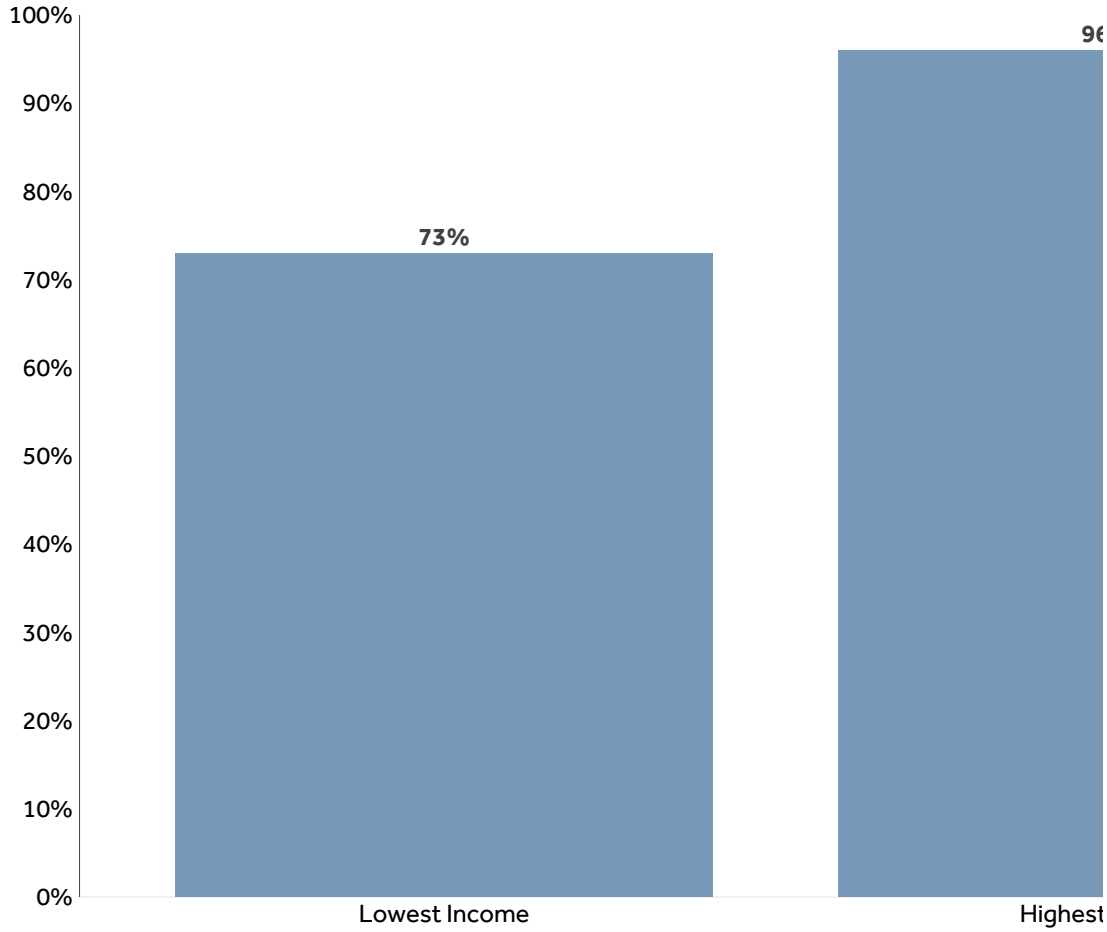
The U.S. has a higher degree of income inequality than any comparably wealthy and sizable country. The Gini index is a measure of income inequality on a scale of 0 to 100, where higher values indicate a less equal distribution of income. The most recent available data from the World Bank indicate that the U.S. has the highest level of income inequality among comparably wealthy and sizable nations. This trend has held steady for at least 2 decades in the countries with available data.

Americans with lower incomes are less likely to report being in good health than those with high incomes

Percent of population age 15+ reporting good health, by income quintile, 2013



Source: OECD (2015), Perceived health status by income level, 2013 (or nearest year), in Health at a Glance 2015, OECD Publishing, Paris. DOI: http://dx.doi.org/10.1787/health_glance-2015-graph33-en

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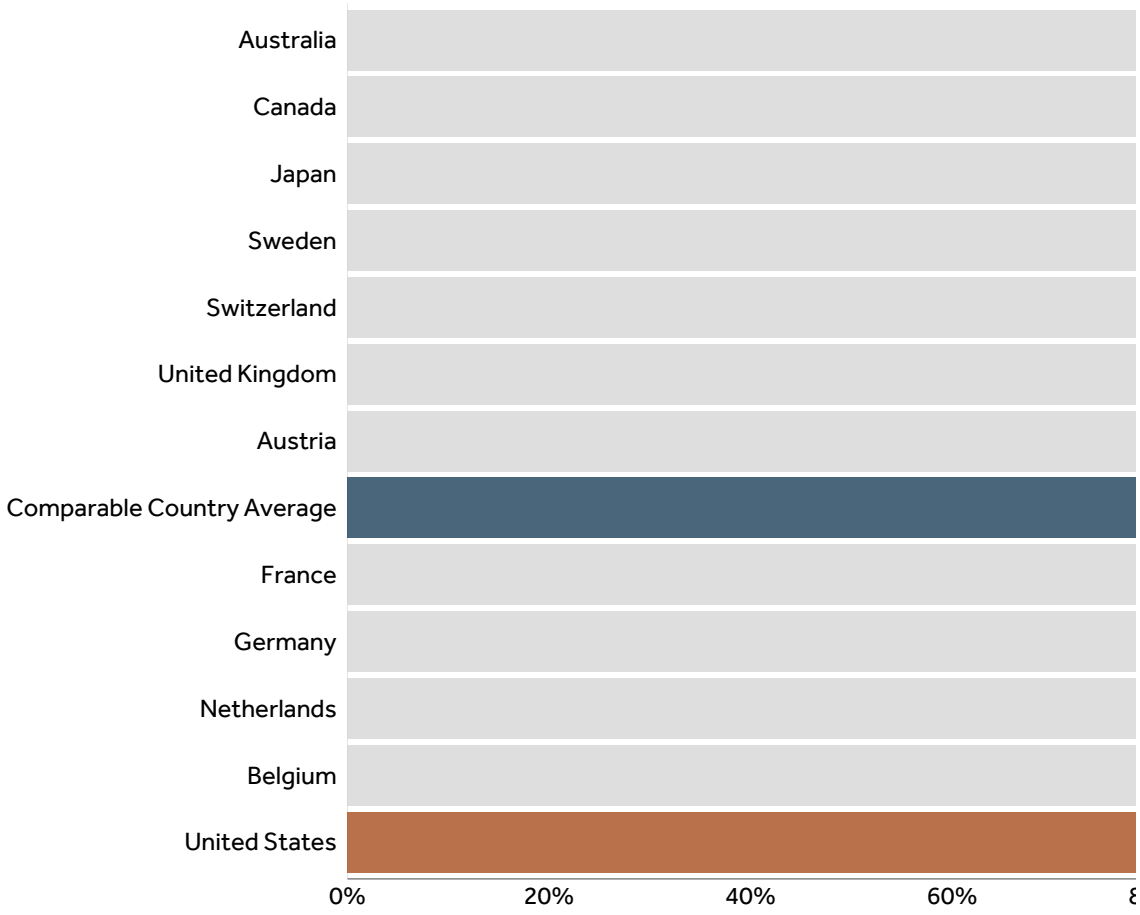
The complex nature of social determinants makes it difficult for researchers to estimate their relative contribution to health. Racial inequality, for example, can coincide with other factors that affect health, such as income and education. A large body of research has examined the ways in which income can significantly influence health outcomes. People who are lower income are less likely than people with higher incomes to report being in good health, and there is a growing disparity in the life expectancies of low and high income Americans. While income is also correlated with behavioral factors that can influence health, recent research has found that these factors only explain some of the difference in outcomes between low and high income people.

The U.S. has the lowest insured rate of comparable countries

Percent of total population covered by private and/or public health insurance in 2013 (comparable

countries) or 2014 (United States)



Source: Kaiser Family Foundation analysis of 2014 U.S. Census data, available here https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf; and data from OECD (2015), "OECD Health Data: Social Protection", OECD Health Statistics (database). (Accessed on September 16, 2015). Note: Data for Japan were unavailable for 2013, so data from the previous year are shown.

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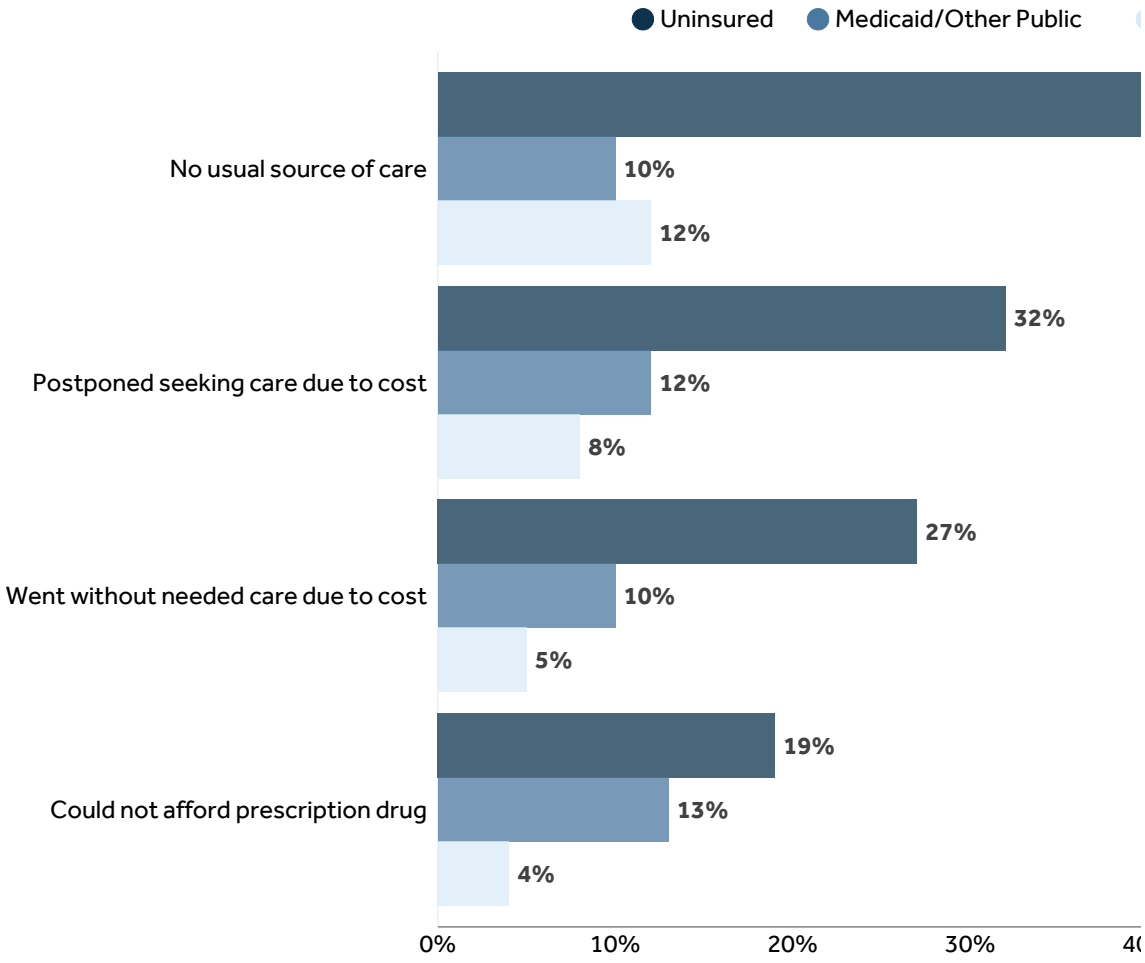
Health insurance shelters people from high medical costs that can result from illness and injury and therefore improves access to care. Although coverage in the U.S. has increased recently with implementation of the Affordable Care Act, the U.S. still has a lower rate of health coverage (89.6% in 2014) than any comparable country all of which cover 100% of their citizens.

Uninsured adults are much more likely to go without needed medical care due to costs

Barriers to health care among nonelderly adults by insurance status, 2014



Source: Kaiser Family Foundation analysis of National Health Interview Survey. Report available here: http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

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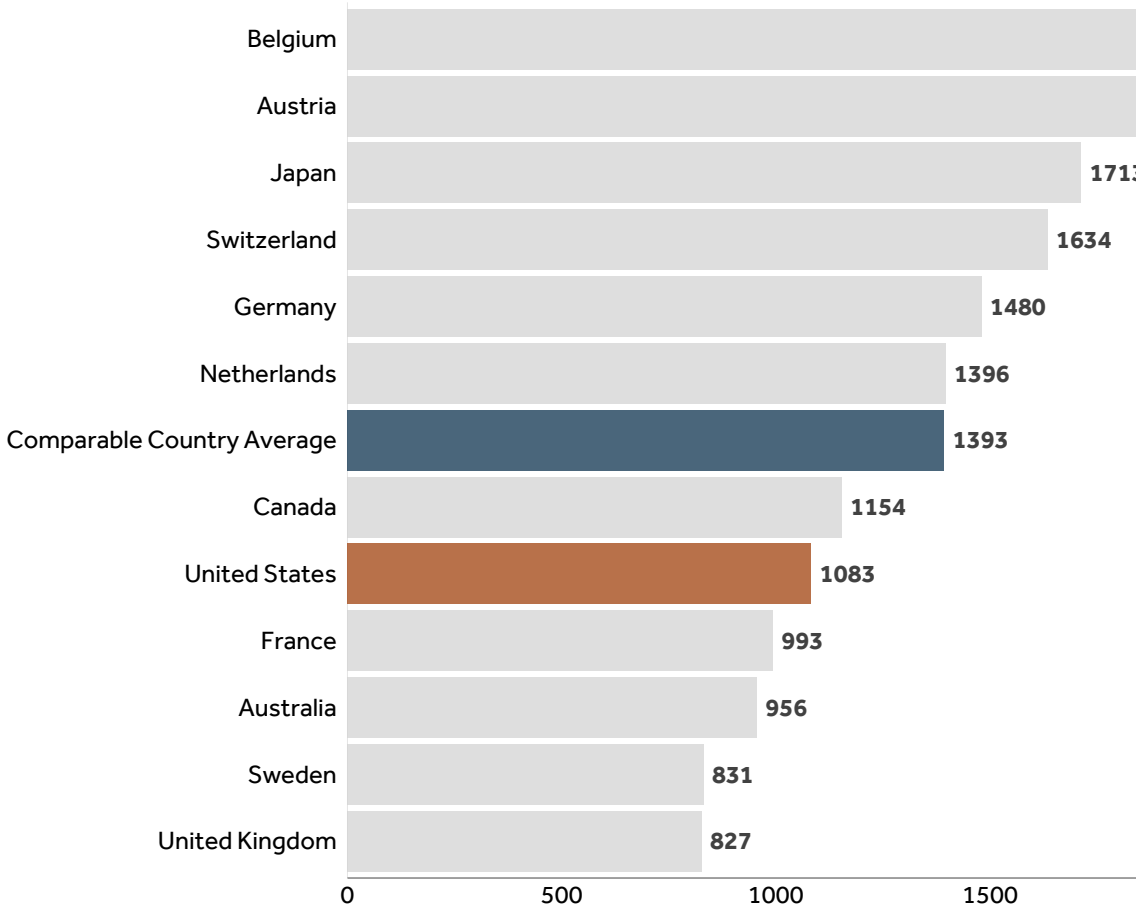
Uninsured adults in the U.S. have consistently experienced more difficulty accessing health care due to cost than insured Americans. The U.S. is unusual in that insurance coverage has been generally tied to employment status.

Per capita cigarette consumption is lower in the United States than in comparably wealthy countries

Number of cigarettes smoked per capita per year, age 15+, 2014



Source: World Lung Foundation and the American Cancer Society. The Tobacco Atlas. Available at: http://www.tobaccoatlas.org/topic/cigarette-use-globally/ (Accessed on January 5, 2016).

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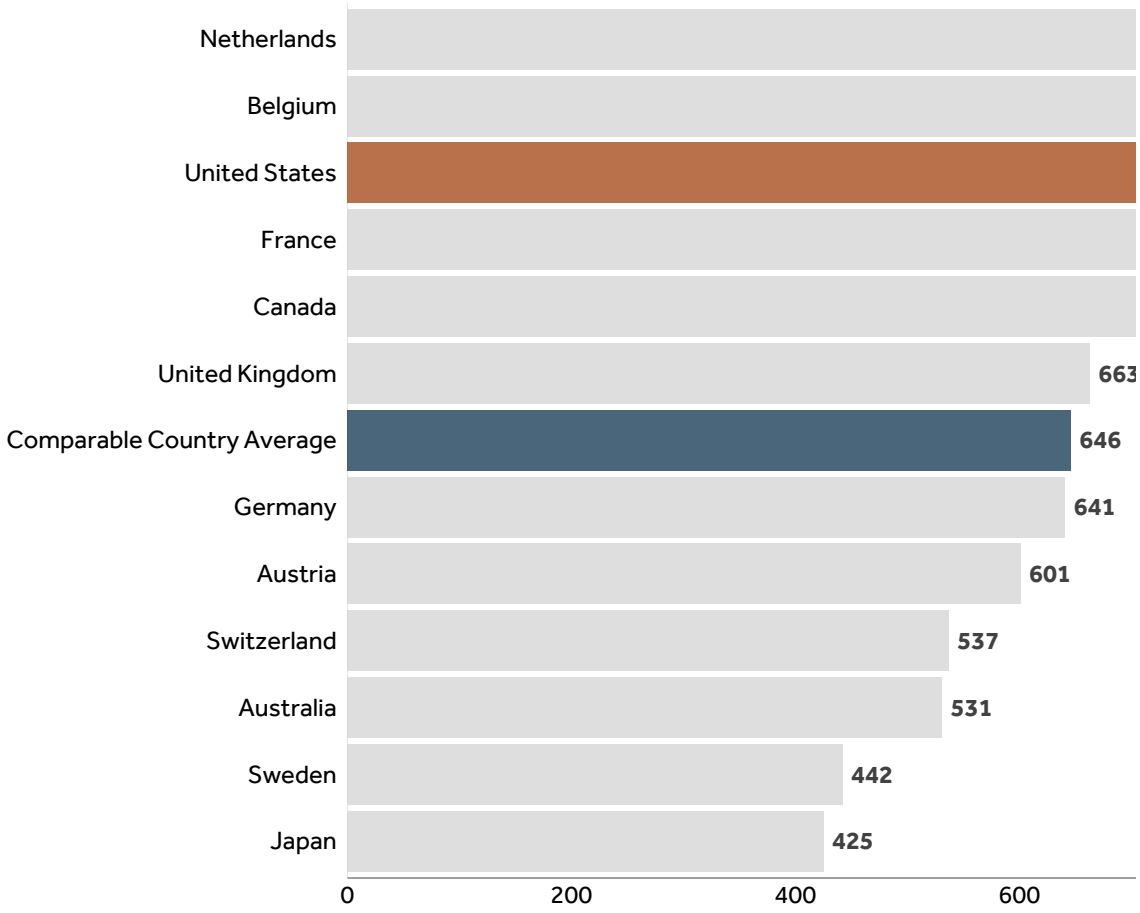
Tobacco use is a well-documented risk factor for adverse health outcomes and puts individuals at a higher risk of premature mortality than any other behavioral factor. According to OECD data, overall tobacco consumption (total grams per capita) has decreased dramatically in both the U.S. and comparable countries since the 1980s, with U.S. total consumption similar on average to that of other sizable and wealthy countries. Data from the World Lung Foundation and The American Cancer Society show that fewer cigarettes are smoked per capita per year in the U.S. than in most comparable countries.

The U.S. has higher than average disease burden from lung cancer

Lung, tracheal, and bronchus cancer age-standardized disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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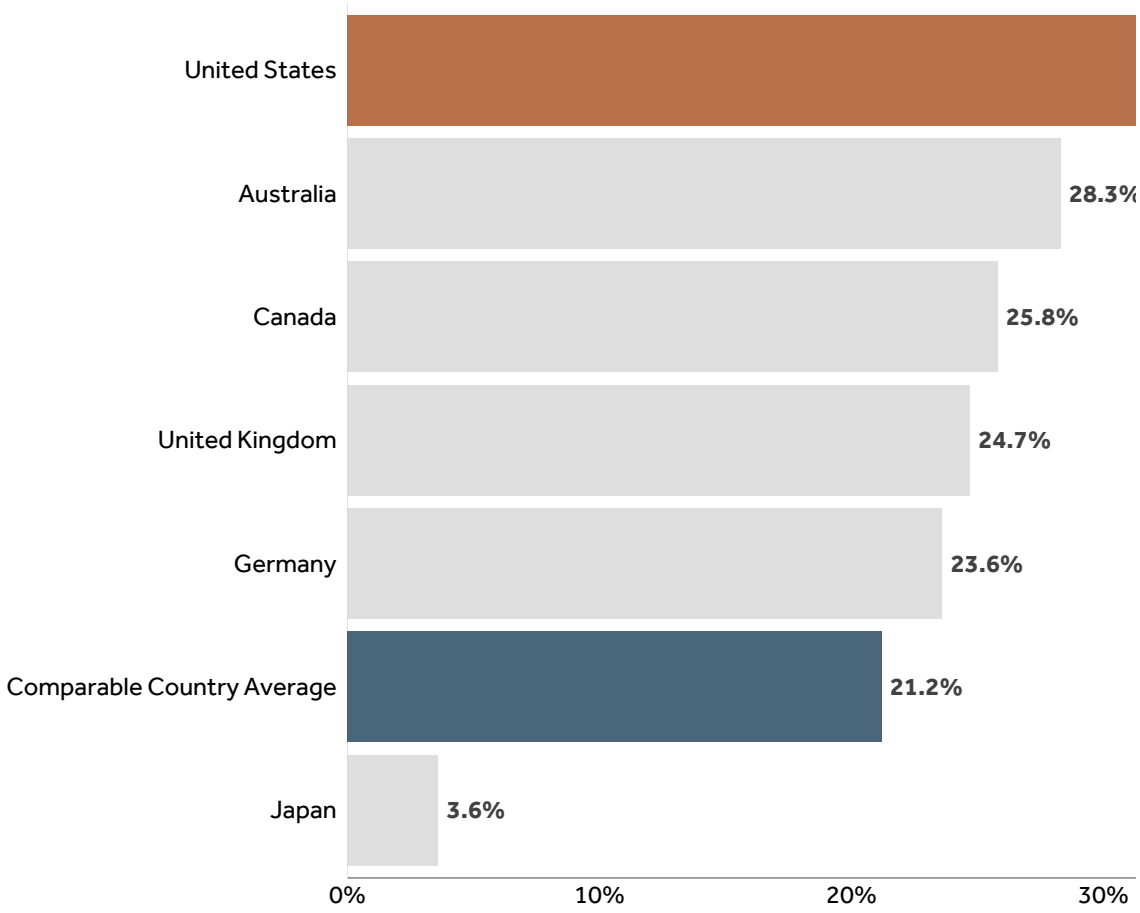
Cigarette smoking is the primary risk factor for lung cancer. The U.S. has higher than average disease burden from lung and related cancers (795 DALYs per 100,000 capita), compared to similarly wealthy countries (646 DALYs per 100,000 capita).

Smoking is linked to almost 9 out of 10 instances of lung cancer, and is known to cause cancer in the trachea, bronchus, and elsewhere in the body. Use of tobacco products other than cigarettes also increases the risk of lung and other respiratory organ cancers. Despite a dramatic decrease in overall tobacco consumption in the past fifty years, the risk of developing lung cancer is much higher for smokers today, due in part to changes made to cigarettes over time.

The U.S. has the highest prevalence of

obesity among comparable countries

Prevalence of obesity, BMI ≥ 30, age-standardized estimates, 2012 or nearest year



Source: Kaiser Family Foundation analysis of data from OECD (2016), "Non-medical determinants of health", OECD Health Statistics (database). DOI: http://dx.doi.org/10.1787/data-00546-en (Accessed on 21 January 2016). Note: Comparable countries here include Australia, Canada, Germany, Japan, and the United Kingdom. Data for Australia are for 2011 and data for Canada are for 2013.

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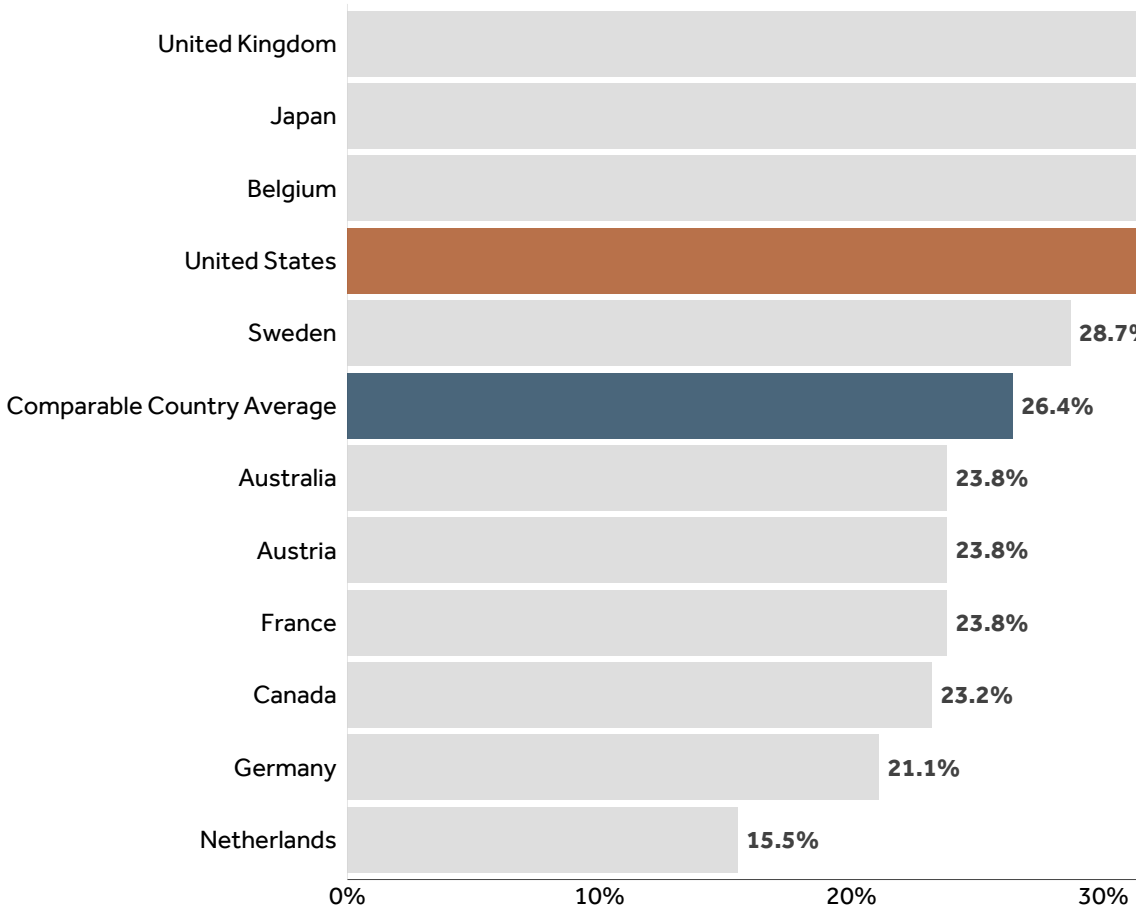
Poor dietary intake and insufficient activity levels present a risk of adverse health outcomes including obesity, identified by the World Health Organization as the percentage of people with a body mass index (BMI) at or above 30 kg/m2. The most recently available data from both the OECD (2012) and the WHO (2014 estimates) indicate that the U.S. has the greatest prevalence of obesity among high-income countries. Over a third of the U.S. is obese, compared to just over a fifth on average in comparable countries. Our analysis of 2011 data from OECD finds that the U.S. has higher than average daily per capita caloric (3639 vs 3386 Kcal) and fat intake (161.6 vs 143.7 g) relative to comparably wealthy countries.

More adults in the U.S. have a sedentary lifestyle than in most comparable countries

Prevalence of insufficient physical activity among adults aged 18+ years, age-standardized estimate, 2010



Source: Kaiser Family Foundation analysis of data from the World Health Organization. Available at: http://apps.who.int/gho/data/view.main.2463?lang=en (Accessed on November 22, 2015). Note: Data not available for Switzerland.

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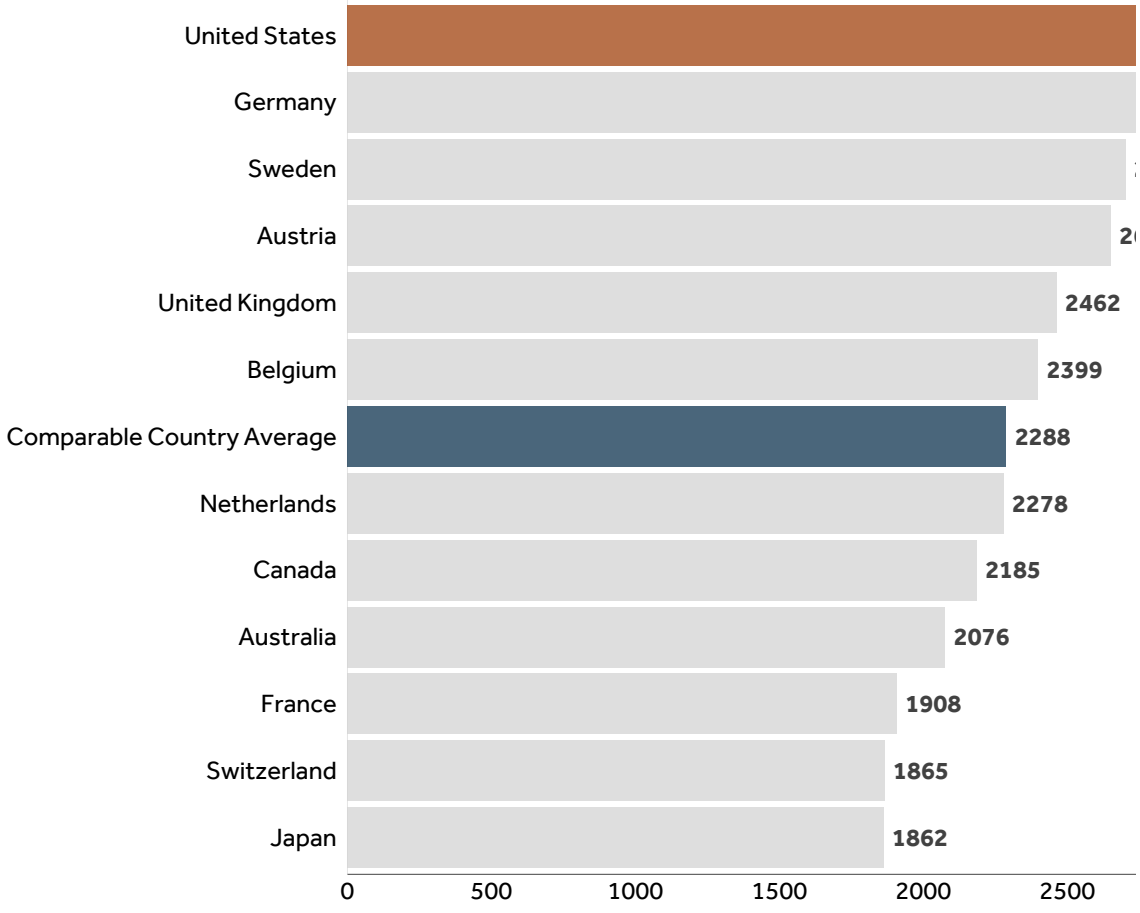
Sedentary lifestyle increases the risk of heart disease, obesity, and other health problems, and is associated with low socioeconomic status. Data from the World Health Organization indicate that 32% of adults in the U.S. have insufficient physical activity, compared to 26% on average in comparable countries.

The U.S. has a higher than average

disease burden caused by cardiovascular diseases

Age-standardized Disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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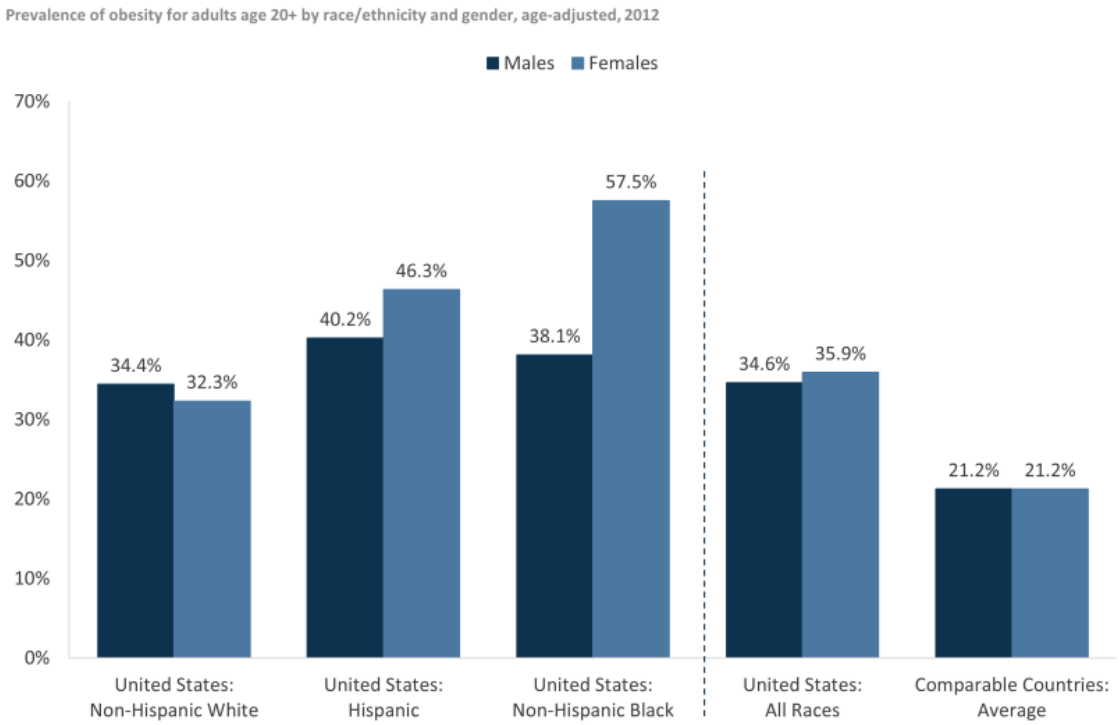
The higher-than average rates of obesity and inactivity in the U.S. may contribute in some ways to the U.S.'s higher than average disease burden from cardiovascular conditions. Though rates of disease burden caused by these conditions have improved across the U.S. and other countries, the U.S. has not seen as rapid improvement.

In the U.S., whites, blacks, and Hispanics all have higher prevalence of obesity than

the average of comparable countries



Source: Data by race are from CDC/National Center for Health Statistics, "Health, United States, 2014: With Special Feature on Adults Aged 55–64," available at http://www.cdc.gov/nchs/hus.htm; comparable country data are from OECD (2016), "Non-medical determinants of health", *OECD Health Statistics* (database). DOI: http://dx.doi.org/10.1787/data-00546-en (Accessed on 21 January 2016). **Note:** Comparable countries here include Australia, Canada, Germany, Japan, and the United Kingdom. Data for Australia are for 2011 and data for Canada are for 2013.

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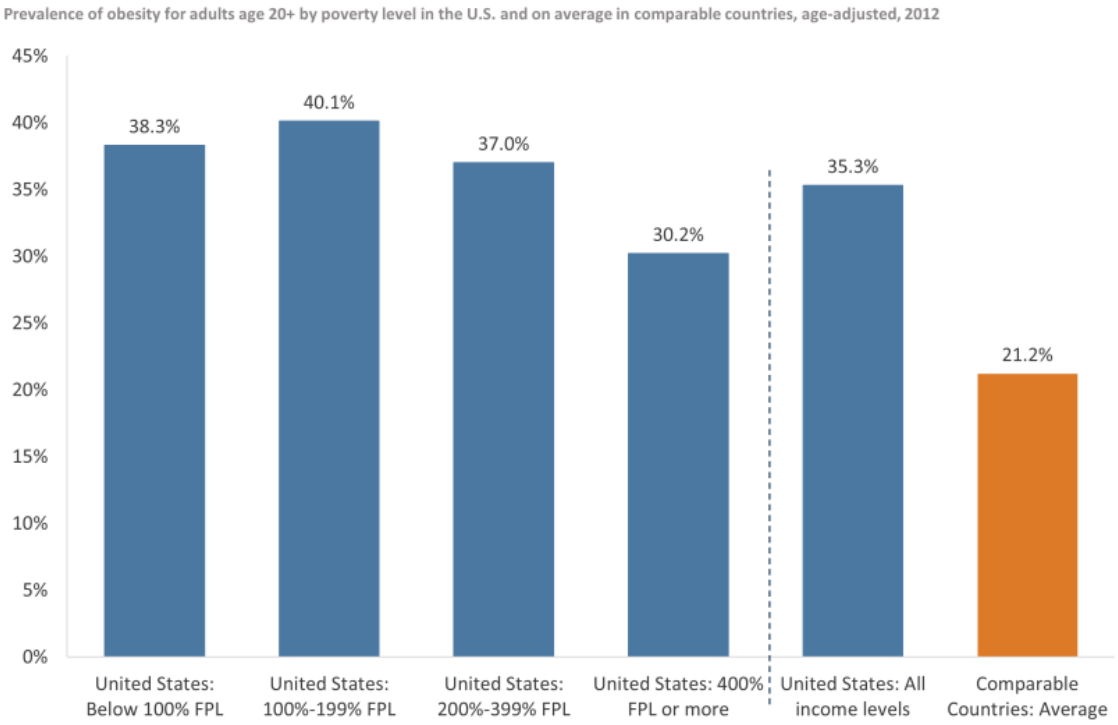
Hispanics and non-Hispanic blacks in the U.S. have a significantly higher prevalence of obesity than non-Hispanic whites in the U.S. As obesity is one of the most important risk factors for several diseases and mortality in general, improvements in obesity among blacks and Hispanics could reduce other disparities in health outcomes. Even so, it is worth noting that whites in the U.S. have higher obesity rates than the prevalence for comparably wealthy and sizable countries for which data is available.

Income level may contribute to the higher prevalence of obesity in the United States than in similar countries



Source: Data by poverty level are from CDC/National Center for Health Statistics, "Health, United States, 2014: With Special Feature on Adults Aged 55–64," available at http://www.cdc.gov/nchs/hus.htm; comparable country data are from OECD (2016), "Non-medical determinants of health", *OECD Health Statistics* (database). DOI: http://dx.doi.org/10.1787/data-00546-en (Accessed on 21 January 2016). **Note:** Comparable countries here include Australia, Canada, Germany, Japan, and the United Kingdom. Data for Australia are for 2011 and data for Canada are for 2013.

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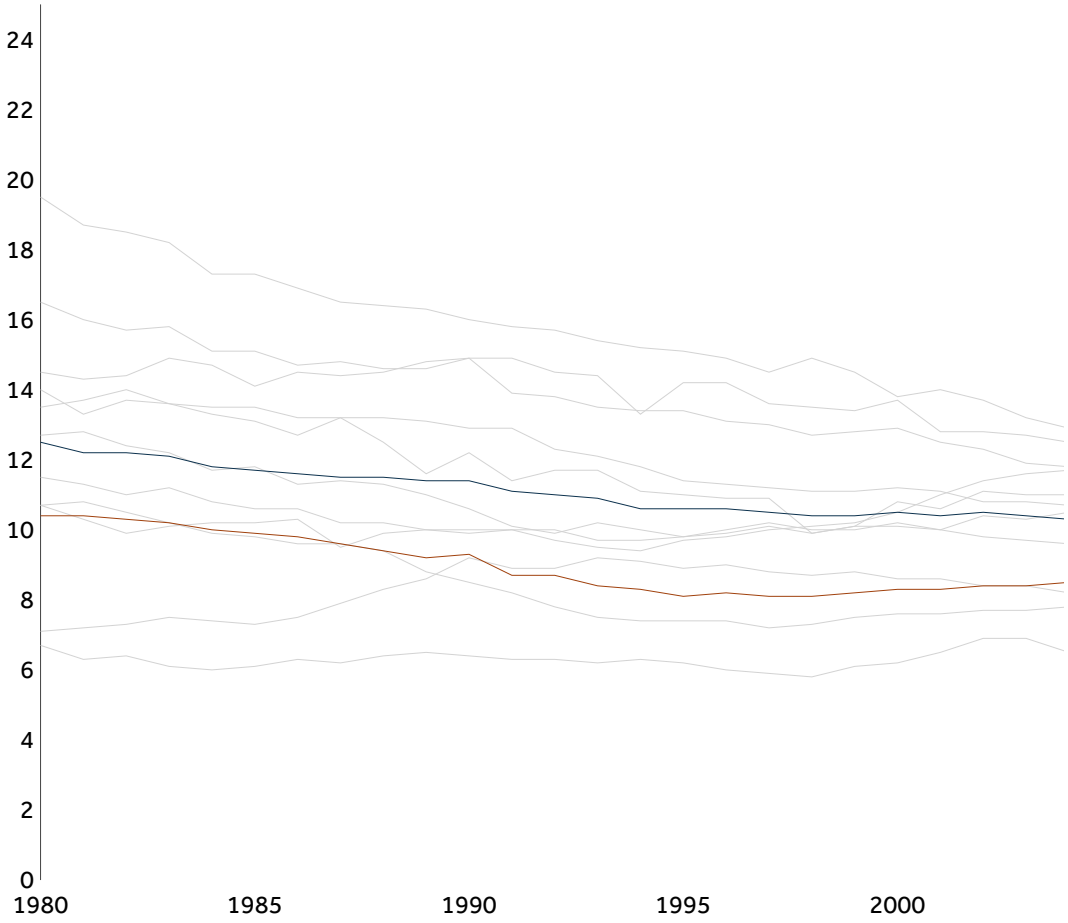
In the U.S., lower-income groups have higher rates of obesity than higher-income Americans.

The U.S. has consistently had lower average alcohol consumption than most comparable countries

Liters consumed per capita, age 15+, 1980-2012



Source: Kaiser Family Foundation analysis of data from OECD (2015), "OECD Health Data: Non-Medical Determinants of Health", OECD Health Statistics (database). doi: 10.1787/data-00546-en (Accessed September 29, 2015). Note: Data for Austria were unavailable for 2012, so data from the previous year are shown.

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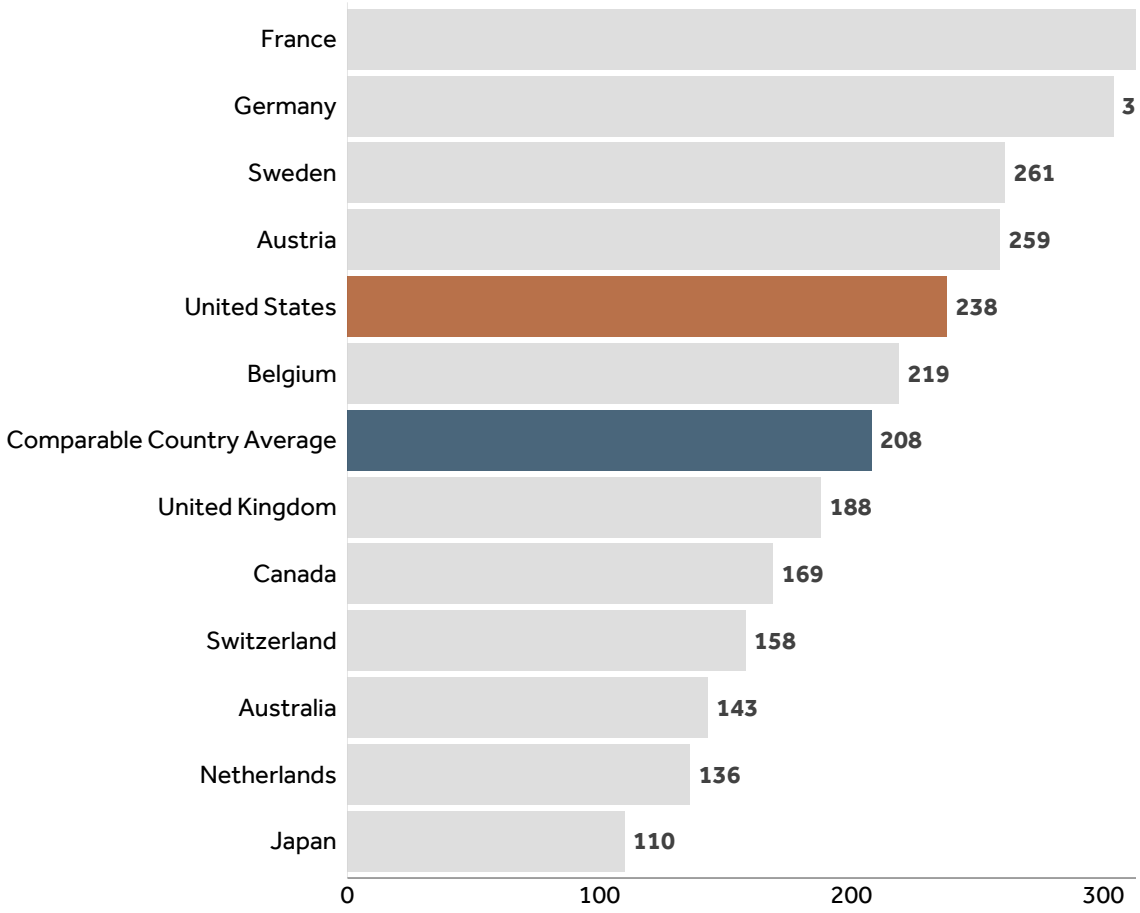
In terms of liters per capita, people in the United States consume less alcohol on average than those in comparable countries. However, research has shown that in countries where alcohol consumption is more restricted and less frequently integrated into meals and other daily activities - as is the case in the U.S., Canada, and much of Scandinavia - more people tend to abstain from drinking, but those who drink alcohol do so more heavily and are more likely to become intoxicated.

Disease burden from alcohol abuse disorders is higher than average in the U.S.

Age-standardized Disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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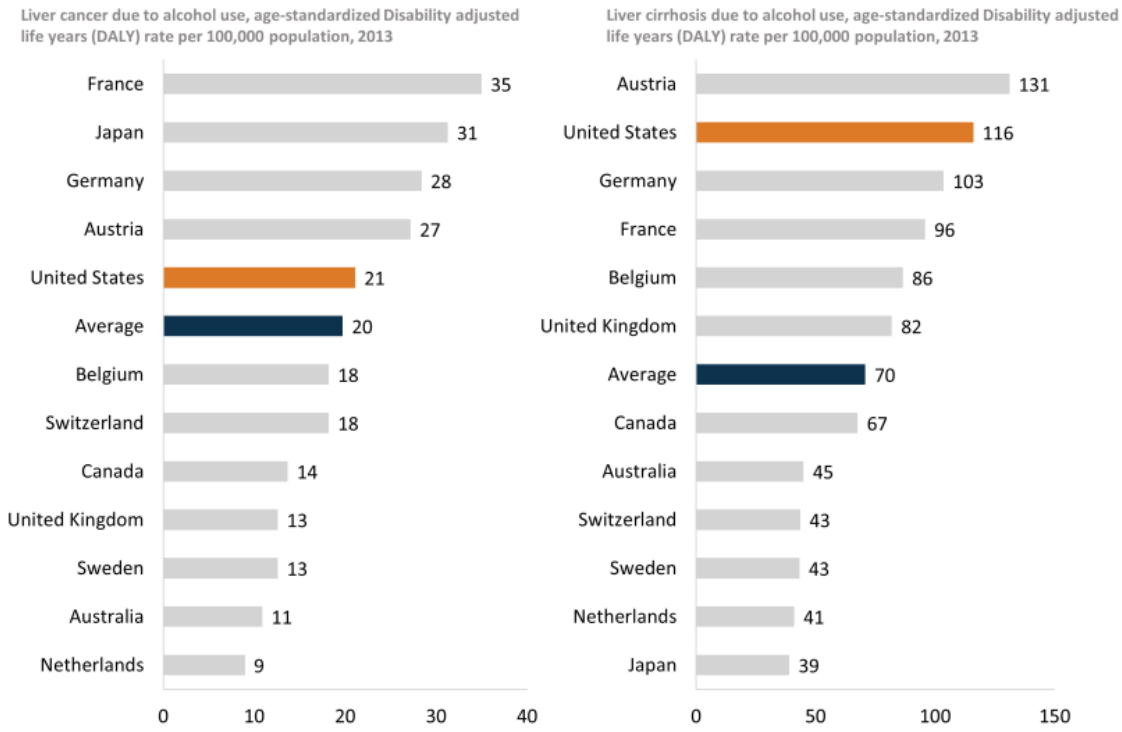
When we consider disease burden, alcohol abuse disorders have a higher than average impact on years of life lost to disability and death in the U.S. compared to other high-income countries.

The U.S. has higher than average disease burden caused by liver conditions due to alcohol use



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015). **Note:** "Average" is the simple average of the comparable countries shown above. Comparable countries are defined as those with above median GDP and above median GDP per capita in at least one of the past ten years.

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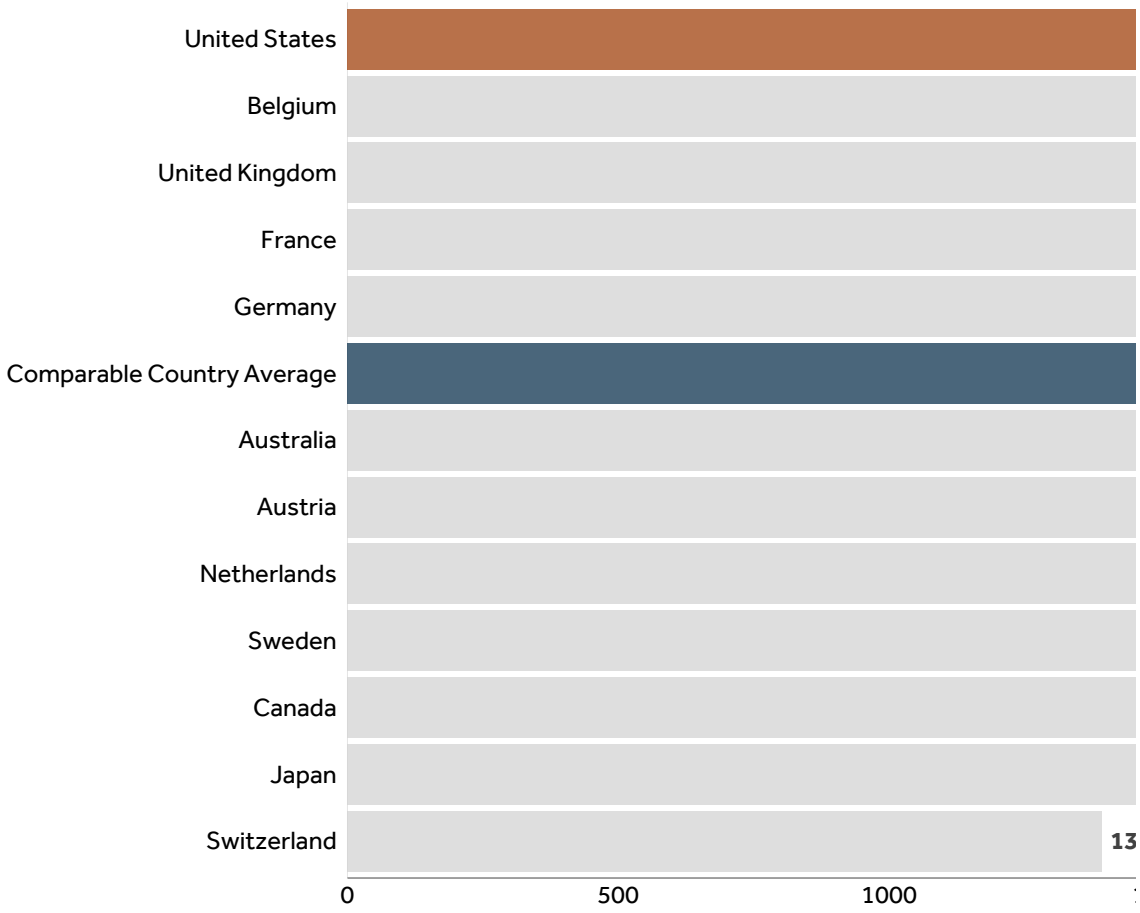
The U.S. has a higher DALY rate per 100,000 population for both liver cancer due to alcohol use and liver cirrhosis due to alcohol use.

The U.S. has the highest environmental burden of disease compared to other high-income countries

Total environment attributable DALYs per 100,000 capita, 2004



Source: Kaiser Family Foundation analysis of data from the WHO Global Health Observatory Data Repository. Available at: http://apps.who.int/gho/data/node.main.162?lang=en (Accessed on November 22, 2015).

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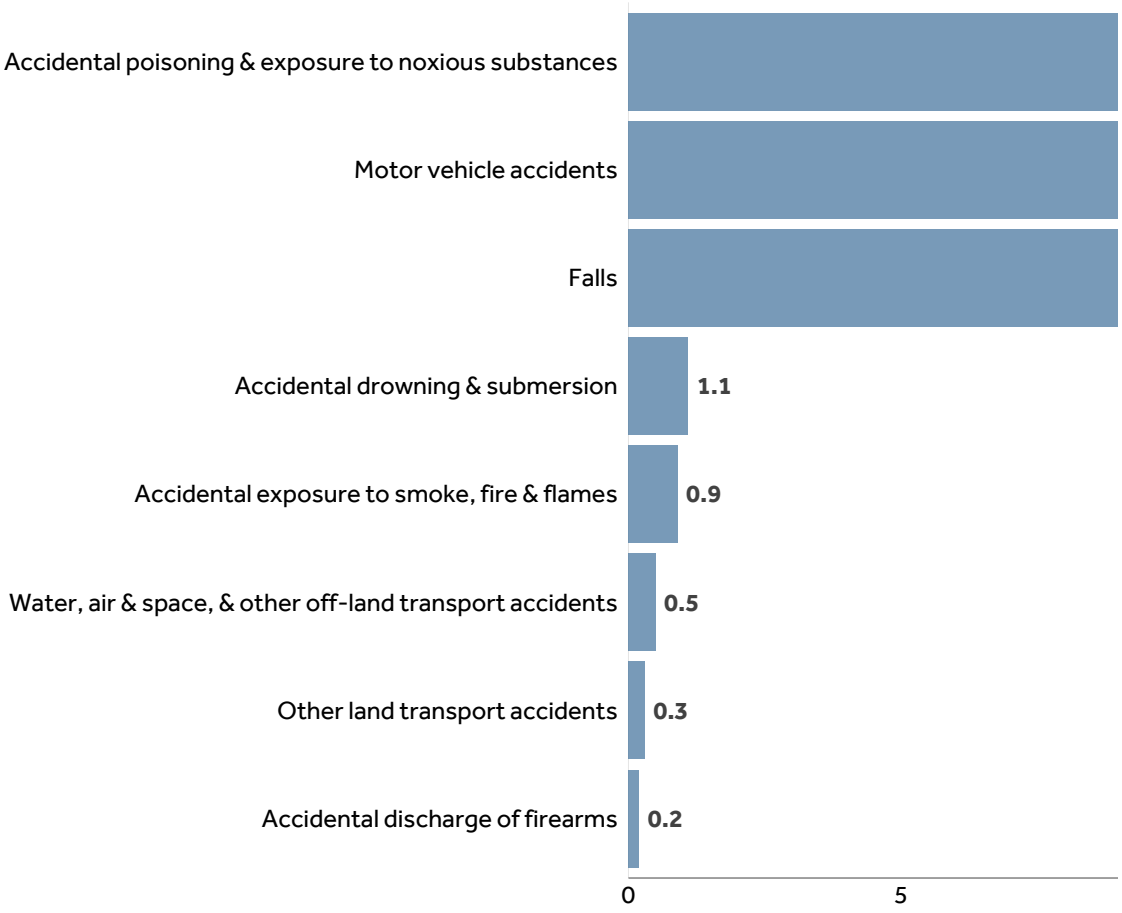
The World Health Organization quantified the effect of environmental factors, such as pollution, occupational risks, agricultural methods, climate change, and food contamination. Taken together, these factors present a higher burden of disease in the U.S. (1,861 DALYs per 100,000 capita) than in comparable countries, whose average environmental burden of diseases is 1,590 DALYs per 100,000 capita.

Poisonings, car accidents, and falls are the leading causes of accidental death in the United States

Mortality rate per 100,000 population, by cause of death, 2013



Source: CDC (2013). Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

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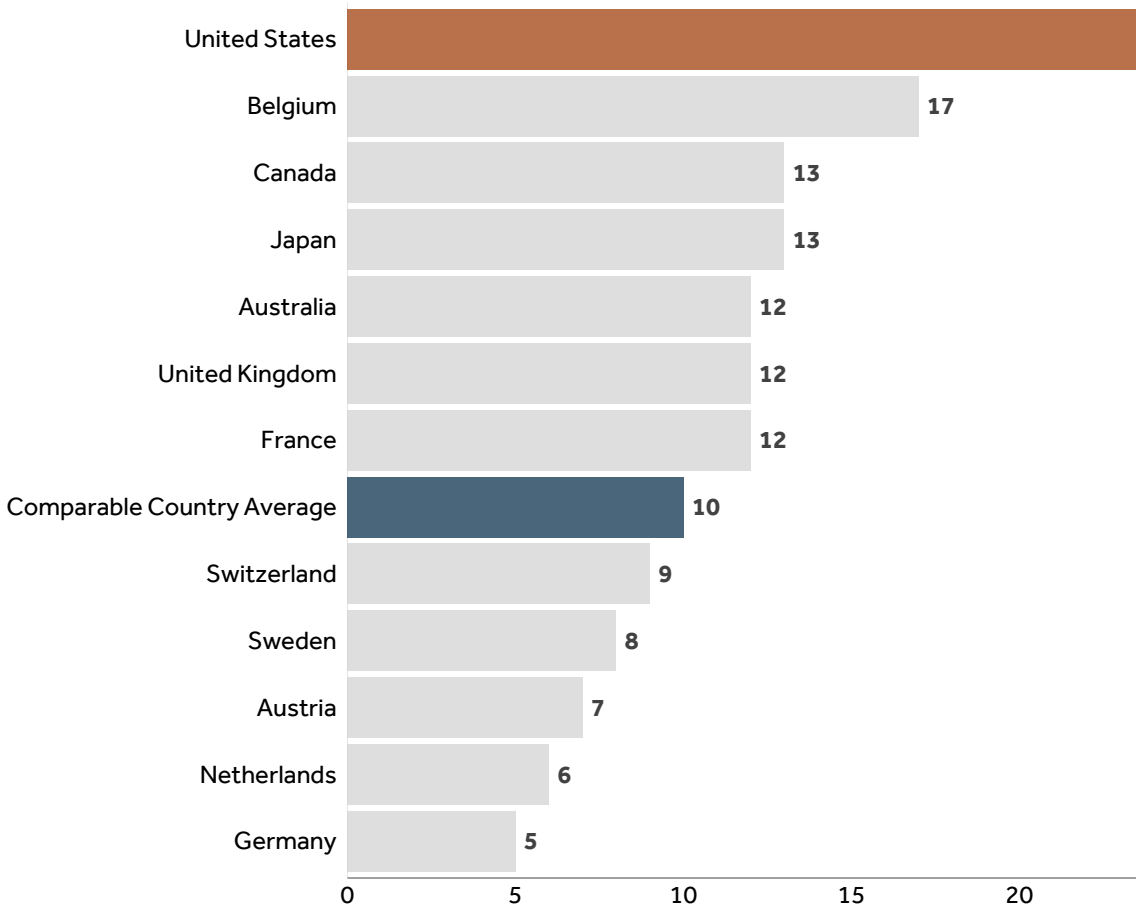
External causes (such as accidents, suicides, and violence) are the fourth leading cause of death in the U.S., and are more common than in comparable countries. According to data from the Centers for Disease Control and Prevention, unintentional poisonings (often due to prescription drug overdose) are the leading cause of accidental death in the United States, followed by motor vehicle accidents and falls.

Accidental poisonings lead to more than twice the years of disability in the U.S. than in comparable countries

Age-standardized Disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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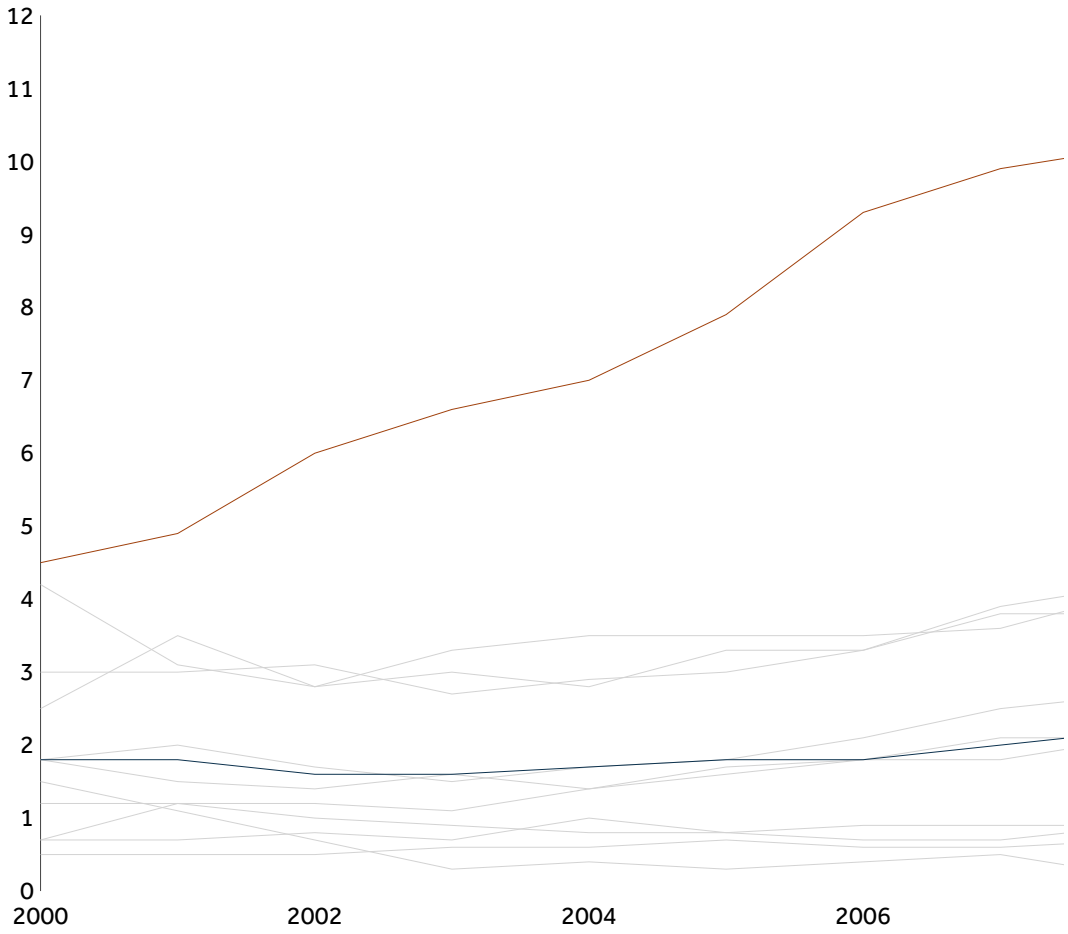
In the U.S., the DALY rate per 100,000 population for unintentional poisonings is the highest of all comparable countries. 27 years of life per 100,000 people are lost to disability and death from accidental poisonings in the U.S., as compared to 10 years in comparable countries.

Relative to comparable countries, the U.S. has higher rates of death from accidental poisonings, such as drug overdoses

Standardized mortality rate for accidental poisonings per 100,000 population, 2000-2010



Source: Kaiser Family Foundation analysis of 2013 OECD data: OECD Health Statistics (database). doi: 10.1787/data-00540-en (Accessed on December 15, 2015). Notes: Where data were unavailable (United Kingdom in 2000 and Australia for 2005), the previous year's data were used. Data for Switzerland omitted. Break in series for Austria in 2002, Canada and France in 2000, and the United Kingdom in 2001.

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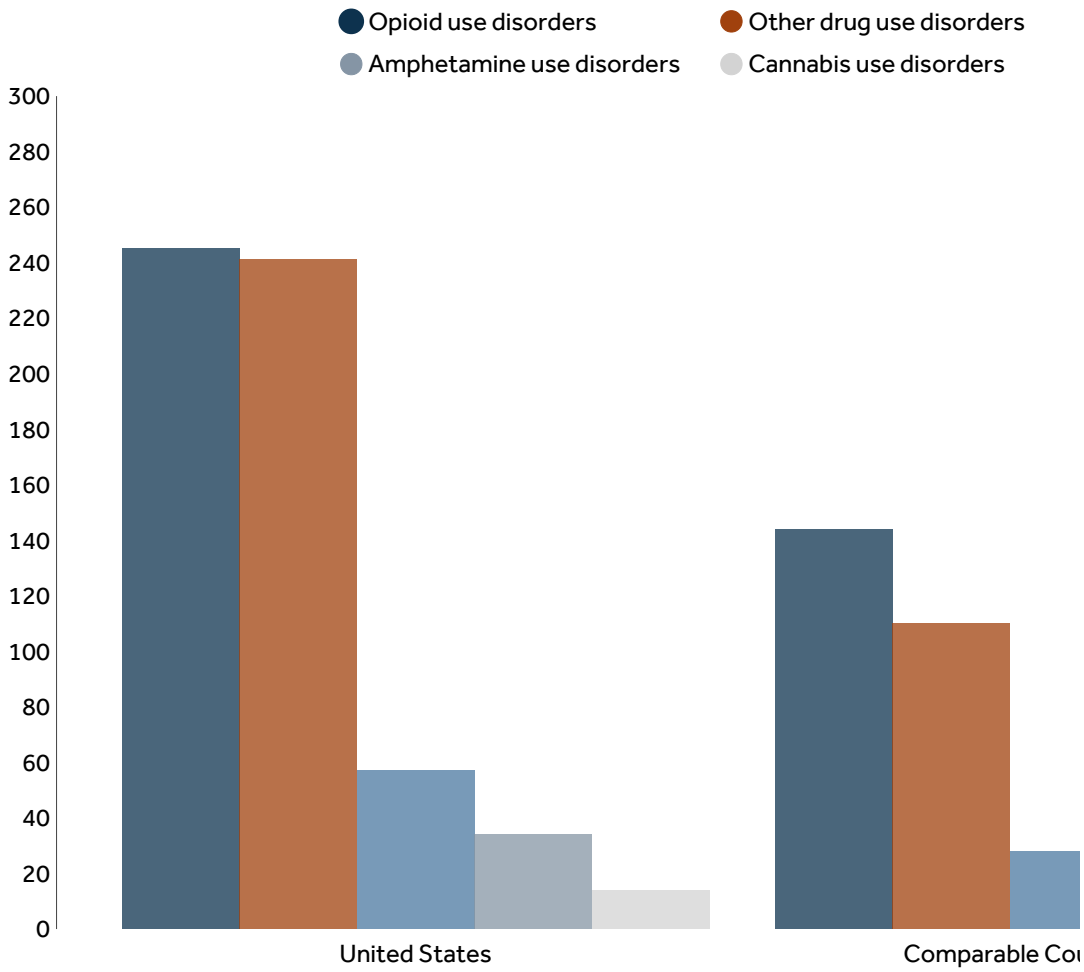
The U.S. had a higher than average mortality rate from accidental poisoning in 2000. Over time, the U.S. has become an outlier, now with far higher death rates from accidental poisoning than any comparable country. According to the CDC, in 2013, opioid pain killers were involved in 37% of drug poisoning deaths.

Disease burden from drug abuse disorders is higher in the U.S. than in comparable countries

Age-standardized Disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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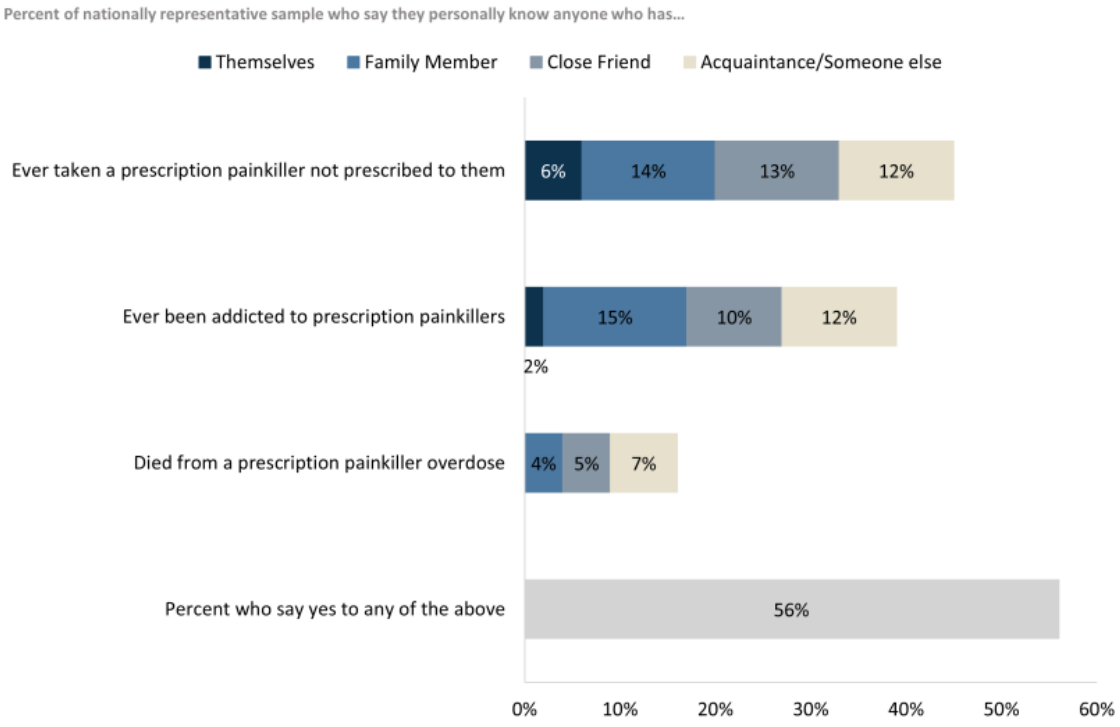
Data from the Institute for Health Metrics indicate that the U.S. has a higher rate of DALYs per 100,000 people due to drug abuse disorders than the comparable country average. Opioid use disorders in the U.S. result in more than double the rate of disease burden than in comparable countries.

56 percent of people in the U.S. report having a personal connection to prescription painkiller abuse



Source: Kaiser Family Foundation. Kaiser Health Tracking Poll: November 2015. Available at: http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2015/

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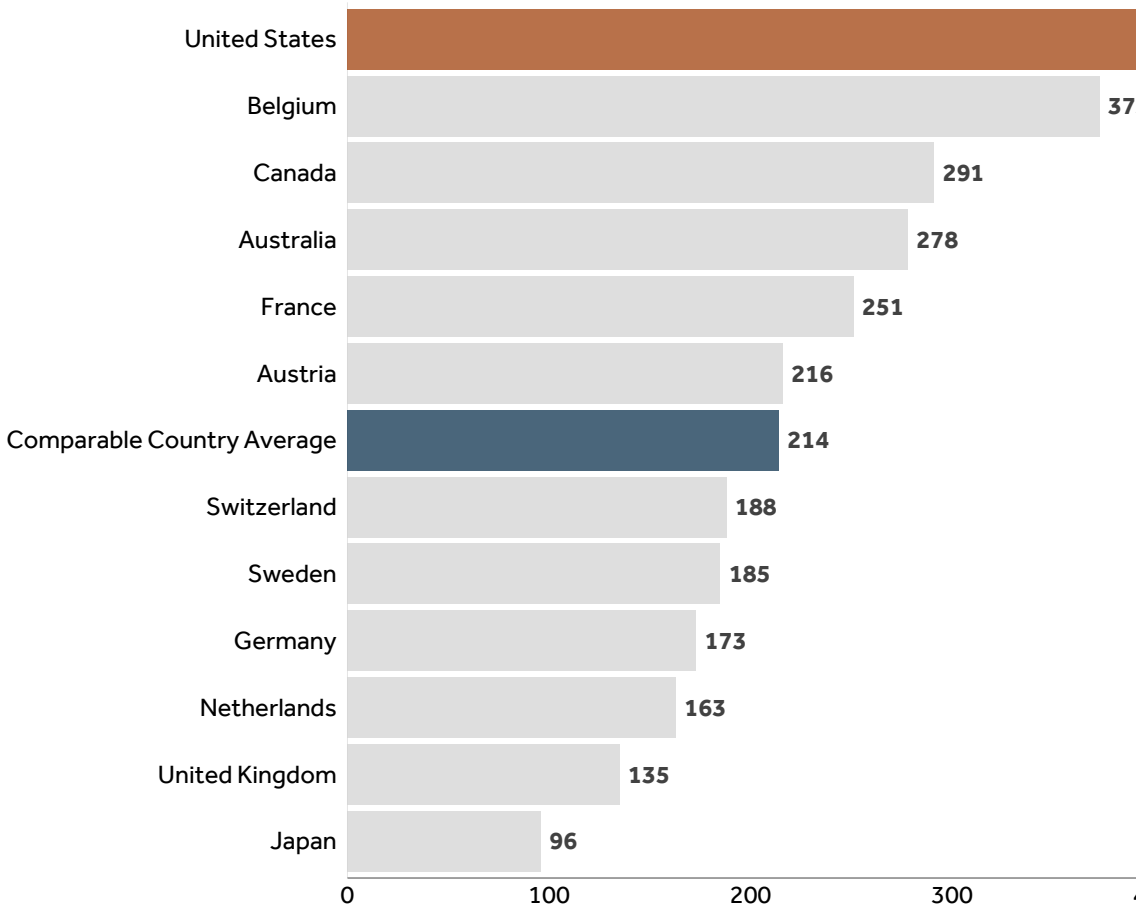
Prescription painkillers have recently been brought to nationwide attention as a leading cause of accidental poisonings and thus of accidental deaths. A November 2015 Kaiser Family Foundation poll found that 56 percent of people in the U.S. report having at least one personal connection to prescription painkiller abuse, either through taking one not prescribed to them or experiencing addiction to one themselves, or through knowing someone who has done either or has died from prescription painkiller overdose. Sixteen percent report knowing a family member, close friend, or someone else who has died from such an overdose.

The U.S. has the highest disease burden from motor vehicle road injuries

Age-standardized Disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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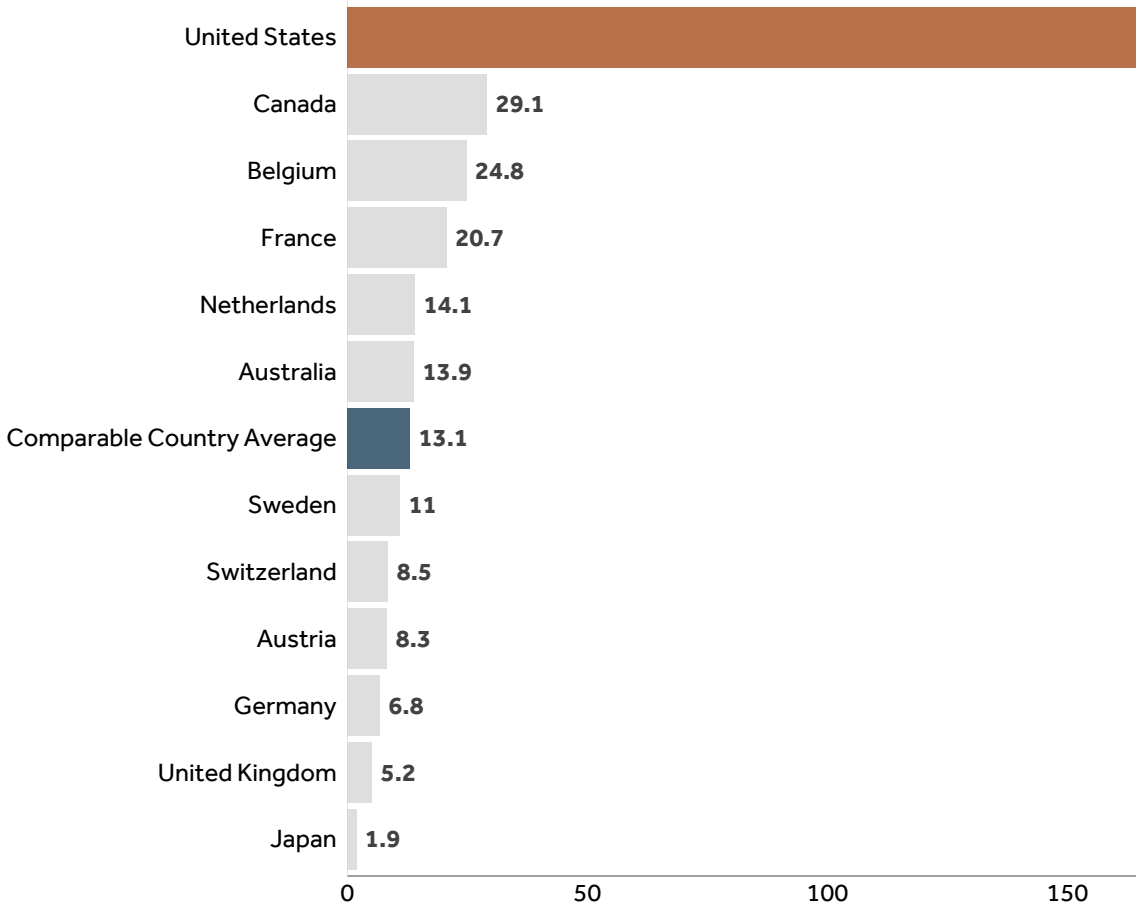
After poisonings (which includes drug overdoses), the next leading cause of accidental death in the U.S. is motor vehicle accidents. The DALY rate per 100,000 people due to motor vehicle road injuries is 462, more than double the average rate for comparable countries on average.

The U.S. has the highest rate of years of life lost to disability and premature death due to firearm assaults

Age-standardized Disability adjusted life years (DALY) rate per 100,000 population, 2013



Source: Kaiser Family Foundation analysis of data from the University of Washington Institute for Health Metrics and Evaluation. Available at: http://ghdx.healthdata.org/global-burden-disease-study-2013-gbd-2013-data-downloads (Accessed on November 23, 2015).

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In addition to accidental death, violence is another type of death due to external causes. In the U.S., 206 years of life per 100,000 people are lost to disability and premature death as a result of assault by firearm - almost 16 times the comparable country average of 13 years of life per 100,000 people.

CHART COLLECTIONS

How has health spending changed over time?
(http://www.healthsystemtracker.org/chart-collection/how-has-health-spending-changed-over-time/)

What are recent trends in cancer spending and outcomes?
(http://www.healthsystemtracker.org/chart-collection/what-are-recent-trends-in-cancer-spending-and-outcomes/)

How much is health spending expected to grow?
(http://www.healthsystemtracker.org/chart-collection/the-latest-health-spending-projections/)

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